Removing the Exclusionary Criterion about Depression in Cases of Bereavement:

Executive Summary of a Report to the ADEC Board of Directors

The Scientific Advisory Committee to the

ADEC Board of Directors

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A Proposed Change to the Diagnostic and Statistical Manual of Mental Disorders

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) is being revised. Many persons know of the efforts to include the diagnostic category of Prolonged Grief Disorder (PGD) in DSM-V (Prigerson, Vanderwerker, & Maciejewski, 2008). Another proposed revision is to allow clinicians to diagnose a person with major depression even within the early days and weeks following a death,

The DSM-IV-TR classifies bereavement as a clinical condition that is not a mental disorder. The exclusionary criterion states that a bereaved person who meets diagnostic criteria for a depressive disorder should not be diagnosed as having major depression unless certain symptoms not characteristic of a "normal" grief reaction are present. These symptoms 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 voice of, or transiently sees the image of, the deceased person" (American Psychiatric Association, 2000, p. 741).

Reasons Given for Eliminating the Exclusionary Criterion

The impetus for removing the bereavement exclusionary criterion in the DSM-V appears to be derived from clinical experiences with bereaved clients who manifest depressive symptoms, and who are seen as potentially benefitting from treatment for depression should the exclusionary criterion be removed. These clinical experiences have led to a review of research examining whether depression differs for bereaved and non-bereaved persons; this examination led to the conclusion that research has not found evidence that depression of bereaved people differs from depression of the non-bereaved (Kendler et. al., 2008; Kessing, et. al., 2010; Zisook & Kendler, 2007). While this finding is important, we note that the preponderance of studies that were reviewed did not focus on people who were bereaved in the initial two months following the death, a time limit central to the exclusionary criterion.

Sidney Zisook and Kenneth Kendler are major figures in psychiatry who have argued for the change. They have written that "Bereavement remains the only life event that excludes the diagnosis of MDE" [major depressive episode] (Zisook & Kendler, 2007, p. 780). They reviewed research literature to see what had been uncovered about bereavement and depression as compared to other stressful life events and depression. They concluded that on all points used for comparison bereavement-related depression was indistinguishable from depression related to other stressful life events. They maintained that between 13% and 46% of bereaved people meet diagnostic criteria for depression in the first two months of their bereavement.

The Scientific Advisory Committee consider the Zisook and Kendler article to be severely limited, and believe the limitations militate against using the findings as support for the removal of the bereavement exclusion for the diagnosis of depression. Zisook and Kendler compared studies that used different age groups and different times at which participants were assessed. Outcomes were assessed using different assessment tools. A weak analytic technique, rather than a meta-analytic approach, was used.

In two related studies (Kendler et. al., 2008; Kessing et. al., 2010) researchers examined whether depression differed in persons who were bereaved and in persons whose depression was related to other life stressors or to no identifiable life stressor. Kendler and his colleagues reported that in only minor ways did bereavement-related depression differ from depression linked to other related events or not linked to stressful events. They acknowledged that not all statistical findings from their research supported their position. Kessing and his associates made no effort to distinguish persons whose depression lasted two months or more after the onset of bereavement from persons whose depressive symptoms ameliorated within the first two months of bereavement. These researchers did not compare pre-two month from post-two month groups, and all of their data were retrospective in nature.

Zisook and two of his colleagues (Lamb, Pies, & Zisook, 2010) have offered what they term modest steps to make it more likely that bereaved individuals can benefit from treatment for depression in the first two months following the death. These steps in effect would eliminate the exclusionary criterion. The steps are

1. Increase the time duration for symptoms from two weeks to four weeks in the absence of the severe symptoms already recognized by DSM-IV-TR.
2. If the individual has a well documented prior history of depression, the time duration for symptoms may be reduced to one week.

Responses of Experienced Clinicians

We contacted clinicians well-known to ADEC who have extensive experience working with bereaved persons and who are immersed in the bereavement literature. We asked them for their reactions to the proposal to eliminate the exclusionary criterion. Here is a summary of five themes in their comments.

1. Bereaved people generally do not match the criteria for Major Depressive Disorder.
2. Bereavement symptoms overlap with Major Depressive Disorder, but primarily differ in cognitive attributions (for instance, persons with Major Depressive Disorder have morbid feelings of worthlessness).
3. Thorough assessment is vitally important. Grief is contextual and thus more than one assessment is necessary in order to include Major Depressive Disorder in the diagnosis.
4. Exceptions to the bereavement exclusion should occur when it is clear that the client is engaging in self-destructive and dangerous behaviors.
5. Clinicians work from a pragmatic focus on what is in the best interests of the specific client being served, not from an eye on what the DSM states.

