This statement was developed by a workgroup at the meeting of the International Work Group on Death, Dying and Bereavement in Victoria, British Columbia on April 28 – May 3, 2013. You have full permission to translate the document into other languages, and to distribute it via websites, blogs, the media, and other venues. It is our intention that the message be shared widely.

When does a broken heart become a mental disorder?

Rarely, if ever.

But don't tell that to the American Psychiatric Association, which has just released its fifth version of the *Diagnostic and Statistical Manual of Mental Disorders*. The *DSM* is a catalogue of mental disorders, hundreds of them, each trailing a listing of symptoms. The manual informs selection of a diagnosis, which is required by U.S. insurance companies for reimbursement for mental health care.

There's a major change in the newest version, *DSM-5*, with serious implications for the millions of people who are coping with the death of a child, spouse, parent, friend, or other loved one.

But first, a quick glimpse at the history of this publication, often referred to as the bible of psychiatry. The very first edition, published in 1952, didn't even refer to grief, considering it an accepted and normal reaction to the death of a loved one. The third edition added an exclusion statement under Major Depressive Disorder, referred to as the "bereavement exclusion." Under this exclusion, a diagnosis of Major Depressive Disorder could not be made for a full year after a death. They recognized that normal and common reactions to the death of a loved one could look like symptoms of depressive disorder, for example, sadness, disturbed sleep, lack of concentration, changes in eating, and loss of interest in things that were once pleasurable.

In 1994 the 4th version of the *DSM* reduced the bereavement exclusion to two months after a death, and this new version removes the bereavement exclusion completely, meaning in effect that anyone can receive a diagnosis of Major Depressive Disorder two weeks after the death of a child, parent, spouse, friend, or anyone.

Why does this matter? For at least three reasons:

First, normal reactions to the death of a loved one will be easily misclassified as the mental disorder depression. Grief is not the same experience as major depressive disorder. It is not an illness to be treated or cured. It is a healthy response to a painful reality that one's world is forever altered, and will never be the same. Absorbing this loss, and adapting to all the changes it unleashes, has its own unique course for every person, and will not be stilled or stopped by quick fixes or simple solutions. Death is a life-altering event, but grief is not a pathological condition.

Second, antidepressants are commonly and frequently prescribed. There is a strong likelihood that newly bereaved people will qualify for a diagnosis of Major Depressive Disorder just two weeks after a death even though their reactions are normal. Antidepressants have not been shown to be helpful with grief-related depressive symptoms, and there is accumulating evidence of long-term negative effects of being on antidepressants. We need to ask why psychiatry is pathologizing grief and therefore making inappropriate pharmacological treatment easier. And we should not overlook the self-interest of

pharmaceutical companies who see a new and substantial market for antidepressants, currently a multi-billion dollar industry.

Third, about 80% of prescriptions for antidepressants are written by primary care physicians, not psychiatrists. We have the expectation that physicians, as well as psychologists, social workers, and clergy, to whom many of us turn for help after losses of all kinds, have professional training, solid research backing, and supervised experience to guide them. Some do, but in fact, a considerable majority of practitioners with these degrees have no professional training at all in responding to the bereaved.

The caution here? Be wary of physicians or other medical professionals who rush to prescribe anti-depressants to address your grief.

Here's a better prescription: Mourn the death of your loved one in your own way. There is no prescribed formula. You may cry; you may not. Your reactions will be shaped by many things: the relationship you had with the deceased, your personality style, and the support or lack of support you receive from others. Push aside those who tell you to move on, that every cloud has a silver lining. What one person finds comforting might not work for another. Find friends and family who understand, and with whom you can share your experience. If they won't listen or help, or if their help is not enough, search for support groups through your local hospital, hospice or community organizations. Don't be afraid to seek professional help, but if you do, ask about the person's training, qualifications, and experience with grief, loss, and bereavement.

We grieve as deeply as we love. We can get off track with love, and we can respond to our grief in ways that aren't healthy, or don't serve us well. But let's not make love, or grief, a mental disorder.

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This document was written by a group of concerned professionals in response to the release of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5).*

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