

COMMENTARY

The DSM-5 and the Bereavement Exclusion: A Call for Critical Evaluation

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The discipline of social work has long prided itself on taking a holistic view of human suffering and well-being and for advocating for conditions that enhance the quality of life for vulnerable populations. Yet, as others have pointed out (Carney, 2012), social workers have remained mostly silent when it comes to the changes proposed for the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). This is perplexing, given the debate this revision process has sparked in the mental health professions. In addition, social workers provide a substantial portion of mental health services in the United States, typically using the DSM (Frazer, Westhuis, Daley, & Phillips, 2009), and any changes to the manual will likely have far-reaching effects on the individuals social workers serve and on the profession as a whole.

For this reason, the DSM-5 changes require critical evaluation from social work. Though a wide range of changes has been proposed, we wish to consider just one aspect that has generated heated debate and public outcry: a change to the criteria for major depressive disorder (MDD). Whereas DSM-IV offers a bereavement exclusion that discourages the use of this diagnosis within a two-month postdeath period, DSM-5 proposes to eliminate this exclusion and allow a diagnosis of MDD two weeks after a death. We consider this proposal in light of its potential effect on bereaved parents, who constitute an especially vulnerable population socially, emotionally, and even economically (Song, Floyd, Mailick Seltzer, Greenberg, & Hong, 2010), due to the traumatic nature of infant and child death.

Although bereavement is widely recognized as a unique life event, the effects of loss must be considered within the context of individual experiences such as the relationship to the deceased and the

circumstances surrounding the death. Among bereaved parents there are many variables that affect the intensity and duration of grief, such as the degree and quality of attachment (Kreicbergs, Valdimarsdottir, Onelov, Henter, & Steineck, 2004), manner of death (Arnold, Gemma, & Cushman, 2005), religious affiliation (Wijngaards-de Meij et al., 2005), ethnicity (Laurie & Neimeyer, 2008), prior history of mental disorder (Hensley, 2006), concordant partner responses (Dyregrov & Dyregrov, 1999), and perceived level of social support (Cacciatore, Schnebly, & Froen, 2009; Mann, McKeown, Bacon, Vesselinov, & Bush, 2008). The current edition of the DSM fails to take many of these factors into consideration, and instead relies on an arbitrary two-month cutoff point before symptoms of grief contribute toward a diagnosis of MDD. However, it is well accepted that grief often lasts well beyond two months (Shuchter & Zisook, 1993), even under the best of circumstances, and that there is a significant overlap with depressive symptoms. Symptoms common to both states include sleep disturbances, fatigue, anhedonia, changes in appetite, and enduring emotional distress. These effects may be especially pronounced in bereaved parents, and feelings of worthlessness or shame and suicidal ideation, also considered symptoms of depression, are not uncommon in this population (DeFrain, 1986; Murphy, Tapper, Johnson, & Lohan, 2003; Qin & Mortensen, 2003).

Because of their intense reactions, bereaved parents are at high risk of having their understandable suffering misinterpreted as signs of a mental disorder if the bereavement exclusion is eliminated. The change to DSM-5 would allow a diagnosis of MDD as early as two weeks following the death of a child. This move reflects a wider trend of narrowing the bereavement exclusion over time, as the DSM-III allowed up to one year for the bereavement

exclusion. This was subsequently shortened to two months in DSM-IV. However, overall, DSM-III-R criteria have been shown to yield a lower rate of false positives and to do a better job of distinguishing complicated from uncomplicated bereavement than does DSM-IV (Wakefield, Schmitz, & Baer, 2011). Removing the bereavement exclusion entirely may result in an even higher rate of false positives (Wakefield et al., 2011) as well as subsume what have been shown to be normal responses to loss under the MDD category.

An increase in false positives would translate into more individuals being given a diagnosis of MDD inappropriately, which could lead to misguided treatment. It is likely that many bereaved individuals would receive psychotropic medication, as it is the most frequent, and increasingly the sole, mode of treatment offered for various mental disorders (Mojtabai & Olfson, 2008; Olfson & Marcus, 2010), despite a growing body of research questioning the efficacy and safety of this approach (see Andrews, Thomson, Amstadter, & Neale, 2012). It is important to note that there is no sound empirical data supporting the effectiveness of such medications for grief (Hensley, 2006). Yet preliminary research suggests that bereaved parents are too often prescribed psychiatric medications shortly after the death of a child, sometimes even the same day, before criteria for most mental disorders could possibly have been met (Cacciatore & Thieleman, 2012). The DSM-5, in making it easier to diagnose MDD immediately following a loss, may legitimize this alarming trend even though this practice is not evidence based.