Diagnostic and Treatment Implications Should the Change Be Adopted

What are the consequences of maintaining the present exclusionary criterion versus eliminating it? Proponents for eliminating the criterion argue that some people who are actually experiencing depression may not receive treatment for it for two months, unless their symptoms include specific extreme symptoms (e.g. suicidal) or are atypical of normal bereavement (e.g. morbid feelings of worthlessness). Apparently, advocates for eliminating the exclusionary criterion believe depression in the first two months of bereavement occurs in ways outside the six symptoms the DSM-IV-TR identifies for a diagnosis of depression to be made. Alternatively, proponents for retaining the exclusionary criterion (see for instance Frances, 2010) argue that people who are experiencing normal bereavement but do not exhibit any of the six symptoms atypical of normal grief may be incorrectly diagnosed with major depression and inappropriately receive treatment for this condition if the exclusionary criterion is removed.

We see four potential problems with removing the exclusionary criterion for diagnosis of depression in the first two months of bereavement.

1. Years of clinical experience have led to the conclusion, in consort with Freud's (1957/1917) views and backed by empirical data (Bonanno & Kaltman, 2001), that relatively few bereaved persons are clinically depressed. To the degree that being labeled as having a major mental disorder has an iatrogenic effect on people, persons in normal grief may be harmed by the

proposed change. Removing the exclusionary criterion about depression could lead to pathologizing normal grief.

2. Co-morbidity of major depression and disordered grief means that many people with disordered grief might be mistakenly treated for major depression. Because criteria for prolonged grief disorder require a longer time period after the death than Major Depressive Disorder, it may be that people in the early process of a prolonged grief disorder would be mistakenly diagnosed with a Major Depressive Disorder were the exclusion removed. Given that the appropriate treatment for depression and prolonged grief disorder differ, the diagnosis of depression may lead to an inappropriate treatment and interfere with the person's coping with the distress of bereavement.
3. If diagnosed with a Major Depressive Disorder within the first two months of bereavement, it is likely that many individuals who are seen by medical professionals will receive antidepressant medication because it is cheaper and "easier" to medicate than to be involved therapeutically. Antidepressants have negative side effects. Bereaved people, it is argued, will have difficulty distinguishing the side effects of antidepressant drugs from the normal effects of grief.
4. The proposed change does not make a distinction of severity of symptoms required to reach a diagnosis of major depression for recently bereaved persons. The current instructions from the DSM-IV-TR identify the severe

symptoms atypical of normal grief that, if present, call for a diagnosis of a Major Depressive Disorder within the first two months of bereavement.

Position Statement

Given the current state of knowledge, we contend that the negative impact of dropping the bereavement exclusionary criterion outweighs the benefits.

Summary comments

Part of the reasoning for changing the exclusionary criterion stems from the cautionary assumption that it is better to be safe than sorry. Sidney Zisook is quoted as saying that, "I'd rather make the mistake of calling someone depressed who may not be depressed, than missing the diagnosis of depression, not treating it, and having that person kill themselves" (Spiegel, August 2, 2010).

Evidence-based practice should serve as the basis for diagnoses of Major Depressive Disorder in bereaved individuals. At present, most of the research has been inadequate because of a) selective samples, b) failure to include appropriate comparison groups, c) variability in the ages and assessments of the respondents, and d) variability in the timing of assessment. It is also important to consider the time factor in assessment of Major Depressive Disorder. Currently, the criterion in DSM-IV-TR is two months, and yet, as research such as that conducted by Bonanno (2009) and Parkes and Prigerson (2009) indicate, the "road to recovery" is much longer, particularly in the case of parental bereavement.

Recommendations for ADEC Action

Recommendations were made to the Board for action ADEC can take. These recommendations focus on providing training and education via webinars, workshops, conference foci, and any other venues that promote learning at beginning, intermediate, and advanced levels. Specifically, ADEC is urged to provide

- ongoing training on the diagnosis and treatment of bereavement;
- training in recognizing and responding to depressive symptoms in bereaved clients and patients;
- education for mental health professionals and general medical practitioners on normal, prolonged, and traumatic grief; and
- education about comprehensive evaluation of bereaved persons.

Two Points Centered on Research

Regardless how the debate turns out over the exclusionary criterion, continuing and rigorous investigations into bereavement remain of paramount importance. The Scientific Advisory Committee called specifically for qualitative and quantitative research

- investigating the complications of bereavement; and
- examining the differences between depression that appears to have no external stressor as a trigger (sometimes called endogenous depression) and depression triggered by life stressors (sometimes called exogenous or reactive depression).

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