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# When a Child Dies: A Critical Analysis of Grief-Related Controversies in *DSM-5*

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## Abstract

The upcoming fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has incited vociferous debate among academics, clinicians, and the general public. Two contested changes are eliminating the bereavement exclusion from the major depressive disorder diagnosis and creating a new category for intense and prolonged grief called *persistent complex bereavement-related disorder*. This article critically analyzes research and debate regarding these two changes and considers the likely implications for bereaved parents and other traumatically bereaved groups, who may be especially vulnerable to consequences of the two proposed changes.

## Keywords

*DSM-5*, bereavement exclusion, major depressive disorder, persistent complex bereaved-related disorder, bereaved parents

There is a great deal of controversy surrounding the upcoming fifth edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Because the manual is used by clinicians in psychiatry and related fields such as psychology and social work, some degree of controversy seems normal and predictable simply based on the nature of the diagnostic process. There are no biological tests, such as those used in other branches of medicine, which can be used to diagnose any of the disorders in the manual. The manual's developers are tasked with selecting and justifying the demarcation between normal and disordered psychological functioning using a checklist of symptoms commonly found in the general population or emotions predicated on normal human experiences such as the subjective experience of sadness (Horwitz & Wakefield, 2007).

The current edition of the manual, *DSM-4-TR* (Fourth Edition, Text Revision), recognizes these limitations in the introduction by acknowledging that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder" (APA, 2000, p. xxxi) while still attempting to draw useful boundaries for clinical practice and research (Widiger & Clark, 2000). Thus, it is no wonder that revisions to the manual incite some controversy. Two contentious changes are related to bereavement: the elimination of the bereavement exclusion (BE) from the diagnosis of major depressive disorder (MDD) and the creation of a new disorder called *persistent complex bereavement-related disorder* (PCBRD). There has been much public outcry since these changes were proposed, in particular the removal of the BE, with many citing concerns that it will alter the ways in which clinicians, researchers, insurance providers, and the general

public view grief by linking it more closely to a mental disorder (e.g., Carey, 2012; Greenberg, 2012; O'Connor, 2012).

Indeed, many groups have expressed concern related to various *DSM-5* proposals, including the American Counseling Association, American Psychological Association, the Society for Humanistic Psychology, and Association for Death Education and Counseling. However, social workers have remained relatively silent on the topic (Carney, 2012), a cause for curiosity considering a significant proportion of mental health services are provided by social workers (Frazer, Westhuis, Daley, & Phillips, 2009) and changes to the manual will directly affect them and the clients they serve. In addition, the *DSM* trend toward disregarding context in diagnosis and focusing on deficits appears to be at odds with the person-in-environment and strengths-based perspectives endorsed by this field (Gomory, Wong, Cohen, & Lacasse, 2011). Though a few social work academics have engaged in this debate (Littrell & Lacasse, 2012), clinical social workers largely have not (Carney, 2012).

Below we briefly review the research and arguments regarding two bereavement-related changes before we discuss them in light of their possible implications for one specific population of the traumatically bereaved: parents who have experienced the death of a child. Traumatic bereavement often results under the following circumstances: (1) deaths are

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sudden and unexpected, (2) survivors have little or no prior experience or ability to prepare, (3) there is little knowledge of how to react or what to expect, (4) the experience is not common to most others, resulting in a sense of isolation, (5) the aftermath has an unpredictable trajectory, (6) survivors experience a lack of control and increased helplessness, a strong sense of loss, and the feeling that their lives have been disrupted or destroyed, (7) there may be a perception or actual threat to the life of self or significant other, and (8) the event holds high emotional impact (Figley, 1983). The death of a child is widely accepted as a form of traumatic bereavement, noted to produce especially intense reactions, which typically last more than a year, and sometimes decades (Arnold, Gemma, & Cushman, 2005; Middleton, Raphael, Burnett, & Martinek, 1998; Rando, 1985; Sanders, 1979–1980).

