SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

A critical analysis of the debates on grief and depressive disorder in the age of the Diagnostic and Statistical Manual of Mental Disorders

Un análisis crítico de los debates acerca del duelo y el trastorno depresivo en la era del Manual Diagnóstico y Estadístico de los Trastornos Mentales

Francisco Pizarro Obaid[1], Rodrigo De La Fabián Albagli[2]

[1]Psychologist. PhD in Sexuality, Reproduction and Perinatal Medicine. Associate Professor, Director of Postgraduate Studies, Faculty of Psychology, Universidad Diego Portales, Santiago, Chile.

[2]Psychologist. PhD in Fundamental Psychopathology. Associate Professor, Faculty of Psychology, Universidad Diego Portales, Santiago, Chile.

ABSTRACT Since the incorporation of the major depressive disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980, and until its update in the DSM-IV-TR, the DSM classification system considered it necessary to include the criterion of "bereavement exclusion", with the aim of differentiating normal sadness linked to a loss, from a mental disorder, such as the major depressive disorder. In its latest version (DSM-5), this exception was removed, giving rise to a controversy that continues to this day. The debate has set those who are in favor of maintaining this exclusion and extending it to other stressors against those who have intended to eradicate it. Our hypothesis is that these positions account for two qualitatively diverse clinical and epistemological matrices, linked to major transformations in health sciences and in psychiatry. We show that this debate involved a profound renewal of the meaning of psychiatric practice, a change in the function of diagnosis and in the way of conceiving the etiology of mental disorders, as well as a reformulation of the patient's suffering status for the medical act.
KEY WORDS Mental Health; Major Depressive Disorder; Diagnostic and Statistical Manual of Mental Disorders.

RESUMEN Desde la incorporación del trastorno depresivo mayor en el Diagnostic and Statistical Manual of Mental Disorders (DSM-III) de 1980, hasta su actualización en el DSM-IV-TR, el sistema clasificatorio DSM consideró necesario incluir el criterio de "exclusión por duelo", con el objetivo de diferenciar la tristeza normal, vinculada a una pérdida, de un trastorno mental, como el trastorno depresivo mayor. En su última versión (DSM-5), esta excepción fue suprimida, dando lugar a una controversia que se extiende hasta nuestros días. El debate ha confrontado a quienes están a favor de mantener y extender la exclusión a otros estresores y aquellos que han querido erradicarla. Nuestra hipótesis es que estas posiciones darían cuenta de dos matrices clínicas y epistemológicas cualitativamente diversas ligadas a las trasformaciones mayores que han experimentado las ciencias de la salud y la psiquiatría. Mostramos que este debate involucró una renovación profunda del sentido de la práctica psiquiátrica, un cambio en la función del diagnóstico y el modo de concebir la etiología de la enfermedad mental, así como, una reformulación del estatuto del sufrimiento del paciente para el acto médico.
PALABRAS CLAVES Salud Mental; Trastorno Depresivo Mayor; Manual Diagnóstico y Estadístico de los Trastornos Mentales.

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

INTRODUCTION

In the late 1970s, depression was nothing but just a noticeable symptom of most mental disorders and was not a matter of concern in our societies.[1] However, in the early 1980s, its diagnosis registered an exponential increase, and depressive disorder became one of the most frequent psychiatric conditions.[2,3,4,5]

The sustained increase in this diagnosis has led the World Health Organization[6] to estimate that, between 2005 and 2015, the number of people suffering from depression worldwide increased by 18.5%, amounting to over 300 million in 2017. This figure accounts for 4.4% of the world population, making it the disease that most contributes to the years of life lived with disability globally. It is estimated that in the following years, nearly one-third of the world population will comply with the diagnostic criteria for major depressive disorder at some point in life.[5] Moreover, the increase in depression diagnosis has been associated with a significant increase in the use of antidepressant drugs,[7,8] noting, for example, that in those member countries of the *Organization for Economic Co-operation and Development* (OECD)[9] the use of psychotropic drugs has doubled between 2000 and 2015.

