

Grief, Depression, and the DSM-5 By Rochelle Perper, Ph.D.

The relationship between grief and depression following bereavement has been debated in the literature as well as in the general public media. Much of the recent conversation has focused on the implication for the Diagnostic Statistical Manual of Mental Disorders, version 5 (DSM-5). The DSM-5 was published in May, 2013 by the American Psychiatric Association. This is the first major rewriting of the manual since the DSM-IV was published in 1994. Among the many changes to the DSM-5 the bereavement exclusion was eliminated to the diagnostic criteria for a Major Depressive Episode. Thus, it is now up to the clinician's discretion to differentiate a Major Depressive Episode following bereavement from a typical grief reaction following bereavement (J. Fawcett, M.D., personal communication, June 8, 2013).

At the closing of the American Psychiatric Association's "DSM-5 – What you Need to Know" conference in San Diego, Sidney Zisook, M.D., researcher in the field of grief and loss and Professor of Psychiatry at UCSD Department of Psychiatry discussed the bereavement exclusion in the new version of the manual. Dr. Zisook clarified that the state of bereavement is a natural response to a loss and is characterized by feelings of sadness and depression. However, at this time bereavement is not a clinical diagnosis (personal communication, June 9, 2013). Dr. Zisook reminded the audience that Major Depression can occur in the context of bereavement in a similar way that it can occur in the context of other life events such as the loss of a job, a relationship, or a traumatic event (Kendler et.al, 2008). Simply put, Dr. Zisook said, "you can grieve *and* be depressed!" (personal communication, June 9, 2013).

This article will explore the differences between Grief and Depression, the arguments for and against the recent change in the DSM-5, and the future for grief and loss research in upcoming revisions of the DSM-5. Upon completion of this article, the reader should be able to: (a) Understand unique aspects of grief and bereavement following the loss of a loved one; (b) Differentiate between a typical grief reaction and clinical indicators of a Major Depressive Episode; (c) Begin to incorporate the elimination of the bereavement exclusion to the diagnostic criteria for Major Depression in the DSM-5; and (d) Identify signs of Persistent Complex Bereavement Disorder in future work with clients.

Understanding Grief and Bereavement

The experience of a loss by death is a universal human experience frequently associated with a period of grief and mourning. Grief is a process in which the bereaved remembers the loved one who has died and works to adjust to his or her life without them. Although a grief reaction is different for everyone, the phases of grief typically involve emotional and psychological reactions in the griever that include affective, cognitive, physiological, and behavioral symptoms (Worden, 2002). Affective reactions for bereaved individuals many include sorrow, anxiety, loneliness, guilt, and anger. Cognitive reactions may include disbelief, confusion, and helplessness. Physiological and somatic symptoms may include loss of appetite, sleep disturbances, and fatigue. Behavioral actions may include social withdrawal, restlessness, crying, and nightmares of the deceased. These symptoms are likely to impact the bereaved person's

performance both at work or at home. For example, a bereaved individual can experience mental lapses, decreased enthusiasm, difficulty with decision-making, poor concentration, preoccupation and distraction, social withdrawal, and increased interpersonal conflicts.

The grief experience is typically recognized by professionals as an entirely normal and expected emotional response to a loss. However, the bereavement literature has yet to show consensus on a distinct course and duration of a typical grief response. The variability that exists in a person's grief is influenced by factors such as the quality of the relationship with the deceased, the bereaved persons' coping resources, and the nature and context of the loss (Bonanno, et al. 2002). Although there are individual differences, many clinicians agree that a typical course of bereavement might last one to two years, and the bereaved individual will experience intermitted symptoms of grief following a significant loss for the rest of their lives (S. Zisook, M.D., personal communication, June 9, 2013).

Major Depression in times of Grief

Major Depressive Disorder is the classic condition that is characterized by discrete episodes of at least 2 weeks' duration (although most episodes last considerably longer) involving changes in affect, cognition, and neurovegetative functions and may include remissions over time (American Psychiatric Association [APA], 2013). Grief-stricken patients frequently report symptoms that are also typical of major depression, such as intense sadness, tearfulness, and problems sleeping, concentrating, eating and interacting with others. But, as numerous researchers have noted, grief rarely produces the cognitive symptoms of depression such as low self-esteem or feelings of worthlessness (Bonanno, 2001; Bonanno, Wortman, & Nesse, 2004). Although bereaved patients may fantasize about being reunited with a lost loved one through death, they do not generally experience the explicit and persistent suicidal ideation typical of major depression (Friedman, 2012). Other symptoms that suggest Major Depressive Disorder in the context of grief include: (a) Feelings of guilt that are not associated with the loss; (b) Prolonged and marked difficulty in carrying out the activities of day-to-day living, and (c) Hallucinations other than thinking he or she hears the voice or sees the deceased person (Auster, et al., 2008).

