No diagnostic proposal has been more hotly debated than the American Psychiatric Association (APA) Mood Disorder Task Force’s recommendation to remove the bereavement exclusion from the diagnosis of major depressive disorder (MDD) for the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

The bereavement exclusion in DSM-IV proscribes the diagnosis MDD when depressive symptoms fall within 2 months of the death of a loved one, and does not include marked functional impairment, morbid preoccupation with worthlessness, active suicidal ideation, psychomotor retardation, or psychotic features. Yet in spite of the contentiousness, there are many important points of agreement. No one disputes that bereavement is a universal experience, nor that grief can be inordinately painful, distressing, and protracted. And despite accusations to the contrary, we can claim confidently that DSM-5 does not seek to pathologize human reaction. There also is agreement that MDD is a serious condition that should be diagnosed and treated, as it can be worsened or triggered by stressful life events, and that bereavement itself is a stressful life event.

Further, there is ample agreement that a major depressive episode (MDE) shares some features of acute grief, making the differential diagnosis challenging. Proponents of each side of this debate feel strongly that they are on the “right” side of the evidence, of compassion for suffering, and of their professional obligation to protect the public. The intent of this collection of articles is to shed additional light on this diagnostic and clinical dispute.

DIAGNOSTIC BOUNDARY

The passionate disagreement is about how to conceptualize and define the diagnostic boundary between grief and MDD. Those in favor of retaining the exclusion argue that there are fundamental differences between those depressive syndromes that are targeted by the bereavement exclusion (BE) and other, nonbereavement-related instances of MDD, whereas proponents in favor of removing the BE argue that data support the similarity of bereavement-related depression and MDD, regardless of the context. It is worth noting that no rigorous prospective study has been done to specifically answer the question of whether there are important, clinically significant differences between MDD after bereavement compared with MDD that occurs in other contexts. Therefore, the authors of DSM-5 needed to make their best judgment about this challenging issue.

Those who want to retain the exclusion claim that its removal will medicalize normal grief; label and stigmatize bereaved people; and lead to harmful, inappropriate, and injudicious use of pharmacologic interventions for normal sadness. They point to epidemiologic data that individuals excluded from the diagnosis of MDD on the basis of the BE are less likely to experience recurrent episodes than are other individuals with MDD. They argue that it is important to exclude mild and brief depressive syndromes because these cannot be easily differentiated from normal grief. In addition, they assert that without a specific bereavement exclusion, many people suffering bereavement would be burdened further by being misunderstood and inappropriately labeled and treated as mentally ill.

We, the authors of this commentary, are on the other side of this debate: we believe the BE should be eliminated on the premise that MDD is a serious, highly recurrent, potentially fatal disorder regardless of its apparent cause or precipitant. Furthermore, MDD has been shown to have negative health effects even in its milder form. The BE creates a roadblock to diagnosis and treatment that may improve a person’s
quality of life as well as enhance the capacity to effectively grieve.

The diagnostic challenges are similar to the diagnostic dilemmas posed by medically ill patients whose depressive symptoms overlap with physical illness. We now know that the presence of a syndromal cluster of depressive symptoms in a medically ill patient is clinically significant, regardless of the cause of the symptoms; depression impedes healing and is associated with impaired functioning and quality of life, and increased morbidity and mortality. Similarly, most of the available evidence shows that MDD occurring soon after bereavement is clinically meaningful, not unlike MDD occurring in other contexts. In both cases, following general medical illness or after bereavement, diagnosing MDD can be challenging but may be a vital step towards healing and well-being.

