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Review Article

Complicated grief in the DSM-5: Problems and solutions

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More Information

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The Diagnostic Statistical Manual of Mental Disorders volume 5 (DSM-5) is the influential textbook published in 2013, by the American Psychiatric Association, as a guide to psychiatric diagnosis. It helps to ensure that doctors are consistent in their use of diagnostic terms.

In an important section entitled 'Definition of a Mental Disorder' it states "An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder". This said there are at least three places in DSM-5 that are relevant to those providing help to bereaved people.

- Detailed clarification of the difference between Major Depression [including both Major Depressive Disorder (MDD) and Bipolar Disorder (BP)] and Grief.
- The acknowledgement that 'Separation Anxiety Disorder', formerly recognised in childhood, can now be diagnosed in adult life.
- The inclusion in Conditions for Further Study of a possible new diagnosis of 'Persistent Complex Bereavement Disorder' (PCBD).

Since the DSM5 was published in 2013 a great deal of research and debate has taken place. As a result the PCBD has been modified and renamed Prolonged Grief Disorder (PGD).

Major depression after bereavement

It has long been recognised that episodes of MDD and BP can be triggered by a wide variety of major stresses. In order to reduce the risk of confusing grief with major depression previous editions of DSM have excluded the first time diagnosis of major depression during the first six months after bereavement while permitting it to be made following other types of loss. Critics have pointed out that severe major depression can be triggered by bereavement and may even cause suicide. It is illogical and unfair to deprive depressed people of the privileges of medical diagnosis and treatment simply because they have been bereaved. In DSM-5 this exclusion has been removed.

"Responses to a significant loss may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss ...which resemble a major depressive episode (MDE)".

Distinguishing Grief from Major Depressive Episodes.	
GRIEF	MAJOR DEPRESSIVE EPISODE
May feel empty and lost	Persistent Depressed Mood and the inability to anticipate happiness or pleasure.
Decrease in intensity over days to weeks and occurs in waves, the so-called 'pangs of grief' ...associated with thoughts or reminders of the deceased.	More persistent for most of the day, every day
Any self-derogatory ideation typically involves perceived failings vis-a-vis the deceased	Self-critical and pessimistic ruminations and feelings of worthlessness
Any thoughts about death or dying are focussed on the deceased and possibly about 'joining them'	Any such thoughts are focussed on ending ones own life because of feelings of worthlessness, undeserving of life, or unable to cope with the pain of depression.

This shows the diagnostic features that distinguish MDE arising after bereavement from normal grief. For further details the DSM-5 textbook should be consulted. It should be pointed out that these criteria are well supported by much careful research. Indeed one of the reasons that DSM is respected in medical fields is just that, it is evidence based, not the whim of individual practitioners, however senior.

It has been suggested that removing the 'bereavement exclusion' will result in just the confusion that the DSM exists to prevent. While there may be some doctors for whom this is true, major depression is one of the commonest psychiatric

conditions seen in medical practice and every doctor should know how to diagnose it. The existence of the DSM helps to ensure this and provides authoritative evidence that can be used in cases of medical negligence.

Separation anxiety disorder

In DSM-5 Separation Anxiety Disorder (SAD) is a sub-category of Anxiety Disorders all of which are characterised by fear ("...the emotional response to real or perceived imminent threat") or anxiety ("...the anticipation of future threat") "and related behavioral disturbances".

It is included here for three reasons, 1) it is often triggered by the loss of an attached person, 2) it is a frequent precursor of prolonged grief disorder 3) and separation distress is a distinctive feature of the 'pang' of grief.

Diagnostic Criteria of SAD

A) Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent and excessive distress when anticipating or experiencing separation from home or from major attachment figures.

2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters or death.

3. Persistent and excessive worry about experiencing an untoward event that causes separation from an attachment figure (e.g. getting lost, being kidnapped...)

4. Persistent reluctance or refusal to go out, away from home, to school, to work or to elsewhere because of fear of separation.

5. Persistent and excessive fear or reluctance about being alone or without major attachment figures...

6. Persistent reluctance or refusal to sleep away from home or to go to sleep without attachment figure.

7. Repeated nightmares involving the theme of separation.

8. Repeated complaints of physical symptoms (e.g. headaches, stomach aches, nausea and vomiting) when separation from major attachment figures occurs or is anticipated.

B) The fear, anxiety, or avoidance is *persistent, l*asting at least 4 weeks in children and typically 6 months in adults.

C) The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D) ...not better explained by another mental disorder...

Prevalence: In adults in the USA 0.9%-1.9%, in children c.4%. More frequent in females than males in the community.

Development and Course Separation anxiety is normal in early childhood and tolerance of separation increases with age and is a sign of security of attachment. In adults separation anxiety disorder may limit the sufferer's ability to cope with changes in circumstances (e.g. moving, getting married). ...typically over-concerned about [separation from] offspring and spouses... [this may lead to] parental overprotection, checking and intrusion.

