The DSM-5 and the Continuing Transformation of Normal Sadness into Depressive Disorder

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The prominence of depression is new. Before the psychiatric profession adopted the third edition of its Diagnostic and Statistical Manual in 1980 (DSM-III), depression had been considered a serious, chronic, but relatively rare, condition. The DSM-I (1952) and DSM-II (1968), the two manuals that preceded the DSM-III, characterized it as a psychosis marked by gross misinterpretations of reality, delusions, hallucinations, and vegetative states (American Psychiatric Association [APA], 1952, p. 25). These manuals associated depression with conditions that typified the conditions of hospitalized patients more than the symptoms of clients of general physicians or outpatient psychiatrists. Subsequent to the publication of the DSM-III, the prevalence of MDD grew exponentially. Between 1987 and 1997, the proportion of the U.S. population receiving outpatient therapy for conditions called “depression” increased by more than 300% (Olfson et al., 2002). In 1987, 0.73 persons per hundred adults in the United States were treated for depression; by 1997, these rates leaped to 2.33 per hundred. While 20% of patients in outpatient treatment in 1987 had a diagnosis of some kind of mood
disorder, most of which were MDD, these diagnoses nearly doubled by 1997 to account for 39% of all outpatients. In 2002 there were 51.7 million outpatient visits for mental health care: depression accounted for fully 21 million of these (http://www.cdc.gov/nchs/fastats/mental.htm).

Its apparent ubiquity led MDD to become perhaps the brightest light in the firmament of the new diagnostically oriented campaigns, Internet web sites, and stories in the mass media widely trumpeted the huge amount of putative depressive disorder in the population. Mental health advocacy groups took advantage of the huge estimates of the number of people who suffered from depression to show how mentally ill people were not unusual misfits but had genuine biological diseases. Moreover, they comprised a substantial portion of the population. Institutions such as the National Institute of Mental Health and the World Health Organization (WHO) made depression the centerpiece of their efforts to convince the public that mental illness was a serious, widespread, and treatable form of disease. This article argues that the recent prominence of depression is due to the way that the DSM-III diagnostic criteria incorporated mild and transient as well as severe and chronic symptoms. “Depression,” therefore, encompassed not only the melancholic conditions that had previously characterized it but also normal responses to common stressors. Although the DSM-5 had the opportunity to correct the blatant conflation of normal sadness and depressive disorder that marked earlier manuals, remarkably, the changes it made in the MDD diagnosis exacerbated this confusion. MDD remains both psychiatry’s signature diagnosis and the most conspicuous example of its inability to separate normal from disordered mental states.

A Brief History of Depression

Depression is one of the few psychiatric conditions that have been characterized in a consistent manner from the earliest writing of the Hippocratic physicians through the DSM-III in 1980. In the 5th century BC, Hippocratic writings defined the symptoms of what was then called “melancholia” in a remarkably similar way as current definitions of depression: “aversion to food, despondency, sleeplessness, irritability, restlessness” (Hippocrates, 1923–1931, p. 185). Yet, diagnosticians routinely distinguished normal sadness that is contextually appropriate from depressive mental disorder. Their definition of melancholia made clear that symptoms alone were not sufficient indicators of a mental disorder: “If fear or sadness last for a long time it is melancholia” (Hippocrates, 1923–1931, p. 263). Natural fear and sadness persist proportionately to their generating context: only symptoms that “last for a long time” indicate disorder.

Several centuries later, the renowned Greek physician Areteaus of Cappadocia (c.150–200 AD) elaborated the distinction between normal and disordered conditions: “[Melancholic] patients are ... dejected or unreasonably torpid, without any manifest cause; such is the commencement of melancholy. And they also become peevish, dispirited, sleepless, and start up from a disturbed sleep. Unreasonable fear also seizes them” (Jackson, 1986, p. 39). This definition shows the importance of social context in definitions of natural grief and other deep states of sadness. The criterion of “without any manifest cause” differentiated disorders that are “unreasonable” from natural sadness, indicating how normal conditions are easily misdiagnosed as disorders when symptoms alone are taken into account.

