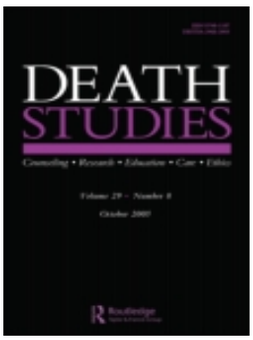

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The Medicalization of Bereavement: (Ab)normal Grief in the DSM-5

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This article examines the recently published changes to eliminate the bereavement exclusion (BE) from the criteria for the diagnosis of major depression in the fifth edition of the *Diagnostic and Statistical Manual* (DSM-5). Numerous scholars and critics have expressed concerns by calling these changes a "medicalization" of grief. This article first considers the removal of the BE and then examines the macrolevel and microlevel consequences of this medicalization of grief, including overdiagnosis and overtreatment, a potential expanded market for pharmaceutical companies, and the loss of traditional and cultural methods of adapting to the loss of a loved one.

Medicalization is a process by which certain behaviors and conditions are defined as medical conditions or disorders and then become monitored and treated by the medical profession. There are a number of consequences of medicalization including increased medical treatments, insurance coverage, and changes in stigma. Common misconceptions of medicalization are that it means overmedicalization or that it is good or bad. However, experts note that it is not a normative process and thus neither positive nor negative (Conrad, 2007). Rather, sociologists study how a condition becomes medicalized and with what consequences.

The recent removal of the bereavement exclusion (BE) from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013) has prompted much debate about what is considered a socially appropriate length of time for bereaved individuals to grieve. Several scholars in the field have vocalized concerns that these changes signify a "medicalization of grief" (Frances, 2010; Wakefield & First, 2012; Wakefield, Schmitz, First, & Horwitz, 2007). Although grief has been described as a pathology (Granek, 2014; Walter, 2000), this article approaches the elimination of the BE in the DSM-5 from a sociological point of view to more precisely examine the changing nature of what our society deems as normal and abnormal behavior. First, I review the initial inclusion of bereavement for the diagnosis of depression in the DSM-3 and consider the arguments for and against the removal of the BE in the DSM-5. I then examine the consequences of the medicalization of grief by considering the macro and micro-level effects of the changes to the BE in the DSM-5.

The medicalization framework is important in considering the consequences of the elimination of the BE in the DSM-5. There are three major macrolevel and microlevel consequences of this medicalization of grief. As with other changes that have been medicalized, removing the BE may lead to the overdiagnosis and overtreatment of major depression, as more individuals fall under the criteria for major depression. Second, there is the potential for the pharmaceutical industry to market a treatment for this increased population of those considered to have major depression. Finally, the changes to the BE call into question the loss of traditional and cultural methods of grieving with the introduction of psychiatry in the human emotion of grief.

HISTORICAL AND RECENT CHANGES TO BEREAVEMENT IN THE *DSM*

Bereavement first appeared in the third edition of the DSM (DSM-3) in 1980 as a V code for a

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"Supplementary Classification of Factors Influencing Health Status and Contact with Health Services" (APA, 1980). The DSM-3 distinguished between uncomplicated, or a normal reaction to loss, and complicated grief:

> A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia [uncomplicated grief]. However, morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation are uncommon and suggest that the bereavement is complicated by the development of Major Depression. (p. 333)

Unless an individual experienced severe expressions of grief including those of the latter half of the statement, then he or she was considered to exhibit normal grief. Notably, even though these behaviors were not considered abnormal reactions to grief, they are still listed as symptoms, a term often used to describe a medical problem or disorder.

The incentive to include bereavement in the DSM-3 came from the need to contextualize bereavement in relation to depressive symptoms. The DSM-3 committee noted that depressive symptoms, within the context of bereavement, were a normal reaction to the death of a loved one, whereas if these symptoms occurred outside of bereavement, they would be abnormal (Mojtabai, 2011). Depression in the DSM-3 was also based on putative scientific evidence and symptoms, and incorporating scientific data into diagnostic criteria in the DSM led to the notion that grief could be conceptualized as a disease (Granek, 2014).

A number of studies on widows and widowers revealing an improvement in their symptoms of depression over time (e.g., Clayton, Desmarais, & Winkour, 1968) served as the impetus for the guidelines in the fourth edition of the DSM (DSM-4; APA, 1994). The DSM-4 operationalized the duration of these symptoms as persisting for longer than two months after the loss, stating:

> The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are present 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include 1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voices of, or transiently sees the image of, the deceased person. (pp. 684–685)

These symptoms had to exist for at least 2 weeks, although the diagnosis could not be given until at least 2 months following the death of a loved one.