Risk and prognostic factors

Environmental often develops after life stress, especially a loss (e.g., the death of a relative or pet...). Parental overprotection and intrusiveness may be associated with SAD.

Genetic and physiological Heritability ...73% in a community sample of six-year old twins, with higher rates in girls. Children with SAD display enhanced sensitivity to respiratory stimulation using CO_2 enriched air.

Cultural ...Issues Cultural variation in ...expectations of tolerance of separation, age of separation of children from parents and ...expectations of interdependence.

Gender ...Issues Girls avoid school more than boys. But boys more indirect in expressing fear.

Suicide Risk and threats. Increased in all anxiety disorders including SAD.

Proposed diagnostic criteria in 2020

Prolonged Grief Disorder (PGD): At the time of writing the iteration given here has been approved by the DSM subject only to consideration of comments made in a public 40 day consultation. This is now ended and we await the final approval along with any further modifications.

Diagnostic Criteria of PGD

A. The death of a person close to the bereaved at least 12 months previously.

B. Since the death, there has been a grief response characterized by intense yearning/longing for the deceased person or a preoccupation with thoughts or memories of the deceased person. This response has been present to a clinically significant degree nearly every day for at least the last month.

C. As a result of the death, at least 3 of the following symptoms have been experienced to a clinically significant degree, nearly every day, for at least the last month:

1. Identity disruption (e.g., feeling as though part of oneself has died)

2. Marked sense of disbelief about the death
3. Avoidance of reminders that the person is dead
4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death
5. Difficulty moving on with life (e.g., problems engaging with friends, pursuing interests, planning for the future)
6. Emotional numbness
7. Feeling that life is meaningless
8. Intense loneliness (i.e., feeling alone or detached from others)

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration of the bereavement reaction clearly exceeds expected social, cultural or religious norms for the individual's culture and context.

F. The symptoms are not better explained by another mental disorder.

The DSM's research panel concluded that there was strong evidence that: this proposed category met the definition of a mental disorder; it manifested substantial evidence of validity; there was strong evidence of clinical utility; it had good discriminant validity; and it appeared that the individual criteria could be applied with good test-retest reliability. In addition, the panel found that the data strongly supported a cut-off of 3/8 symptoms for Criterion C, and that a duration of 12 months after the bereavement was indicated before the diagnosis was made.

Ethical Issues

Sufferers already worry about their mental health and Dyregrov's research [1] suggests that, far from being upset by a psychiatric diagnosis, they and their families are reassured that they have a known condition for which treatment is possible and that they are not psychotic ('going mad'). In my view the privileges of diagnosis and treatment usually outweigh the stigma that faces all psychiatric diagnosis. Illness can also evoke sympathy and families are less likely to reject or judge sufferers for being 'weak' or 'dependent' than they are at present. Doctors too are more likely to take an interest in the patient and, in the many areas in which no adequate services for bereaved people exist, to ensure that they are introduced. If PTSD is anything to go by, the inclusion of PGD in the DSM will attract much more research than has taken place to date and ensure that any weaknesses in the diagnostic criteria are improved.

DSM-5 includes SAD as a disorder of childhood and adulthood. My own research into the relationship between insecure attachments and responses to loss particularly those that predispose to inhibited and prolonged grief, proved highly relevant to the understanding of complications of bereavement [2]. I showed a correlation between separation anxiety in childhood and prolonged grief in adult life, a finding that was confirmed by Vanderwerker, et al. [3]. This provides us with yet another explanation for PGD and another opportunity to obtain treatment for those cases of PGD that arise out of SAD. It seems common sense to recognise that death causes separation and also to recognise that separation by death is one of the many causes of problems in grieving.

Treatments

The DSM is only concerned with diagnosis and is not concerned with treatment. It is aimed primarily at medical practitioners who may now be encouraged to improve their care of bereaved people, to develop methods of treatment and to work more closely with non-medical caregivers.

Recent therapies for PGD that have passed the test of random assignment studies include Shear K, et al. [4], Boelen, et al. [5], and Rosner, et al. [6]. Shear's therapy includes an introductory phase during which the therapist provides information about normal and complicated grief and describes the dual process model. In the middle phase, both orientations were examined and exercises were undertaken, including "revisiting exercises" in which the patient told the story of the death of the lost person and related it to the level of distress. These exercises were tape recorded and played between sessions. The loss orientation was also addressed during these sessions, in the form of imaginary conversations with the dead person, the aim being to evoke positive emotions. The restoration orientation was addressed by encouraging the patient to set goals and identify ways of working toward them. In the final phase, progress was reviewed, achievements acknowledged, and further targets agreed on. Boelen, et al. [5], used cognitive restructuring and exposure therapy and Rosner, et el. [6-8], an integrative cognitive behaviour therapy.

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