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MOOD DISORDERS (SM STRAKOWSKI, SECTION EDITOR)

The Removal of the Bereavement Exclusion in the DSM-5: Exploring the Evidence

Alana Iglewicz · Kathryn Seay · Samuel David Zetumer · Sidney Zisook

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Abstract Since 1980, the DSM-III and its various iterations through the DSM-IV-TR have systematically excluded individuals from the diagnosis of major depressive disorder if symptoms began within months after the death of a loved one (2 months in DSM-IV), unless the depressive syndrome was 'severely' impairing and/or accompanied by specific features. This criterion became known as the 'bereavement exclusion'. No other adverse life events were noted to negate the diagnosis of major depressive disorder if all other symptomatic, duration, severity and distress/impairment criteria were met. However, studies since the inception of the bereavement exclusion have shown that depressive syndromes occurring after bereavement share many of the same features as other, non-bereavement related depressions, tend to be chronic and/or recurrent if left untreated, interfere with the resolution of grief, and respond to treatment. Furthermore, the bereavement exclusion has had the unintended consequence of suggesting that grief should end in only 2 months, or that grief and major depressive disorder cannot co-occur. To prevent the denial of diagnosis and the consideration of sometimes much needed care, even after bereavement or other significant losses, the DSM-5 no longer contains the bereavement exclusion. Instead, the DSM-5 now permits the diagnosis of major depressive disorder after and during bereavement and includes a note and a comprehensive footnote in the major depressive episode criteria set to guide clinicians in making the diagnosis in this context. The decision to make this change was widely and publically debated and remains controversial. This article reports on the rationale for this decision and the way the DSM-5 now addresses the challenges of diagnosing major depressive disorder in the context of someone grieving the loss of a loved one.

Keywords Major depressive disorder · MDD · Grief · Bereavement · Bereavement exclusion · DSM-5 · Diagnosis · Mood disorders · Psychiatry

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A. Iglewicz (✉) · S. D. Zetumer · S. Zisook
Department of Psychiatry, University of California, San Diego, 9500 Gilman Dr. #9116A, La Jolla, CA 92093, USA
e-mail: aiglewicz@ucsd.edu

A. Iglewicz · S. D. Zetumer · S. Zisook
Veterans Affairs San Diego Healthcare System and Veterans Medical and Research Foundation, La Jolla, CA, USA

K. Seay
University of California and San Diego State Joint Doctoral Program in Clinical Psychology and Veterans Medical, Education and Research Foundation, La Jolla, CA, USA

Introduction

One of the most contentious changes in the DSM-5 has been the removal of the bereavement exclusion (BE) from the diagnosis of major depressive disorder (MDD). For many of those in favor of retaining the BE, removing the BE became symbolic of the overarching concerns about the DSM-5—concerns regarding financial incentives and the respective medicalization of "normal" conditions. Part of the outcry against the decision to remove the BE is the concern that clinicians will now over-diagnose MDD, especially in individuals who are "just" grieving. The feared consequences of removing the BE include: 1) there will be a resultant explosion in the numbers of individuals diagnosed with MDD; 2) clinicians will be left with the impossible feat of disentangling grief from depression; and 3) grief, a natural human experience, will be pathologized.

Meanwhile, there are simultaneous dangers to not removing the BE. These risks become elucidated by exploring the answers to the following questions: 1) are bereavement related depressions (BRDs) similar to non-bereavement related

depressions (NBRDs); 2) was the BE serving its purpose by ensuring that grief was not misdiagnosed as MDD; and 3) moving forward, does the DSM-5 meet the goals of correctly identifying MDD when it exists, but not falsely labeling individuals with 'normal' sadness or grief as having a mental condition, better than does the DSM-IV?

In order to help readers understand the reasons for the removal of the BE in the DSM-5, this paper will review the BE in the DSM, the background for the BE, the literature regarding both the feared consequences of removing the BE and the dangers of retaining the BE, and the changes regarding bereavement and MDD in the DSM-5.