It is important to note that complicated grief (CG) is a contested category of intense and prolonged grief that differs from major depression in that it is characterized by an intense sense of yearning, recurrent thoughts of the deceased person, and feelings of intense loneliness and hopelessness, which can result in a variety of poor behaviors (Prigerson et al., 1995; Shear et al., 2011). There was much debate as to whether prolonged grief disorder should be included in the DSM-5, with the ultimate decision being not to include it (Bryant, 2014).

The DSM-5 that was released in May 2013 changed the BE, removing the 2-month waiting period (Fawcett, 2010). The new criteria allow a bereaved individual to be diagnosed with major depression after 2 weeks of experiencing symptoms. There are four major arguments that prompted the removal of the BE in the DSM-5. First, the changes are based on data from recent studies finding no major difference between bereavement-related depression and depression caused from other life stressors (Fawcett, 2010; Flaskerud, 2011; Kendler, Myers, J., & Zisook, 2008; Zisook & Kendler, 2007). For example, bereavement-related depression was considered similar to depression related to other stressful life events in terms of risk factors, intensity, characteristics, biology, symptoms, and response to treatment (Pies & Zisook, 2010; Zisook & Kendler, 2007).

The second major argument that prompted the proposal for removing the BE came from three international studies including those of Karam et al. (2009), Kessing et al. (2010), and Corruble et al. (2009) (Lamb, Pies, & Zisook, 2010). These three studies from Lebanon, Denmark, and France revealed that individuals who were excluded from the diagnosis of depression due to bereavement actually had more severe symptoms than those with nonbereavement related depression (Lamb et al., 2010). These studies implied that bereaved individuals who are excluded from receiving the diagnosis of major depression may develop more severe depression because they are unable to access different treatments for their depression. In addition, others have argued that the inability to recognize and treat these symptoms may result in a "public health disaster" for those who did not receive treatment (Pies & Zisook, 2010).

A third argument for removing the BE in the DSM-5 is that this change would be parallel to existing international criteria in the International Classification of Disease (ICD-10; Pies & Zisook, 2010). The unification of the criteria for depression related to bereavement in

the DSM and the ICD would make the diagnosis more consistent.

Finally, the fourth rationale for removing the BE in the DSM-5 is that clinicians should be able to properly distinguish "productive" grief from more serious reactions of grief including feelings of isolation and the inability to be consoled. Moreover, clinicians should evaluate patients' experiences and examine phenomenological differences rather than solely using diagnostic check-lists (Pies & Zisook, 2010). This idea of the phenomenology of grief comes from the notion that there is a distinction between normal sorrow and severe depression that clinicians are best able to evaluate. This idea is that sorrow, bereavement, severe grief, and depression have biological differences and that there is a range of different emotions in which normal sorrow and sadness are on one end and more severe depressive responses on the other end (Pies, 2008). Sorrow involves a feeling of being closely connected with others, whereas depression includes feelings of loneliness and separation from others. It is important for clinicians to distinguish between normal and more severe reactions to grief (Pies & Zisook, 2010). These medical and psychiatric professionals are some of the important claims-makers in the changes the DSM-5, yet there are many others who oppose their views.

Although the revisions for bereavement-related depression were accepted into the new DSM-5, several prominent members of the psychiatric and medical community have voiced their criticisms about these changes. In fact, quite a debate has ensued around the narrower and broader levels of both the research studies that support the removal of the BE as well as the consequences for the new criteria. There are three major criticisms of the removal of the BE in the DSM-5. First, longitudinal data indicate that those who experienced a single, brief depressive episode due to bereavement had unique symptoms and no greater risk for future depression compared to those who experience other types of depression (Mojtabai, 2011). Similarly, a comparison of bereavement-related depression and depression from other sources revealed that there are distinct differences between uncomplicated and complicated depression for both bereavement and other losses (Wakefield et al., 2007). These two studies support the previous criteria in the DSM-4 of the BE as a way to distinguish between different types of depression and thus do not support the elimination of the BE in the DSM-5.

Second, there have also been important criticisms of the studies cited as evidence for the BE changes in the DSM-5. Some research compared all bereavement-related depression to depressions caused from other life stressors (Zisook & Kendler, 2007). Critics of the changes considered this type of comparison problematic because they believed there needed to be a distinction between uncomplicated and complicated reactions to grief in the bereavement-related depression group because the BE did in fact distinguish between the two categories (Wakefield & First, 2012). In addition, the international studies by Kessing et al. (2010), Corruble et al. (2009), and Karam et al. (2009) that were previously mentioned were also criticized because they were believed to have either not correctly tested the BE or used samples that were too small to draw any worthy conclusions (Wakefield & First, 2012).

