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Literature Review on the Recent Elimination of the Bereavement Exclusion of Major Depressive Disorder in DSM-5

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Abstract

Bereavement is a universal phenomenon in which a depressive episode is expected to follow. Due to this expectation and the normality of depressive episodes, bereavement has been excluded from the list of stressful life events that can act as a precursor for major depressive disorder since the DSM-3. However, this tradition was removed in the recent edition of the DSM which generated intense arguments amongst mental health professionals. Reasons for eliminating the bereavement exclusion criteria were lack of supporting evidence differentiating bereavement from other life stressors and the risk of overlooking major depressive disorders in bereft individuals (Pies, 2014). However, some argue that the elimination of the bereavement exclusion criteria prompts pathologizing normal grief, overdiagnosis, and use of unnecessary treatments (Jones & Fox, 2013). Despite these arguments, one conviction is agreed upon; the DSM-5 does not provide a valid measure to distinguish normal grief from pathological grief, which puts an ethical burden on mental health professionals (Jones & Fox, 2013). This paper establishes that, while both sides of the dispute are grounded in empirical evidence, arguments that support the elimination of the bereavement exclusion criteria are more conclusive, justifying the decision made in the DSM-5.

Keywords: DSM-5, bereavement exclusion, major depressive disorder

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Literature Review on the Recent Elimination of the Bereavement Exclusion of Major Depressive Disorder in DSM-5

A long-held tradition of excluding bereavement from the list of life stressors deemed to be a precursor to major depressive disorder (MDD) has been eliminated in the DSM-5, generating much debate amongst psychologists. The bereavement exclusion criteria (BEC) is a criterion under the MDD diagnostics that restricts MDD diagnosis from bereft individuals unless their symptoms are abnormally severe in the context of mourning as a grief response is expected to follow (Florence et al., 2015). The main rationale behind the elimination of the BEC was the lack of evidence that ratifies depression following bereavement to be in any form different from depression following other life stressors, as well as the risks associated with overlooking MDD in bereft individuals (Wakefield & Schmitz, 2013). On the other hand, psychologists criticizing the decision had concerns centered around the possibility of pathologizing normal grief, significant increases in depression diagnoses and subsequent use of unnecessary medication as treatment (Jones & Fox, 2013). While the research in this area is mixed, as they challenge each other's findings with contradicting evidence, the research literature is more concrete and abundant in the direction of eliminating the bereavement exclusion criteria in the DSM-5. The argument over this controversial topic is intense, however, there is one variable that psychologists on both sides agree on; the DSM-5 does not provide clinicians guidelines that distinguish pathological grief from a normal grief response (Jones & Fox, 2013). Not only does this create confusion for clinicians, it puts an ethical burden on them as well. Several suggestions have been provided to mediate this issue.

History of Bereavement Exclusion Criteria

In order to comprehend the background of this dispute, it may be useful to gain some understanding of the history behind the BEC. The BEC is a criterion under the MDD diagnostics that restricts MDD diagnosis from bereft individuals unless their depressive state is substantially more severe than a normal grief response (Florence et al., 2015). It was made to avoid diagnosing MDD if the depressive state of an individual is better accounted for by bereavement (Zisook et al., 2012). The BEC initially emerged in the DSM-3 with the aim to defend against pathologizing normal grief and avoid diagnosing MDD when the depressive state is insignificant. It made a distinction between normal grief and pathological grief, defining them as uncomplicated grief and complicated grief, respectively. Only those who were deemed to be experiencing