The BE in the DSM-III and DSM-III-R

With the primary goal of ensuring that clinicians do not misdiagnose MDD in grieving individuals when the depressive symptoms are normal, common, and conceivably even adaptive [1•, 2•], the bereavement exclusion (BE) was added in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). The term "uncomplicated bereavement" was used in DSM-III to reference what most mental health professionals currently term "bereavement". In DSM-III, "uncomplicated bereavement" was added as both an exclusionary criterion for the diagnosis of a major depressive episode (MDE) and a V-code—a clinical condition that is *not* a mental disorder. According to DSM-III, "uncomplicated bereavement" "can be used when a focus of attention or treatment is a *normal* (i.e., healthy) reaction to the death of a loved one (bereavement). A full depressive syndrome is a *normal* (i.e., expected or typical) reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss and insomnia. The reaction to the loss may not be immediate, but rarely occurs after the first two or three months. The duration of "*normal*" bereavement varies considerably among different subculture groups" [3].

To help differentiate "uncomplicated bereavement" from MDE, DSM-III outlined several distinguishing features: (a) a bereaved individual typically regards the depressed mood as "normal," although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia; (b) depressives symptoms in "normal" bereavement do not last more than 2–3 months after the loss; (c) "normal" grief reactions do not generally include specific symptoms of *guilt* about things other than actions taken or not taken by the survivor at the time of the death, *thoughts of death* other than the survivor feeling that he or she would be better off dead or should have died with the deceased person, morbid preoccupation with *worthlessness*, or *hallucinatory experiences* other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person or marked *psychomotor retardation*, and (d) "normal" grief does not result in prolonged or marked *functional impairment*.

The BE in the DSM-IV and DSM-IV-TR

With some modification, the BE was continued into DSM-IV and DSM-IV-TR. The term "uncomplicated bereavement" from DSM-III was replaced with "bereavement" in DSM-IV. The DSM-IV V-code for bereavement included a more sharply defined time-frame, explaining that a diagnosis of MDD should not be made unless the symptoms are still present two months after the loss. Subtle wording revisions allowed any one 'severe' feature (i.e., psychomotor retardation, suicidal ideation, marked functional impairment, psychotic symptoms, or morbid preoccupation with worthlessness) to override the exclusion and suffice for a diagnosis of MDE [4•].

The V code was also expanded, differentiating a MDE from bereavement with several symptoms which are not typical of "normal" grief: *"(1) guilt about things other than action taken or not taken by the survivor at the time of the death; (2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; (3) morbid preoccupation with worthlessness; (4) marked psychomotor retardation; (5) prolonged and marked functional impairment; and (6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person"* [5].

Bereavement remained the only stressful life event that excluded the diagnosis of MDE. The BE even applied to individuals who previously had experienced a MDE or recurrent MDD. Also, the wording in the DSM-IV and DSM-IV-TR contained a double negative, with resultant confusion about its application. Notably, the BE has never been included in the International Diagnostic Classification of Diseases (ICD).

Background History of the Bereavement Exclusion

The addition of the BE to the DSM-III was based on the pioneering series of studies initiated by Paula Clayton and colleagues at the University of Washington in the 1960s and early 1970s [6–11]. These studies, as summarized by Hensley and Clayton [12•] and Zisook et al. [13] , were based mainly on bereaved widows and widowers and demonstrated that symptoms of depression are exceedingly common in individuals experiencing normal grief for the loss of a loved one. In the first month of bereavement, study participants often experienced symptoms of a major depressive syndrome, including depressed mood, crying, anorexia and/or weight loss, difficulty concentrating and/or poor memory, and sleep disturbance. Most somatic symptoms dramatically improved by the end of the first year. However, insomnia (48 %), restlessness (45 %), periodic low mood (42 %) and crying (33 %) persisted in over one third of participants [9, 11]. The 1 year incidence of a full

depressive syndrome was high (47 % in the bereaved versus 8 % in the non-bereaved controls), but rates of full depressive syndromes appreciably declined over the first year (35-42 % of the bereaved at 1 month versus 16 % at 1 year) [13]. This work laid the foundation for the BE, as it highlighted the importance of not confusing a MDE with a normal phenomenon, grief.