Such Hippocratic-based definitions of depression prevailed for millennia. The most celebrated work on depression, Robert Burton’s Anatomy of Melancholy (1621/2001), provided a profound distinction between contextually appropriate sadness, which was a ubiquitous aspect of the human condition, and depressive disorder (both of which were called “melancholy” at the time):

Melancholy ... is either in disposition or habit. In disposition, it is that transitory melancholy which goes and comes upon every small occasion of sorrow, need, sickness, trouble, fear, grief,
passion, or perturbation of the mind, any manner of care, discontent, or thought, which causeth anguish, dullness, heaviness, and vexation of spirit…. And from these melancholy dispositions, no man living is free…. Melancholy, in this sense is the character of mortality. (Burton, 1621/2001, pp. 143–44)

In contrast to such natural melancholic feelings that arise after losses such as the death of an intimate, which are the “character of mortality,” melancholic disorders arise “without any apparent occasion.” Burton also emphasized how the normal response to deaths of intimates need not be mild but often reached intense extremes:

This is so grievous a torment for the time, that it takes away their appetite, desire of life, extinguisheth all delights, it causeth deep sighs and groans, tears, exclamations … howling, roaring, many bitter pangs … brave discreet men otherwise oftentimes forget themselves, and weep like children many months together. (Burton, 1621/2001, pp. 358–359)

Almost 300 years later, Sigmund Freud (1917/1957, p. 238) made a comparable distinction between normal grief and melancholic disorder:

Although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition and hand the mourner over to medical treatment. We rest assured that after a lapse of time it will be overcome, and we look upon any interference with it as inadvisable or even harmful.

While Freud asserted that symptoms associated with mourning are both intense and “grave departures from the normal,” he nevertheless insisted that grief is not a “morbid” condition and insisted that suffering was a natural part of responding to the death of an intimate. Indeed, he emphasized that it would “never occur to us” to provide medical treatment to the bereaved. Freud stressed that grief of even the deepest intensity is self-healing, so that with time the mourner returns to a normal psychological state. Medical intervention, he suggested, could actually harm the grieving person through interfering with natural healing processes.

Diagnostic criteria in psychiatric manuals before the DSM-III also separated contextually appropriate grief from depressive disorders. For example, the DSM-II defined depressive neurosis as follows: “This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession” (APA, 1968, p. 25). This definition clearly recognizes that psychiatrists should not consider as mental disorders reactions such as “the loss of a love object” that are proportionate and not “excessive” to their contexts. This diagnostic tradition that separated normal sadness from depressive disorder that persisted for millennia was abruptly abandoned when the American Psychiatric Association published the DSM-III in 1980.

The Symptom-Based Revolution in Psychiatric Diagnosis

Beginning with the DSM-III, psychiatry profoundly changed the diagnostic criteria for depression. It used overt symptoms themselves instead of the proportionality of symptoms to their context (“excessive”) or the cause of symptoms (“due to an internal conflict or to an identifiable event”) to define this condition. The new criteria specified that anyone who displayed five symptoms out of the following nine during a 2-week period receives a diagnosis of major depression (the five must include either depressed mood or diminished interest or pleasure): (a) depressed mood; (b) diminished interest or pleasure in activities; (c) weight gain or loss or change in appetite; (d) insomnia or hypersomnia (excessive sleep); (e) psychomotor agitation or retardation (slowing down); (f) fatigue or loss of energy; (g) feelings of
worthlessness or excessive or inappropriate guilt; (h) diminished ability to think or concentrate or indecisiveness; and (i) recurrent thoughts of death or suicidal ideation or suicide attempt (APA, 2000, p. 356).

Nonetheless, this symptom-based definition contained one attempt to distinguish normal sadness from depressive disorder. It exempted bereaved people from a MDD diagnosis unless their symptoms were still present after 2 months or were especially severe:

The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (APA, 2000, p. 356)

In other words, patients do not receive a diagnosis of depression if their symptoms are due to what the DSM defines as a normal period of bereavement after the death of a loved one, lasting no more than 2 months and not including especially serious symptoms.

