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DSM-5 and Bereavement: The Loss of Normal Grief?

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The mood disorder work group has proposed to eliminate the bereavement exclusion criterion from the diagnosis of major depression in the 5th edition of the American Psychiatric Association's (2012) *Diagnostic and Statistical Manual of Mental Disorders.* The proposal would break tradition with the long-held distinction between depression and normal bereavement. This article reviews the development of the bereavement exclusion, discusses evidence for and against the proposal, and offers some relevant implications for counselors in light of the research on depression and bereavement.

Keywords: *DSM-5*, bereavement exclusion criterion, grief, major depression, diagnosis.

The American Psychiatric Association (APA, 2012) mood disorder work group has proposed to eliminate the bereavement exclusion from the criteria for classification of a major depressive episode in the upcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) to be published in May 2013. The term *bereavement* refers to the grief reaction associated with the loss of a loved one. The aim of the bereavement exclusion was to help counselors identify individuals who are experiencing normal grief reactions to a loved one's death and avoid misdiagnosing them with major depression.

The mental health community has recognized the qualitative difference between depression and grief since antiquity, long before the exclusion criterion surfaced in the *DSM* terminology (Wakefield, Schmitz, First, & Horwitz, 2007). However, the *DSM-5* mood disorder work group proposed to revise the current distinction between bereavement and major depression, arguing that there is insufficient evidence to suggest that bereavement is a unique stressor (Zisook & Kendler, 2007). On the other hand, notable figures like Allen Frances, Chair of the *DSM-IV* Task Force, have warned that revising over 30 years of clinical work may not only lead to the medicalization of normal grief, but also exacerbate mental health costs because of overdiagnosis of major depression (Frances, 2010).

Eliminating the bereavement exclusion has implications for how counselors conceptualize and treat both bereavement and major depression. Diagnosing bereavement as depression may run the risk of pathologizing the cultural norms established for individuals who grieve the death of a loved one. However, counselors who fail to recognize the sometimes harmful extremes of a grief response risk dismissing the serious signs of major depression as a normal part of the mourning process.

Despite this revision's potential to introduce great change in the delivery of mental health services, it has yet to receive any attention in the peer-reviewed counseling journals. Furthermore, the counseling profession lacks a voice in the research and decision-making process of the *DSM-5*, and advancing this discussion within the counseling literature may help resolve this dilemma for the profession. The purpose of this article is to present information related to the *DSM-5* mood disorder work group's proposal to eliminate the bereavement exclusion. This article will review the development of the bereavement exclusion criterion, discuss the evidence and arguments for both eliminating and retaining the criterion, and offer some implications for counselors awaiting the release of the *DSM-5*.

Bereavement Exclusionary Criterion

Since its first appearance in the *DSM-III* (APA, 1980), the criteria for a major depressive episode has included an exclusionary criterion that requires counselors to *not* diagnose major depressive episode if an individual's depressive symptoms can be better accounted for by bereavement. Lamb, Pies, and Zisook (2010) observed that the *DSM-III* and subsequent editions sought to create a diagnostic system that was not partial to any theory of psychopathology and instead focused on the "intensity and duration of symptom patterns and on significant distress or dysfunction" (p. 20). Unless the bereft individual's symptoms matched the *DSM-III's* description of "severity, duration, and clinically significant distress or impairment" (Lamb et al., 2010, p. 20) for a major depressive episode, then the exclusion criterion defined the experience as a normal reaction to loss. The exclusion criterion narrowed between the *DSM-III-R* (APA, 1987) and the *DSM-IV* (APA,

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1994), by shortening the time frame to 2 months (previously 1 year), requiring (previously suggesting) a diagnosis of major depression if a single exclusion symptom was present, and adding psychosis to the list of complicating symptoms (Wakefield, Schmitz, & Baer, 2011). The aim of the bereavement exclusion was to identify and avoid misdiagnosis of individuals who are experiencing normal grief reactions to a loved one's death.

