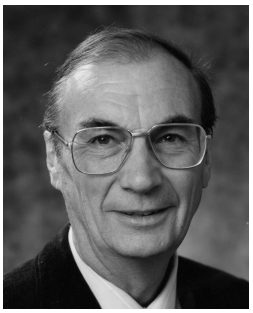
Diagnostic criteria for complications of bereavement in the DSM-5



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Abstract: the *Diagnostic Statistical Manual of Mental Disorders Volume 5* (DSM-5) is the most recent update (2013) in a series published by the American Psychiatric Association which aims to provide authoritative guidance to psychiatrists on the diagnosis of mental disorders. This article outlines the main changes in the DSM-5 regarding issues relating to bereavement, including discussion of diagnostic categories of Major Depressive Episodes, Adjustment Disorder, Persistent Complex Bereavement Disorder (PCBD) and Separation Anxiety Disorder.

Keywords: DSM-5, DSM-IV, complicated grief, prolonged grief disorder, persistent complex bereavement disorder (PCBD)

This article contains the essential information regarding issues relating to bereavement in the *Diagnostic Statistical Manual of Mental Disorders Volume 5* (DSM-5). This is the fifth volume of an influential book published by the American Psychiatric Association in 2013 whose aim is to provide authoritative guidance to psychiatrists on the diagnosis of mental disorders. Along with its sole rival, the WHO's International Classification of Diseases (ICD-10) Classification of Mental and Behavioural Disorders, it is respected in medical circles as a reliable source of diagnostic criteria for all of these disorders.

Previous editions have recognised that bereavement can trigger a variety of mental disorders including post-traumatic stress disorders and reactive forms of anxiety and depressive disorder. All serious students of bereavement were anxiously awaiting the publication of the fifth edition. Our anxiety stemmed from the public controversy occasioned by a consultation paper which proposed the inclusion in DSM-5 of a form of prolonged grief which seemed to meet reasonable grounds, based on extensive research, for being regarded as a mental disorder. The main opposition came from those who consider all forms of grief to be a normal response to loss and oppose any suggestion that bereaved people be stigmatised by labelling them as mentally ill.

DSM-5 appeared in June 2013 and, in addition to noting that several mental disorders, such as Major Depressive Disorder, can be triggered by bereavement, and that Separation Anxiety Disorder (gross intolerance of separation from a loved person) in both childhood and adult life, can make people extremely vulnerable to losses, it describes two conditions peculiar to bereavement. One is 'Adjustment Disorder following the death of a loved one when the intensity, quality, or persistence of grief reactions exceeds what normally might be expected, when cultural, religious, or age-appropriate norms are taken into account' (p287). And the other is the diagnosis 'Persistent Complex Bereavement Disorder' (PCBRD) which has been confined to a special category 'for further research'.

In summary, DSM-5 is of particular relevance to readers of *Bereavement Care* for its inclusion of several conditions relevant to bereavement:

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- The diagnosis of Major Depressive Episodes when these follow bereavement.
- The inclusion of death of a loved one as a potential cause of Adjustment Disorder.
- The inclusion in *Conditions for Further Study* of a possible new diagnosis of 'Persistent Complex Bereavement Disorder' (PCBD).
- The acknowledgement that 'Separation Anxiety Disorder', formerly recognised in childhood, when it is a common cause of school refusal, can now be diagnosed in adult life.

Major depression after bereavement (pp125-134)

Severe major depression can be triggered by bereavement and may even give rise to suicide.

In order to reduce the risk of confusing grief with episodes of major depression, the last edition (DSM-IV) discouraged the first-time diagnosis of major depression during the first two months after bereavement while permitting it to be made following other types of loss. In DSM-5 the two months exclusion has been removed and the differential diagnosis between grief and Major Depressive Episodes is clarified in Table 1, which has been adapted from the footnote to pp126 and 134 of DSM-5.

Although the two month exclusion may have reduced the risk of misdiagnosis, it deprived depressed people of medical help and treatment during a period of maximum vulnerability, simply because they had been bereaved. No such restriction was applied following other traumatic life events.

Major depression is the commonest psychiatric disorder and every doctor should be familiar with its correct diagnosis. But doctors today are functioning in a world in which diagnoses are scrutinised in the light of public information systems. They are aware that they will be held accountable if they make mistakes. Following bereavements this may lead them to cover themselves by prescribing anti-depressants 'just in case' a patient is depressed.

Most of those who experience major depression following bereavement will have suffered similar episodes in the past and may themselves recognise the difference between their grief and their depression.

Can grief itself be a mental disorder?