The Feared Consequences of Removing the Bereavement Exclusion

Explosion in Numbers Diagnosed with MDD

One feared consequence of removing the BE from the DSM-5 is that there would be a resultant explosion in the numbers of people diagnosed with MDD. Population-based studies exploring rates of both bereavement related depression (BRD) and bereavement excluded depression allow us to examine this concern. Only 0.5 % of the total population in the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) database met criteria for "bereavement excluded depression" [14•]. Similarly, in the National Comorbidity Study (NCS) 4 % of those with MDE had DSM-III-R defined BRD, whereas less than 1 % of the total population had DSM-III-R BRD [15] and even fewer would meet the stricter criteria for BE excluded depression [4•]. Furthermore, only (0.25 %) of the total population in the Virginia Twin Study of Psychiatric and Substance Use Disorders (VATSPSUD) study met criteria for the DSM-III-R BE [16] . Population based studies thus indicate that the numbers of individuals who will no longer be excluded from a diagnosis of MDD based on the removal of the BE in the DSM-5 are far from overwhelming.

The facts that there is no BE in the ICD-10 and that the BE was not added to the DSM until 1980 provide us with another lens with which to examine the concern about overwhelming numbers of people being diagnosed with MDD with the removal of the BE. Comparing rates of MDD from countries that utilize the DSM to those that use the ICD-10 in addition to rates of MDD prior to the addition of the BE in 1980 to rates after 1980 can be revealing. Similar rates of depression were ascertained in European studies comparing ICD-10 and DSM-IV criteria [17] and no data signify that MDD is diagnosed more frequently in parts of Europe which utilize the ICD-10 [18•]. No known data suggest that MDD was diagnosed or treated more or less frequently after the addition of the BE to the DSM-III in 1980 compared to prior to 1980, notwithstanding the 'Prozac revolution' which was unrelated to the BE and occurred much later in the 1980s [19•]. Overall, the literature suggests that removing the BE will not result in an unmanageable number of people being diagnosed with MDD.

Distinguishing Bereavement from MDD

Another concern regarding the removal of the BE is that clinically distinguishing grief from MDD is often perceived as a nearly impossible task. Part of this concern relates to the amorphous use of the term 'depression'. The term 'depression' is applied to a varied range of phenomena, from normal sad feelings to the mood state associated with a major depressive episode (MDE). Many even use the term 'depression' interchangeably with a major depressive disorder (MDD). The ambiguousness of the term 'depression' also applies to its adjective form, 'depressing'. It is hard to imagine too many life experiences more 'depressing' than losing a loved one, as 'depression' is one of the key features of bereavement. Yet, 'depression' is also a key feature of MDD. As has been articulated in recent articles [19•], those who advocated for removing the BE from the DSM-5 do not believe that the feeling state of 'depression' at any temporal point after the loss of a loved one should ever be medicalized. However, individuals meeting the full criteria for MDD, beyond experiencing the emotion of 'depression', should not be discounted as simply grieving. As Pies articulates, we should take care to avoid the "fallacy of misplaced empathy" in which we negate the possibility of MDD just because someone's "depression" is understandable [20•]. Grief and MDD are not mutually exclusive. Rather than conceptualizing them as either/or, it is more fruitful to think of them as grief alone or grief plus MDD. Neglecting to identify and treat MDD in grieving individuals can prolong suffering and contribute to the development of grief complications [21, 22•].

Another reason for the apprehension about clinically disentangling grief from MDD is that the symptoms of bereavement and MDD overlap considerably. Sleep disturbance, anhedonia, sad mood, guilt and occasionally suicidal ideation may be present in both conditions [22•, 23•, 24]. However, essential qualitative differences exist between the seemingly similar symptoms of normal grief and MDD. These qualitative differences are the key to differential diagnosis [19•].

Anhedonia manifests in both grief and MDD. But in grief, anhedonia is specifically linked to a longing for the deceased loved one, whereas in MDD, anhedonia is more pervasive [19•]. Sadness is a key feature of both grief and MDD, yet it presents differently in each condition. With grief, sadness is blended with pleasant feelings and often comes in waves—what people term the 'pangs of grief'. In juxtaposition, sadness is usually widespread with MDD [25, 26]. Similarly, guilt is common in both grief and MDD. In grief, feelings of guilt are commonly linked to thoughts of not having done enough for the deceased love one (the haunting "only ifs", "could haves" and "should haves"). In MDD, guilt can be extensive and characteristically relates to feelings of worthlessness [22•, 23•]. Grieving persons rarely suffer from acute suicidality unless they are experiencing a simultaneous comorbid MDD. However, grieving individuals often have thoughts of dying.

