# Grief as a diagnosis

In connection with the revision of the diagnosis manuals ICD-10 and DSM-IV, a proposal was launched to introduce a separate diagnosis for grief following the loss of a loved one. This proposal has met with considerable opposition, the reasons for which include resistance to regarding normal grief as a disease. Adherents claim that this will make it easier to identify those who struggle to overcome their grief and thus provide them with adequate treatment.

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Grief is a natural and expected reaction to the loss of a loved one. However, it has for long been observed that grief following a death can also lead to disease. Neither of the two classification systems for mental disorders, the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), has so far included a separate diagnosis for grief.

Since the 1990s, systematic research efforts have been undertaken to attempt to establish consensus on a proposal for a separate diagnosis of grief. Frontrunners have included the American psychiatrists Mardi Horowitz and Katherine Shear, and not least the epidemiologist Holly Prigerson. European research communities have also been involved, for example in Switzerland, the Netherlands and Norway. Several proposals for a designation have been put forward, such as «traumatic grief», «complicated grief» and «prolonged grief disorder».

The DSM-5, which is to be completed in 2013, now includes a specific proposal to include grief as a sub-category of adjustment disorders. The proposal in ICD-11, which will be published in 2015, is to categorise «prolonged grief disorder» as a separate diagnosis under stress-related disorders (1). Despite the different names, the criteria are mainly identical in the ICD-11 and the DSM-5. In this article, I have chosen to use the designation «prolonged grief disorder».

## What is prolonged grief disorder?

Today, many regard grief as a continuum ranging from normal to abnormal or pathological grief (2). In other words, the intensity and duration of the symptoms, as well as the degree of functional impairment, determine whether grief should be regarded as pathological.

The core symptom in prolonged grief disorder is separation distress. This manifests itself in the form of intense and persistent yearning for the deceased, emotional pain or excessive preoccupation with the deceased and/or the circumstances around his/her death (3, 4). In addition, there may be difficulties in accepting the death, anger/bitterness, avoidance of reminders of the deceased, problems in carrying on with life, an altered sense of identity, a feeling that life is empty and meaningless, problems in planning for the future or in participating in activities or relationships. In brief, prolonged grief disorder can be described as a form of chronic grief. The condition is often characterised as «being stuck» in grief (5).

While the proposal for ICD-11 points out that the symptoms must persist for more than six months after the loss (1), the proposal for DSM-5 is more conservative, stating that the symptoms must persist for more than 12 months (six months in children). A significant criterion in both ICD-11 and DSM-5 is that the symptoms must entail a loss of function in everyday life. It is also emphasised that the symptoms must be disproportionate when seen in relation to cultural, religious or other norms appropriate for the age of the sufferer.

It is estimated that approximately 7–10 % of those who lose a loved one develop prolonged grief disorder, although significantly higher rates have been documented in parents who have lost a child or in those bereaved after sudden, violent deaths (6–9). Prolonged grief disorder has a high co-morbidity with other mental disorders (3), while an estimated 30–50 % will demonstrate symptoms of prolonged grief disorder only (9, 10).

