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DSM-5-TR turns normal grief into a mental disorder

Joanne Cacciatore ✉ • Allen Frances

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Prolonged grief disorder, which is now included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, Text Revision* (DSM-5-TR) as of March, 2022,[1] has a remarkably easy symptom threshold to meet, and its inclusion is a huge mistake that solves no existing problem and creates many new ones. There is no uniform expiration date on normal grief. This is particularly true when the relationship with the person who died was very close or the death was catastrophic, such as deaths by suicide, homicide, or accident, or the death of child.

Additionally, responses vary greatly depending on individual, familial, and cultural norms, the availability of family and social support, characterological traits, trauma, or loss history, and the presence of other stressors.

Pathologising grief is an insult to the dignity of loving relationships—it proclaims grievers as mentally ill and will too often result in the careless prescription of antidepressants or other drugs to treat enduring symptoms, without consideration of the context. The misuse of psychiatric medication for grief will be particularly problematic in primary care, where most antidepressants are prescribed.

This pathologising reflects the undue influence that a small group of researchers can exert on the diagnostic system. Experts love their diagnoses and thus perceive benefits, while ignoring risks. Critics have expressed concerns about pernicious conflicts of interest once a proposal becomes a diagnosis.[2,3] Mental disorders that might work well in the hands of researchers are often a disaster when applied in general practice.

Worse, in our opinion, is that the evidence for prolonged grief disorder is surprisingly thin. And since it has never been field tested, there has been no meaningful determination of reliability or validity. Including prolonged grief disorder in the DSM-5-TR with such weak empirical support represents a lack of appropriate caution and naive hope over past painful experience. New disorders introduced in the past have often stimulated diagnostic inflation, over-treatment, stigma, and misallocation of resources.[4] We realise that some grievers, especially when their loss is catastrophic, might need psychological care. In those cases, adjustment disorder is a less risky and offensive reimbursement code.

It would be preferable if US-based insurers did not predicate payment for supportive grief counselling on a medical code; this would be much more respectful of grievers. Many people, recognising that bereavement can be an intense exogenous stressor,[5] want to leave grief, and grievers, safely out of the reach of well meaning but intrusive doctors and treatments. Grief warrants strong social support and compassionate connection, not medicalisation.

This online publication has been corrected. The corrected version first appeared at thelancet.com/psychiatry on July 6, 2022

We declare no competing interests.

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