When these occur, the thoughts focus on a specific desire for reuniting with the deceased loved one. In contrast, suicidal ideation in persons suffering from MDD regularly relates to feelings of worthlessness, thoughts that living existence is unbearable, and perceptions that others would be better off without them alive [21]. The overall theme that helps one distinguish symptoms of grief from symptoms of MDD is that symptoms of grief are loss centered whereas symptoms of MDD typically are both centered on the self and pervasive. Freud's distinction outlined in *Mourning and Melancholia* still applies. Sadness and anger are directed toward the self with MDD, but not with the normal experience of grief [27].

The mix of pleasant and unpleasant feelings present in grief allows us to further distinguish grief from MDD. Both grieving individuals and individuals with MDD often experience sadness, guilt, anger, and shame. However, unlike individuals with MDD, grieving individuals without a co-morbid MDD experience these emotions as intermixed with positive emotions. The more trying emotions of grief are intermingled with feelings of warmth in recalling the closeness they felt with their loved one, the ability to enjoy remembering happier times, and the sharing of amusing and/or touching anecdotes of their deceased loved one [23•]. Grieving individuals typically still feel joy and take pleasure in being alive despite also experiencing pangs of grief. Not uncommonly, grieving individuals experience either relief from the burden of caregiving and/or relief that their loved one is no longer suffering [19•].

So, by taking into account the distinction between the emotion of depression and the experience of MDD, considering phenomenological differences between grief and MDD, and being cognizant of the intermixed positive and negative feelings of grief, one can usually distinguish between grief and MDD. This comment is not to say that this distinction is simple. In fact, making the clinical diagnosis of MDD in a grieving individual can be challenging, even for seasoned clinicians. When in doubt, an individual's past personal or family history of MDD can be helpful in clinically deciding whether or not that grieving individual also has a co-morbid MDD [18•]. Sometimes, a presumptive or preliminary diagnosis can be made initially, using the passage of time to help confirm or negate the initial impression as more data unfold.

Pathologizing Grief

Critics of the DSM-5 Task Forces' decision to eliminate the BE claim the change is tantamount to pathologizing grief, or labeling normal sadness as a mental illness [28, 29•]. While this claim has achieved broad popular appeal [30, 31•], closer inspection reveals little merit for its validity. First, the DSM-5 carefully distinguishes normal sadness from major depressive disorder and emphasizes that major depression should not be diagnosed in the absence of the requisite constellation of symptoms that meet criteria for severity, duration, distress and dysfunction. "Sadness" is only one small part of the total picture of a major depressive episode, and not even an essential one at that [32]. Second, nowhere does the DSM-5 say that grief may not be terribly painful, distressing and prolonged. It can be [33]. But the DSM-5 acknowledges the well-known and universally accepted fact that the death of a loved one may precipitate a major depressive episode in an otherwise vulnerable person [34, 35], and that grief and major depressive episodes – both potentially triggered by loss – may co-exist in the same bereaved person. Acknowledging that simple truth does not negate or 'pathologize' either grief or depression, but it may help clinicians provide accurate diagnosis and focused care. That is not to say that diagnosing a major depressive episode in the context of someone who also is acutely bereaved is always easy, but it is no more or less challenging than diagnosing major depression in someone who has been diagnosed with cancer [36], who has recently suffered a stroke [37] or who has a neurocognitive disorder [38•]. Yet, in each of these cases, accurate diagnosis and treatment of depression may have enormous health implications. Finally, depression is not the only serious consequence of bereavement; but we are not aware of anyone claiming that heart disease [39•] or breast cancer [40] that may be associated with the death of a loved one should not be diagnosed lest bereavement be 'pathologized'. Thus, it simply makes no sense to ignore the diagnosis of major depression for fear of pathologizing bereavement.