The proximate reason for the bereavement exclusion was the empirical research of one of the members of the DSM Task Force on Affective Disorders, Paula Clayton (see Clayton, Halikas, & Maurice, 1972), who found that over 40% of bereaved people met criteria similar to MDD 1 month after the death of an intimate. Further, Clayton found that relatively few bereaved people remained depressed for extended periods of time. Her findings reflect the common intuition that people naturally become intensely sad after a loved one dies. Indeed, social norms regarding feeling rules mandate that people are expected to show sadness and grief after an intimate dies; those who don’t grieve evoke surprise or condemnation (Hochschild, 1979). Clayton’s findings also reinforced Freud’s contention that ordinary grief was transient and self-healing. After 3 months, only about 15% of her sample remained seriously depressed.

The DSM-III recognized that bereavement was not a psychiatric disorder, noting that “A full depressive syndrome frequently is a normal reaction to [the death of a loved one]” (APA, 1980, p. 333). Its criteria, however, also realized that grief can indicate a disorder when it was prolonged or involved symptoms such as marked impairment and psychomotor retardation that went beyond normal grief. While most bereaved people who would otherwise meet the criteria for MDD do not have mental disorders, in some cases the severity and length of the grieving process indicates a disorder. The DSM-III thus associated normal grief with three essential components: it is context-specific, arising after the death of an intimate; its intensity is roughly proportionate to the importance and centrality to one’s life of the lost individual; and it gradually subsides over time as people adjust to their new circumstances and return to psychological and social equilibrium.

Yet, this bereavement exclusion was the only remnant of an unbroken history of psychiatric thought from the Hippocratics to the DSM-II, which understood that psychological states that might otherwise seem to indicate a mental disorder but that emerged in stressful contexts are natural, not pathological. It was the definition’s sole acknowledgment that some instances of intense sadness might satisfy the MDD symptomatic criteria but still not be pathological. The bereavement exclusion, however, raised a fundamental issue in how to separate normal sadness from depressive disorder: is it a unique exception or, alternatively, a model for all stress-related symptoms of sadness?

Extending the Bereavement Exclusion?

In our book, The Loss of Sadness, my coauthor Jerome Wakefield and I argued that bereavement should be a model for all kinds of loss situations, not a unique exemption to the depression criteria. Wakefield and his collaborators went on to conduct a number of empirical studies that conclusively showed that
other uncomplicated stress-related losses were virtually identical to uncomplicated bereavement-related losses in terms of symptoms, durations, treatment histories, and degree of impairment. (Wakefield, Schmitz, First, & Horwitz, 2007). Moreover, all complicated conditions that were especially severe or prolonged, whether related to bereavement or to other losses, resembled each other and differed from the uncomplicated group.

Empirical research thus convincingly showed that the depression criteria mistakenly singled out bereavement as the single exclusion to the MDD diagnosis. The mental health consequences of bereavement were similar to depressions that stemmed from any kind of loss whether the death of a loved one, divorce, unemployment, and the like and were distinct from complicated depressive conditions. The critical distinction was not between bereavement and other losses but between uncomplicated conditions and conditions with especially prolonged duration or severe symptoms such as suicidal thoughts, marked functional impairment, morbid preoccupation with worthlessness, or psychotic symptoms. There was, that is, no good reason to single out bereavement as the sole exception to the diagnostic criteria. The logical conclusion seemed to be that bereavement exclusion should be extended to cover all kind of losses that weren’t particularly intense or prolonged.

Researchers connected to the development of the DSM-5 were attentive to these findings. One prominent psychiatric researcher and member of the DSM-5 Depression Task Force, Kenneth Kendler, used his own data set to test the contention that bereavement was a model for other stressors. His data, however, replicated our finding that depression that developed after bereavement was identical to that following other stressful life events (Kendler, Myers, & Zisook, 2008). “The DSM-IV position is not logically defensible. Either the grief exclusion criterion needs to be eliminated or extended so that no depression that arises in the setting of adversity would be diagnosable,” Kendler wrote (http://psychnews.psychiatryonline.org/ doi/full/10.1176%2Fpn.46.20.psychnews_46_20_3_1).