Lamb et al. (2010) explained that the reasoning behind the exclusion criterion was based primarily on empirical investigations of grief during the 1960s and 1970s, which found that normal reactions to grief often symptomatically resemble a major depressive episode. For example, Paula Clayton and colleagues published a series of studies in the 1970s documenting the high prevalence of major depressive syndromes occurring during bereavement. Three of these studies were particularly influential in creating the bereavement exclusion for the *DSM-III* (see Clayton, 1974; Clayton, Desmarais, & Winokur, 1968; Clayton, Herjanic, Murphy, & Woodruff, 1974). In general, Clayton and colleagues found that despite the similar symptoms between participants suffering from bereavement and participants diagnosed with depression, one distinguishing characteristic was the duration of both groups' symptoms. A significant majority of participants mourning the loss of a loved one experienced symptom relief within several weeks (6 to 10), whereas participants suffering from depression took longer. Also, they found that bereft individuals experienced significantly less suicidal ideations and feelings of guilt. Last, they found that normal bereavement is accompanied by three primary symptoms: (a) depressed mood, (b) sleep disturbance, and (c) crying, along with three secondary symptoms that include (a) difficulty concentrating, (b) loss of interest in television and news, and (c) anorexia and/or weight loss. In reexamining these earlier findings, Clayton (2010) stated,

> I conclude that the usual bereaved individual has many of the symptoms of major depression in the first months after the loss. These symptoms typically dissipate slowly over time, but even at their worst, most do not have suicidal thoughts, feelings of worthlessness, or self-deprecation, and they do not have psychomotor retardation. (pp. 359–360)

From the foundational studies by Clayton and colleagues, the *DSM-III* created the bereavement exclusion for what they believed to be a normal response to loss that has remained in the manual up until its most recent edition. In the *DSM-IV-TR* (APA, 2000), to be diagnosed with major depressive episode, one must meet at least five of the following nine criteria: (a) feeling sad or depressed, (b) anhedonia, (c) decreased appetite or weight loss, (d) sleeping more or less than normal, (e) psychomotor retardation, (f) loss of energy, (g) feeling worthless or guilty, (h) inability to think or concentrate, and (i) suicidality. However, Criterion E, referred to as the bereavement exclusion criterion, prohibits diagnosis of major depression if the client has also experienced the loss of a loved one within the past 2 months or if his or her symptoms are "characterized by functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation" (p. 356). The wording of Criterion E echoes the earlier findings of Clayton and colleagues (e.g., Clayton, 1974; Clayton et al., 1968, 1974). As Wakefield et al. (2007) asserted, the purpose of the exclusion criterion was to avoid the potential of false positive diagnoses of major depression, meaning it prevents clinicians from defining a normal experience as pathological. However, the validity of this exclusionary criterion has been called into question by research investigating the commonalities and differences between bereavement and major depression.

Support for Removing the Bereavement Exclusion

The *DSM-III* considered bereavement to be a different construct from clinical depression, and this distinction has persisted up until its more recent edition, the *DSM-IV-TR*. A criticism of the bereavement exclusion is that other major life stressors (e.g., illness or divorce) may predispose individuals to depression, yet they are not included as exclusionary factors (Kendler, Myers, & Zisook, 2008). In an argument for removing the bereavement exclusion, Kendler (2010), a member of the *DSM-5* mood disorder work group, stated that individuals who suffer other severe life stressors, such as illness, divorce, physical assault, rape, and job loss, are as likely to develop major depression as those suffering bereavement, yet these stressors are not grounds for exclusion of a major depression diagnosis. The current revision of the *DSM* seeks to amend what previous editions held as a special exception in the clinical presentation of depression.