In addition, grief tends to be trigger-related. In other words, the person may feel relatively better while in certain situations, as when friends and family are around to support them. But triggers, like the deceased loved one's birthday, could cause the feelings to resurface more strongly. Major depression, on the other hand, tends to be more pervasive, with the person rarely getting any relief from their symptoms. In addition, unlike those suffering from a Major Depressive Episode, bereaved individuals appear to intuitively understand that time, space, and support is required for healing and adjusting to life (APA, 2013).

The table below is a summary of the major differences between a typical grief reaction following a loss and clinical indicators of a Major Depressive Episode.

Clinical Indications of typical Grief	Clinical Indicators of Major Depression
May have tendency to isolate, but generally maintains emotional connection with others	Extremely “self-focused”; feels like an outcast or alienated from friends and loved ones
Hope and belief that the grief will end (or get better) someday	Sense of hopelessness, believes that the depression will never end
Maintains overall feelings of self-worth	Experiences low self-esteem and self-loathing
Experiences positive feelings and memories along with painful ones	Experiences few if any positive feelings or memories
Guilt, if present, is focused on “letting down” the deceased person in some way	Guilt surrounds feelings of being worthless or useless to others (not related to the loss)
Loss of pleasure is related to longing for the deceased loved one	Pervasive anhedonia
Suicidal feelings are more related to longing for reunion with the deceased	Chronic thoughts of not deserving, or not wanting to live
May be capable of being consoled by friends, family, music, literature, etc.	Often inconsolable

Implications for the DSM-5

A primary objective of the DSM-5 is to provide a more streamlined classification of Depressive Disorders to enhance both clinical and educational use of the diagnoses in this category. As such, the DSM-5 separates “Depressive Disorders” from the chapter on “Bipolar and Related Disorders.” Among the changes to the Depressive Disorders, the bereavement exclusion has been eliminated from the diagnosis of Major Depressive Episode in the DSM-5. Explanatory notes are included for differentiating bereavement and major depressive disorders to provide more clinical guidance than was provided in the bereavement exclusion criteria from the previous version.

This move suggests that a Major Depressive Episode after the loss of a loved one lacks any meaningful difference from a Major Depressive Episode after any other form of loss or significant life event. As such, patients who experience five out of the nine symptom criteria for two weeks, a diagnosis of Major Depressive Disorder should be made, regardless of any originating cause. The DSM-5 states the following:

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. Bereavement–related depression tends to occur in persons with other vulnerabilities to depressive disorders, and recovery may be facilitated by antidepressant treatment. (p. 155)

In an open letter from the American Psychiatric Association DSM-5 Mood Disorder Work Group, Kenneth S. Kendler, M.D., (2010) stated: “A broad range of evidence agreed to by both sides of this debate shows that there are little to no systematic differences between individuals who develop a major depression in response to bereavement and in response to other severe stressors.” He goes on to clarify that although the vast majority of individuals exposed to grief do not develop major depression, it is understood that these individuals still do grieve (Kendler, Myers & Zisook, 2008). He states: “Depression is a slippery word and we are so used to using it to mean ‘sad’, ‘blue’, ‘upset’ or, in this specific case, ‘grieving.’ Major depression – the diagnostic term – is something quite different.”

Proponents of the change say that removal of the bereavement exclusion will be helpful for diagnostic consistency and provide rapid treatment options to bereaved people who experience symptoms of Major Depression. In a recent article in the *New York Times*, Dr. Sidney Zisook, Psychiatrist at UCSD said that sometimes grieving people need help. He said, “Depression can and does occur in the wake of bereavement, it can be severe and debilitating, and calling it by any other name is doing a disservice to people who may require more careful attention” (as cited in Carey, 2012). Opponents of this exclusion say that the research on bereavement is limited, and until it is better understood, bereavement should be distinguished as a unique phenomenon. Concerns include the risk of false positives and possible tendency to pathologize normal grief (Wakefield & First, 2008).