The prevalence of depressive disorder and the alarming increase in the use of psychotropic drugs have led to consider depression as a global public health crisis[10] and a genuine "modern epidemic."[11]

Wakefield and Demazeux[12] state that two types of hypotheses are found in the extensive literature that attempts to explain the causes of the exponential growth of this disease. The first hypothesis, called *realistic perspective,* assumes that this phenomenon has "realistic" or "objective" causes, such as the excess of individualism prevailing in neoliberal societies or better diagnosed neurochemical imbalances, among others. The second hypothesis, on the contrary, considers the depression "*boom*" as the result of an *artificial diagnostic inflation*, primarily associated with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders,* or *DSM-III*,[2] which included, for the first time, the category of "major depressive disorder."[3]

The purpose of the article is to analyze one of the most updated and relevant dimensions of the debate among representatives of these two positions to understand the modern-day depression boom: the controversy caused by the removal of bereavement as a differential diagnostic criterion in the field of mood disorders,[14,15,16] as a result of the publication of the fifth and latest edition of the DSM-5 psychiatry manual.[13] According to Ronald Pies:

> Without question, this was one of the most contentious decisions the DSM-5 work groups made — and, by some lights, the most controversial decision by the American Psychiatric Association (APA) since homosexuality was removed from the list of psychiatric disorders in 1973.[17]

In fact, from the publication of the DSM-III[2] onward and through all its updates – DSM-III-R,[18] DSM-IV,[19] DSM-IV-TR[20] – the manual deemed it necessary to distinguish between major depressive disorder and bereavement. Therefore, "bereavement exclusion" implied that after the death of a loved one, if the patient developed a condition symptomatically equivalent to a major depressive disorder for a duration of up to two months – not aggravated by symptoms such as a psychotic condition or suicidal ideation, for example –, it should be understood as a normal response to loss. However, from the publication of the DSM-5 in 2013[13] onward, this differential criterion was removed over the primacy of the symptom, excluding the value of any biographical circumstance concomitant to the illness.

On the one hand, the experts who advocated in favor of removing the criterion of *bereavement exclusion* from the DSM-5, inspired by a *realistic perspective* as regards major depressive disorder, attempted to reduce the probability of producing *false negatives*

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

and, consequently, decrease the risk of underdiagnosing this disease.[21,22,23,24,25] On the other hand, other authors considered that the *bereavement exclusion* was not only essential, but also that it should be extended to new stressors (loss of a job, dissolution of affective bonds, among others), as its removal would irreversibly produce *false positives* and, therefore, an *artificial* overdiagnosis of the disease.[26,27,28,29,30,31)

Given these precedents, this article assumes that the understanding of the debates between depressive disorder and bereavement derived from the innovations introduced in the DSM-5 requires both an analysis of the evolution of the criteria related to mood disorders in the DSM classificatory system, as well as of the transformations suffered by the clinical and epistemological matrix of the health sciences, in general, and of psychiatry in particular. The relevance of this theoretical research study first resides in the development of an original critical analysis of the evolution of probably the most influential psychiatric diagnostic manual in Latin America and the entire world:

> its influence extends] across all the regions and countries of the world, not only becoming the most successful *best-seller* in psychiatric literature, but also an obligatory reference point for clinical, educational, administrative, legal, or heuristic work at a universal level.[32] [Own translation]

Second, this research study proposes, based on the notion of "collective health,"[33.34] a socio-historical and genealogical analysis of the building process of a dominant diagnostic category,[35] such as major depressive disorder. Under these premises, it will be argued that the understanding of the problems regarding the debate on the elimination of the bereavement exclusion requires considering the transformations undergone by the hegemonic epistemological model of biomedical sciences. Inasmuch as these changes implied a profound renewal of the meaning and aim of psychiatric practice, a change in the function of diagnosis, an innovation in the way of conceiving the etiology of mental illnesses, as well as a reformulation of the patient's suffering status for the medical act.

BACKGROUND

The debate regarding grief, sadness, and depression: the historical-conceptual evolution of the DSM

The regular updates to the classification of the DSM and its pragmatic implementation in the health field frequently leave behind the significant differences that might be distinguished between the bases and criteria that shaped its first editions and the principles that underpinned the development of its recent manuals. Therefore, the paradigmatic transition from DSM-II to DSM-III was decisive for the reconfiguration of mood disorders, and the change from the IV edition to the V edition critically impacted grief and depression destinations.

From the historical-conceptual review of the changes in the DSM, it is possible to observe that the first two editions of the manual were strongly influenced by the etiological conceptions of the psychoanalytic theory, by Adolph Meyer's psychobiological perspective, as well as by Karl Menninger's theory that, from a psychosocial perspective, considered mental diseases as an obstacle of the individuals to adapt to their environment.[36,37] Generally, according to Wilson,[38] both of these manuals shared several central points: they considered that there was a dimensional continuity between the normal and the pathological,[39] clearly differentiating the psychotic disorders from the neurotic disorders; and finally, both manuals shared a particular discredit for Kraepelin's descriptive diagnostic model, in favor of the intrapsychic etiological model of psychoanalysis.