The president of the American Psychiatric Association, John Oldham, also noted the similarity of bereavement to other losses:

[the bereavement exclusion is] very limited; it only applies to a death of a spouse or a loved one. Why is that different from a very strong reaction after you have had your entire home and possessions wiped out by a tsunami, or earthquake, or tornado; or what if you are in financial trouble, or laid off from work out of the blue? In any of these situations, the exclusion doesn’t apply. What we know is that any major stress can activate significant depression in people who are at risk for it. It doesn’t make sense to differentiate the loss of a loved one as understandable grief from equally severe stress and sadness after other kinds of loss. (quoted in Frances, 2012, p. 1)

For these psychiatrists, however, the similarity of grief to other stressors indicated that the BE (bereavement exclusion) should be abandoned, not extended.

To address the critique that the equivalence of grief and other stressors showed that grief was not unique and so there was no justification for the BE, Wakefield and collaborators went on to conduct studies that showed an even more striking finding: people who developed uncomplicated depressions after all kinds of losses were more similar to those who were not depressed than those who had complicated depressive conditions (Wakefield & Schmitz, 2012, 2013a, 2013b). Using data gathered at two points of time, they found that individuals with uncomplicated cases have similar recurrence rates (3.4%) to people with no history of depression (1.7%); both groups had far lower rates than those with complicated cases (14.6%). Other studies also showed that 3 years after experiencing a bereavement episode people were no more likely than the nondepressed to have subsequent depressive episodes (Majtabai, 2011). Bereaved people were far more comparable to people who had never been depressed than ones with serious or enduring depressive symptoms.
The similarity of all loss-related depressions that weren’t especially severe or enduring to the conditions of nondepressed people presented a fundamental challenge to the logic of the depression diagnosis. As commentators since antiquity had recognized, symptoms of sadness after loss were often normal, not pathological. If many people who had enough symptoms to meet diagnostic criteria were, in fact, normal, the basic principle of the symptom-based MDD diagnosis would be undermined.

The DSM-5 work group was thus faced with a stark choice. On the one hand, they could expand the bereavement exclusion to cover all uncomplicated responses to loss-related stressors. On the other hand, they could abolish the BE so that all symptoms meeting the 2-week MDD criteria were mental disorders. This was an especially consequential decision because, as noted, for the past 30 years MDD had been the most common psychiatric diagnosis. Extending the bereavement exclusion, therefore, threatened the client base of mental health treatment itself.

**The DSM-5’s Confusion of Normal Sadness and Depressive Disorder**

A new edition of the DSM, the DSM-5, was published in May 2013. The DSM-5 symptom and 2-week duration criteria (presented before) for MDD had remained virtually unchanged since the DSM-III. Yet, the DSM-5 eliminated the bereavement exclusion from the textual criteria:

> The DSM-5 Mood Disorders Work-group has recommended the elimination of the bereavement exclusion criteria from major depressive episodes in light of evidence that “the similarities between bereavement related depression and depression related to other stressful life events substantially outweigh their differences.” [http://www.dsm5.org/ProposedRevision/Pages/proposed-revision.aspx?id=44](http://www.dsm5.org/ProposedRevision/Pages/proposed-revision.aspx?id=44)

The DSM-5 adds a note to the text that states:

> Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in [the symptom criteria], which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss. (APA, 2013, p. 161)

This note does not contain any diagnostic criteria so that the MDD criteria themselves would incorporate normal as well as disordered grief.

The DSM-5 criteria modify the earlier definition in two major ways. First, any grieving person is liable to a depressive diagnosis after a 2-week, rather than a 2-month period, which many experts believed was already far too short (e.g., Kleinman, 2012). Second, it no longer requires the presence of especially severe symptoms to override the criteria for depression. Anyone who has suffered the loss of an intimate and has normal symptoms of grief such as sadness, a loss of pleasure, sleeping and eating problems, and fatigue that last for a 2-week period following the death would meet the criteria.