Conditions for future clinical attention

A subset of bereaved individuals has been recognized in the literature as experiencing acute grief reactions characterized by an intense and persistent longing for the deceased, a sense of anger and disbelief over the death, and a disturbing preoccupation with the deceased. This group has been described as experiencing a syndrome called Complicated Grief (Shear, et al., 2005). Complicated grief bears some resemblance to Posttraumatic Stress Disorder (PTSD), although there are important differences (Prigerson, et al., 2000). McKissock and McKissock (1991) described bereavement as a “natural disaster” and identified factors that complicate the grieving process. These complicated factors are: (a) The death of a child; (b) Sudden death; (c) Ambivalence in the relationship; (d) Pre-existing psychosocial stressors; (e) Perceived preventability of the death; (f) Centrality of the relationship to the bereaved person’s life; (g) Lack of diversity of social roles; (h) Concurrent crises; and (i) Lack of social support. Others have looked at traumatic aspects of grief and have developed diagnostic criteria for Traumatic Grief (Jacobs, Mazure, & Prigerson, 2000). Risk factors for Traumatic Grief include violent loss and loss by suicide as well as the witnessing of horrific events, homicide, multiple losses or personal long-term caring for the dying person.

The body of research examining Complicated Grief was the inspiration behind proposed changes to the DSM-5 that included the addition of a diagnosis consistent with a Complicated Grief syndrome. Although such a diagnosis was ultimately not included in the final version of the manual, the final chapter of the DSM-5 includes proposed criteria for other conditions that may be a focus of clinical attention. Among these proposed criteria is Persistent Complex Bereavement Disorder. This condition is characterized by symptoms lasting at least 12 months (6 months in children) following the loss of a loved one. The criteria were set by expert consensus

and included informed literature review, data reanalysis and field trial results when available (APA, 2013). Persistent Complex Bereavement Disorder is described below:

The condition typically involves a persistent yearning/longing for the deceased (Criterion B1), which may be associated with intense sorrow and frequent crying (Criterion B2), or preoccupation with the deceased (Criterion B3). The individual may also be preoccupied with the manner in which the person died (B4). Six additional symptoms are required, including marked difficulty accepting that the individual has died (Criterion C1) (e.g., preparing meals for them), disbelief that the individual is dead (Criterion C2), distressing memories of the deceased (Criterion C3), anger over the loss (Criterion C4), maladaptive appraisals about oneself in relation to the deceased or the death (Criterion C5), and excessive avoidance of reminders of the loss (Criterion C6). Individuals may also report a desire to die because they wish to be with the deceased (Criterion C7); be distrustful of others (Criterion C8); feel isolated, (Criterion C9); believe that life has no meaning or purpose without the deceased (Criterion C10); experience a diminished sense of identity in which they feel a part of themselves has died or been lost (Criterion C11); or have difficulty engaging in activities, pursuing relationship, or planning for the future (Criterion C12). (p. 790)

The criteria for Persistent Complex Bereavement Disorder can include a traumatic bereavement specifier. In such cases, the death was due to homicide or suicide and includes persistent distressing preoccupations regarding the traumatic nature of the death that are often in response to loss reminders including, but not limited to the loved one's last moments, imagined suffering, or the imagined intentions of the perpetrator (in the case of homicide) (DSM, 2013).

Members of the work committees in development of the DSM- 5 hope that the conditions for further study like Persistent Complex Bereavement Disorder will provide a common language for researchers and clinicians. In addition, they hope to encourage and promote research that will lead to better understanding of these conditions and the possibility for placement in forthcoming editions of the DSM (personal communication, June 8-9, 2013).

Conclusion

The experience of grief following the loss of a loved one is an understandable and widely accepted reaction that shares several symptoms of major depression. However, there are some fundamental differences between depression in the context of grief and the signs of clinical depression. Such differences include a more persistent and chronic state of depressed mood associated with a Major Depressive Episode that is tied to specific thoughts or preoccupations of suicide. In addition, individuals who suffer from Major Depressive Disorder experience self-critical or pessimistic ruminations and have a lowered sense of self-esteem. The Diagnostic Statistical Manual of Mental Disorders, version 5 (DSM-5) which was published in May, 2013 includes the elimination of the bereavement exclusion to the diagnosis of Major Depressive Disorder. This change allows the occurrence of a Major Depressive Episode in the context of bereavement. The DSM-5 also includes proposed criteria for Persistent Complex Bereavement Disorder. This condition is characterized by persistent yearning or longing for the deceased, intense suffering, and preoccupation with the deceased and the circumstances of the death that

causes reactive distress and social/identity disruption that occurs twelve months or longer after the loss. The need for clinicians to carefully consider the differences between normal sadness and clinical indicators of a Major Depressive Episode following a loss is heightened. It is critical that clinicians working with bereaved individuals are skilled at making such a distinction and develop confidence making the appropriate treatment considerations.

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