The consequences of these assumptions had a direct influence on the understanding of mood disorders, given that both manuals considered it relevant to differentiate if depression was to be found in the field of

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

psychotic or psychoneurotic disorders.[40] The DSM-I,[41] in accordance with Mayer, used the psychopathological "reaction" category, distinguishing the "psychotic reactions" – in its two modalities, manic-depressive and depressive – from the "depressive reaction," which was part of the psychoneuroses. Moreover, the DSM-II[42] decided to remove the notion of "reaction" and extended the influence of psychoanalysis, differentiating *major emotional disorders or emotional psychoses* from *depressive neurosis*.

Nevertheless, the changes in criteria and the assumptions related to mental disease featured in the first editions of the manual were not only limited to a merely nosographic problem, but also generated changes in the understanding of the normal and the pathological, both at a medical level as well as at a social level. Generally, these changes fostered a gradual process of expansion of psychiatric limits beyond the institutionalized population and extended its competencies to people's daily lives, thus recognizing the influence of environmental factors in triggering moderately severe psychopathology, such as psychoneurosis. According to Grob, the DSM-I and DSM-II implied:

> ...an extraordinary broadening of psychiatric boundaries and a rejection of the traditional distinction between mental health and mental abnormality. To move from a concern with mental illnesses in institutional populations to the incidence in the general population represented an extraordinary intellectual leap.[43]

While shifting into the second edition was important, publishing the third edition represented a qualitative milestone, as it definitely separated from the psychogenic etiological models or the traditional psychiatric principles, as the

> ...DSM-III radically transformed the nature of mental illness. In a remarkably short time, psychiatry shed one intellectual paradigm and adopted an entirely new system of classification.[44]

The factors that influenced this transformation are heterogeneous. First, during the 1960s and 1970s, the antipsychiatric criticism of the diagnosis and the legitimacy of the profession were associated with an effort to validate, both scientifically and politically, the diagnostic criteria.[36] Second, since the 1970s, discontent over the psychoanalytic model and a growing interest in the descriptive diagnostic perspective of a neo-Kraepelinian nature emerged.[38] Third, the limited clarity in the definition of the normal and the pathological blurred the role of the physician, who started to compete with other professionals – such as psychologists, counselors, among others – in the treatment of less severe diseases. Last, the development of new ways of standardized measurement – for instance, anxiety or depression scales – as well as the development of psychopharmacology and its decisive influence on the methods of producing and differentiating the diagnostic categories[40] generated, along with these changes, the favorable conditions for the psychiatric revolution resulting from the publication of the DSM-III.

Generally speaking, the paradigmatic shift registered by the classification system implied the rejection of the traditional division between neurosis and psychosis – which finally turned the page to more than a century of psychiatry – as well as the pharmacologization and, therefore, the re-medicalization of psychiatry, to reduce the diagnosis to a descriptive sign defined under temporal parameters (duration, frequency) and severity standards (mild, moderate, severe). More specifically, with regard to the incorporation of major depressive disorder, it remained completely included under the category of *mood disorders*.

Within mood disorders, *major depressive disorder* is defined as an episodic disease that may or may not exhibit psychotic symptoms, whereas *dysthymia* is defined as a mild and chronic condition. Furthermore, with the aim of limiting psychiatric action and reducing the likelihood of mistaking a normal depressive reaction for a disorder,[15] the diagnostic exclusion for *normal grief* was introduced.

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

The historical precedents for bereavement exclusion date back to more than a century ago.[45] However, two precedents stand out: first, the distinction between normal and pathologic grief proposed by Sigmund Freud in his classic text *Mourning and Melancholia*[46] in 1917; and second, a research study conducted by Clayton, Desmarais, and Winokur in 1968,[47] which highlights that in the process of bereavement, a significant minority tends to develop an important number of depressive symptoms that spontaneously subside between six and ten weeks after the loss. To be able to make the differential diagnosis, not only for the DSM III but also for the DSM-III-R, it was necessary to determine the bereavement status and its evolution. Normal grief was referred to as "uncomplicated grief" and, on the one hand, was differentiated from *complicated grief,* which is characterized by the emergence of severe depression symptoms or long-term less severe symptoms after the loss, and on the other hand, from *major depressive disorder per se*, which was not diagnosed concomitant to the loss of a loved one, except if experiencing complicated grief. In that case, this bereavement exclusion remained mostly unchanged until the fourth revised edition of the DSM (DSM-IV-TR), which was eliminated in the DSM-5.

