Bereavement, Complicated Grief, and *DSM*, Part 1: Depression

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> *To spare oneself from grief at all costs can be achieved only at the price of total detachment, which excludes the ability to experience happiness.*
>
> —Erich Fromm

The Case of Mr A

Mr A is a 73-year-old man whose wife of 50 years died 5 weeks previously. He has no appetite, has lost 8 lb in the past month, consistently awakens at 4 AM, "can't think straight," and no longer takes any pleasure in customary activities. He denies feelings of guilt or worthlessness. Although he denies suicidal intent, he confides that he wishes to join his dearly departed wife. When discussing his wife, he shows moderate psychomotor agitation and spends most days mindlessly sitting in front of his television.

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (*DSM-IV-TR*),[1] Mr A does not have a psychiatric condition; consequently, treatment with antidepressants or formal psychotherapy is not indicated. Mr A would be assigned the V-code, bereavement, and reassured that nothing is wrong. However, according to the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (*ICD-10*),[2] Mr A has major depressive disorder (MDD). Ostensibly, decisions about treatment would be made just as they would after any other, non–bereavement-related, episode of MDD. The question to be addressed in the following discussion is whether the best available evidence more strongly supports the *DSM-IV-TR* or the *ICD-10*.

History of the *DSM* Bereavement Exclusion

Prior to the 1980 publication of the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (*DSM-III*),[3] *bereavement* was not part of psychiatry's official nomenclature. *DSM-III* introduced recent bereavement as an exclusion for the diagnosis of major depressive episode (MDE) and as a V-code (other conditions that may be a focus of clinical attention but are not themselves instances of mental disorders):

> As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a MDE.…the duration and expression of "normal" bereavement vary considerably among different cultural groups.…the diagnosis of Major Depressive Disorder (MDD) is generally not given unless the symptoms are still present 2 months after the loss…however, the presence of certain symptoms (guilt, suicidal thoughts, worthlessness, psychomotor retardation, marked functional impairment and psychotic features) that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a MDE (pp 40–41).

Thus, according to the *DSM-IV-TR*, an individual who meets all symptomatic, duration, and impairment criteria for MDD but is recently bereaved may not have MDD; in contrast, a nonbereaved individual with the same clinical constellation of symptoms who is recently divorced, impoverished, or disabled or who cannot identify any recent adversity *does* have MDD. Does the preponderance of available data support this distinction?

In the most current *DSM* edition, *DSM-IV-TR*, bereavement remains an exclusion for the diagnosis of MDE and continues as a V-code, but bereavement is also mentioned as an exclusion for the diagnosis of adjustment disorder and, under certain circumstances, for the diagnosis of posttraumatic stress disorder (PTSD). Of interest, the *ICD-10* does not exclude the diagnosis of MDE or adjustment disorder based on recent bereavement and does not have a V-code for bereavement. That there are differences in the ways the *DSM-IV-TR* and the *ICD-10* deal with the nosologic status of bereavement speaks to uncertainty, disagreement among "experts," and the lack of reliable data to guide diagnostic and treatment decisions in the context of bereavement. Given that one of the goals of the *DSM-V* development committees is to better align diagnostic criteria with *ICD-10* and *ICD-11*, the time has come to evaluate relevant evidence for and against present diagnostic conventions and to make changes based on the best available evidence. This 2-part series focuses on the 2 most controversial issues regarding the role of bereavement in psychiatric diagnoses. Part 1 focuses on the question, Should the recent death of a loved one continue to exclude the diagnosis of MDE? and part 2 focuses on the question, Is there a point at which grief fails to be adaptive and should be diagnosed as a clinical condition requiring formal treatment? The authors will conclude with recommendations for *DSM-V* based on the best available data.

Bereavement and Depression

Bereavement is a universal stressor that is one of the most likely to precipitate an episode of major depression.[4,5] Studies show that approximately one-third of all widows or widowers manifest a full major depressive episode 1 month after the death of a spouse; approximately one-fourth, at 7 months; approximately 15%, at 1 and 2 years; and up to 10% may meet criteria for MDE for the entire year.[6–8] Yet, many clinicians are confused by the relationship between grief and depression and are uncertain about when to make the diagnosis of MDE in bereaved individuals. The principal source of diagnostic confusion is the common occurrence of low mood, sadness, and social withdrawal in both bereavement and MDE. The *DSM-III* and its subsequent iterations have attempted to prevent overdiagnosis of MDD in bereaved persons who are sad and withdrawn by excluding recently (less than 2 months after the death) and acutely (duration less than 2 months) bereaved individuals from the diagnosis of MDE unless they also meet certain other conditional criteria (worthlessness, psychomotor retardation, suicidal ideation, psychotic features, severe distress or dysfunction). However, many grief experts, rather than considering a full major depressive syndrome in the context of grief to be "normal," question the *DSM-IV-TR* convention of waiting a full 2 months before making the diagnosis.