Another consideration regarding pathologizing grief relates to the V-code that accompanied the BE in DSM III and IV which unintentionally 'pathologized' bereavement. It stated that depression may be 'normal' (i.e., part of ordinary or uncomplicated bereavement) for up to 2 months, but 'pathological' at day 60, implying that grief lasting more than 2 months morphs into a clinical depression. This artificial time limit is patently nonsensical. Bereavement is **not** a pathological state – even if intense grief lasts for several months. This time limit was also culturally insensitive, since time spent grieving has a strong cultural component. By eliminating this artificial time limit for dysphoria related to bereavement, the DSM-5 may actually have helped de-pathologize bereavement.

The Dangers of Retaining the Bereavement Exclusion

Are BRDs Different from Non-BRDs?

By singling out bereavement as the singular life event to exclude the diagnosis of a major depressive disorder, even when all other symptom, severity, duration and distress criteria are met, the DSM-III and IV tacitly assume that major depressions following bereavement are fundamentally different than major depressive episodes following other life experiences, or, for that matter, occurring out of the blue. Otherwise, it makes no sense to single out bereavement as the only

life event that negates the diagnosis of major depression. **If**, on the other hand, major depressive episodes occurring after the death of a loved one are similar to other major depressive episodes on most depressive disorder validators, and **if** other major depressive episodes – such as those occurring after the onset of a severe or disabling general medical or neurological condition, after economic hardship or becoming homeless, or after divorce – are legitimate mental conditions warranting the diagnosis of major depressive disorder, then the DSM-5 got it right by eliminating the BE.

And that indeed seems to be the case. First, the field of psychiatry has long since recognized the validity of adverse life events ostensibly triggering major depressive episodes [41–43]. Second, the predominance of studies comparing bereavement related depressions to non-bereavement related depressions shows that they are much more similar than otherwise [15, 16, 44, 45•, 46•], although debate in the literature exists [47, 48•, 49, 50•, 51•]. Bereavement related major depressive episodes and major depression occurring in any other context share several clinically relevant characteristics: both are genetically influenced; both are most likely to occur in individuals with past personal and family histories of major depression; both share similar personality characteristics, patterns of comorbidity, and, at least in some studies, the likelihood of chronicity and/or recurrence, and both respond to antidepressant medications [18•, 52, 53]. Furthermore, compared to bereaved persons who may be acutely grieving and in great distress, but who do not also meet criteria for major depression, bereaved persons with grief plus major depressive episodes suffer more, are more likely to feel worthless and have suicidal ideation for months to years, have poorer general medical health, and worse interpersonal and work function, experience biological perturbations associated with MDE, have a worse prognosis, and may be at risk for particularly intense and prolonged grief reactions [54–56•]. Thus, grieving the death of a loved one does not preclude the worsening or onset of a co-occurring major depression. In fact, the loss may trigger the major depression in a vulnerable individual. When that occurs, the depressive episode has all the characteristics of any other major depressive episode.

More than its predecessors, the DSM-5 attempts to ensure that clinicians and patients understand that major depression can occur in someone who is bereaved, just as it can occur in someone who is going through a divorce, who has been diagnosed with a fatal medical condition, who becomes disabled, who faces financial ruin, or even in someone whose life is apparently going well. Moreover, there are no known clinically meaningful differences in the severity, course or treatment response of major depressive episodes that occur after the death of a loved one compared to those occurring in any other context. According to the best research currently available, any very stressful life event can trigger a serious major depressive episode in a vulnerable person regardless of the context in which it occurs. Prompt recognition and appropriate treatment of major depressive disorders can be life-promoting and even life-saving.

Was the Bereavement Exclusion Serving its Purpose?

The major goal of the BE was to ensure that the "normal" condition of bereavement was not pathologized. Somewhat ironically, no studies directly and formally tested the efficacy of the BE despite many people assuming it nobly served its purpose. As delineated above, we know that MDD is not diagnosed more commonly in countries which do not use the DSM and that there was not a major change in rates of MDD after the BE was introduced that relates to the BE. However, a hidden danger of the BE emerged. We ended up with a situation in which MDD was normalized, undiagnosed, and thus untreated.