The exclusion of normal grief in the last edition of the manual takes place within a context of an undermining of the difference between the normal and the pathological. Three years before the DSM-5 was published, Allen Frances warned about this risk:

> DSM5 appears to be promoting what we have most feared — the inclusion of many normal variants under the rubric of mental illness, with the result that the core concept of "mental disorder" is greatly undermined.[48]

As Joel Paris[49] mentioned, one of the characteristics of this manual is to make the difference between the normal and the pathological increasingly dimmer and less relevant to the physician's duties.

Several of the most significant structural changes introduced in the DSM-5 to this effect are: first of all, the elimination of the multiaxial diagnostic system[50] which, since the DSM-III, had organized the manual into five axes. This change resulted in the elimination of all remaining references to the distinction between neurosis and psychosis, that is to say, between actual psychiatric disorders and psychotherapeutic conditions that, somehow, were preserved by axes I (clinical syndromes or mental diseases) and II (mental retardation and personality disorders). Moreover, the elimination of axis IV left the psychosocial and contextual factors unrecorded, in other words, the old stressors or triggers of mental disorders.[39] Last but not least, the DSM-5 criticized the categorical diagnosis that has prevailed since the DSM-III, which officially recognized the continuous and dimensional nature of mental disorders, no longer based on the psychoanalytic theory – as in the case of the DSM-I and II – but on the dimensional model of neurosciences.[39]

Overall, it may be stated that the evolution of almost 60 years of this diagnosis manual reveals not only nosographic changes, but also a greater process of transformation in health sciences, in general, and in psychiatric sciences, in particular. Since the 1950s, the elimination of the distinction between psychiatric conditions that are typical of institutionalized patients and less severe disorders related to everyday life has promoted a transformation of health technologies into life-management technologies, as currently:

> ...contemporary medical technologies do not merely seek to cure diseases, but to control and manage vital processes of the body and mind. They are no longer technologies of health but technologies of life.[51]

However, even when the DSM-III attempted to define more clearly the limits between the normal and the pathological, as well as the boundary between the actual psychiatric field of action and other non-medical practices,

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

the result seemed to have been the opposite. Indeed, the rejection of the fundamental division between neurosis and psychosis and the descriptive and atheoretical redefinition of the diagnosis only contributed to blurring the limits even further and to broadening the field of action of psychiatry toward people's everyday lives. Thus, according to Rose, in the 1980s, psychiatry experienced a significant transformation:

> ... it had become much more than a specialty for the management of a small minority of persons unable to live in the world of work, family, and civility — it had become a widespread "discipline of mental health" whose rationale was not so much cure as "coping" helping troubled individuals manage themselves in their everyday lives.[52]

This process of the expansion of psychiatry to people's everyday lives, which entailed the redefinition of the classic approaches to health and disease, of the normal and the pathological, was highlighted with the publication of the DSM-5 in 2013. While the traditional medical model proposed a therapeutic practice located in the *normal-pathological* axis, the new technologies seem to not differentiate between an action that intends to reestablish health and an action that seeks to improve people's lives, being placed in a different axis: *suffering-wellbeing*. Under these considerations, psychiatry in the 21st century is changing into a technology whose main purpose is no longer to "cure" the disease but to seek "the maximization of individual potential, the minimization of sadness and anxiety, the promotion of well-being, even happiness."[52]

It is in this context that the debate regarding grief and depression gains its importance and epic nature. Rather than a psychopathology in particular, this distinction questions the medical work and confronts the psychiatric knowledge with two very heterogeneous ways of understanding the clinical work.

CRITICAL ANALYSIS OF THE DEBATE

Normal bereavement exclusion from the depression diagnosis: normalization of the well-being promise

By the end of the first decade of the 21st century, the preparation of the DSM-5 gave rise to a deep discussion regarding the relevance of maintaining or eliminating the distinction between normal grief and depressive disorder. This interesting debate, which is far from concluded, took place in the academic setting, in opinion editorials, radio programs, and interviews with the main experts on the topic, and was thoroughly compiled.[14,15,53] Therefore, in methodological terms, we will focus our analysis on actual scientific texts as well as texts with scientific outreach that were published immediately before the publication of the DSM-5. The reason is that in these texts we can see the crystallization process of the two clearly differentiated positions that ignite the debate, without any substantial transformations to this date. In this respect, our hypothesis proposes that the differences between these two positions, put into perspective, were not reduced to a merely classificatory or factual matter. Proof of this, as we will see, is that the results of the investigations did not differ significantly except for the emphasis placed on the heterogeneous ways of interpreting them and on the clinical consequences derived from one or another position.