Many studies support the long-lasting nature of grief in the population (e.g., Keesee, Currier, & Neimeyer, 2008; Leahy, 1992–1993; Rogers, Floyd, Seltzer, Greenberg, & Hong, 2008). For example, Rando (1983) found that grief in this group peaked during the third-year postloss. In a comparison of adults who had lost a spouse, a parent, or a child, Sanders (1979–1980) found that bereaved parents had more intense grief reactions and scored higher than the other two groups on a number of measures including atypical grief responses, despair, anger, loss of control, somatization, death anxiety, loss of appetite, and physical symptoms 2 months after the loss. Reactions noted in this study include intense preoccupation with thoughts of the dead child, a sense of unreality, and rumination.

## The BE for MDD

Distinguishing grief from MDD may be difficult for clinicians, as the two share a number of features, including feelings of sadness and emptiness, loss of interest and energy, sleep or weight changes, and impaired concentration (Horwitz & Wakefield, 2007). However, despite this overlap, grief and depression have been culturally accepted as separate and historically distinct in the *DSM*. Currently, grief as a V-code is recognized as a reaction to an external event—the death of a loved one—while depression is viewed as an internal dysfunction within the individual (Horwitz & Wakefield, 2007). The challenge for mental health professionals is to distinguish grief from depression using a checklist of symptoms common to both, while considering whether the response is proportionate to the external context. The BE is intended to serve as a guidepost for clinicians and researchers in distinguishing normal reactions (grief) from a pathological state (MDD).

The BE specifies that MDD should not be diagnosed prior to 8 weeks after the death of a loved one. However, a recently bereaved person may still receive this diagnosis within the 8-week time frame when certain severe features are present, specifically “marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor agitation” (APA, 2000, p. 356). Indeed, throughout iterations of the *DSM*, clinicians have been allowed

to exercise their judgment to diagnose MDD following bereavement, even if the BE would otherwise exclude the individual from a diagnosis. The controversial change in *DSM-5* is to remove the BE entirely, allowing MDD to be diagnosed following bereavement if the symptoms persist for 2 weeks, the duration criteria for the diagnosis overall (APA, 2012a).

Proponents of the BE’s elimination argue that it lacks validity and should not be retained (e.g., Zisook et al., 2012). This position notes that bereavement-related depression bears some resemblance to nonbereavement-related depression and is thought to respond to antidepressant medication, rendering a distinction unnecessary (Zisook et al., 2012). There is concern expressed among this group that the BE might prevent some individuals from receiving adequate treatment if a Major Depressive Episode occurs following bereavement, possibly even culminating in suicide completion (e.g., Zisook, Shear, & Kendler, 2007), in spite of the ability of clinicians to override the BE. Some have also pointed out that the BE is an anomaly, as it is the one adverse life event singled out for exclusion in a diagnostic manual that otherwise largely does not concern itself with the context in which symptoms occur (e.g., Karam et al., 2009). However, a recent study highlights that contextual criteria are in fact important and necessary components in the *DSM* that serve to reduce false positive and improve validity (Wakefield & First, 2012a).

Opponents of removing the BE note that grieving individuals may be misdiagnosed as having MDD and unnecessarily treated (Wakefield & Schmitz, 2012a). Wakefield and Schmitz (2012b) also point out that those with bereavement-related depression have not been found to be at increased risk of suicide attempts. In addition, they note that the study cited by Zisook et al. (2012) to support the efficacy of antidepressants among those with bereavement-related depression consists of a single, small, open-label trial (Zisook, Shuchter, Pedrelli, Sable, & Deaciuc, 2001) in which the improvement noted in participants coincided with the normal course of grief. Another argument in favor of retaining the BE is that its elimination would likely increase the rate of false positives (Wakefield & First, 2012b), eroding the validity of the MDD diagnosis by including nonpathological responses to loss with truly disordered states that call for intervention. This could potentially lead to negative effects on research, clinical practice, and the lives of patients. Indeed, research shows that grief regularly persists well beyond 2 weeks after the death of a loved one (Wakefield & First, 2012b).