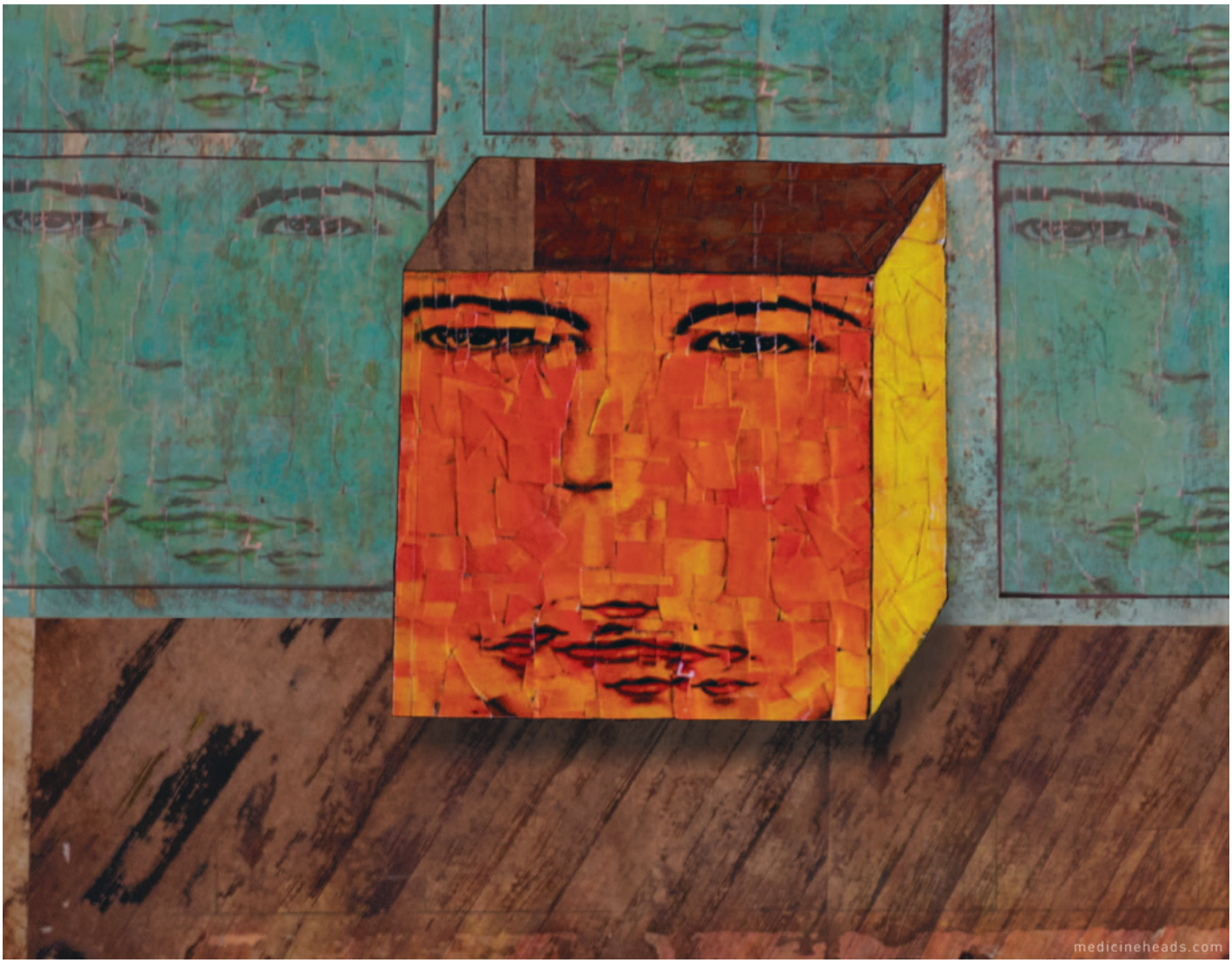
## Research supporting the proposal for a grief diagnosis

To be defined as a mental disorder, a behavioural or psychological syndrome or pattern appearing in an individual must be present, leading to clinically significant distress or functional impairment (11). Moreover, this should not be an expected reaction or a culturally accepted reaction to a particular incident. The symptoms must be differentiated from other symptoms of mental disorders and have diagnostic validity with regard to distinctive risk factors, prognoses and treatment responses.

Studies have shown that fulfilling the criteria for prolonged grief disorder beyond six months after the loss of a loved one is a predictor for long-term physical and/or mental afflictions, such as heart problems, immunological dysfunction, hypertension, depression, suicidal tendencies, reduced quality of life and increased consumption of tobacco and alcohol, independently of other mental disorders (3, 4). Increased occurrence of insomnia, frequent medical attention, sick leave and hospitalisation have also been documented (12).

Studies undertaken on the basis of factor analysis have shown that the symptoms partly overlap with, but also are different from, depression, anxiety and post-traumatic stress disorder (3). Prolonged grief disorder is distinguishable from its «diagnostic neighbours» mainly by an intense and persistent yearning. When compared to other mental disorders, prolonged grief disorder implies certain distinctive risk factors (13), and can be associated with increased activation of the reward centre of the brain, the *nucleus accumbens* (14). Prolonged grief disorder is not an exclusively Western phenomenon; it has also been documented in Pakistan, Japan, China, Rwanda, Israel and Iran (4).

Norwegian researchers have also reported findings that support the proposal for introduction of a grief diagnosis. In their study of bereaved persons two years after the tsunami disaster in 2004, Kristensen and collaborators found that fulfilling the criteria for prolonged grief disorder was associated with functional impairment unrelated to depression and post-traumatic stress disorder (9). While forms of psychotherapy that are effective against depression, such as interpersonal therapy, have elicited little response in treatment of prolonged grief disorder, forms of intervention that target the core problems have proven to be more effective (15, 16).