The publication of *The loss of sadness*[27] in 2007 and the subsequent research studies by Jerome C. Wakefield and his collaborators put forward a clear position in facing this problem. In Wakefield's point of view, the definition of a strictly descriptive diagnosis of depression, that is to say, without taking into consideration the context, caused confusion between normal and pathological sadness, highly increasing the number of false positives. This thesis was strengthened by the research study carried out that same year,[26] when comparing episodes with uncomplicated depressive symptoms, related to

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

the loss of a loved one, to similar episodes related to other types of losses, such as the dissolution of the marital bond or the unexpected loss of a job, among others. The authors concluded that there was no substantial difference between these two groups, hence arguing that the bereavement exclusion should be extended to include other types of stressors in order to limit the diagnosis of major depressive disorder.

In contrast to Wakefield *et al.*, Zisook, Shear, and Kendler[21] undertook the task of reviewing the research studies where depressive episodes related to bereavement – both complicated and uncomplicated episodes – were compared to all types of depressive episodes and concluded that there were no substantial differences between these two groups. A year later, these discoveries were expanded by Kendler, Myers, and Zisook,[22] demonstrating that there were no significant discrepancies between depressive episodes – whether complicated or not – associated with bereavement and depressive episodes – whether complicated or not – related to other stressors. Despite the similarities that could exist with the results of Wakefield *et al.*,[26,27] Kendler *et al.*[21,22] arrived at a different interpretation. Using this interpretation, they refuted the validity of the bereavement exclusion to diagnose major depression and warned that "extending this exclusion to still other loss events could create a public health disaster. Our patients deserve better."[54]

Therefore, it is clear that this dispute cannot be reduced to a merely factual discussion about heterogeneous scientific discoveries. Precisely, to understand what is at stake, it is necessary to critically analyze the way whereby these two positions understand core aspects of clinical practice and mental disorders.

From this perspective, Wakefield and Horwitz's stance implies that the job of a health professional is not only, and not primarily, to attempt to relieve suffering. In the sense that, before aiming to do so, the physician should ask and answer a priority question: is any such suffering normal or pathological?

> While it is true that physicians have always helped suffering people — with or without a disorder — they have also explicitly addressed the diagnostic issue of whether the patient's distressed condition is normal or disordered. [...] The distinction between normal and disordered sadness is similarly real despite considerable boundary fuzziness, with clear cases on both sides — some of which are misclassified by DSM criteria.[55]

In order to address this challenge, Wakefield[53] proposes a type of diagnostic analysis of mental disorders called "harmful dysfunction." This procedure establishes that for a psychiatric condition to be cataloged as a disorder, such condition should be considered "harmful" in accordance with social values, and it should be assessed as "dysfunctional," in terms of an alleged "biological design" of a physical or psychological mechanism. In other words, the former associates the distinction between the normal and the pathological with what society traditionally believes in that respect, while the latter compares an individual's functioning to the design that the evolution of the species has assigned to its different psychological and biological mechanisms.

Therefore, Wakefield *et al.*, by resorting to what is *socially permitted* and the *evolutionary function* of sadness, conceive the "uncomplicated depressive reaction" as normal, as an adaptive and proportional response to a loss. Thus, the primary function of medical knowledge, using specific normative criteria external to the patient's suffering, would be to determine the boundaries between the normal and the pathological, with the aim of framing the praxis of this dichotomy and eliminating the risk of "medicalizing" normal life.

In contrast to this view, the supporters of eliminating the bereavement exclusion define this way of diagnosing as a "fallacy of misplaced empathy."[25] This fallacy arises when a well-intentioned physician may paradoxically misdiagnose a major depressive disorder by thinking and believing that "anybody" facing a serious stressor should feel

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

depressed, and they emphasize their criticism, highlighting that:

> ...it simply does not follow logically that, just because one's reaction to an event is "understandable," it cannot be pathological and in many cases severely debilitating.[25]

Moreover, they add that the main task of a physician is not to differentiate if suffering is normal or not, that is, proportional or not with respect to a stressor, but to attempt to relieve that suffering.