One of the arguments for removing the bereavement exclusion in DSM-5 is that the features and course of depression are the same, no matter what kind of event may have triggered an episode (Zisook et al., 2012). However, studies have yielded disparate results, with some suggesting that depressive symptoms following bereavement may be different from other forms of depression (see Gilman et al., 2012). These postulations are confounded by the fact that most studies on which the latter assumptions are made are based on conjugal grief research, and findings may not apply to all bereavement experiences. For example, there is very little research conducted with bereaved parents on this topic. The evidence suggests that this particular population may be different from other

bereaved groups, and this may be the case with other specific groups as well.

For most people, no other loss is as painful and agonizing as the death of a child. Reactions to such a loss are typically intense, with evidence that symptoms of grief persist for a year or longer (Dyregrov & Matthiesen, 1991). In one study, 41 percent of parents, none of whom had a history of any mental disorder, showed significant levels of grief-related separation distress an average of 4.5 years following the death of their child (McCarthy et al., 2010). Another study found that it took about nine years following the death of a child for loss-related symptoms to fully abate (Kreicbergs et al., 2004). Regardless of symptom levels, it is not unusual for grief following the death of a child to last a lifetime and to change in intensity over time. In one study (Arnold et al., 2005), 63.5 percent of parents reported that their grief continued an average of 24 years following the death of a child. There were no differences in overall life satisfaction between these parents and those who felt their grieving process had ended. For the majority of the bereaved parents, intense grief does not indicate pathology; instead, continued grieving, even when it includes intense reactions, represents a way to maintain a connection to the deceased child (Arnold et al., 2005).

These findings highlight the importance of recognizing what is normal within a population, rather than on a comparison with the general population. Given the traumatic nature of the death of a child and the documented parental responses, it appears unreasonable to expect that grief-related symptoms will resolve within two weeks or two months. To rely on either one of these arbitrary cut-off points for diagnosing disorder, without consideration of the context, risks pathologizing normal human emotion and challenges what it means to be human and to love deeply. As social workers know, context *does* matter, and studies have documented that mental health professionals do consider context when assigning diagnoses (Kim, Paulus, Nguyen, & Gonzalez, 2012). The DSM criteria for depression do not appear to be adequate for distinguishing normal responses from psychopathology in bereaved parents.

There are many other criticisms of the MDD criteria, including that this category encompasses minor depressions that are likely to be time limited even if untreated (Pies, 2012) and that the criteria

focus on traits more common in women, potentially leading to gender bias (Hartung & Widiger, 1998). Certainly, the existing criteria are far from perfect. However, removal of the bereavement exclusion only compounds these problems. For instance, women tend to report higher levels of distress and to be more emotionally expressive following a loss, areas that are typically the focus of grief measures (Dyregrov & Dyregrov, 1999), so more bereaved mothers than fathers are likely to qualify for the MDD diagnosis under DSM-5.

We believe that some grieving individuals do need treatment. Of course, sensitive and compassionate support and professional help should be available to anyone who needs and desires it. However, mental health professionals should be cautious of assigning a label of a mental disorder simply to allow someone to obtain insurance reimbursement for such help. There are legitimate forms of suffering that are not caused by a mental disorder, of which the normal, though intense and enduring, distress experienced by bereaved parents is but one example. If changes are to be made to the MDD diagnosis, perhaps retaining an expanded bereavement exclusion that recognizes the long-lasting effects of loss is the most appropriate move.

Overall, there has been little empirical justification for the changes proposed for DSM-5. Like many of the proposals for DSM-5, the revision of the MDD criteria lacks the empirical evidence and thorough field testing to evaluate its utility and possible effects. For the population of bereaved parents, this move appears highly problematic and risks pathologizing normal human reactions. The DSM-5 process has also been widely criticized for lack of transparency and ability to self-correct, and in the past there have been concerns that special interests such as ties between drug companies and DSM committee members may have been driving the process more than rigorous science (Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006). The lack of transparency in DSM-5 makes many of the proposed revisions even more problematic.

We have covered just one aspect of proposed changes to DSM-5. There are many other proposed revisions that may be problematic and require careful consideration and active debate. Social workers, with their unique strengths perspective and recognition of the variety of factors that influence behavior and well-being, have

valuable input in these matters. Yet social workers have remained strangely silent when it comes to the DSM. We encourage social workers to critically evaluate all of the proposed changes in light of how they might affect the populations social work is committed to serving and in terms of potential conflicts with the stated values of NASW. **SW**