Readers may be aware of the controversy that met the publication of two beta drafts of DSM-5 'for consultation'. These evoked critical comments, notably from people who opposed the idea that grief could ever be regarded as a mental illness (Dreher, 2013; Granek, 2012). These resulted in major modifications to the final version of DSM-5. Indeed, in an important section entitled 'Definition of a Mental Disorder' in DSM-5 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.' (p20)

This, of course, allows for the possibility that there will be abnormal forms of grief that are neither expectable nor culturally approved. Indeed there is a general consensus among most serious researchers in the field of bereavement that persistent grief is a not uncommon cause of disabling illness. See, for instance, the review in a *Symposium on complicated grief* published in a special edition of *Omega* (Parkes *et al* 2006a).

Adjustment disorders (p286-289)

This category of mental disorders has been included in previous editions of the DSM. DSM-5 recognises that 'Adjustment Disorders are common... in out patients mental

Table 1: Distinguishing grief from Major Depressive Episodes.

Grief	*Major Depressive Episode*
Sufferer may feel empty and lost.	Persistent depressed mood and the inability to anticipate happiness or pleasure.
This decreases 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, nearly every day.
Any self-derogatory ideation typically involves perceived failings vis-a-vis the deceased.	Self-critical and pessimistic ruminations and feelings of worthlessness.
The pain of grief may be accompanied by positive emotions and humour.	Pervasive unhappiness and misery.
Any thoughts about death or dying are focussed on the deceased and possibly about 'joining' them.	Any such thoughts are focussed on ending one's own life because of feelings of worthlessness, undeserving of life, or unable to cope with the pain of depression.

health settings ...5% to 15%, and in hospital psychiatric consultations settings ...reaching 50%.' (p287).

Diagnostic criteria

The diagnostic criteria for Adjustment Disorder include:
A. Emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s).
B. ...one or both of...:

1. Marked distress that is out of proportion to the severity or intensity of the stressor taking into account the ...context and the cultural factors...
2. Significant impairment in social, occupational, or other important areas of functioning.

C. ...does not meet the criteria for another mental disorder.
D. The symptoms do not represent *normal* bereavement. [The word 'normal' has been added since DSM_IV].
E. Once the stress or its consequences have come to an end, the symptoms do not persist for more than another six months. [It is likely that the consequences of a major bereavement will not end. We are all permanently changed by major bereavements though not, necessarily, for the worst].
Further subdivisions are specified and coded according to whether or not the adjustment disorder is associated with depressed mood, anxiety, both, disturbance of conduct, mixed or unspecified.

Diagnostic features

Stressor(s) include a wide range of single, recurrent or multiple events affecting individuals, families or communities.

The following has been added in DSM_5 (my emphasis):

> 'Adjustment disorders *may be diagnosed following the death of a loved one when the intensity, quality or persistence of grief reactions exceeds what might normally be expected when cultural, religious, or age-appropriate norms are taken into account.* A more specific set of bereavement-related symptoms has been designated *persistent complex bereavement disorder.'* (p287)

While it is logical to recognise that grief is not confined to bereavement by death the term the 'emotional or behavioral symptoms' are not sufficiently specified to make this a useful set of diagnostic criteria. Certainly the diagnosis lacks the precision that we have come to expect of the DSM and which have been identified by Prigerson and her colleagues in many research projects and proposed in Prigerson *et al,* 2009. The authors seem aware of this defect, as indicated in the final sentence quoted above, yet the more precise symptoms that are given below are for research use only.

Persistent Complex Bereavement Disorder (PCBD) (p789-792)

Diagnostic criteria

Proposed Criteria for PCBD in adults (criteria for PCBD in children are here shown separately for the sake of clarity)**:**
A. The individual has experienced the death of someone with whom he or she has a close relationship.
B. Since the death <u>at least one of the following</u> symptoms is experienced *on more days than not* to a clinically significant degree and...for at least 12 months after the death:

1. Persistent yearning/longing for the deceased.
2. Intense sorrow and emotional pain in response to the death.
3. Preoccupation with the deceased.
4. Preoccupation with the circumstances of the death.

C. Since the death <u>at least six of the following</u> symptoms ...on more days than not and to a clinically significant degree, and persisting for at least 12 months after the death:
<u>Reactive Distress to the death.</u>

1. Marked *difficulty accepting the death*.
2. ...*disbelief or emotional numbness* over the loss.
3. *Difficulty in positive reminiscing* over the deceased.
4. *Bitterness or anger* related to the loss.
5. Maladaptive appraisals about oneself ...[re.] the deceased or the death (eg. *shame*).
6. Excessive *avoidance of reminders* of the loss (... individuals, places or situations...).

<u>Social Identity disruption</u>

7. A *desire to die* in order to be with the deceased.
8. *Difficulty trusting* individuals since the death.
9. *Feeling alone or detached* from others...
10. Feeling *life is meaningless or empty* without the deceased, or ...one cannot function...
11. *Confusion over one's role in life*, or a diminished sense of one's identity (eg. feeling that part of oneself died with the deceased).
12. Difficulty or *reluctance to pursue interes*ts ...or to plan for the future.