Pies[23] exemplifies this view through a really eloquent analogy: a physician who has to face the challenge of diagnosing a myocardial infarction does not question himself if it was caused by poor dietary habits or if it set in spontaneously and inexplicably. When analyzing the symptom, the context is not important. The symptom is always considered to be harmful and, therefore, is treated as such. Thus, directly criticizing the evolutionary approach of Horwitz and Wakefield, Pies concludes that:

> ...the physician's primary role has always been to relieve suffering and incapacity — not to act as an amateur evolutionary biologist and sit in lofty judgment, as regards how "proportionate" a patient's response is to some putative stressor.[23]

Hence, the debates over the consideration of bereavement as a separate entity or not of major depressive disorder illustrate two heterogeneous ways of understanding the sense or *telos* of medical practice. On the one hand, the distinction between the normal and the pathological is of prime importance, a task that implies classifying the patient's suffering through normative external criteria. On the other hand, the essential meaning of medical practice is to relieve suffering, therefore, determining whether the suffering is normal or not is no longer of vital importance. In this sense, while Wakefield *et al*. understand medical practice in the *normal-pathological* axis, Kendler and others understand this practice as a service to the patient's quality of life, that is to say, in the *suffering-wellbeing* axis.

Nevertheless, the differences that the protagonists of the debate uphold do not end with the considerations related to the possible relationships between the normal and the pathological. The different views on this problem are, in turn, translated into different ways of understanding the etiology of depression and justifying its diagnosis.

Pies argues that the concept of "a disease trigger" involves considerable clinical and epistemological problems. From his point of view, it is not clinically relevant to know if an illness was triggered by a stressor or not, in addition to being virtually unverifiable because there are distortions of different natures – such as chronological, medical, among others – that make the information unreliable. If there was a medically relevant trigger, it would be neuromolecular:

> ...the construct of a depressive 'trigger' is nebulous and empirically unverifiable, except perhaps in highly unusual scenarios (for instance, a euthymic subject is injected with a powerful, short-acting biogenic amine-depleting agent; severe depressive symptoms develop within 2 hours and then spontaneously remit over the next 12 hours).[23]

Consequently, Pies adds, the only way to effectively determine if the diagnosis of major depressive disorder within two months after a loss is a false positive is to have a "depression test" that, at the neuromolecular level, could provide a reliable result. Thus, depression has become a molecular event, as this is the only scale that can justify the truth or falsehood of a diagnosis.

According to Wakefield *et al*., the neuromolecular dimension of major depressive disorder does not determine, by itself, whether a diagnosis is true or false.[6] Even if a possible "depression test" could determine the existence of a major depressive disorder, this datum would not settle the matter of determining whether it is a pathology or a normal reaction. Depression as a disease is

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

a "hybrid" construct[56] with biological bases, but it can only exist as a disease in a social and evolutionary context that differentiates it from normal sadness.

Therefore, both positions agree that a patient's suffering is not directly related to the truth of a diagnosis as, on the one hand, the truth is contextual, and on the other hand, the truth is neuromolecular. However, these positions differ in the clinical status of suffering, more precisely, in the relationship between suffering and the way of legitimizing the medical act. According to Wakefield *et al.*, suffering and relief are not enough to justify or understand the medical act. For example, according to these authors, even when a medication produces beneficial effects in a person suffering or not from an underlying disease, it is essential to distinguish between these two situations, hence they argue that:

> We are not opposed to medicating patients with normal distress; rather, we object to mislabeling conditions as disorders, thus biasing prognosis, informed consent, and treatment planning.[55]

In other words, the act of medicating is not legitimized by the patient's suffering, but rather by the normal/pathological distinction, in order not to confuse the therapeutics with the pursuit of well-being.

On the other hand, according to Kendler *et al.*, as they refuse to place themselves in a normative exteriority from which to assess the "proportionality" of suffering, increasing the well-being of patients becomes an essential clinical aim, as well as the main reason for carrying out the clinical act. As Rose[57] highlights, this specific way of understanding the medical practice is related to major changes in the biomedical sciences that have taken place in recent years, which are characterized by turning indistinguishable therapeutic practices from human enhancement technologies and their pursuit of well-being.[58] That is to say, for a medical act to be legitimate, it is currently not essential to determine the truth of the diagnosis, but the degree of relief that may be provided to the patients, who, in turn, become new patients-consumers that do not expect to be normalized, but to obtain a response to their requests for greater well-being.

Generally speaking, we can assure that the two analyzed positions convey two different clinical and epistemological matrices as they differ in decisive aspects, such as: the meaning of psychiatric duty, the function of diagnosis, the etiology of mental illnesses, as well as the status of the patient's suffering for the medical act.

CONCLUSION

While critically examining the bereavement exclusion from the DSM-5, it is clear that the problem exceeds the merely classificatory arguments. On the one hand, it gives an account of several radical changes in rationality, technologies, and the imagination of the biomedical sciences in recent years. On the other hand, it describes the shift from a psychiatric practice understood as a technology of normalization to a technology of management of people's daily lives.