The *DSM-5* mood disorder work group based its rationale for eliminating the bereavement exclusion criterion primarily on a meta-analysis conducted by Zisook and Kendler (2007). They found significant empirical support to suggest that bereavement and depression are similar syndromes, and this conclusion was bolstered by a similarly designed meta-analysis by Zisook, Shear, and Kendler (2007). For example, they found that both bereavement and major depression are especially prevalent in young people who have past individual or familial histories of depression, poor social support systems, and poor physical health. In addition, they found that bereavement and major depression have similar symptomatology: They are both characterized by impaired psychosocial functioning, comorbidity with other mood disorders, feelings of worthlessness, suppressed immune function, sleep disturbance, psychomotor changes, and suicidality. From a biological perspective, bereavement and depression both increase adrenal cortical activity and decrease immune system functioning, and both respond to antidepressant medication. Furthermore, Zisook

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and colleagues found that both bereavement and major depression respond to antidepressant medication. However, in both studies, the authors noted that the vast majority of the research they surveyed was conducted on participants after the 2-month exclusion period. Because they did not find many studies that included this critical time frame and compared the symptoms of grieving individuals before the 2-month exclusion period to similar participants diagnosed with major depression, they implored the research community to fill this important gap in the literature.

Even more recent research has added evidence to suggest that bereavement is a legitimate etiological contributor to major depression. Corruble, Chouinard, Letierce, Gorwood, and Chouinard (2009) found that the bereaved participants had more severe symptoms of depression, including more suicidal ideations, thoughts of worthlessness, apparent sadness, reported sadness, reduced sleep, reduced appetite, weight disturbance, inability to feel, and pessimistic thoughts, compared with participants who suffered from major depression. Furthermore, they found that participants who were excluded from a diagnosis of major depression due to bereavement were more depressed and had more suicidal thoughts and thoughts of worthlessness than matched control participants who were diagnosed with major depression. In fact, clinicians were unable to distinguish between participants suffering from bereavement and matched participants with a diagnosis of major depression. Kendler et al. (2008) came to similar conclusions. They found no significant difference between bereft participants and depressed participants in terms of the number of prior depressive episodes; frequency of severe impairment; severity of the depressive episode; risk of future depressive episodes; suicidal ideation; changes in appetite, sleep, and concentration; and pattern of comorbidity with other psychiatric disorders. Of particular interest was the finding that participants with bereavement and participants with depression were equally symptomatic using *DSM-IV* criteria for major depression. However, Kendler et al. did find that participants with bereavement were significantly less likely to feel guilty than their depressed counterparts.

Kessing, Bukh, Bock, Vinberg, and Gether (2010) added another dimension to the literature by investigating if there was a difference among individuals who experienced their first episode of depression (a) with bereavement, (b) from other stressful life events, and (c) without stressful life events. They found that the differences among the groups were minimal. In fact, when bereaved participants were matched to participants with depression related to another stressful life event, there was no significant difference when comparing age, gender, level of education, work status, or marital status. Likewise, when the authors matched bereavement-related depression to depression without a significantly stressful life event, the only difference was that participants with bereavement were significantly older. Also, they found only one significant difference between bereaved participants and participants with depression from other stressful life events: Bereaved individuals were more likely to be diagnosed with depressive personality disorder. Perhaps the most significant finding from their study was the discovery that participants from all three groups did not differ significantly based on clinical setting (inpatient vs. outpatient) and symptom presentation, including (a) severity of depression according to the *International Statistical Classification of Diseases and Related Health Problems* (World Health Organization, 2008); (b) melancholic, psychotic, or atypical features; (c) suicidal ideations; (d) comorbid diagnosis; (e) diagnosis of Clusters A, B, or C personality disorders; (f) rate of symptom reduction after first antidepressant treatment; and (g) scores on a number of diagnostic inventories.

First (2011) gave a cost-benefit analysis of including bereavement as a source of major depressive disorder in the *DSM-5*. The first benefit is logical consistency with other major components of the disorder. Currently, depressive symptoms due to other significant losses, such as a job or a relationship, are not grounds for exclusion in the diagnosis of major depression. This raises the following question: What makes bereavement a normal response when it shares so many similar symptoms with other forms of depression? The second benefit is reducing false negative diagnosis of major depressive disorder. If bereavement prevents clients from being diagnosed with major depressive disorder, it follows that there is a potential for clinicians to withhold needed treatment for a client no matter how "abnormal" their response is to a death. Similarly, Shear et al. (2011) argued, on the basis of professional experience and a study by Johnson et al. (2009), that people recovering from grief often experience a sense of liberation when their problem is diagnosed and then treated thoroughly. Last, adding bereavement to the *DSM's* list of mental disorders would allow clients to not only receive treatment for it, but also enable them to receive insurance reimbursement for services.