The bereavement exclusion was originally introduced immediately after publication of a series of reports by Clayton et al[7,8] documenting the high prevalence of major depressive syndromes occurring during bereavement. Because these depressive syndromes tended to be relatively mild, usually dissipated over time without treatment, and "differed" from clinical depression in several ways, Clayton cautioned against overdiagnosing major depression during the first year of bereavement. Since then, however, 2 reviews[6,9] have noted the similarities between bereavement-related depressive syndromes and other non–bereavement-related MDD in terms of clinical and biologic characteristics, common comorbidities, course, and treatment response. In addition, 3 secondary analyses of large population-based databases[10–12] have demonstrated

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similarities between bereavement-related major depressive syndrome and other life-event–related depressions with respect to demographic and clinical characteristics, intensity, familiality, course, associated features, and treatment responses. In addition, in a large population-based prospective study, Karam et al[13] reported that the global symptom profile of depressed individuals and their risk for depressive recurrence were similar in bereaved and nonbereaved subjects, and the duration of illness was actually *longer* in the bereaved group. Further, in a large, case-control, cross-sectional study of a national database, Corruble et al[14] found that subjects who are excluded from the diagnosis of MDE on the basis of current *DSM-IV-TR* conventions are, if anything, even *more* severely depressed than MDD controls without bereavement. None of these reviews or studies provides support for the special treatment given to bereavement-related depression in the *DSM*. The conclusion is either that *all* depressive episodes that occur soon after a stressful life event and are not associated with the conditional features of morbid feelings of worthlessness, psychomotor retardation, suicidal ideation, psychotic features, or marked and prolonged functional impairment should *not* be given the diagnosis of MDE (the position of Wakefield et al[10]) or that the bereavement exclusion should be eliminated from the *DSM-V* (the conclusion of Zisook and Kendler,[6] Zisook et al,[9] Kendler et al,[11] Kessing et al,[12] Karam,[13] Corruble et al,[14] and possibly Clayton[8]).

Returning to the Case of Mr A

The preponderance of available evidence supports the *ICD-10* convention of diagnosing MDD when all symptomatic, duration, and severity criteria are met. It does not support the exclusivity of bereavement as the only life event that negates the diagnosis of MDD. Mr A would be ill-served if his MDD were "explained away" by his grief and if he were thereby denied the best available treatment for his depression.

Recommendations for *DSM-V*

On the basis of the best available data as briefly reviewed in this article, we recommend that *DSM-V*:

1. Eliminate the bereavement exclusion for the diagnosis of MDD.
2. Either eliminate the V-code *bereavement* or specify that it should not be used when symptoms can be better explained by MDD, adjustment disorder (space does not permit discussion of why we believe the bereavement exclusion for adjustment disorder also should be eliminated), PTSD, or complicated grief. More useful than the V-code as now conceived would be a fuller description of uncomplicated grief and of the phenomenological distinctions between the dysphoria associated with grief and with major depression.[15]

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REFERENCES

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association; 2000.
2. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*. http://www.who.int/classifications/icd/en/. Accessibility verified June 4, 2010.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*. Washington, DC: American Psychiatric Association; 1980.
4. Shear MK, Clayton PJ. Bereavement-related depression. *Psychiatr Ann*. 2008;38(10):643–646.
5. Zisook S, Paulus M, Shuchter SR, et al. The many faces of depression following spousal bereavement. *J Affect Disord*. 1997;45(1-2):85–94, discussion 94–95.
6. Zisook S, Kendler KS. Is bereavement-related depression different than non-bereavement-related depression? *Psychol Med*. 2007;37(6):779–794.
7. Clayton PJ, Desmarais L, Winokur G. A study of normal bereavement. *Am J Psychiatry*. 1968;125(2):168–178.
8. Clayton PJ. V code for bereavement. *J Clin Psychiatry*. 2010;71(3):359–360.
9. Zisook S, Shear K, Kendler KS. Validity of the bereavement exclusion criterion for the diagnosis of major depressive episode. *World Psychiatry*. 2007;6(2):102–107.
10. Wakefield JC, Schmitz MF, First MB, et al. Extending the bereavement exclusion for major depression to other losses: evidence from the National Comorbidity Survey. *Arch Gen Psychiatry*. 2007;64(4):433–440.
11. Kendler KS, Myers J, Zisook S. Does bereavement-related major depression differ from major depression associated with other stressful life events? *Am J Psychiatry*. 2008;165(11):1449–1455.
12. Kessing LV, Bukh JD, Bock C, et al. Does bereavement-related first episode depression differ from other kinds of first depressions? [published online ahead of print August 20, 2009] *Soc Psychiatry Psychiatr Epidemiol*.
13. Karam EG, Tabet CC, Alam D, et al. Bereavement related and non-bereavement related depressions: a comparative field study. *J Affect Disord*. 2009;112(1-3):102–110.
14. Corruble E, Chouinard VA, Letierce A, et al. Is *DSM-IV* bereavement exclusion for major depressive episode relevant to severity and pattern of symptoms? a case-control, cross-sectional study. *J Clin Psychiatry*. 2009;70(8):1091–1097.
15. Lamb K, Pies R, Zisook S. The bereavement exclusion for the diagnosis of major depression. *Psychiatry*. In press.

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