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## Advantages and disadvantages

There is little doubt that the proposal to introduce a separate grief diagnosis has been met with considerable scepticism. The strongest argument against its introduction is the fear of «medicalising» normal grief (17). The American sociologist Jerome Wakefield claims that the symptoms of prolonged grief disorder are not distinctively different from normal grief reactions, and that there has been a failure to distinguish the condition sufficiently from intense normal grief, where the healing process is gradual and prolonged (18). Wakefield claims that the research on prolonged grief disorder is at odds with recent knowledge on how long a normal grief process may require, and that this will result in numerous false-positives.

It is obviously important to recognise that a person may be stricken by intense and persistent grief, but that this cannot necessarily be characterised as abnormal or as a type of grief that cannot be accelerated or «healed» by treatment. There is also a risk of stigmatisation and of being branded as ill when going through profound grief. Others fear that their social network may withdraw when greater emphasis is placed on treatment of grief, but there is little research evidence for this assertion (13).

Adherents claim that the introduction of a grief diagnosis will make it easier to identify those who endure problems because of their grief, thus enabling them to receive help and support that are better adapted to their needs (13). In this respect, the introduction of a grief diagnosis may have a clinical value. With current practices, those who are stuck in their grief may be given various diagnoses that are not necessarily adequate for their problems. A recent Danish study showed that providing information on prolonged grief disorder to general practitioners may make them recognise the condition more easily, and thus have a positive effect on the subsequent clinical pathway (19). Moreover,

the introduction of a grief diagnosis may prompt allocation of funds for research in key areas such as risk factors, prevention and treatment. Diagnoses also imply certain entitlements as regards access to treatment, sick leave and social compensation.

Last, but not least, it is claimed that a grief diagnosis will not only provide better knowledge for those who should help grieving people, it can also be of help to those who are stricken. The well-known psychiatrist and grief researcher Colin M. Parkes claims that those who struggle with grief may be met with greater recognition of their problems, an increased understanding of the nature of prolonged grief disorder and a confirmation that help is available (20). A study from the USA supports this assertion (21). Otherwise, however, there is a paucity of research in this area.

Some questions still remain with regard to the introduction of a grief diagnosis, such as how it should relate to other sub-groups of pathological grief (22). As yet, the main emphasis has been placed on prolonged grief with intense separation distress, while other variants such as traumatic grief, where intrusive memories/thoughts of a dramatic death block the release of normal grief, and delayed or inhibited grief are not recognised in the same manner. These subtypes are clinically interesting and may give rise to other therapeutic challenges than prolonged grief disorder. Nor would the proposal for a separate grief diagnosis have an effect on current practices, for example with regard to granting sick leave to mourners before six months have passed since a bereavement, even for those who experience intense grief reactions and considerable functional impairment.

In addition, it is necessary to review critically whether the criteria are appropriate for describing grief in children and adolescents. Even though prolonged grief disorder has been described also in these age groups (23), it remains a fact that many children have greater problems in regulating emotions than adults, which may lead to more avoidance of thoughts and feelings (24). A development perspective is thus key to understanding how children cope with loss and grief, and some adaptations have been suggested in DSM-5 (25).

The strong sense of loss that may characterise the grief felt after the loss of a loved one may be just as prevalent after other types of loss, and it remains unclear why grieving after a death should be so fundamentally different from the experience of loss of a job, function or health, or a spouse lost through divorce etc. A study undertaken after hurricane «Katrina» showed that not only loss of loved ones, but also other types of loss (including job and financial position) were related to prolonged grief disorder (26).

The introduction of a grief diagnosis may entail certain practical implications. In practice, many of those who struggle with their grief will most likely be in contact with the health services already. Some studies also show that many of those who suffer from prolonged grief disorder do not seek any help (27). In other words, the introduction of a grief diagnosis may result in increased attention to the need for and entitlement to therapy, which may represent a challenge to the hard-pressed health services.

## Conclusion

It is common knowledge that grief may lead to illness. In a clinical and research perspective, it is crucial to study the health problems that may follow from grief and loss after bereavement. However, new diagnoses should be introduced only when they are strictly needed, and many are worried about excessive diagnosing and treatment of normal grief, since the distinction between normal and pathological grief may appear somewhat unclear. I would nevertheless maintain that there is ample research documentation to show that the persistent and intense yearning felt after bereavement is not identical to depression or anxiety, but represents a distinctive syndrome that may entail considerable physical and mental consequences and is treatable. I am therefore of the opinion that the advantages of introducing the diagnosis appear to outweigh the disadvantages.

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