The committee’s decision came at the cost of undermining the intellectual coherence of the DSM itself. Consider the DSM-5’s own definition of mental disorder:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental
disorders are usually associated with significant distress or disability in social, occupational, or other important activities. 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. (APA, 2013, p. 20)

This overall definition of mental disorder uses “the death of a loved one” to illustrate the difference between a painful but normal emotion and a mental disorder. The equivalence rationale thus contradicts the DSM-5’s sensible requirement that “An expectable ... response to ‘a common stressor or loss, such as the death of a loved one,’ is not a mental disorder”!

The removal of the BE also undermines the central logic behind psychiatric diagnosis itself. The point of distinguishing one diagnosis from another is to help specify the causes, courses, outcomes, and treatments of various conditions. Yet, combining uncomplicated depressive symptoms that stem from grief, unemployment, divorce, and the like with those that “come out of the blue” does the opposite: it blurs conditions that are environmentally caused and sustained with those stemming from individual predispositions; those that are transient and unlikely to recur with ones that are more enduring; and those that are likely to improve without treatment from those that respond to professional interventions.

The decision to remove the BE from the MDD criteria also undermines the as-yet-unrealized assumption that mental disorders will ultimately be found to stem from abnormal brain functioning. As diagnosticians for millennia have recognized, 2-week periods of uncomplicated grief represent the way that normal brains naturally respond to the death of a loved one. Neuroscientific research that relies on the DSM-5 criteria will hopelessly confound brains that are operating naturally with those that are dysfunctional.

The DSM-5 group also argued that the former bereavement exclusion could prevent grieving people from getting treatment that can help them. It cited Zisook’s study of 22 bereaved people that claimed over half who were treated with the antidepressant buproprion improved after 2 months (Zisook, Schuchter, Pedrelli, Sable, & Deaciuc, 2001). Yet, this study had no placebo group and its claimed success rate of a little more than half (13 of 22) did not exceed placebo recovery rates in other studies. Proponents of removing the BE exclusion also cited the possibility of untreated grief leading to suicide, urging diagnosis of the bereaved on the grounds that the benefits of treating people who have “suicidal ideation, major role impairment or a substantial clinical worsening” far outweighed the costs of eliminating the exclusion (http://psychnews.psychiatryonline.org/doi/full/10.1176%2Fpfp.46.20.psychnews_46_20_3_1). Zisook stated: “I’d rather make the mistake of calling someone depressed who may not be depressed than missing the diagnosis of depression, not treating it, and having that person kill themselves” (Wakefield & First, 2012, p. 6). This was a disingenuous argument: the preexisting DSM-IV bereavement criteria already considered grieving persons with especially severe or impairing symptoms such as suicidal risk as not meeting the exclusion criteria.

Finally, the DSM-5’s abandonment of the BE risks an enormous pathologization when MDD encompasses people who grieve for 2 weeks. Given that about 40% of the bereaved meet these criteria a month after their loss, a majority of the bereaved likely could be diagnosed with MDD after a 2-week period (Clayton, 1982). Because nearly everyone will suffer the loss of an intimate at some point in their lives, abandoning the bereavement exclusion renders a majority of the population as liable to a diagnosis of depressive disorder.

The elimination of the BE in the DSM-5 thus has no grounding in good conceptual, empirical, or treatment-related reasons. “There is no scientific basis,” two experts in psychiatric diagnosis conclude, “for removing the bereavement exclusion from the DSM-5” (Wakefield & First, 2012, p. 9). A leading critic of the DSM-5, Allen Frances, asserted: “This was a stubbornly misguided decision in the face of universal opposition from clinicians, professional associations and journals, the press, and hundreds of
thousands of grievers from all around the world” (Frances, 2013, p. 186). Moreover, “without [the bereavement exclusion] the DSM loses its credibility” (Greenberg, 2013, p. 114). What led the DSM-5 to alter the MDD diagnosis in the face of such powerful opposition?