A number of reviews of prior studies have been put forth in an attempt to offer guidance on the BE debate, mainly focusing on the validity of the BE (Lamb, Pies, & Zisook, 2010; Zisook & Kendler, 2007; Zisook et al., 2007). If the BE is valid, research should show a difference between bereavement-excluded depression, that is, symptoms of depression occurring within 2 months of the death of a loved one without the severe features (such as suicidal ideation or psychotic symptoms), and depressive symptoms occurring in any other context. If the BE is not valid, research should show no such difference, supporting the view that depression is the same, regardless of the

context. However, due to the limited data in this area, many studies fail to address the BE specifically or have methodological limitations, and thus they are not able to directly inform this debate. Among the three studies (Karam et al., 2009; Kendler, Myers, & Zisook, 2008; Wakefield, Schmitz, First, & Horwitz, 2007) included in a recent review (Lamb et al., 2010) that did apply the BE criteria, results were inconclusive. More rigorous methodological studies were called for to reveal whether bereavement-excluded depression is significantly different than other forms of depression (e.g., Karam et al., 2009; Zisook et al., 2007).

Three recent studies with superior methodologies using epidemiological data do shed more light on the validity of the BE, though the authors do not all reach the same conclusion. The first study (Gilman et al., 2011) used data from the National Epidemiologic Survey on Alcohol and Related Conditions. This study found a lower rate of preexisting and subsequent psychiatric conditions, fewer depressive episodes, a lower rate of seeking treatment, and less psychosocial impairment among those with bereavement-excluded depression, compared to those who met criteria for MDD. The authors concluded that bereavement-related depression was “in many ways less indicative of psychopathology than MDD” (Gilman et al., 2011, p. E1). However, the authors advocated eliminating the BE based on the finding that complicated (nonexcluded) bereavement was more similar to bereavement-excluded depression than to MDD.

A second study (Mojtabai, 2011) used data from the same survey and found similar results on a different set of variables. Those with bereavement-excluded depressive episodes experienced less role functioning impairment, fewer comorbid anxiety disorders, a lower rate of past treatment history, and were less likely to experience a sense of worthlessness, suicidal ideation, increased sleep, and fatigue compared to those with nonbereavement-related depressive episodes. Perhaps the most compelling finding was that experiencing a bereavement-excluded depressive episode did not appear to put a person at increased risk of future episodes. This replicates the dramatic findings of Gilman et al. (2011) and stands in contrast to several studies that have shown MDD to be recurrent in nature (e.g., Zisook et al., 2007). Indeed, this study found that individuals with bereavement-excluded depression were at no greater risk of recurrence than the general population with no prior history of depression. The author concluded that the BE was valid and should be retained in *DSM-5*.

A third study (Wakefield & Schmitz, 2012a) replicated Mojtabai's (2011) key finding regarding recurrence of episodes using data from a separate source, the Epidemiologic Catchment Area Study. This study also found no increased risk for future depressive episodes among those with bereavement-excluded depression, providing support for the argument that there are important differences between bereavement-excluded and nonbereavement-related depression, with the former being less severe and pathological. The authors of this study also concluded that the BE is valid and should be retained.

These three studies, using nationally representative samples of adults in the United States, provide the most compelling

evidence to date regarding the validity of the BE. However, it should be noted that these were epidemiological studies conducted with the general population, and the relevance of the findings to bereaved parents is unclear. Recently, the *DSM-5* task force announced the final decision to move ahead with eliminating the BE from the MDD criteria and will include a note to clinicians regarding the similarity between normal loss reactions and MDD: “The normal and expected response to an event involving significant loss (e.g., [*sic*] bereavement, financial ruin, natural disaster), including feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss, may resemble a depressive episode. The presence of symptoms such as feelings of worthlessness, suicidal ideas (as distinct from wanting to join a deceased loved one), psychomotor retardation, and severe impairment of overall function suggest the presence of a Major Depressive Episode in addition to the normal response to a significant loss” (APA, 2012a). How clinicians and researchers will utilize the footnote is unknown at this time and remains to be seen.

