

Dr Zisook and Colleagues Reply

To the Editor: We thank Dr Clayton for her thoughtful comments and careful reading of our article describing why we believe the bereavement exclusion has outlived its usefulness.¹ Dr Clayton's seminal work in this area is both historically and conceptually noteworthy. It is with the utmost respect and admiration that we disagree with her position on this matter. First, to highlight and clarify an important myth regarding eliminating the bereavement exclusion: those who favor the change do not want to imply that grief should be over within 2 weeks, 2 months, or even longer after the death of a loved one. Elsewhere, we have pointed out that grief and major depression are separate constructs, although there is some symptomatic overlap, and that many bereaved individuals grieve intensely for protracted periods, if not for a lifetime, whether or not they also meet criteria for a major depressive episode (MDE). Further, grief does not become pathologic or transform into major depression at 2 months. Rather, "normal" grief may last, in its various forms, for months to years.^{2,3} However, we do think it important to point out that, for vulnerable individuals, the death of a loved one may precipitate an episode of major depression. When that happens, the grief may be even more severe and protracted than otherwise.

We also would like advocates of retaining the bereavement exclusion to consider 4 hypothetical cases: Mr A, Mr B, Mr C, and Mr D. In each instance, the individual meets full symptomatic criteria for an MDE, has no suicidal ideation or morbid feelings of worthlessness, and has moderate levels of dysfunction. The cases are identical in all ways, with the exceptions that in Mr A's case, it is 4 weeks after the death of his dearly departed wife; Mr B's wife is fine, but he has been diagnosed with terminal lung cancer; Mr C and his wife are both healthy and retired, but have just lost their life's savings and home to terrible investments; and Mr D and his wife are healthy, wealthy, and wise.

According to the *DSM-IV-TR* (but not, we might add, the *ICD-10*), only Mr B, Mr C, and Mr D have an MDE; in contrast, Mr A has "bereavement." But this distinction makes sense only if Mr A's depressive syndrome is fundamentally different, with a better prognosis or unique treatment requirements compared to Mr B's, Mr C's, or Mr D's MDE. However, we are unaware of any published data supporting the argument that depressive syndromes occurring after the death of a loved one are in any meaningful way different than other, non-bereavement-related depressions. Instead, several recent studies⁴⁻⁷ have found bereavement-related major depressions to be

essentially identical to other, non-bereavement-related depressions, and 2 recent literature reviews^{8,9} have found that the preponderance of available data provide little support for the bereavement exclusion. Bereavement-related depressions are similar to other, non-bereavement-related depressions in risk factors, intensity, course, comorbidity, biologic features, and treatment response.

In one of her seminal studies on grief and depression,¹⁰ Clayton concluded that “grief is grief and grief is not a good model for psychotic depression.” We agree. In fact, we do not think it is a model for any MDE. Rather, grief is a model for stress and, like other severe stressors, may precipitate or worsen a variety of other conditions, including, perhaps most prominently, an MDE. And just like other, non-bereavement-related MDEs, bereavement-related MDEs are often recurrent, genetically influenced, impairing, and treatment responsive.⁵ Thus, we do not feel that we are doing the person a service by calling their depression by another name (ie, *bereavement*).

Instead, we believe that the most humane and data-based response is to be watchful for the emergence of depressive symptoms in recently bereaved individuals, especially those with other risk factors, and to make the diagnosis of MDE when the full symptomatic, duration, and severity features are present. We do not advocate actively treating every episode of major depression as we recognize that spontaneous remissions are the rule rather than the exception, especially for relatively mild MDEs.¹¹ Rather, we recommend that clinicians consider treatment decisions (whether, how, and when to treat) on the basis of past history, severity, suicide risk, persistence and pervasiveness of symptoms, comorbidity, and patient preferences.¹²

We strongly feel that it is no longer justifiable to deny appropriate diagnosis and access to meaningful treatment on the basis of a bereavement exclusion that has not been empirically validated in the 30-plus years of its existence. We welcome further dialogue on this important issue and continued data-based refinement of definitions and boundaries for major psychiatric disorders. While we are at one with Dr Clayton in affirming the validity of grief, we will not grieve the loss of the bereavement exclusion from the DSM-5.

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