Support for Keeping the Bereavement Exclusion

Pies (2009b) directed the discussion surrounding the exclusion criterion to phenomenological research that maintains that there is still a qualitative difference between bereavement and depression despite accumulating quantitative evidence to the contrary. For instance, Pies observed that, when people experience the sorrow of loss, they are able to feel an intimate connection to the people around them, whereas in depression, they tend to feel socially exiled or isolated. Bereavement is characterized by an outward focus, whereas depression may be called a "morbid preoccupation with *me*" (p. 39). Pies also argued that phenomenological research has demonstrated that, in bereavement, people believe that their sorrow is temporary and that they will eventual experience relief. In contrast, depression retains a sense of permanence: The sadness will

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last into the foreseeable future without a cure. Again, Clayton (1974) finds relevance, in particular, in that bereft individuals tend to view their subjective experience as normal and fitting to their context, whereas depression is viewed as a departure from the norm. In addition, Clayton noted that individuals in mourning are a less likely to seek clinical help for the symptoms compared with their depressed counterparts.

Maj (2008) noted that past research into bereavement and depression may be lacking a key methodological qualification. The death of a loved one represents a clear, discernible life event that is outside of a person's ability to control. However, depression attributed to other stressful life events may lack these qualities. For example, the depressive state can exaggerate a person's recall of negative contributing factors to their emotional disturbance (Cohen, Towbes, & Flocco, 1988) and influence their exposure to negative events that will maintain or worsen their depressive symptoms (Williamson, Birmaher, Anderson, & Al-Shabbout, 1995). Furthermore, the grief reaction is such a complex phenomenon with multiple varied responses, it is challenging to standardize methodologically (Howarth, 2011). These findings call into question the validity of comparing bereavement to depression given that it is difficult to ascertain which came first, the depressive emotional state or the attributed cause, when the depressive episode is not linked to a clearly defined event, such as the death of a loved one, and when the experience is so difficult to control for in experimental research.

Zisook and Shear (2009) acknowledged that, even though bereavement and depression share similar symptomatology, the two are not necessarily the same syndrome. For instance, in their meta-analysis of bereavement, they found that, despite the fact that people experiencing the loss of a loved one undergo intense sadness, most do not fit the *DSM-IV-TR* criteria for major depression. Furthermore, they found that grief is a conglomeration of positive and negative emotions that are most intense at the beginning of the grief cycle. However, these episodes of intense affect are more variable and more spread out as time progresses, and these episodes are often determined by internal and external reminders of the deceased. In contrast, depression "tends to be more pervasive and is characterized by significant difficulty in experiencing self-validating and positive feelings" and "is composed of a recognizable and stable cluster of debilitating symptoms, accompanied by a protracted, enduring mood" (p. 70). However, Zisook and Shear also warned about the potential for bereavement to develop into major depression that often accompanies premature death through suicide. For clinicians to dismiss major depressive symptoms in the context of human loss can not only delay symptom relief by withholding adequate treatment but can also be potentially fatal. Therefore, they recommended treating bereavement in a similar fashion to depression to prevent missing any important warning signs of suicidality.