The decision to eliminate the BE in favor of a footnote has led to some skepticism, as the *DSM-5* committee appears to have ignored the called-for evidence needed to decide the issue (Thieleman & Cacciatore, in press; Wakefield, 2012). However, others point out the limitations of these studies and note that rigorous prospective, rather than retrospective, data on this topic are needed (Zisook et al., 2012). The debate expanded beyond the evidence provided by recent studies to encompass other arguments. For instance, one proponent of removing the BE who initially called for rigorous tests later suggested that no evidence at all is needed to remove the BE, as its original inclusion was not based on solid evidence (Pies, 2012a). Regardless of how the BE came to be included in the *DSM*, it seems questionable to justify ignoring the existing evidence in a revision process that is meant to rely on the best available evidence (Wakefield & First, 2012c).

## The BE and Bereaved Parents

Bereaved parents may already be in danger of having their traumatic bereavement reactions diagnosed as MDD, even when applying the BE. This population experiences a higher rate of the severe symptoms that may lead clinicians to override the BE, such as feelings of worthlessness or shame, suicidal ideation, and psychotic experiences such as hearing the cries or voice of the deceased child (DeFrain, 1986; Murphy, Tapper, Johnson, & Lohan, 2003; Qin & Mortensen, 2003). However, these features are common for bereaved parents and not necessarily indicative of abnormality or psychopathology (Cacciatore, Lacasse, Lietz, & McPherson, in press; Wakefield, 2012). Bereaved mothers may be especially at risk of being diagnosed with depression, as they tend to show more emotional symptoms compared to fathers (Dyregrov & Matthiesen, 1991).

The rate at which depressive symptoms diminish following a loss appears to be different in bereaved parents than other studied groups. For instance, one early study of bereaved spouses noted that 24% of the sample met criteria for

depression at 2 months, 23% did so at 7 months, and 16% met criteria at 13 months (Zisook & Shuchter, 1991). This study found evidence for a decreasing trend in depressive symptoms over the first 13 months. In contrast, Dyregrov and Matthiesen (1991) found that 52% of women and 28% of men met criteria for depression 1 month following the death of a child, 63% of women and 35% of men did so at 6 months, and at 13 months 57% of women and 24% of men met criteria. In this study, rates of depression increased before they began to decline, and when they did decline it was at a slower rate. This suggests that such symptoms do subside in bereaved parents, but at a slower rate and follow a different course than in other bereaved population.

Other studies have supported this finding that symptoms of depression, indistinguishable from some symptoms of grief, often persist among bereaved parents. A recent study found that almost 58% parents qualified for a depression diagnosis an average of 4.36 years after the death of a child (Cacciatore et al., in press). Other data suggest that bereaved mothers had higher rates of depression (60.3%) than bereaved daughters (26.3%) or spouses (49.6%) within the 2 years following the death (Leahy, 1992–1993). Another study found higher rates of depression among bereaved parents compared to nonbereaved controls up to 6 years later, after which there was no significant difference in the two groups (Kreicbergs, Valdimarsdottir, Onelov, Henter, & Steineck, 2004).

Taken together, these findings suggest that applying norms based on conjugal bereavement outcomes to bereaved parents is a questionable practice, though the *DSM* proposal appears to do just this. Against the general body of bereavement and depression literature, bereaved parents' grief responses may indeed appear abnormal. Yet, the finding that symptoms that meet the criteria for depression are so commonly present in bereaved parents following the death of a child suggests that this is a normative response and thus calls into question the wisdom of assigning an MDD diagnosis as early as 2 weeks following a death in this group. It seems dubious to label experiences found in the majority of a population as pathological and in need of treatment when a more likely explanation is that it constitutes a normative, if intense, response. Indeed, *DSM-4-TR* recognizes that a response must be disproportionate in order to count as a disorder in stating that a "syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one" (APA, 2000, p. xxxi). There is compelling evidence that the intense and long-lasting reactions of bereaved parents constitute a normal and expectable response to a devastating and life-changing event. The note *DSM-5* plans to add stating that responses to loss may resemble depression may simply be inadequate for alerting clinicians to the unique needs of this population.