complicated grief could be diagnosed with MDD however, there was some ambiguity in how to distinguish it from uncomplicated grief (Zisook et al., 2012). The BEC was carried over into the DSM-4 and the edition was published with a much more concise diagnostic criteria for complicated grief. It contained a list of abnormal grief responses which include depressive and psychotic symptoms that are out of proportion to the context of the bereavement, such as suicidal ideation, psychomotor retardation, sense of worthlessness, and marked functional impairment lasting over two months (Jones & Fox, 2013). If a patient meets the duration criterion and one or more of the symptoms, the patient is categorized as having complicated grief thus, may be diagnosed with MDD. In doing so, the 4th edition of the DSM provided a valid method to diagnose MDD for a minority of the bereft population. However, the DSM-5 eliminated the BEC entirely, allowing bereft individuals to be diagnosed with MDD if their symptoms meet five out of nine major depression-specific symptoms which continue for two weeks or more; these criteria also apply for any other life stressors deemed to prompt depression, such as divorce and loss of a job (Pies, 2014). Many psychologists claimed removal of the BEC prompts overdiagnosis and false positives of MDD when most depression symptoms following bereavement are weaker in severity, fade over time and are less likely to be chronic than depression symptoms not following bereavement (Wakefield, 2014). However, the psychologists involved in the elimination of the BEC stated that this change is intended to solely enable bereft people who are severely depressed, but do not meet the criteria of complicated grief in the DSM-4, to receive necessary attention and treatment (Pies, 2014). They argued that it does not imply that most bereft people would or should be diagnosed with MDD (Pies, 2014).

Arguments For and Against the Bereavement Exclusion Criteria Elimination

Validity of the Bereavement Exclusion Criteria

This controversy started when the DSM-5 proposed the elimination of the BEC. The rationale behind the removal was the lack of evidence to support differentiating bereavement from other stressful life events that are acknowledged to contribute to the development of MDD, as well as the risk of overlooking severe depression and its fatal consequences in those limited by the BEC from MDD diagnosis and treatment (Pies, 2014). Depressive episodes induced by bereavement showed no significant differences when compared to depressive episodes following other life stressors in recurrence, dysfunction, psychomotor retardation, sense of worthlessness, suicidality, and response to treatment (Karam et al., 2013). They were also similar in the number

of displayed depressive symptoms, severity, and functional impairments (Pies, 2014). Duration of depressive episodes were found to be even longer for bereavement than for other life events (Karam et al., 2013). Moreover, when compared with the average population of patients diagnosed with MDD, including those which developed spontaneously and due to other life stressors, bereft individuals displayed more severe symptoms of depression, heightened sense of worthlessness, and suicidal ideation (Jones & Fox, 2013). Therefore, the need for bereavement to have an exclusion criterion, while other life stressors do not, was discredited.

Psychologists in support of the BEC removal also claim that, despite not meeting the complicated grief criteria, a portion of the uncomplicated grief population displayed similar severity of depression as the complicated grief population (Zisook et al., 2012). They were not significantly different on cognitive functioning, scores on the Montgomery–Asberg Depression Rating Scale, and response to treatment (Porter et al., 2013). Additionally, self-ratings of the uncomplicated grief individuals on their severity of depression were found to be higher than those reported from MDD patients (Zisook et al., 2012). Overall, this shows that bereaved individuals excluded by the BEC show the same or worse depressive responses compared to those who experienced other stressful life events, the complicated grief population, and MDD patients overall (Porter et al., 2013; Zisook et al., 2012). Thus, it is evident that bereavement is not distinct enough from other life stressors to be excluded from the list of life events that can induce MDD. While bereavement should be noted when diagnosing MDD, it should not be a factor that restrains one from being diagnosed with MDD (Zisook et al., 2012).

However, as previously mentioned, the research on this topic is mixed. Psychologists opposing the removal of the BEC claim that it should not be eliminated because there are indeed substantial differences between complicated and uncomplicated bereavement. Wakefield and Schmitz (2013) found that uncomplicated bereaved individuals show no recurrence and the displayed depressive symptoms are those of normal distress rather than clinical. While the symptoms may resemble those of MDD, they are non-pathological, adaptive, and the numbers of symptoms are lower (Wakefield & Schmitz, 2013). The average duration of depressive episodes was found to be shorter for the uncomplicated bereaved population and they were less likely to seek treatment as their depressive state did not heavily interfere with their lives (Wakefield & Schmitz, 2013). In addition, it is argued that, while depression following bereavement and MDD may be deemed to be similar, bereaved individuals experience a different type of depression than

