

Correspondence

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Grief is not an illness

Maciejewski & Prigerson contend that ‘leading authorities’ agree ‘prolonged, intense, disabling grief constitutes a mental disorder’,¹ but fail to reference this statement. Clinicians who frequently see bereaved patients in routine practice may disagree.

The authors’ main thesis is that a rival definition of pathological grief² is incorrect because that entity is too prevalent, at 62% of bereaved individuals; their own definition, on the other hand, must be valid because it results in a prevalence of just 12%.³ In their estimation, a state of mind experienced by a majority of people in a given situation is not a psychiatric disorder,¹ but one experienced by a significant minority, perhaps as great as 49%, is. Such logic warrants further scrutiny.

Maciejewski & Prigerson’s recognition that ‘bereavement is a common, ubiquitous life event’¹ seems at odds with their conclusion that one in eight become mentally ill as a result. For sake of argument, let us assume that the average person has eight close acquaintances; by the authors’ reckoning, on average, every death would directly result in one case of mental illness. A particularly well-loved individual’s death could cause a small epidemic. This is simply absurd.

As clinicians, we must not let our own value judgements colour our diagnostic processes. Instead, when we assess people who see no purpose in living following the death of a soul mate, say, perhaps a year or more after the event, we have to put ourselves in their shoes. A display of such empathy, assuming it is genuine, can be helpful in itself. An individual’s feelings of loss and their effects upon functioning might seem excessive to us, but a good clinician will be able to understand and validate such thoughts and emotions rather than belittle them with a label of mental disorder.

Of course, such people deserve doctors’ compassion and encouragement to focus on positive aspects of their lives, but grief is not an illness⁴ and medical treatment is not indicated. On the contrary, it is surely reasonable to suppose that grief is a necessary psychological response to bereavement, which marks us out as human and that should not be artificially suppressed. Yet, shockingly, in a large cohort of British older adults, 18% received new psychotropic medication within a year of their partner’s death, compared with 6% of non-bereaved controls.⁵

Although counselling to guide people through their grief may be helpful, there is no logic for this to be provided by healthcare organisations. The role of medical professionals should be confined to exclusion of true psychiatric illness while offering compassion and understanding.

1 Maciejewski PK, Prigerson HG. Prolonged, but not complicated, grief is a mental disorder. *Br J Psychiatry* 2017; **211**: 189–91.

2 Cozza SJ, Fisher JE, Mauro C, Zhou J, Ortiz CD, Skritskaya N, et al. Performance of DSM-5 persistent complex bereavement disorder criteria in a community sample of bereaved military family members. *Am J Psychiatry* 2016; **173**: 919–29.

3 Maciejewski PK, Maercker A, Boelen PA, Prigerson HG. “Prolonged grief disorder” and “persistent complex bereavement disorder”, but not “complicated grief”, are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry* 2016; **15**: 266–275.

4 The Lancet. Living with grief. *Lancet* 2012; **379**: 589.

5 Shah SM, Carey IM, Harris T, DeWilde S, Victor CR, Cook DG. Initiation of psychotropic medication after partner bereavement: a matched cohort study. *PLoS One* 2013; **8**: e77734.

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Authors’ reply: We thank Dr Braithwaite for his clear expression of his views on the universal normality of grief, which he undoubtedly shares with many other clinicians who may be unfamiliar with the extensive research literature on disordered grief.

There is substantial evidence in support of our assertion that ‘prolonged, intense, disabling grief constitutes a mental disorder’¹ in the scientific literature (for example Maciejewski *et al.*,² Prigerson *et al.*^{3,4}). These studies demonstrate that symptoms of grief are distinct from those of bereavement-related depression and anxiety and that prolonged grief disorder (PGD), consistent with criteria for establishing mental disorders,⁵ has distinct: (a) risk factors (for example emotionally dependence on the deceased), (b) outcomes (for example elevated risk of increases in suicidality over and above symptoms of depression and anxiety), and (c) responses to treatment. Experts in psychiatry who participated in DSM-5 and ICD-11 workgroups evaluated the evidence from these and many other studies of bereavement from around the globe in a variety of contexts of loss. Both workgroups independently concluded the evidence merited consideration of PGD as a new mental disorder (for example Maercker *et al.*⁶). The identification of symptoms, and their severity and duration, has resulted not only in the accurate detection of the disorder, but the development of new and effective interventions that have helped when traditional antidepressant and psychotherapies have not.

Mental health professionals would agree that sadness, anxiety and apprehension, *per se*, are not illnesses, but that major depressive disorder, generalised anxiety disorder and post-traumatic stress disorder are. Dr Braithwaite’s unqualified assertion that grief is not an illness, i.e. that all forms of grief are normal, is in opposition to scientific evidence. There exists a substantial evidence-base in support of the assertion that intense, prolonged, functionally impairing grief levels constitutes a mental disorder. Generally speaking, grief is not an illness, but PGD is. Accordingly, those who experience PGD will benefit from its clinical recognition and treatment.

Clinical acceptance of PGD is almost certain to increase as mental health professionals become more familiar with the concept, evidence in support, and, perhaps most importantly, the clinical utility of PGD as a diagnostic entity. We are near the completion (in the final data analysis phase) of a National Institute of Mental Health funded trial designed to evaluate the impact of a PGD tutorial on mental health professionals’ recognition of PGD as opposed to major depressive disorder, post-traumatic stress disorder and normal grief and also to evaluate informed clinicians’ assessments of the clinical utility of PGD. Materials employed in this study are accessible online (<https://endoflife.weill.cornell.edu/grief-resources>). This trial is likely to demonstrate the ease with which mental health professionals can learn and accurately apply the PGD criteria following a brief tutorial, and the potential for broad, informed clinical recognition of the need and utility of PGD.

1 Maciejewski PK, Prigerson HG. Prolonged, but not complicated, grief is a mental disorder. *Br J Psychiatry* 2017; **211**: 189–91.

2 Maciejewski PK, Maercker A, Boelen PA, Prigerson HG. “Prolonged grief disorder” and “persistent complex bereavement disorder”, but not “complicated grief”, are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry* 2016; **15**: 266–275.

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- 6 Maercker A, Brewin CR, Bryant RA, Cloitre M, van Ommeren M, Jones LM, et al. Diagnosis and classification of disorders specifically associated with stress: proposals for ICD-11. *World Psychiatry* 2013; **12**: 198–206.

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