## Persistent Complex Bereavement-Related Disorder

A second proposed change to the manual that addresses grief-related difficulties is the addition of a new diagnosis, PCBRD, in section III of the manual, an area for diagnoses recommended

for further study. Proponents of a grief-related category have noted that there is no diagnosis in the *DSM* that captures grief-related problems unrelated to depressive symptoms or posttraumatic stress disorder (Bonanno et al., 2007; Prigerson et al., 2009). There is a concern that some individuals are not able to obtain needed treatment due to a lack of a diagnostic category for their unique concerns (Horowitz, 2005–2006). It has been argued that there are clearly cases in which something has gone wrong in the grieving process and that a grief disorder is needed to adequately capture this phenomena (Prigerson et al., 2009). However, some of those who support a grief disorder are opposed to the current criteria set proposed by *DSM-5* (e.g., Boelen & Prigerson, 2012).

According to the *DSM-5* website (APA, 2012b), PCBRD requires the presence of grief-related symptoms that persist for at least 12 months following the death. An individual must show one of the following symptoms "on more days than not and to a clinically significant degree" (APA, 2012b): yearning or longing for the deceased, intense emotional pain or sorrow, preoccupation with the person who died, or with the circumstances under which the death occurred. In addition, an individual must show a total of at least six symptoms indicative of "reactive distress to the death" (difficulty accepting the death, feeling numb, shocked, or stunned, problems accessing positive memories of the deceased, bitterness or anger, self-blame or other negative appraisals of oneself, avoidance of reminders of the death) or of "social/identity disruption" (wanting to be with the deceased, problems trusting others, feeling detached or alone, feeling that life is empty or meaningless or feeling unable to function, role or identity confusion, or problems pursuing interests; APA, 2012b). The symptoms must cause "clinically significant distress or impairment" in one or more areas of functioning, and the "bereavement reaction must be out of proportion or inconsistent with cultural, religious, or age-appropriate norms" (APA, 2012b).

The proposed PCBRD criteria draw on research over the last couple of decades regarding prolonged and intense grieving, which has variously been called *complicated grief* or *prolonged grief disorder* (PGD). Different criteria sets for a grief-related diagnosis have been proposed (e.g., Horowitz et al., 1997; Prigerson et al., 2009; Shear et al., 2011). Of the criteria sets suggested for inclusion in *DSM-5*, the Prigerson et al. (2009) criteria have undergone the most extensive testing and can claim the most empirical support. However, the proposed PCBRD criteria appear to be a mixture of two criteria sets (Prigerson et al., 2009; Shear et al., 2011) with the addition of some features not found in either of the previous criteria sets (such as a 12-month duration criterion), with no explanation offered to support such changes. Because this combination of symptoms and the duration criterion have not been tested, there is no information on how valid and reliable this conceptualization of a grief disorder may be. The proposed PCBRD criteria contain symptoms that overlap with normal grieving, particularly certain subsets of the population, and thus risk pathologizing normal responses as well as being overinclusive and capturing many individuals experiencing normal grief (Boelen

& Prigerson, 2012; Wakefield, 2012). As proponents of other criteria sets for a grief disorder point out, adopting the new criteria may lead to a disruption in research and clinical practice (Boelen & Prigerson, 2012), much of which has been based on earlier criteria sets.

Though other criteria sets may be preferable to what *DSM-5* is proposing, these are not without problems either. For example, though Wakefield (2012) agrees abnormal grieving does exist, he argues that none of the proposed criteria to date provide an adequate distinction between normal and abnormal grieving. It is widely agreed that none of the proposed symptoms for a grief disorder are qualitatively different from those seen in normal grief. Thus, proposed criteria sets tend to rely on a duration criterion in order to distinguish normal from abnormal grieving (Wakefield, 2012), with the idea being that it is the prolonged nature of such grief that is problematic. However, all proposed duration criteria are within the time line of normal, if intense, grief, leading back to concerns that normal grievers will be misdiagnosed as disordered. It appears to be very difficult and controversial to select a one-size-fits-all time point after which grieving becomes abnormal, hindering efforts to create a sound grief-related disorder category.