In the context of these changes, medical rationality increasingly starts to deal with aspects that had previously been considered normal and of spontaneous remission. Wakefield *et al*. considered that this process implied the risk of increasing false positives in the diagnosis of depression. However, in conjunction with the *medicalization of sadness*, a *depathologization of depression* was developed. For that reason, Kendler *et al*. considered that it was no longer urgent to distinguish between the normal and the pathological, reducing depression to a subjective experience of discomfort, against which the risk of false negatives should be prevented.

From the point of view of collective health, it is essential to understand that the definitions of health and disease are not thoroughly explained using scientific knowledge, as these definitions, in turn, express power relationships in specific historical and social contexts.[34] Consequently, this article has

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

brought to the fore that the redefinition of the epistemological frame that contemporary psychiatry has registered accounts for a dispute where "knowledge" and "power" are closely connected.[59] If the arguments of Wakefield *et al*. were, in fact, ineffective, this was largely due not to their lack of scientific persuasion, but to a relative loss of power within the psychiatric discipline. Indeed, the frustration and surprise that Wakefield felt because his arguments were not listened to led him to point out that the debate had ceased to be scientific, as his opponents seemed to be fully convinced of their position and, thus, ignored any type of criticism.[15] However, maybe Wakefield was not wrong at all and the strong opposition that he had experienced was the result of a game of power inside psychiatry, which made Wakefield face not so much his lack of scientific clarity, but the obsolescence of the epistemological matrix that supports his studies and the beginning of the hegemony of a new way of understanding psychiatric practice, its aim, and purposes.

REFERENCES

1. Ehrenberg A. La fatiga de ser uno mismo: Depresión y sociedad. Buenos Aires: Nueva visión; 1998.

2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. Third Edition (DSM-III). Washington DC: American Psychiatric Association; 1980.

3. Shorter E. Before Prozac: The troubled history of mood disorders in psychiatry. Oxford: Oxford University Press; 2009.

4. Wakefield JC, Schmitz MF. When does depression become a disorder?: Using recurrence rates to evaluate the validity of proposed changes in major depression diagnostic thresholds. World Psychiatry. 2013;12(1):44-52. doi: 10.1002/wps.20015.

5. Wakefield JC, Horwitz AV. Psychiatry's continuing expansion of depressive disorder. In: Wakefield JC, Demazeux S, (eds.). Sadness or Depression?: International perspectives on the Depression Epidemic and its Meaning. Dordrecht: Springer; 2016.

6. World Health Organization (WHO). Depression and other common mental disorders: Global health

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

estimates [Internet]. 2017 [cited 13 may 2019]. Available from: https://tinyurl.com/y57565pg.

7. Jirón M, Machado M, Ruiz I. Consumo de antidepresivos en Chile entre 1992 y 2004. Revista Médica de Chile. 2008;136(9):1147-1154. doi: 10.4067/S0034-98872008000900009.

8. Gualano MR, Bert F, Mannocci A, La Torre G, Zeppegno P, Siliquini R. Consumption of antidepressants in Italy: Recent trends and their significance for public health. Psychiatric Services. 2014;65(10):1226-1231. doi: 10.1176/appi.ps.201300510.

9. Organization for Economic Co-operation and Development. Health at a Glance 2017: OECD Indicators [Internet]. 2017 [cited 10 jul 2019]. Available from: https://tinyurl.com/yyfhyng8.

10. World Federation for Mental Health (WFMH). Depression: a global crisis [Internet]. 2012 [cited 13 may 2019]. Available from: https://tinyurl.com/y2uh9ltp.

11. Hidaka BH. Depression as a disease of modernity: Explanations for increasing prevalence. Journal of Affective Disorders. 2012;140(3):205-214. doi: 10.1016/j.jad.2011.12.036.

12. Wakefield JC, Demazeux S (eds.) Sadness or depression?: International perspectives on the depression epidemic and its meaning. Dordrecht: Springer; 2016.

13. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. Fifth Edition (DSM-5). Washington DC: American Psychiatric Association; 2013.

14. Bandini J. The medicalization of bereavement: (ab)normal grief in the DSM-5. Death Studies. 2015;39(6):347-352. doi: 10.1080/07481187.2014.951498.

15. Zachar P, First MB, Kendler KS. The bereavement exclusion debate in the DSM-5: A history. Clinical Psychological Science. 2017;5(5):1-17. doi: 10.1177/2167702617711284.

16. Kendler KS. Historical precedents for the DSM-III bereavement exclusion criteria for major depression. Psychological Medicine. 2018;48(16):1-10. doi: 10.1017/S0033291718000533.