MDD (Jones & Fox, 2013). While MDD patients are typically inwardly focused, socially withdrawn, and acknowledge that their state of being is abnormal, depressed bereaved individuals are outwardly focused, highly engaged with social circles, and think of their state as normal and temporary (Jones & Fox, 2013; Zisook et al., 2012). Also, while MDD patients have low self-esteem, bereaved individuals' self-esteem is preserved (Clesse et al., 2015). Sense of worthlessness is the central factor that reduces self-esteem, which bereaved individuals are less likely to experience (Mojtabai, 2011). Moreover, one critical characteristic of MDD is the inability to feel happiness and the extensive state of depression, whilst bereaved individuals are able to feel positive emotions and go into depression when they are reminded of the bereaved (Jones & Fox, 2013). Additionally, psychologists opposing the elimination of the BEC took a different perspective as research fails to support the difference between bereavement and other life stressors. They argue that, considering the similarities, the exclusion criteria should be expanded and applied to all types of stressful life events rather than discarded (Wakefield & Schmitz, 2013). When the BEC was theoretically applied to people with MDD preceded by other life stressors, the findings suggested that a portion of the population met the category of uncomplicated grief thus, may be regarded as not suffering from pathological depression if the exclusion criteria was to be expanded (Mojtabai, 2011; Wakefield & Schmitz, 2013). Furthermore, contrasting to the findings of those in support of the BEC elimination, Mojabai (2011) discovered that bereaved individuals exhibited a modest number of depressive symptoms compared to MDD patients who experienced other life stressors. Moreover, it was discovered by his 3-year follow-up study that bereavement-induced depressive episodes are more likely to be a single occurrence with recurrence rates as low as those of people who do not have a history of depression, namely the general population.

Suicidality

Another rationale behind the elimination of the BEC was that excluding bereaved individuals from being diagnosed and treated for MDD can culminate in overlooked severe depression which not only leads to delays in receiving necessary treatment, it also puts the uncomplicated grief population at an increased risk of suicide attempts (Jones & Fox, 2013; Karam et al., 2013). Regardless of MDD diagnosis, bereft individuals showed high suicidal ideation and it is argued that this is due to the extreme sense of loneliness, especially if the lost loved one was one's spouse and, in particular, a husband (Stroebe et al., 2005). The causal

associations of depressive symptoms and how each symptom can give rise to other depressive symptoms are widely acknowledged (Fried et al., 2015). Loneliness, which is reported to be the main daily struggle for bereft individuals, was found to be the strongest depressive symptom that bereavement activates, which in turn gives rise to other symptoms of depression including suicidal ideation (Fried et al., 2015). Suicidal ideation originating from loneliness cannot be mitigated by social support, although lack of social support can further escalate the likelihood of suicide attempts (Stroebe et al., 2005). In other words, social support, which is one of the main protective factors against MDD that a person has access to in daily environments, does not exert its power when it comes to the extreme loneliness of losing a loved one and subsequent suicidal ideation. Thus, in addition to social support, clinical intervention focused on coping with loneliness and cognitive behavioural therapy centered around maladaptive cognitions are essential for the severely depressed bereft population (Fried et al., 2015; Stroebe et al., 2005). Prompt access to such treatment is critical as suicide attempts are most prevalent during the first few weeks following bereavement (Ajdacic-Gross et al., 2008). Elimination of the BEC allows for all bereaved individuals to access the appropriate treatment and support in a timely manner which could lead to a prevention in suicide. Many psychologists believe that this is a benefit that prevails over the risk of over-diagnosing MDD (Jones & Fox, 2013).