### **Persistent Complex Bereavement-Related Disorder and Bereaved Parents**

There are no studies to directly inform the likely impact of the PCBRD diagnosis on bereaved parents. However, others have noted that the proposed criteria are likely to capture many individuals with normal grief-related symptoms (Boelen & Prigerson, 2012; Wakefield, 2012). Additionally, there may be problems with applying even the more empirically validated criteria set for PGD proposed by Prigerson et al. (2009) to bereaved parents. For instance, the developers note that the majority of studies using these criteria have been conducted with White, elderly, conjugally bereaved samples and that the criteria needs to be tested with other populations (Boelen & Prigerson, 2012).

Limiting the discussion to bereaved parents, there are a number of reasons to be circumspect in applying this criteria set to this group. The growing body of research showing that grief at the death of a child tends to be intense and prolonged suggests that the alternative PGD criteria set may not be adequate in this population. The estimated prevalence of disordered grieving varies. Based on existing reviews, it has been proposed that about 15% of the bereaved individuals show a form of disordered grief (Bonanno & Kaltman, 2001). Some studies have simply labeled those with the most intense grief (typically the top 20%) in a sample as being disordered (Prigerson et al., 2009). Many studies use either the Inventory of Complicated Grief (ICG; original or revised version) developed by Prigerson et al. (1995) to measure complicated grief. Recent epidemiological studies conducted in Europe using these instruments found prevalence rates of between 4.8% and 6.7% among bereaved individuals (Kersting, Braehler, Glaesmer, & Wagner, 2011; Newson, Boelen, Hek, Hofman, & Tiemeier, 2011).

Kersting et al. (2011) found that bereaved parents demonstrated a remarkably higher rate of complicated grief, at 23.6%, and Newson et al. (2011) found that the risk was 3.84 times greater among bereaved parents in a study of older adults. Given the body of literature on this population, this should not come as a surprise to researchers or clinicians in the field.

Many other studies have investigated supposed abnormal grieving in bereaved parents. These studies used different labels (complicated grief, prolonged grief) and various cutoff points to indicate disorder. Regardless, the results show an overall trend in which bereaved parents score higher than expected compared to other populations. For instance, in one study 78% of parents bereaved by suicide or accident and 48% bereaved by the death of a baby qualified for a diagnosis of complicated grief about 18 months after the death (Dyregrov, Nordanger, & Dyregrov, 2003), while a different study reported that 30% of bereaved parents qualified an average of about 6 years after the death (Keesee et al., 2008). Another study (Feigelman, Jordan, & Gorman, 2011) reported that the mean ICG score among parents bereaved by overdose or suicide was 28.15 and among those bereaved by a natural causes or accident the mean score was 25, both of which are at or above the commonly used cutoff point of 25 (Prigerson et al., 1995). There was a wide range of time since the loss in this sample, extending beyond 10 years. One research team found that 59% of parents scored above a cutoff point of 30 on the ICG 6 months after the death of a child, and 38% did so at 18 months (Meert et al., 2011). McCarthy et al. (2010) found a similar rate among bereaved parents as in other groups (10.3%), but 41% met criteria for the separation distress component, indicating the persistence of certain symptoms in this population.

These findings suggest that a large percentage, sometimes the majority, of bereaved parents in different samples meet criteria for various proposed grief disorders. However, again, rather than suggesting unusually high rates of psychopathology among bereaved parents, this may instead suggest that the normal and expectable grief response at the death of a child may simply be more intense and enduring than in other populations. For example, one study noted above found that 41% of parents with no history of mental disorder showed significant grief-related symptoms an average of 4.5 years after their child's death (McCarthy et al., 2010). Another study found that loss-related symptoms after the death of a child did not fully abate until about 9 years later (Kreicbergs et al., 2004). Arnold et al. (2005) found that 63.5% of parents reported that their grief continued an average of 24 years postloss. Importantly, this group showed no differences in overall life satisfaction compared to parents who felt their grief had ended. Thus, it appears that is not unusual for the grief of bereaved parents to fluctuate in intensity, perhaps over a lifetime.

