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Misconceptions about the proposal to eliminate the grief exclusion criterion from DSM-IV have been presented online and in the media. Writers have expressed fear that the change will lead to automatic diagnosis of individuals who are grieving with Major Depressive Disorder. I would like to provide some background on the grief exclusion and some insight into thinking behind the proposal to remove it for DSM-5 in order to put this change into perspective.

First, the grief exclusion criterion – which states that someone who has experienced a recent bereavement is not eligible for a diagnosis of major depression – was not present in the two major psychiatric diagnostic systems that formed the basis for the DSM-III – the diagnostic manual that is the immediate precursor of our current DSM-IV. Rather, it was added to DSM-III largely on the basis of the work of one of the DSM-III task force members who was then studying grief and was carried forward with little modification into DSM-IV.

Second, the other major psychiatric diagnostic system used in the world – the International Classification of Diseases – has never had a grief exclusion criterion for major depression.

Third, a broad range of evidence agreed to by both sides of this debate shows that there are little to no systematic differences between individuals who develop a major depression in response to bereavement and in response to other severe stressors – such as being physical assaulted and raped, being betrayed by a trusted spouse whom you learn has been unfaithful or a beloved child whom you are told is dealing drugs, having your doctor tell you that your breast or prostate biopsy for cancer is positive or the loss of your treasured job.

So the DSM-IV position is not logically defensible. Either the grief exclusion criterion needs to be eliminated or extended so that no depression that arises in the setting of adversity would be diagnosable. This latter approach would represent as major shift, unsupported by a range of scientific evidence, in the nature of our concept of depression as epidemiologic studies show that the majority of individuals develop major depression in the setting of psychosocial adversity.

Fourth, the vast majority of individuals exposed to grief and to these other terrible misfortunes do not develop major depression. That does not mean, and here is the source of much confusion, that they do not grieve. They do. It does not mean that they do not feel terrible pain and loneliness. They do. Depression is a slippery word and we are so used to using it to mean “sad”, “blue”, “upset” or, in this specific case, “grieving.” Major depression – the diagnostic term – is something quite different.

Finally, diagnosis in psychiatry as in the rest of medicine provides the possibility but by no means the requirement that treatment be initiated. Watchful waiting is important tool for all skilled clinicians. As a good internist might adopt a watch and wait attitude toward a diagnosable upper respiratory infection assuming that it is unlikely to progress to a pneumonia, so a good psychiatrist, on seeing an individual with major depression after bereavement, would start with a diagnostic evaluation.

If the criteria for major depression are met, then he or she would then have the opportunity to assess whether a conservative watch and wait approach is indicated or whether, because of suicidal ideation, major role impairment or a substantial clinical worsening the benefits of treatment outweigh the limitations. As with the psychiatric response to the other major stressors to which we humans are all too frequently exposed, good clinical care involves first doing no harm, and second intervening only when both our clinical experience and good scientific evidence suggests that treatment is needed.