

### Dr Corruble and Colleagues Reply

**To the Editor:** The aim of the bereavement exclusion E criterion for major depressive episode (MDE) is to discriminate subjects with a modest “normal” depressive syndrome that should not be medicalized prematurely.

Our results,<sup>1</sup> in line with previous ones,<sup>2</sup> actually show that this criterion has a poor discriminant validity in treatment-seeking individuals. Indeed, among 11,510 individuals with depressive symptoms, matched subjects fulfilling the MDE A, B, C, and D criteria, and differing only on the presence/absence of the E criterion based on the clinician's judgment, were not different in terms of 6-week outcome.<sup>1</sup> The strength of our studies is their naturalistic real-world design, no other studies assessing the E criterion reliability having been published.

We do not share the interpretation of our data proposed by Wakefield and First, who argue that our sample “generally did not qualify for exclusion” and that the clinicians did not apply the criterion correctly. Their allegation is based on the presence of some symptoms (worthlessness, suicidal ideation, psychomotor retardation), actually assessed based on the MDE A criterion, which stipulates that “5 (or more) of the criterion A symptoms have to be present during the same 2-week period and represent a change from previous functioning.”<sup>3(p327)</sup> These symptoms are not incompatible with the E criterion exclusion; indeed, the A criterion does not inform about their “persistence for longer than 2 months” or the extent to which they entail “marked” functional impairment or “morbid preoccupation” or whether they are “not better accounted for by bereavement.” For example, suppose Mr A, whose wife died 2.5 months ago, has some mild feelings of worthlessness, consistent with the MDE A criterion, but is not judged to be “morbidly preoccupied” with worthlessness. He also has psychomotor retardation and suicidal ideation, consistent with the A criterion, but neither symptom has been present for more than 2 months. Mr A also has moderate but not “marked” functional impairment. He could qualify for the MDE A criterion but not necessarily be disqualified for the BE. Thus, our colleagues err in asserting “Yet any one of these symptoms disqualifies an individual from BE exclusion.”

We share the viewpoint of our colleagues, and of Clayton,<sup>4</sup> about the wording of the E criterion, which is confusing, in part because of its double negative formulation. Moreover, this criterion is markedly polythetic, mixing relationship to bereavement and 4 different symptoms as assessed for duration, functional impairment, or morbid preoccupation. The statement “symptoms are not better accounted for by Bereavement”<sup>3(p327)</sup> is also confusing because it refers mainly to the implicit model of each clinician. Indeed, we performed a brief survey among 20 psychiatrists, investigating their understanding of the E criterion. Fourteen of them did not understand it correctly. Thus, the polythetic, subjective, complex, vague, and ambiguous E criterion does not work in routine practice.

This discussion has implications for the *DSM-5*: Should the E criterion for the diagnosis of MDE be retained? If so, to what extent and based on which data? Or should it be deleted? Unfortunately, our data cannot answer these questions. Nonetheless, on the basis of the absence of published data about what could be a relevant, coherent, and evidence-based rewording, the suggestions of Clayton,<sup>4</sup> and previous reports (especially from Dr Wakefield) arguing that bereavement and other life stressors should not have different status,<sup>5</sup> we would argue for deleting the BE, while possibly retaining a V code for bereavement. Although there are some concerns that this could lead to an unacceptably high rate of major depressive disorder (MDD) being diagnosed, there are other ways of addressing this concern, such as insisting on a higher criterion A symptom cutoff score<sup>6</sup> or a longer duration of symptoms.<sup>7</sup> And this risk should be balanced against potential risk associated with retaining the BE, eg, failure to recognize bona fide MDD.<sup>8</sup>

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**Emmanuelle Corruble, MD, PhD**  
emmanuelle.corruble@bct.aphp.fr  
**Bruno Falissard, MD, PhD**  
**Philip Gorwood, MD, PhD**

**Author affiliations:** Department of Psychiatry, Paris XI University, INSERM U 669, Bicêtre University Hospital, Assistance Publique–Hôpitaux de Paris, Le Kremlin Bicêtre (Dr Corruble); Department of Biostatistics and Public Health, Paris XI University, INSERM U 669, Paul Brousse Hospital, Assistance Publique–Hôpitaux de Paris; Villejuif, France (Dr Falissard); and Department of Psychiatry, Paris V University, INSERM U 894, Sainte-Anne Hospital; Paris, France (Dr Gorwood). **Potential conflicts of interest:** Dr Corruble has, within the last 5 years, received consulting fees and speakers honoraria from Wyeth, Lilly, Servier, Lundbeck, UCB-Pharma, Pfizer, Bristol Myers Squibb, Janssen-Cilag, and Eisai. Dr Falissard has received consulting fees and honoraria within the last 5 years from Lilly, Servier, Sanofi, Pfizer, Novartis, Genzyme, HRA, Otsuka, and Janssen. Dr Gorwood has, within the last 5 years, received research grants from Eli Lilly and Servier and speakers honoraria from Lundbeck, Servier, and UCB-Pharma and served on the advisory

boards for Janssen, Servier, Wyeth, Bristol-Myers Squibb, and AstraZeneca. **Funding/support:** None reported. **Acknowledgments:** The authors would like to thank Dr Ron Pies and Dr Sidney Zisook for their comments about this letter.  
doi:10.4088/JCP.11r07147a  
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