The third major criticism to the removal of the BE is that the BE already considered severe expressions of grief. About 10–15% of bereaved individuals reportedly experience severe expressions of grief (Bonanno, 2004). It is these individuals to which the new DSM targets (Flaskerud, 2011). Many proponents of the changes argue that the DSM-5 will allow health professionals to identify bereaved individuals who need help. Yet, the criteria to help these individuals who experience severe grief already existed in the DSM-4 (Frances, 2010). For example, the BE in the DSM-4 already accounted for thoughts of suicide, and thus the individual would, by definition, classify as having a mental illness (Wakefield & First, 2012). These issues illuminate the importance of paying careful attention to the way the DSM defines the BE.

With the introduction of bereavement-related issues in the DSM beginning with the DSM-3, there has been a transformation in the culture around issues of death and dying that has led to changes in who and what social institutions can intervene in these once-deemed private emotions. Western society can be characterized as death-denying in which death is a taboo subject (Harris, 2009). There has been a historical transformation in the nature of grief as an object of psychological study, such that changes "around death, dying, and grieving in the 20th and 21st centuries represent shifts in ideology and culture that have left an open space for psychologists to step in and provide guidance amid this uncertainty and ambiguity surrounding mourning" (Granek, 2014, p. 32). Although religious institutions historically provided ways for dealing with issues around death and grief (Granek, 2014; Seale, 1998), there are now societal expectations of how bereaved individuals should behave (Harris, 2009).

MACRO- AND MICROLEVEL CONSEQUENCES OF REMOVING THE BE: THE MEDICALIZATION OF GRIEF

The notion that the changes in the DSM-5 could lead to the broader consequence of the "medicalization of grief" has stirred up controversy among medical and psychiatric professionals and has emerged in popular media sources, reaching the general public. The revisions to the DSM-5 have also created quite a debate among experts, who argue that these revisions could lead to a standard of what is considered "appropriate

grief,'' both in the duration and magnitude of depressive feelings (Frances, 2010; Granek, 2014, Wakefield & First, 2012; Wakefield et al. 2007). Several scholars have described the ways in which grief has historically been regulated by societal expectations and values (Granek, 2014; Holst-Warhaft, 2000; Walter, 2000), yet the elimination of the BE has led to new questions about the medicalization of the process of grieving and the ways in which our society will respond to these new definitions of grief by way of clinical diagnostic criteria. The medicalization of grief results in three major consequences including overtreatment and overdiagnosis, an expanded market for pharmaceutical companies, and the loss of traditional and cultural methods of grieving that are all expressed on both the macro- and microlevels.

Overtreatment and Overdiagnosis

One important macrolevel consequence of the elimination of the BE is that it could lead to overdiagnosis and overtreatment of grief (Frances, 2010). By eliminating the 2-month ''normal'' grieving period, it is possible that the symptoms of those who seek treatment immediately (following the 2-week minimum for the presence of symptoms) may eventually resolve on their own without medical or psychiatric intervention. In this case, longitudinal data are invaluable, as they would be helpful in determining if these feelings of depression do in fact resolve over time. On a macro-level, overdiagnosis would result in an expanded number of individuals considered to have major depression. In response to the changes to the DSM-5, several opponents have also called for clinicians to attend to the potential for overdiagnosis and to be careful in determining when intervention is needed. Clinicians should be both mindful and skilled in their ability to differentiate between clinical depression and normal depressive emotions in recently-bereaved persons (Friedman, 2012). Further, clinicians and researchers should recognize the importance of the context of the death, especially for those who have experienced traumatic deaths (Thieleman & Cacciatore, 2013).

Overtreatment is also a microlevel concern. If intervention for some individuals' grief is unnecessary, their feelings or symptoms may worsen with treatment (Horwitz & Wakefield, 2007). On a microlevel, as with any condition that requires treatment with prescription drugs, there may be side effects which oftentimes are worse than the condition itself and may lead to other conditions (Flaskerud, 2011).

Expanded Market for Pharmaceutical Companies

A second important macro-level consequence of the elimination of the BE is the opportunity for pharmaceutical companies to create new markets for drugs (Frances, 2010; Friedman, 2012). As with many conditions that have been medicalized, there is oftentimes an opportunity for the pharmaceutical industry to become involved and take a stake in the market for a new condition by developing new drugs and earning profits. Death is a naturally occurring life event; 2.5 million Americans die each year (Murphy, Xu, & Kochanek, 2010). Medicalizing grief would potentially open up a huge market for pharmaceutical companies. This medicalization of grief could also have repercussions on insurance companies by legitimatizing coverage for prescription medications.

An examination of 36 psychiatrists' views of the DSM illustrates the DSM's influence on insurance coverage (Whooley, 2010). These psychiatrists reported that they often embellished a diagnosis using a DSM code to ensure that patients get reimbursed for certain medications or treatments. This example of overdiagnosis stems from standards created by insurance companies to cover only certain treatments and demonstrates the autonomy of psychiatrists in their ability to use the DSM categories to the financial advantage of the patient. With the elimination of the BE, psychiatrists will have more leeway in diagnosing major depression after 2 weeks following the death. It is likely that psychiatrists will continue these practices to limit potential patients' out-of pocket expenses when prescription drugs become available, in effect serving to increase the medicalization of grief.