On the contrary, while it is recognized by both groups of psychologists that bereavement can bring on depression and suicidal thoughts, the group of psychologists criticizing the removal of the BEC argue that because one of the complicated grief criteria is suicidal ideation, suicidal bereft individuals are fully identified despite the BEC (Wakefield & Schmitz, 2014). Also, as suicidal ideation is a strong predictor of suicide attempts and MDD, it is argued that uncomplicated grief individuals, who do not tend to have suicidal ideations, are not at risk of future suicide attempts and undiagnosed MDD (Wakefield & Schmitz, 2013). To test this argument, a study was conducted to compare the rate of suicide attempts in complicated and uncomplicated grief individuals. The findings showed that the uncomplicated bereavement population has a lower rate of suicide attempts than the general population even years after bereavement (Wakefield & Schmitz, 2014). Comparatively, rates of suicide attempts in the complicated grief population were found to be more than twice as likely when compared with the general population. These findings attempt to refute the claim that the uncomplicated bereavement population is at increased risk of undiagnosed MDD and suicide attempts. Rather it

asserts that the BEC plays its intended role of discriminating those experiencing severe depression to the point of suicidal ideation from those experiencing normal grief.

Pathologizing Normal Grief

Psychologists criticizing the decision to eliminate the BEC expressed several concerns which include pathologizing normal grief, overdiagnosis of MDD in bereaved people, and use of unnecessary treatment. The DSM-5's two-week duration criteria for the diagnosis of MDD is also of concern to psychologists, as they argue that it is of cultural normality for bereaved individuals to grieve and show symptoms of depression for up to a year, largely due to anniversaries, holidays, and birthdays (Dodd et al., 2019). They state that intervening in normal grief early with treatment, as they are mistakenly judged to have MDD, can unnecessarily intrude on the individual's own perseverance in recovering from normal grief. Some further claim that preoccupation with recurrent thoughts of death, including the death of oneself, is normal in the conditions of mourning and thus should not be mistaken as suicidality derived from clinical MDD (Clesse et al., 2015). Grieving varies from cultural experience, relationship with the lost one, context of death, and numerous other factors (Wakefield & Schmitz, 2014). Psychologists state it is challenging to correctly distinguish between normal and pathological grief without the BEC and the risk of misdiagnosis is high (Wakefield & Schmitz, 2014).

Furthermore, the elimination of the BEC permits MDD diagnosis to all bereaved individuals who meet the general criteria of MDD (Pies, 2014). This lack of restriction disturbs psychologists who worry that it will lead to increased numbers of bereaved individuals diagnosed with MDD. The reason behind the implementation of the BEC in the DSM-3 and DSM-4 was to restrain clinicians from diagnosing MDD in bereaved individuals solely based on exhibited symptoms, unless the symptoms are significantly disproportionate to the context of mourning (First, 2011). However, with the elimination of the BEC, some psychologists worry that clinicians will be more inclined to diagnose bereft individuals who come to them for symptom relief, such as for a prescription of sleeping pills to aid in their difficulty sleeping, with MDD to validate their decision in prescribing psychotropic medications (First, 2011). To factualize the concern of increased MDD diagnosis, Clesse et al. (2015) conducted a nation-wide study where they applied both the DSM-4 and DSM-5 diagnostics of MDD to bereaved individuals. The results showed a 10% increase in MDD diagnosed bereft individuals with the DSM-5 diagnostics compared to the DSM-4, while the MDD prevalence of the general population remained stable

(Clesse et al., 2015). The individuals who were diagnosed with MDD by the DSM-5 diagnostics but were excluded in DSM-4 due to the BEC displayed lower numbers of symptoms and no psychomotor retardation compared to those diagnosed with MDD with the BEC in place (Clesse et al., 2015). These findings justify psychologists' concerns that the prevalence of MDD patients in the bereaved population may increase with the elimination of the BEC in the DSM-5. Lastly, there is a possibility of MDD diagnoses becoming less valid due to increased misdiagnosis, which threatens the credibility of the DSM-5 and the general psychiatric field (Jones & Fox, 2013).