Two large studies of individuals self-referred for the treatment of depressive symptoms in France give us insight into the dangers of the BE [57, 58•]. An incidental finding from these studies indicates that even clinicians explicitly trained in the use of the BE misapply it and exclude grieving individuals who have a concurrent MDE from being diagnosed and thus treated for their MDD [46•]. In both of these studies, clinicians were specifically trained in the DSM-IV criteria for MDD, including the BE. Interestingly, individuals who were excluded from being diagnosed with MDD based on the clinicians' application of the BE were found to have more severe psychic and somatic symptoms of MDD than were non-grieving individuals diagnosed with MDD who were matched by age, gender, marital status, and education in a cross-sectional study [57]. BE excluded patients were also found to have more severe depressive symptoms and higher self-rated symptoms of anxiety and depression than were non-bereaved individuals diagnosed with MDD in another similar, but prospective study [58•]. Contrary to the study's hypothesis, individuals excluded from a diagnosis of MDD based on the BE had similar outcomes to non-bereaved individuals diagnosed with MDD after six weeks of treatment. Based on a strict application of the BE, many of the BE excluded individuals from both of these studies should not have been excluded from a diagnosis of MDD. This incidental finding highlights the danger of the BE as applied in the real world—that clinicians, even those trained in using the BE, misapply it in such a way that patients with moderate to severe MDD are "dismissed" from having MDD if they are simultaneously grieving. Clinicians may logically deduce "if someone is grieving, then they are excluded from having MDD". Obviously, this was not the intent of the BE, but may have been an unfortunate outcome.

The authors observe the same pattern of misuse of the BE in our work with trainees. We initially justified that this misuse of the BE reflected the trainees' lack of knowledge about the content of the DSM. However, over time, it became clear that many medical students and psychiatry residents are more

familiar with the nuances of the DSM-IV than are seasoned practicing clinicians. Despite being able to cite the specifics of the BE as outlined in the DSM-IV with impressive sophistication, many trainees still concluded that if someone is grieving, even 1 year after the death of their loved one, the individual would not simultaneously be diagnosed or treated for a MDE, even if the symptoms of the MDE were moderate to severe. This misapplication of the BE is likely commonplace, but has never been tested formally and directly.

The Changes Regarding Bereavement and MDD in the DSM-5

What Does the DSM-5 say about the Relationships of Grief and Bereavement to the Diagnosis of MDD?

In deciding how to improve the diagnosis of major depressive episodes without pathologizing normal grief or overdiagnosing major depressive episodes in the context of grief, the DSM-5 Mood Disorders considered all of the factors described above, and summarized here: 1) The DSM-III and IV BE is confusing and has not served its purpose; 2) The BE falsely implies that bereavement typically lasts only 2 months; 3) Bereavement is a severe psychosocial stressor that can precipitate a MDE in a vulnerable individual, generally beginning soon after the loss; 4) When MDE occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder; 5) Bereavement-related major depression is most likely to occur in individuals with past personal and family histories of MDD. 6) Bereavement-related major depression is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non–bereavement-related major depressive episodes; and 7) The depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as do non–bereavement-related depression [59]. To accomplish its goal, the DSM-5 considered relevant diagnostic issues throughout the text.