REFERENCES

- Andrews, P. W., Thomson, J. A., Amstadter, A., & Neale, M. C. (2012). Primum non nocere: An evolutionary analysis of whether antidepressants do more harm than good. *Frontiers in Psychology, 3*. Retrieved from www.frontiersin.org/psychology
- Arnold, J., Gemma, P. B., & Cushman, L. F. (2005). Exploring parental grief: Combining quantitative and qualitative measures. *Archives of Psychiatric Nursing, 19*, 245–255.
- Cacciatore, J., Schnebly, S., & Froen, J. F. (2009). The effects of social support on maternal anxiety and depression after stillbirth. *Health and Social Care in the Community, 17*, 167–176.
- Cacciatore, J., & Thielemann, K. (2012). Pharmacological treatment following traumatic bereavement: A case series. *Journal of Loss and Trauma, 17*, 557–579.
- Carney, J. (2012, March 27). 1984 & DSM5, revisited: Where are the social workers? [Web log message]. Retrieved from <http://www.madinamerica.com/2012/03/1984-dsm5-revisited-where-are-the-social-workers/>
- Cosgrove, L., Krimsky, S., Vijayaraghavan, M., & Schneider, L. (2006). Financial ties between DSM-IV panel members and the pharmaceutical industry. *Psychotherapy and Psychosomatics, 75*, 154–160.
- DeFraim, J. D. (1986). *Stillborn: The invisible death*. Lexington, MA: Rowman & Littlefield.
- Dyregrov, A., & Dyregrov, K. (1999). Long-term impact of sudden infant death: A 12- to 15-year follow-up. *Death Studies, 23*, 635–661.
- Dyregrov, A., & Matthiesen, S. B. (1991). Parental grief following the death of an infant—A follow-up over one year. *Scandinavian Journal of Psychology, 32*, 193–207.
- Frazer, P., Westhuis, D., Daley, J. G., & Phillips, I. (2009). How clinical social workers are using the DSM-IV: A national study. *Social Work in Mental Health, 7*, 325–339.
- Gilman, S. E., Breslau, J., Trinh, N., Fava, M., Murphy, J. M., & Smoller, J. W. (2012). Bereavement and the diagnosis of major depressive episode in the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 73*, 208–215.
- Hartung, C. M., & Widiger, T. A. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin, 123*, 260–278.
- Hensley, P. L. (2006). Treatment of bereavement-related depression and traumatic grief. *Journal of Affective Disorders, 92*, 117–124.
- Kim, N. S., Paulus, D. J., Nguyen, T. P., & Gonzalez, J. S. (2012). Do clinical psychologists extend the bereavement exclusion for major depression to other stressful life events? *Medical Decision Making*. Advance online publication. doi:10.1177/0272989X12443417
- Kreicbergs, U., Valdimarsdottir, U., Onelov, E., Henter, J. I., & Steineck, G. (2004). Anxiety and depression in parents 4–9 years after the loss of a child owing to a malignancy: A population-based follow-up. *Psychological Medicine, 34*, 1431–1441.

- Laurie, A., & Neimeyer, R. A. (2008). African Americans in bereavement: Grief as a function of ethnicity. *OMEGA: Journal of Death and Dying, 57*, 173–193.
- Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R., & Bush, F. (2008). Predicting depressive symptoms and grief after pregnancy loss. *Journal of Psychosomatic Obstetrics & Gynecology, 29*, 274–279.
- McCarthy, M. C., Clarke, N. E., Ting, C. L., Conroy, R., Anderson, V. A., & Heath, J. A. (2010). Prevalence and predictors of parental grief and depression after the death of a child from cancer. *Journal of Palliative Medicine, 13*, 1321–1326.
- Mojtabai, R., & Olfson, M. (2008). National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry, 65*, 962–970.
- Murphy, S. A., Tapper, V. J., Johnson, L. C., & Lohan, J. (2003). Suicide ideation among parents bereaved by the violent deaths of their children. *Issues in Mental Health Nursing, 24*, 5–25.
- Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *American Journal of Psychiatry, 167*, 1456–1463.
- Pies, R. W. (2012, April 6). DSM-5's bereavement bind: Time for an independent review. *Psychiatric Times*. Retrieved from <http://www.psychiatrictimes.com>
- Qin, P., & Mortensen, P. B. (2003). The impact of parental status on the risk of completed suicide. *Archives of General Psychiatry, 60*, 797–802.
- Shuchter, S. R., & Zisook, S. (1993). The course of normal grief. In M. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 23–43). New York: Cambridge University Press.
- Song, J., Floyd, F. J., Mailick Seltzer, M., Greenberg, J. S., & Hong, J. (2010). Long-term effects of child death on parents' health-related quality of life: A dyadic analysis. *Family Relations, 59*, 269–282.
- Wakefield, J. C., Schmitz, M. F., & Baer, J. C. (2011). Did narrowing the major depression bereavement exclusion from DSM-III-R to DSM-IV increase validity? *Journal of Nervous and Mental Disease, 199*, 66–73.
- Wijngaards-de Meij, L., Stroebe, M., Schut, H., Stroebe, W., van den Bout, J., van der Heijden, P., & Dijkstra, I. (2005). Couples at risk following the death of their child: Predictors of grief versus depression. *Journal of Consulting and Clinical Psychology, 73*, 617–623.
- Zisook, S., Corruble, E., Duan, N., Iglewicz, A., Karam, E. G., Lanuette, N., et al. (2012). The bereavement exclusion and DSM-5. *Depression and Anxiety, 29*, 425–443.

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