Removal of the BEC yields the risk of pathologizing normal grief which may ultimately result in inappropriate use of medication for treatment. As presented by psychologists who support the elimination of the BEC, grieving individuals were reported to respond well to anti-depressants (Porter et al., 2013). This claim led opposing psychologists to worry about the unnecessary usage of anti-depressants. It is argued that the depression that bereaved individuals experience is a different form of depression from MDD, hence it should not be treated with anti-depressants or any other types of medication (Jones & Fox, 2013). The normal depressive state following bereavement contains symptoms that resemble MDD (Wakefield & Schmitz, 2013). However, because they are weaker in severity and less likely to be chronic, it is argued that they do not require medication as treatment (Jones & Fox, 2013; Porter et al., 2013). Of concern, research has found that general health care professionals prescribed antidepressants to a similar percentage of MDD diagnosed bereaved individuals as the general MDD population, despite the differences in their types of depression (Clesse et al., 2015).

To ease these concerns, psychologists in favor of the BEC elimination provided counterarguments. Their counterarguments were centered around the claim that, while they acknowledge the risk of overdiagnosis and misdiagnosis, such risks are overshadowed by the risk of underdiagnosis and putting severely depressed and bereaved individuals at risk of unwarranted extensive suffering without access to adequate and much deserved treatments (Jones & Fox, 2013; Zisook et al., 2012). Not only are bereaved individuals at a heightened risk of developing MDD, they are also more susceptible to adopting dysfunctional coping mechanisms such as self-medicating that culminates in substance abuse, which in turn results in further destruction of physical and mental health (Jones & Fox, 2013). Therefore, psychologists firmly stand by the termination of the BEC in the DSM-5. In addition, they argue that the two-week duration criteria for diagnosis of MDD is a general guide and is unlikely to be a huge factor that contributes to the

risk of overdiagnosis in bereft individuals (Pies, 2014). Psychologists claim that those bereft individuals who visit a psychiatrist office early on are generally in an alarming state of distress and functional impairment or are brought in by their families as they are regarded as being suicidal, psychotic, or severely malfunctioning from a third-person perspective (Pies, 2014). Namely, the two-week criterion of MDD diagnosis, reduced from the two-month criterion of the BEC, will only impact a minority of the bereaved population, who have a high probability of severe depression and are in desperate need of intervention. They also address the primary issue with the complicated grief criteria of the BEC. They argue that the BEC only allows a certain group of bereft individuals who show psychotic, suicidal, or severely impaired symptoms to be diagnosed with MDD while prohibiting those with other severe depressive symptoms to be diagnosed and treated (Pies, 2014). In other words, although excluding those without psychotic, suicidal, or severely impaired symptoms was the initial rationale of implementing the BEC, they cannot disregard the occurrence of the BEC being misapplied leading severely depressed people to go undiagnosed (Zisook et al., 2012). Also, they state the possibility of underdiagnosing bereaved individuals who meet the symptoms of complicated grief but do not feel comfortable or safe to disclose such symptoms (Pies, 2014). For example, those who were mentally healthy before bereavement may fear that disclosure of their sudden suicidal ideation could potentially put them in a psychiatric ward as involuntary patients who they are stripped of their freedom (Pies, 2014). Furthermore, supporting psychologists refute the concern that the removal of the BEC will increase the use of unnecessary medications. It was claimed that most professionals believe talk therapy to be sufficient in treating depression for bereft individuals, do not regard use of medication as a necessity, and have no intention of prescribing such medications until proven necessary (Pies, 2014). Namely, although the diagnosis of MDD in bereaved individuals may increase, the diagnosis itself does not convince mental health professionals to prescribe anti-depressants unless they have a reason to (Pies, 2014). All in all, psychologists in support of discarding the BEC in the DSM-5 reassure opposing psychologists that their aim is not to medicalize bereavement. Instead, it is to prevent overlooking severely depressed individuals and avoid normalizing destructive responses to bereavement (Dodd et al., 2019; Pies, 2014).

