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COMMENTARY

Once Again: Grief Is Not a Disorder, But It May Be Accompanied by Major Depression

A Response to Dr John Grohol

By Ronald W. Pies, MD | 27 de enero de 2012
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The New York Times *recently ran a front-page story*[1] *regarding numerous controversies surrounding the DSM-5, most notably, the issue of eliminating the so-called bereavement exclusion in diagnosing a major depressive episode. Psychologist and Editor of the Psychcentral Web site, John Grohol, PsyD, offered his thoughts on this controversy*,[2] *citing some of my own writing on the relationship between ordinary grief and major depression. Here is my response to Dr Grohol's article, "Will Depression Include Normal Grieving Too?"*[1] *No doubt, this complex controversy will continue to flare for a long time to come!*

Many thanks, John, for the thoughtful reflections on this controversial issue, and for generously referencing my earlier work! I'd like to add just a few comments, since nearly everything I believe about this issue is found in the "Two Worlds" article[3] you cited.

First, it's very unfortunate that the print edition of the *New York Times* article carried the headline, "Grief Could Join List of Disorders."[1] I don't blame the writer, Ben Carey—a very careful reporter—since it's usually an editor that comes up with the headline. In truth, nobody in the mood disorders field (including the DSM-5 folks) wants to claim that "grief" by itself is a "disorder"!

As you indicate, the debate is what to do when a "grieving" patient comes in within 2 months of a loved one's death and meets the full DSM criteria for a major depressive episode. Should the diagnosis of major depression be denied or "excluded" simply because the person has experienced a recent death of a friend or family member and lacks certain "conditional" features, such as suicidal ideation and psychomotor retardation? Sid Zisook and I, along with many others, say "no." [See Zisook and colleagues.[4]]

Put in colloquial terms, "If it looks like a duck, walks like a duck, and quacks like a duck, there's a high probability it is a duck, until proved otherwise." That is to say, just because a person is grieving over a loss does not mean she doesn't (also) have a major depression, if she meets full symptom and duration criteria for it. As you suggest, grief and depression may coexist, and sometimes a severe depressive episode can actually interfere with the normal and adaptive process of grieving or mourning.

My earlier piece that you reference ("Is Grief a Mental Disorder? No, But It May Become One"[5]) actually

had a somewhat misleading title (my fault). It implied that grief may somehow "morph" into depression, a bit like those cartoon characters that suddenly transform from one creature into another! That is not the current understanding of grief and depression. A person who grieves a loss may indeed develop a major depressive episode—but not because their grief has "morphed" into another "creature." Usually, they are still grieving—but now they have the equivalent of a cold, wet blanket wrapped around their grief, interfering with the "grief work" they need to do, and which usually occurs unencumbered by major depression. (Alternatively, they may have developed what some call "complicated grief" or "pathological grief," in which the grief has come to dominate the person's entire emotional life, almost like an addictive process. [See Zisook and colleagues.[6]]

Sid Zisook and I would agree with you that we should be very, *very* careful in assessing a person's "depression" in the immediate aftermath of a major loss—whether of a loved one, a beloved pet, or a beloved job. We believe that the DSM-IV's 2-week duration criterion for major depression (likely to be carried over in the DSM-5) is usually too little time to know what the person has, or will develop. I usually prefer to wait 3 to 4 weeks after a major loss before applying the diagnosis of a major depressive disorder. (There are exceptions: eg, if the person has strong suicidal intentions, or meets DSM criteria for melancholia). Often, in my experience, a bereaved person who is simply in a state of grief will show considerable improvement between weeks 2 and 4, whereas the person with an incipient major depression is about the same or worse. That said, grief is often not "over" after week 2 or week 4, and it may continue (with or without a coexisting major depression) for months or even years. Nobody has any business specifying a "cutoff" for ordinary or "productive" grief that is not complicated by serious, incapacitating depressive signs and symptoms!

It's also important that we not mix up the argument for proper diagnosis with the issue of treatment. Sure, there is a risk that dropping the bereavement exclusion will encourage some harried doctors to prescribe antidepressants when medication is neither necessary nor appropriate. (Antidepressants are prescribed mainly by non-psychiatric MDs—sometimes after only a very brief evaluation.) But this is a problem to be addressed by better education of doctors and by ensuring greater access to specialists in mood disorder treatment. Basically, whether a depressed person has lost a loved one or not, antidepressants should be reserved for moderate to severe major depression that has not responded to "talk therapy." Medication should rarely be the treatment of first recourse (exceptions: psychotic depression and severe melancholic major depression with a high suicide risk). The point is this: we should not jigger our diagnostic criteria in order to address a problem of medical education; ie, doctors need better training on when—and when not—to prescribe medication.

Finally, thanks for citing my recent piece on "scrapping" the DSM system.[7] We really need a more in-depth understanding of grief and depression, beyond the symptom checklists of the DSMs. We need to appreciate how the inner world of grief differs from that of depression, so that we can indeed recognize what Thomas à Kempis called, "the proper sorrows of the soul."

Thanks again, John, for covering this topic!

Best regards,

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References

1. Carey B. Grief could join list of disorders. *New York Times.* http://www.nytimes.com/2012/01/25/health/depressions-criteria-may-be-changed-to-include-grieving.html?ref- . Accessed January 27, 2012.
2. Grohol JM. Will depression include normal grieving too? http://psychcentral.com/blog/archives/2012/01/25/will-depression-include-normal-grieving-too. Accessed January 27, 2012.
3. Pies R. The two worlds of grief and depression.

http://psychcentral.com/blog/archives/2011/02/23/the-two-worlds-of-grief-and-depression. Accessed January 27, 2012.
4. Zisook S, Reynolds CF 3rd, Pies R, et al. Bereavement, complicated grief, and DSM, part 1: depression. *J Clin Psychiatry.* 2010;71:955-956.
5. Pies R. Is grief a mental disorder? No, but it may become one! http://psychcentral.com/blog/archives/2008/10/04/is-grief-a-mental-disorder-no-but-it-may-become-one. Accessed January 27, 2012.
6. Zisook S, Simon NM, Reynolds CF 3rd, et al. Bereavement, complicated grief, and DSM, part 2: complicated grief. *J Clin Psychiatry.* 2010;71:1097-1098.
7. Pies R. Why psychiatry needs to scrap the DSM system: an immodest proposal. http://psychcentral.com/blog/archives/2012/01/07/why-psychiatry-needs-to-scrap-the-dsm-system-an-immodes. Accessed January 27, 2012.