SMALL ‘D’ VS. BIG ‘D’ DEPRESSION
A key conceptual issue that creates considerable confusion and fuels the debate is whether to diagnose depression instead of, or in addition to, grief. Proponents of retaining the BE are focused on the differential diagnosis of grief and MDD, whereas those of us who favor eliminating the exclusion believe that this presupposes a false dichotomy; grief and MDD are not mutually exclusive. The problem hinges on the common symptom of sadness. Depression has two separate meanings: One is a synonym for sadness and the other is the name of a mood disorder. Small ‘d’ depression is always associated with grief, and is, in fact, a common experience for most people. To say a bereaved person is depressed (small ‘d’) is to describe a key feature of grief. Big ‘D’ depression refers to the psychiatric condition, MDD, which is a serious medical condition that is not a feature of ordinary grief. When MDD is diagnosed in response to the loss of a loved one, it is not diagnosed instead of grief, but rather in addition to grief.

Many, if not most, bereaved individuals never meet full criteria for MDD. Among those who do, the depression runs the gamut of severity, with some being quite mild and brief, others being severe and persistent, and most being somewhere in the middle. However, even relatively mild depressive episodes are clinically significant. Moreover, when someone is struggling to come to terms with a difficult loss, even a mild MDD can impede healing.

DURATION OF GRIEF
A corollary of the proposition that grief and MDD cannot co-occur is that you cannot diagnose MDD unless grief is no longer present. The BE implies that grief should be resolved by 2 months. However, as grief researchers, we are cognizant that grief is never over. Loss is forever; so is grief. What changes over time is the intensity and dominance of grief symptoms. We favor eliminating the BE, not because we believe grief should be completed in less than 2 weeks or even in 2 months, but rather because we believe that co-occurring MDD can further prolong and worsen an already difficult grieving process.

DIAGNOSIS OF MDD WHEN GRIEF IS PRESENT
Each of the articles in this issue of Psychiatric Annals addresses the question of diagnosing MDD in the face of bereavement and grief. The articles emanate from studies conducted globally and were authored or co-authored by some of the most senior pioneers of the scientific study of bereavement and MDD. Paula L. Hensley, MD, and Paula J. Clayton, MD (see page 256) describe Dr. Clayton’s original series of elegant, ground-breaking studies that were among the first methodologically rigorous, longitudinal studies of depression in bereaved persons, leading the framers of DSM-III to adopt the bereavement exclusion.

Alana Iglewicz, MD; Kathryn Seay, BS; Stefani Vigeant, BS; Sandeep Kaur Jouhal, MD; and Sidney Zisook, MD (see page 261) critically review arguments for and against the elimination of the BE and conclude that the advantages of retaining the BE are outweighed by the advantages of removing it, both in terms of alliance with the best available data and with the interest of optimal patient care.

Elie G. Karam, MD; Caroline C. Tabet, DEA; and Lynn A. Itani, MPH (see page 267) summarize data from a large, population-based, prospective field study that compared symptom profiles, dysfunction, duration of illness, and risk of recurrence among nonbereaved and bereaved individuals who met DSM-IV criteria for MDE. They show that bereavement-related and nonbereavement-related depressive episodes are similar in almost all respects, including impairment and recurrence.

Emmanuelle Corruble, MD, PhD (see page 272) reports on two naturalistic studies from large, French national case-control samples of self-referred individuals seeking treatment for depressive symptoms. Findings from...
these studies suggest that the bereavement exclusion is confusing and often is misused.

Diana Paksarian, MPH, and Ramin Mojtabai, MD, PhD, MPH (see page 276) conducted secondary analyses of three studies from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) and Epidemiologic Catchment Area (ECA) databases that demonstrated low recurrence rates for “bereavement-excluded” depressions, concluding that the BE is warranted and should have been maintained in DSM-5.

The issue concludes with an essay by Ronald Pies, MD (see page 286) that compares how grief and MDD are experienced. Pies argues that grief and MDD are fundamentally different constructs, that they can coexist, and further, that grief does not transform to persistent, pervasive, and pathological depressive symptoms. Pies stresses the importance of accurate diagnosis as a prelude to appropriately targeted care.

Together, this collection of articles provides the reader with a comprehensive look for and against the BE. More important, these articles offer clinicians critical information to understand, diagnose, and treat bereaved patients who are also burdened with persistent, pervasive, and pathological depressive symptoms.

REFERENCES

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