Agreed Upon Imperfections of the DSM-5 and Suggestions

Evidently, the BEC dismissal in the DSM-5 has led to heated debate amongst psychologists. However, there is an element of the DSM-5 regarding diagnostics of MDD for bereft individuals

that both of the opposing groups of psychologists agree is deficient; the DSM-5 guidelines differentiating normal grief from pathological grief are vague and thus put an ethical burden on the clinicians which can result in overdiagnosis or underdiagnosis of MDD (Jones & Fox, 2013). Therefore, to ease the burden of the diagnostic process, there have been several proposed suggestions that may be of assistance. First, a group of researchers created five categories of bereft individuals: endurance, resilience, transient, chronic grief, and chronic depression (Kuo et al., 2017). The first three categories of bereft individuals, endurance, resilience, and transient recovered promptly from grief within a year, as they exhibited lower levels of depression from the beginning. However, the chronic grief and chronic depression categories were marked with prolonged grief reactions which persisted over a year with weak indications of recovery. It is recommended that practitioners assess the bereaved individuals according to the categorial characteristics and focus on the bereft individuals who meet the criteria of chronic grief and chronic depression, as they will be relatively more likely to have or develop MDD (Kuo et al., 2017). Second, normal grief is distinguishable from MDD if it is proportional to the context of bereavement, the person shows similar intensity of grief responses as previous losses, and it fades away as the person adjusts to one's life in the absence of the deceased (Jones & Fox, 2013). Proportionality of grief to the context is an important variable, as the level of grief will differ with regards to the context. For instance, grief will be more turbulent and long-lasting if the loss of a loved one occurred unexpectedly in a tragic accident than if it happened expectedly, such as from a long-suffered chronic illness (Jones & Fox, 2013). Third, clinicians should receive appropriate professional training in order to become capable of assessing MDD in bereaved individuals according to their symptomatology, context of the bereavement, personal life and culture, as well as the length of time grief lasts after the initial depressive episode (Porter et al., 2013). Continuously assessing the individual over time is also critical to avoid prematurely dismissing depression in bereft individuals by disregarding depressive episodes following bereavement (Karam et al., 2013; Porter et al., 2013). Lastly, in all suspected MDD cases, regardless of the cause, the level of distress experienced and expressed by the individual should be the main factor clinicians focus on in attempting to distinguish normal grief from pathological depression (Fox & Jones, 2013). Without the BEC, the clinician's ability to differentiate normal grief from pathological grief is the primary influence on diagnosis (Porter et al., 2013). Fortunately, clinicians reported that they are constantly attempting to distinguish normal

depressive episodes from clinical depression when they examine those who have experienced stressful life events aside from bereavement (Porter et al., 2013). Therefore, with the accumulation of their experiences and implementation of these suggestions, clinicians should be able to successfully distinguish and diagnose MDD in the severely depressed bereaved population without the BEC.

Conclusion

The BEC for MDD diagnosis had decades of historical use before it was removed in the DSM-5. Bereavement is a universal phenomenon that most, if not all, people in the world face in their lifetime, hence the intense debate over the cautious use of MDD diagnoses. In this heated debate, there was grounded research evidence supporting each stance psychologists took in supporting or criticizing the change. Much of the research evidence proposed by psychologists who criticize the change showed contradicting results when measuring the same variable, for instance recurrence rates of depressive episodes in bereaved individuals (Karam et al., 2013; Wakefield & Schmitz, 2013). However, while there may not be an absolute conclusion on which position is correct, evidence proposed by the group of psychologists in support of the BEC removal were more compelling, as they presented evidence that not only supported their claim but successfully refuted the concerns put forth by psychologists criticizing the change. It appears that while both positions have valid arguments, the BEC was eliminated on solid grounds. However, it is agreed that the elimination of the BEC resulted in ambiguity for clinicians in differentiating normal grief from depression in need of professional attention, thus clinicians are expected to make informed judgements using their experiences and recommended procedural suggestions.

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