This discussion suggests that even if an existing criteria set for which there is some support is used, the application of a grief disorder diagnosis to bereaved parents may be imprudent. Such criteria sets label what have been found to be normative symptoms and time lines of grief in this population as pathological. Therefore, applying such criteria to bereaved parents seems very likely to result in a high rate of false positives and

could lead to the kind of pathologization of normal grieving that all parties involved agree is undesirable (Boelen & Prigerson, 2012). While there is a case to be made regarding the need for a specific grief-related diagnosis, no proposals so far seem adequate for this population, and the criteria proposed by *DSM-5* seem especially disconcerting.

## Discussion and Applications to Social Work

Among those suffering traumatic bereavement, such as bereaved parents, it would appear that symptoms which are often viewed as depression or abnormal grieving may actually be normative responses. For some groups, it seems unreasonable and inaccurate to expect that grief-related symptoms would abate within the time frames for the MDD and PCBRD diagnoses. To rely on an arbitrary cutoff point for making a diagnosis following a death, without considering the context in which symptoms develop, risks pathologizing normal human emotions and discounts the importance of attachment ties between two human beings. Even though the *DSM* aims to be atheoretical, evidence suggests that many clinicians do indeed consider context in making a diagnosis (Kim, Paulus, Nguyen, & Gonzalez, 2012).

For the majority of bereaved parents, the presence of intense grief-related symptoms likely does not indicate psychopathology but instead represents a way to maintain a connection to a beloved deceased child (Arnold et al., 2005; Cacciatore & Flint, 2012). Continuing bonds such as these have been shown to be normative and beneficial for some groups (Klass, 2006). However, it is precisely these intense reactions that are thought to characterize pathological conditions among the population of grievers, elevating the risk that bereaved parents may be misdiagnosed with mental disorders. It is thus vitally important for clinicians and researchers to understand that what might be considered psychopathology in another context is part of the normative experience of bereaved parents and perhaps other traumatically bereaved groups.

Social workers must be able to consider grief in context and discern the best way to support bereaved clients through their grief journey, keeping in mind that intense symptoms may be common during the first year and beyond. However, this does not mean that social workers should do nothing for their bereaved clients. Compassionate and sensitive support and professional help should be available to all who desire it, regardless of diagnosis. Bereaved individuals, especially those who feel they require help, may benefit from a variety of interventions over time, including cognitive therapies (Wagner, Knaevelsrud, & Maercker, 2006), complicated grief treatment (Shear, Frank, Houck, & Reynolds, 2005), and support groups (Umpfrey & Cacciatore, 2011). To date, there is no sound empirical data to support the use of psychotropic medications for grief and arguments for their efficacy rely on small, open-label studies (Bui, Nadal-Vicens, & Simon, 2012). In addition there is a growing concern over the safety and efficacy of this approach (e.g., Andrews, Thomson, Amstadter, & Neale, 2012). Thus, psychopharmacology should be used judiciously

with the traumatically bereaved, especially before the trajectory of any disorder can be established. Research suggests that some individuals are prescribed psychotropic medications shortly after a traumatic death, even as early as the same day as the loss (Cacciatore & Thielemann, 2012; Gold, Schwenk, & Johnson, 2008; Lacasse & Cacciatore, under review). Though this needs to be confirmed in more rigorous studies, it does reflect the trend of psychotropic medication becoming an increasingly common treatment for a variety of issues (Mojtabai & Olfson, 2008; Olfson & Marcus, 2010), including the human experience of profound loss.