D. The disturbance causes *clinically significant distress* or *impairment in social, occupational or other important areas of functioning.*
E. The bereavement reaction is *out of proportion to ...the cultural, religious or age- appropriate norms.*

Specify if **with traumatic bereavement** due to homicide or suicide with persistent distressing preoccupations [re.] the traumatic nature of the death...

Proposed Criteria for PCBD in children include all of the above *except:*
B. Requirement reduced to *six months* after the death.
C. Requirement reduced to *six months* after the death and with the following modifications to the numbered categories:

1. ...difficulty accepting death ...depending on the child's capacity to comprehend the meaning and permanence of death.
6. ...avoidance of reminders ...may include avoidance of thoughts and feelings ...[re.] the deceased.

Associated Features supporting the diagnosis (at all ages): 'Hallucinations of the deceased (Auditory or visual) in which they temporarily believe the deceased's presence (eg. seeing deceased in favourite chair). They may also experience diverse somatic complaints (eg. digestive complaints, pain, fatigue), including symptoms experienced by the deceased'.
Prevalence: 2.4%-4.8%. Greater in females than males.
Development and Course: Symptoms usually begin within the initial months after the death, although there may be a delay of months or years before the full syndrome appears.

Likely consequences of PCBD

- Suicide risk: individuals with PCBD frequently report suicidal ideation.
- Deficits in work and social functioning.
- Harmful health behaviors, such as increased tobacco and alcohol use.
- Marked increases in risk of serious medical conditions, including cardiac disease, hypertension, cancer, immunological deficiency.
- Reduced quality of life.

Comment

Most of the above claims are taken from research using Prigerson's *Inventory of complicated grief* (ICG) but several of the criteria adopted in PCBD were not included in that instrument. This makes it hard to compare PCBD with the condition which Prigerson *et al* term *Prolonged Grief Disorder* (PGD). Boelen and Prigerson (2014) have condemned PCBD as '...a hastily conceived and extremely heterogeneous construct that endangers major advances in our understanding of what constitutes dysfunctional grief. It thereby sets the bereavement research clinical clock backwards , and ignores current strides in current understanding...' (See review of their paper in Bereavement round-up on p132).

Separation Anxiety Disorder (p90-195)

In DSM-5 Separation Anxiety Disorder (SAD) is currently a sub-category of Anxiety Disorders, all of which carry an increased risk of suicide.

Diagnostic criteria

A. SAD is '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 (eg. 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 (eg. headaches, stomach aches, nausea and vomiting) when separation from major attachment figures occurs or is anticipated.
B. The fear, anxiety, or avoidance is persistent, lasting 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...

Comment

The inclusion of this condition in DSM is timely in the light of my own research into the psychiatric consequences of insecure attachments to parents (Parkes, 2006b). No mention is made in the DSM that SAD, in both childhood and adult life, is often a precursor of and co-morbid with PGD (Parkes, 2006b; Vanderwerker *et al*, 2006). This suggests that both SAD and PGD may be better located within the category of Attachment Disorders; grief is, after all, an essential and defining aspect of attachment.

Conclusion

Complicated bereavement is complicated. Rando & Doka *et al*, agree that attempts to include all forms of complicated grief under a single title is a major error which has hampered the recognition of Prolonged Grief Disorder (PGD) as a distinct syndrome (Rando *et al*, 2012). Another title for PGD is Traumatic Grief but this term is better reserved for grief that has been triggered by exceptionally traumatic circumstances attending the bereavement and it is complicated by the symptoms of traumatic stress (such as Post Traumatic Stress Disorder).

Although it is unlikely that further research will confirm PCBD as a satisfactory alternative to PGD, its inclusion in

the DSM as worthy of research can be expected to attract a new generation of clinicians and researchers to this important field.

The DSM is not the only source of diagnostic authority. The sole competitor is the World Health Organisation's *International Classification of Disease* now in its 10th edition. The 11th edition (ICD-11; WHO, 2014) is pending and a beta version, with its volume on *The Classification of Mental and Behavioural Disorders*, is currently available on line. It includes a brief account of PGD which sounds much like that proposed by Prigerson and her large body of supporters, and it is to be hoped that the final version will solve the problems generated by the DSM-5.

As to the danger of 'medicalisation of normal life crises', this applies to many of the diagnoses made by psychiatrists and means that psychiatric diagnoses should only be made when the benefits outweigh the disadvantages to the patient or to protect society at large. This said, the diagnosis of Prolonged Grief Disorder would enable psychiatrists to reassure sufferers that they are suffering from a recognised condition, they are not 'going mad' (ie. psychotic), that they are entitled to treatment and, if someone is to blame for the bereavement, to give evidence in support of just compensation.■

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