There is also evidence to suggest that not only is bereavement a different construct from major depression, but that there is a another construct that further distinguishes them symptomatically, called *complicated grief* (Boelen & van den Bout, 2005; Phillips, 2010). Fujisawa et al. (2010) defined complicated grief as "a deviation from the normal grief experience in terms of either the time course, intensity, or both" (p. 352). Shear et al. (2011) acknowledged that research in bereavement has convincingly shown that grief is a normal experience and should not be considered pathological. However, they argued that research has also shown that grief can be "complicated, much as a wound healing can be complicated, such that intensity of symptoms is heightened and their duration prolonged" (p. 104). Though there is variability in the conceptualization of complicated grief, Howarth (2011) argued that the common factor connecting each perspective of complicated grief is that the grieving process is interrupted and never reaches a resolution. In the past, strong evidence in favor of the legitimacy of this construct has led some to believe that it deserves representation in the *DSM* (Horowitz, Bonanno, & Holen, 1993). This conceptualization of complicated grief supports the need for a distinction between bereavement and a major depressive episode by demonstrating that, when grief becomes intense, it is still unique enough to warrant a differential diagnosis. For instance, Shear et al. (2011) concluded that complicated grief is "a condition with a unique constellation of symptoms, unique risk factors and course of illness that requires a specific targeted treatment" (p. 112). In line with earlier conclusions, they went on to contend that there is enough evidence to include complicated grief in the *DSM-5*. In other words, grief is not a form of depression; rather, it can become severe enough to be pathological yet unique enough to be differentiated from a major depressive episode.

First (2011) identified potential drawbacks to the proposal to remove the bereavement exclusion. For example, there is a potential for exaggerating false positives by including bereavement and pathologizing a normal human process. First contended, "The cost to the individual patient involves the risk of having a normal grief reaction misdiagnosed as a major depressive episode, which may result in unnecessary treatment, stigmatization, and other negative discriminatory effects" (p. 9). Wakefield et al. (2011) found that there might be empirical evidence that adds some substance to this fear. Given that the diagnostic threshold for bereavement-related depression lowered substantially from the *DSM-III-R* to the *DSM-IV*, they compared the rates of false negative and false positive diagnoses of major depression in instances of bereavement using both editions' criteria sets. They found that, by narrowing the bereavement exclusion in the *DSM-IV*, the diagnosis of major depression became less valid by increasing the rates of false positive diagnoses. They forecasted that removing the exclusion criteria altogether may make it less valid still. Second, First observed that taking away the bereavement exclusion could further encourage clinicians to regard a major depressive disorder as an actual disease or a discrete category instead of recognizing that it simply

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describes a symptom cluster that happened to occur within a certain time frame.

Implications for Counselors

Research on bereavement and depression has demonstrated mixed results. However, it is true to the data to conclude that there are characteristics of both labels that are distinct (Clayton, 2010; Pies, 2009b; Zisook & Shear, 2009) and yet others that overlap (Corruble et al., 2009; Kendler et al., 2008; Zisook & Kendler, 2007; Zisook et al., 2007). There are also potential benefits and drawbacks to removing the bereavement exclusion for major depression (First, 2011). Whatever the case, there are two possible scenarios that await mental health professionals in the publication of the *DSM-5*: (a) the bereavement exclusion will remain unaltered or (b) it will be revised and, if so, most likely eliminated (Kendler, 2010). In either scenario, there are relevant implications for counselors in light of the current literature on bereavement and depression.

Culture plays a primary role in the process of grief, both in how the loss is mourned and in what is perceived as a loss (Prieto, 2011). In addition, Horwitz and Wakefield (2007) highlighted the importance of recognizing the cultural normality of bereavement. Death and the resulting process of grief is a universal human experience, and each culture has established a learned response pattern for what it considers to be normal bereavement. Removing the bereavement exclusion from the diagnosis of major depression may cause tension in a counselor's adherence to the *ACA Code of Ethics* (American Counseling Association, 2005) to provide clients with an accurate diagnosis (Standard E.5.a.) and yet respect cultural variability in providing that diagnosis (Standard E.5.b.).

As First (2011) observed, clinicians can drift to one of two extremes—underdiagnosis or overdiagnosis. If the *DSM-5* retains the bereavement exclusion, dismissing severe manifestations of depression on the grounds that it is a normal response to loss is clinically misleading and potentially life-threatening to the client (Zisook & Shear, 2009). It is critical for counselors to distinguish when grief goes beyond a normal reaction and becomes pathological, thus requiring a diagnosis of major depressive disorder. To do so, counselors need a clear understanding of what emotions and behaviors are normal given a particular context of human loss. For example, Horwitz and Wakefield (2007) argued that there are three vital elements that define a normal response to loss: (a) it is relative to the context, (b) it is approximately the same intensity as the antecedent loss, and (c) it dissipates as the circumstances change or as the person develops or implements copings skills to his or her new environment following the loss. At the same time, counselors would do well to remain vigilant during episodes of bereavement, because research has indicated that bereavement heightens the risk for developing mood disorders and exacerbates dysfunctional coping strategies, such as substance use (Prigerson et al., 1997).