In considering proposals for *DSM-5*, it is important to keep in mind that the presence of distress is not enough, in and of itself, to justify the diagnosis of a mental disorder. Recasting forms of suffering as mental disorders is especially problematic when such disorders are thought to represent biologically based pathologies and yet there is no empirical support for their biological nature. In fact, the criteria for most disorders are created through a subjective, rather than scientific, process (Caplan, 1995; Kutchins & Kirk, 1997). There are legitimate forms of human suffering that are not pathological, of which intense grief following the death of a loved one is but one example.

Those tasked with revising the *DSM* appear to be in a bind. Clinicians have observed the intense suffering experienced by some bereaved individuals, and noted that there is not a diagnosis in the *DSM* that accurately reflects their struggles. Indeed, some have invoked the need to treat suffering, in whatever form it takes, as a justification for creating new categories (Horowitz, 2005–2006; Pies, 2012b). If categories of distress were simply created in order to facilitate research and best serve patients, there would be little harm in doing this. However, the categories contained in the *DSM* are intended to represent mental disorders, that is, abnormal, pathological states. Under this model, being diagnosed with a mental disorder may have serious consequences, such as becoming part of a permanent health record, potentially influencing future insurance policies and employment, and stigmatizing a normative, if intense, response. Psychiatry simply cannot pursue the goal of reducing suffering in whatever form it finds it as long as it adheres to a strict medical model and states its goals as diagnosing and treating pathological conditions. Based on its own standards, the revisers of *DSM-5* must demonstrate that such conditions are in fact pathological in order to include them among the diagnosable categories in the manual.

Nevertheless, the desire to treat suffering in whatever form it takes may be responsible for the trend toward expanding the number of diagnoses in the *DSM*. In addition, the need for an official diagnosis in order to obtain insurance reimbursement for treatment likely plays a role. This has come at the cost that more and more human experiences are medicalized and redefined as pathological, shrinking the acceptable range of such experiences and expanding the scope of what is thought to require professional intervention. This trend appears to conflict with core social work values and ethics (Gomory et al., 2011). Paradoxically, at the same time that the number of mental disorders is growing, the treatments offered for such conditions

are being called into question. While talk therapy was once the treatment of choice, psychosocial approaches have been phased out in favor of pharmacological treatment (Mojtabai & Olfson, 2008; Olfson & Marcus, 2010). A growing body of research is showing that pharmacological treatments are not as effective as once thought and that there may be serious risks associated with them (Andrews et al., 2012; Kirsch & Sapirstein, 1998). The possibility that bereaved individuals will be prematurely treated with such medications is cause for further concern about the proposed *DSM-5* changes.

Though not an exhaustive review, this article has sought to highlight some of the concerns in applying the changes in *DSM-5* regarding the elimination of the BE and the inclusion of PCBRD to bereaved parents, an especially vulnerable population of grievers. Given the profile of grief expressions among bereaved parents, the majority are likely to qualify for a diagnosis of MDD if the BE is eliminated. Likewise, many bereaved parents are likely to qualify for a diagnosis of PCBRD if it is included as proposed. This is because both the MDD and the PCBRD criteria include symptoms that have been noted to commonly persist in this population beyond the 2-week and 12-month mark, respectively. Many of these concerns may pertain to other traumatically bereaved groups as well, such as those who have lost a loved one to suicide or homicide.

It is a serious mistake to confuse normal forms of human suffering with psychopathology, particularly the suffering resulting from traumatic loss. As nearly 50,000 babies die under age 1 (Froen et al., 2011; National Center for Health Statistics, 2011), and another 45,000 children and young adults die between age 1 and 24 in the United States each year (National Center for Health Statistics, 2011), the proposed changes in *DSM-5* could expose many grieving family members to potential misdiagnosis and perhaps even inappropriate or misguided treatment. Attempts to assist bereaved parents and other traumatically bereaved groups extend well beyond the creation of categories of psychopathology. In the case of the death of a child, known to be life altering to individuals and families, there is no panacea. Perhaps, the answers lie in deep solace, recognition, and respect from the mental and medical health community, respect that goes far beyond that which can be contained in a manual or adequately captured with a label.

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