- In the DSM-5 Basics "Introduction" section (pg. 20), a mental disorder is defined as "*a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behavior…..*" and is further qualified by the caveat that "*An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is* ***not*** *a mental disorder*".
- Also in the DSM-5 Basics section (pg. 19), as part of the discussion of the importance of a clinical case formulation, the DSM-5 advocates for using clinical judgment rather than a checklist approach to diagnosis, emphasizing considering the "*relative severity and valence of individual criteria and their contribution to a diagnosis*". Furthermore, it states that the "*ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context".*
- Later, in the Introduction to Depressive Disorders section (pg. 155), the DSM-5 again cautions against both overdiagnosing major depression in the context of grief and underdiagnosing major depression after bereavement: "*Careful consideration is given to the delineation of* ***normal sadness and grief from a major depressive episode*** *… Bereavement may induce great suffering, but it does not typically induce an episode of major depressive disorder…When they do occur together, the depressive symptoms and functional impairment tend to be more severe and the prognosis is worse compared with bereavement that is not accompanied by major depressive disorder"*.
- As part of the diagnostic criteria for a major depressive disorder (pg. 161), the DSM-5 broadens the discussion of potentially excluding "normal bereavement" from the diagnosis of major depression to other losses and grief reactions, and again emphasizes the importance of clinical judgment in making these determinations: "*Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode…Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered…This decision inevitably requires the exercise of* ***clinical judgment*** *based on the individual's history and the cultural norms for the expression of distress in the context of loss".*
- To aid clinicians and inform their clinical judgment, the DSM-5 adds a footnote to the diagnostic criteria (pg. 161) which delineates ways in which grief might be distinguished from major depression (see Table 1).
- Describing environmental risk factors for major depressive disorders (pg. 166), the DSM-5 cautions: "*Stressful life events are well recognized as precipitants of major depressive episodes, but the presence or absence of adverse life events near the onset of episodes does not appear to provide a useful guide to prognosis or treatment selection"*.
- In a brief but important discussion of differentiating normal sadness from major depression (pg. 168), the DSM-5 says: *"Periods of sadness are inherent aspects of the human experience…These periods should not be diagnosed as a major depressive episode unless criteria are*

Table 1 Differentiating grief from major depressive disorder [59]

	Grief	Major depression
Predominant affect	Emptiness and loss	Persistent depressed mood and the inability to anticipate happiness or pleasure
Dysphoria	Decreases in intensity over days to weeks and occurs in waves, the so-called pangs of grief; waves associated with thoughts or reminders of the deceased	Persistent and not tied to specific thoughts or preoccupations
Pain	Accompanied by positive emotions and humor	Pervasive unhappiness and misery
Thought content	Preoccupation with thoughts and memories of the deceased	Self-critical or pessimistic ruminations
Self-esteem	Preserved; If self-derogatory ideation is present, it typically involves perceived failing vis-à-vis the deceased (e.g. not visiting frequently enough, not telling the deceased how much he or she was loved)	Feelings of worthlessness and self-loathing are common
Suicidal thoughts	Focused on the deceased and possibly about "joining" the deceased	Focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

*met for **severity** (i.e., five out of nine symptoms), **duration** (i.e., most of the day, nearly every day for at least 2 weeks), and clinically significant **distress or impairment**".*

- Finally, recognizing that some individuals may seek help for bereavement related problems other than a major depressive disorder, in the section on 'Other Conditions that may be a Focus of Clinical Attention', the DSM-5 provides a V-Code for 'Uncomplicated Bereavement' (pg. 716): *The focus of clinical attention is a normal reaction to the death of a loved one…Some grieving individuals present with symptoms typical of a MDE…The duration and expression of "normal" bereavement vary considerably among different cultural groups.*

Conclusions

Exploring the literature regarding the major concerns about removing the BE is reassuring. It does not appear that there will be an explosion in the numbers of people diagnosed with MDD with the removal of the BE. Similarly, despite inherent challenges, disentangling grief from MDD and diagnosing MDD in bereaved individuals is far from an impossible task. Meanwhile, examining the unintended consequences of the BE is alarming. Rather than ensuring that grief was not pathologized, the BE inadvertently led to the normalization of MDD in certain bereaved individuals, in turn impeding the appropriate and compassionate diagnosis and treatment of this serious medical condition.

By removing the BE and delineating the phenomenological distinctions between bereavement and MDD, the DSM-5 deals with diagnostic boundaries between bereavement and major depression in a way that does not put artificial timelines on the duration of grief, arbitrarily select certain symptoms of major depression as being more diagnostic than others, limit the discussion of 'grief reactions' to bereavement or force a diagnosis of major depression on someone whose dysphoria might better be accounted for by reactions to loss or other adverse life events. Eliminating the bereavement exclusion does not increase the possibility of misattributing normal grief associated with the death of a loved one as a mental disorder. Indeed, it does not pathologize bereavement, grief or normal sadness. But it does provide "*clinicians an opportunity to make sure that patients and their families receive the appropriate diagnosis and the correct intervention without necessarily being constrained by a period of time*" [60•].

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Compliance with Ethics Guidelines

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