Pies (2009a) cautioned clinicians against being overly simplistic in determining the causality of depression given its complex nature. Focusing on a single etiological cause, such as bereavement, for major depression can magnify its contribution to the client's distress to the neglect of vital co-occurring clinical data. Therefore, incorporating bereavement into the etiology of major depression may run the risk of counselors being trapped in what Pies termed a "convoluted feedback loop" (p. 2), where the search for the cause of a disorder, such as depression, circles back on itself as the clinician loses site of the severity of the client's distress. No matter what the cause may be for the depression, the client's level of distress is a key characteristic of any mental disorder and ultimately guides diagnosis and remediation (APA, 2000).

Conclusion

The *DSM-5* mood disorder work group has recommended eliminating the bereavement exclusion from the diagnosis of major depression. Earlier *DSM* editions included the bereavement exclusion criterion based primarily on the research of Clayton and colleagues (see Clayton, 1974; Clayton et al., 1968, 1974), who found significant differences in symptom presentations between bereaving individuals and individuals with depression. The *DSM-5* mood disorder work group proposed to break with tradition and cited research that found little distinction between bereavement and major depression, evidence that is inconsistent with earlier research into the nature of these two syndromes.

Some are concerned that this proposal will pathologize the normal reaction to a universal human experience—the death of a loved one. However, critics of the bereavement exclusion maintain that individuals who experience other life stressors are just as likely to develop a major depressive disorder as those mourning the death of a loved one (Kendler, 2010). Furthermore, there is evidence to suggest that individuals with depression stemming from other causes are not significantly different than people who are grieving when comparing a number of factors, including symptom presentation (Zisook et al., 2007).

Outside of the work group's stated rational, there is mounting evidence in the years since the *DSM-III* to add greater weight to the view that bereavement and depression are more alike than they are different. In addition, there are some anticipated benefits to revising the exclusion criterion, including logical consistency and the reduction of false negative diagnoses of major depression. However, there is reasoning and evidence to contradict this view. Phenomenological research has upheld the distinction between bereavement and depression by emphasizing the unique subjective experience that contrasts bereavement and depression. In addition, research has also found that, currently, most grieving individuals do not meet the *DSM-IV-TR* criteria for major depression and do not seek treatment. Evidence has also surfaced that suggests that

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bereavement and depression are further separated from each other on a continuum that is mediated by complicated grief. Just as there are potential benefits to removing the bereavement exclusion, there are also potential risks that include false positive diagnosis and misleading clinicians to believe that bereavement in the form of depression is a disease.

There are a number of implications for counselors in light of the research on bereavement and depression. Though conflicting evidence abounds, the clinical presentations of bereavement and depression share similarities yet possess unique differences. As First (2011) noted, counselors must avoid venturing into the two extremes of overdiagnosis and underdiagnosis; diagnostic inclusion or exclusion on the basis of bereavement presents unique challenges to practitioners in either scenario. Removing the bereavement exclusion criterion can create an ethical tension for counselors to be accurate in diagnosis while acknowledging the importance that culture plays in human behavior, especially a ubiquitous experience like the death of a loved one. Finding a balance between cultural sensitivity and accurate diagnosis is an ethical dilemma that counselors will continue to face in the publication of the *DSM-5*. However, research has also demonstrated that grief reactions can be intense to the point of threatening the life of the mourning individual. Rationalizing the client's level of distress as a normal reaction to grief can be harmful to the client. Similarly, searching for the cause of depression can detract attention from the client's distress and waste valuable time counseling that is better spent remediating the client's current level of distress.

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