There is also the controversy that the supporters and creators of the changes in the DSM-5 are financially involved with the pharmaceutical industry. Drug companies will likely benefit from these changes, and strong connections to pharmaceutical companies influence changes to the DSM. According to a 2012 study, 69% of DSM-5 committee members reported financial ties to pharmaceutical companies, which was a 21% increase from the proportion of DSM-4 task force committee members (Cosgrove & Krimsky, 2012). It is unclear how the requirement of committee members to disclose financial ties affects their stance on the BE.

Loss of Traditional and Cultural Methods of Grieving

A third important macro and microlevel consequence of the elimination of the BE is the change in the meaning of grieving from traditional and cultural definitions. Bereavement is not new: Individuals have been grieving and mourning for as long as they have been living, and religious and/or cultural practices help them deal with their grief. On a macrolevel, prescribing a pill for intense feelings of grief may ultimately eliminate traditional coping mechanisms (Flaskerud, 2010). For example, research may illuminate how religious communities have

responded to these changes in the BE, and perspectives from different religious traditions may help to inform how the DSM affects traditional grieving (Peteet, Lu, & Narrow, 2011).

On a microlevel, grief is a very personal matter, and many opponents to the changes question whether there should be a restriction placed on the length of time an individual has to grieve. In other words, is it appropriate for clinicians to intervene, and if yes, when should they do so? Here the authority of the medical profession is visible in its ability to define what is normal and abnormal. The removal of the BE illustrates the relation between social control and medicalization, demonstrating how defining grief in medical and psychiatric terms may erase human difference and individuality in the grieving process.

CONCLUSION

What is an ''appropriate'' length of time to grieve? According to the DSM-4, after 2 months, the individual can be diagnosed with major depression. With the new guidelines in the DSM-5, however, the diagnosis can be made after 2 weeks. Two months may seem a rather arbitrary length of time, but 2 weeks may also be arbitrary given that some individuals experience off-time, sudden, or traumatic deaths that may result in an initial period of shock prior to other expressions of grief. There is a very narrow view of what is considered too much or too little grieving in our society, as those who do not visibly grieve are also seen as ''abnormal.'' The characteristics of grief often depend on the circumstances of the death, the nature of the relationship to the deceased, caregiving responsibilities, and anticipatory grief. Other changes in the DSM-V have also been challenged, but it can be argued that the removal of the BE is very much a personal issue because it involves the intimate human emotion of grief.

The narrow DSM-5 2-week definition will mean that more people will identify as patients and that the diagnosis of depression will increase. Because of this expanded category of depression, on the macro scale in terms of public health, there could be a growth in the number of individuals who will be considered clinically depressed as well as increased and possibly unnecessary spending on health care for the treatment of those considered to have a mental illness. Over the past 30 years there has been a ''diagnostic inflation'' in which active efforts by pharmaceutical companies to market drugs have increased the number of individuals considered to have a psychiatric disorder (Batstra & Frances, 2012); the number of individuals treated with psychotropic drugs will only increase with the DSM-5. On a more microlevel scale, the question of how the diagnosis of major depression following the loss of a loved one will influence the bereaved individual's ability to recover and overcome his or her grief is an important consideration. Will the stigma of having a diagnosis of a mental illness affect the bereaved individual's capacity to move on, or will the diagnosis legitimate one's symptoms?

The key to medicalization is the way a condition or behavior is defined, what is medically and subsequently socially ''appropriate,'' and what treatments are available. The medicalization of grief is no exception, as the psychiatric profession has come to define what is considered (ab)normal. Horwitz and Wakefield (2007) noted a type of ''loss of sadness,'' or the idea that the boundary between normal and disordered sadness is blurred, transforming a normal condition into a medical one and often causing harm to those who experience normal sadness. Similarly, the medicalization of grief narrows the criteria of what is considered ''appropriate grief,'' both in the duration and magnitude of depressive feelings, turning much of normal grief into a psychiatric disorder in need of treatment.

The changes in the DSM-5 were only publicly released in May 2013, and although many critics have spoken out against these revisions and argued that they will lead to a medicalization of grief, there is certainly more criticism to come in the medical, psychiatric, and public spheres as these new guidelines are implemented. Future scientific research likely will not settle this debate. It is also important to acknowledge that it is not that individuals have suddenly changed the ways they grieve, as bereavement has existed for as long as people have been dying, but that ''appropriate'' and ''normal'' grief are now specifically articulated in the newest changes in the DSM-5. Grief is intrinsic to the human condition, but the ways in which we view bereavement and grief are changing and will be shaped by how ''normal'' grief is defined in one of the world's most influential mental health books, the current edition of the DSM.

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