The charitable way of viewing the arguments of the proponents of the new criteria is that they are genuinely interested in alleviating the suffering that accompanies grief. Yet, there is no evidence that drugs or psychotherapy are more effective than letting the condition run its natural course for the vast majority of people suffering from uncomplicated grief. A more cynical explanation is that removing the BE will expand the potential clientele of mental health professionals and pharmaceutical companies. Eight of the 11 members of the APA committee that recommended the new criteria had financial connections to pharmaceutical companies. The chairman of this group, Jan Fawcett, enthusiastically propounds drug treatments for depression: “I’m still working at 78 because I love to watch patients who have been depressed for years come to life again. You need those medicines to do that” (quoted in Whoriskey, 2012). While drugs can help some people overcome grief, the new criteria could open the floodgates to medicate people whose natural suffering will heal without interference from powerful medications. In any case, the criteria they replaced provided ample protection that grieving people with especially severe or prolonged conditions would receive depressive diagnosis.

Perhaps the best explanation for the DSM-5’s decision stems from the nature of professional legitimacy. Psychiatrists are only legitimate sources of treatment for pathological conditions. The BE threatened the rationale behind not just the MDD diagnosis but the DSM’s entire symptom-based edifice. It recognized that one common loss was not pathological but extending this logic would have also excluded many others from diagnosis and treatment. Expanding the BE could have led to a major decline in the number of people who meet MDD diagnostic criteria. The evidence forced the committee to accept that bereavement was equivalent to other losses but they seemed to have no choice but to abandon the exclusion in order to preserve psychiatry’s range of authority.

Conclusion

The distinction between normal sadness and depressive disorder has been part of Western medicine since the earliest recorded documents. Only in recent times has the distinction been greatly eroded and in danger of being substantially lost. Even the symptom- based DSM-III recognized that humans naturally grieve after the death of a loved one. While such responses often fulfill the criteria for a depressive mental disorder in the short run, normal grief naturally dissipates with the passage of time so that it is unwise to make a depressive diagnosis in the absence of an extended period of watchful waiting. A substantial body of recent evidence showed that grief is a model for, not an exception to, how humans respond to losses of all sorts.

Yet, in contrast to the otherwise universal recognition that people naturally become sad after a great variety of losses, the DSM-5 now diagnoses as mental disorder grief that meets its symptomatic criteria after just a 2-week period. It ignores the vast amount of research showing that most people who develop symptoms of depression after a loss are not disordered but experiencing contextually appropriate sadness.

The now abandoned bereavement exclusion recognized that, while most grieving—even among people who temporarily meet criteria for MDD—is normal, some grieving processes indicate that something has gone wrong with the loss response. Such dysfunction-caused conditions tend to feature enduring and/or especially severe symptoms. As the old BE recognized, they should be viewed as legitimate mental disorders within the legitimate domain of psychiatric treatment.

Although the permanency of the loss associated with grief distinguishes it from most other losses, grief need be no different in principle from intense sadness that arises, for example, after the unsought end of a love affair, the news that one’s spouse has been unfaithful, the dissolution of a romantic
relationship, the failure to achieve one’s cherished life goals, the loss of financial resources, or the diagnosis of a serious illness in oneself or a loved one. Indeed, the DSM’s own general definition of mental disorder maintains that “an expectable or culturally approved response to a common stressor or less, such as the death of a loved one, is not a mental disorder” (APA, 2013, p. 20). Yet, emotionally painful responses to other particular loss events such as marital, romantic, health, or financial reversals plainly can be just as “expectable or culturally approved” as those to bereavement, and should fall under the definition’s exclusion as well. Instead of recognizing this, the DSM-5’s criteria for MDD eliminated even the narrow exception carved out for bereavement.

In the name of easing distress, psychiatry would medicate millions of people and interfere with natural healing processes and established cultural rituals and feeling rules. In abandoning the bereavement exclusion, it might have overreached; time will tell if this affront to common sense, science, empirical evidence, and intellectual coherence will destroy the profession’s credibility as the official social arbiter of what normality and abnormality are.

Declaration of Conflicting Interests
None declared.

References