17. Pies RW. The bereavement exclusion and DSM-5: An update and commentary. Innovations in Clinical Neuroscience. 2014;11(7-8):19-22.

18. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. Third Edition-Revised (DSM-III-R). Washington DC: American Psychiatric Association; 1987.

19. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. Forth Edition (DSM-IV). Washington DC: American Psychiatric Association; 1994.

20. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. Forth Edition-Revised (DSM-IV-R). Washington DC: American Psychiatric Association; 2000.

21. Zisook S, Shear K, Kendler KS. Validity of the bereavement exclusion criterion for the diagnosis of major depressive episode. World Psychiatric Association. 2007;6(2):102-107.

22. Kendler KS, Myers J, Zisook S. Does bereavement-related major depression differ from major depression associated with other stressful life events? American Journal of Psychiatry. 2008;165(11):1449-1455. doi: 10.1176/appi.ajp.2008.07111757.

23. Pies RW. Major depression after recent loss is major depression - until proved otherwise. Psychiatric Times [Internet]. 1 dec 2008 [cited 13 may 2019]. Available from: https://tinyurl.com/y4npb89l.

24. Kendler KS, Myers J, Halberstadt LJ. Should the diagnosis of major depression be made independent of or dependent upon the psychosocial context? Psychological Medicine. 2010;40(5):771-780. doi: 10.1017/S0033291709990845.

25. Lamb KR, Pies RW, Zisook, S. The Bereavement exclusion for the diagnosis of major depression: to be, or not to be. Psychiatry (Edgemont). 2010;7(7):19-25.

26. Wakefield JC, Schmitz MF, First MB, Horwitz AV. Extending the bereavement exclusion for major depression to other losses: Evidence from the National Comorbidity Survey. Archives of General Psychiatry. 2007;(64)4:433-440.

27. Horwitz AV, Wakefield JC. The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder. Oxford: Oxford University Press; 2007.

28. Wakefield JC. False positives in psychiatric diagnosis: Implications for human freedom. Theoretical Medicine and Bioethics. 2010;31(1):5-17. doi: 10.1007/s11017-010-9132-2.

29. Frances A. Essentials of psychiatric diagnosis. New York: Guilford Press; 2013.

30. Wakefield JC, Horwitz AV, Lorenzo-Luaces L. Uncomplicated depression as normal sadness:

SALUD COLECTIVA. 2019;15:e2319. doi: 10.18294/sc.2019.2319

Rethinking the boundary between normal and disordered depression. In: DeRubeis RJ, Strunk DR, (eds.). The Oxford Handbook of Mood Disorders. New York: Oxford University Press; 2017.

31. Sabin JE, Daniels N. Seeking legitimacy for DSM-5: The bereavement exception as an example of failed process. AMA Journal of Ethics. 2017;(19)2:192-198. doi: 10.1001/journalofethics.2017.19.2.pfor2-1702.

32. Alarcón RD. DSM-5 y la psiquiatría latinoamericana. Revista de Neuro-Psiquiatría. 2013;76(2):61-62. doi: 10.20453/rnp.v76i2.1186.

33. Bertolozzi MR, De la Torre Ugarte Guanilo MC. Salud colectiva: fundamentos conceptuales. Salud Areandina. 2012;1(1):24-36. doi: 10.33132/23229659.309.

34. Casallas-Murillo AL. La Medicina Social-Salud Colectiva Latinoamericanas: Una visión integradora frente a la salud publica tradicional. Revista Ciencias de la Salud. 2017;15(3):397-408.

35. Onocko R, Massuda A, Valle I. Salud Colectiva y psicoanálisis: entrecruzando conceptos en busca de políticas públicas potentes. Salud Colectiva. 2009; 4(2):173-185. doi: 10.18294/sc.2008.340.

36. Kawa S, Giordano J. A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and implications for the future of psychiatric canon and practice. Philosophy, Ethics, and Humanities in Medicine. 2012;7:2. doi: 10.1186/1747-5341-7-2.

37. Ophir O. Psychosis, psychoanalysis and psychiatry in post war USA: On the borderland of madness. New York: Routledge; 2015.

38. Wilson M. DSM-III and the transformation of American psychiatry: A history. American Journal of Psychiatry. 1993;150(3):399-410.

39. Sandín B. DSM-5: ¿Cambio de paradigma en la clasificación de los trastornos mentales? Revista de Psicopatología y Psicologia Clínica. 2013;18(3):255-286. doi: 10.5944/rppc.vol.18.num.3.2013.12925.

40. Shorter E. How everyone became depressed: The rise and fall of the nervous breakdown. New York: Oxford University Press; 2013.

41. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. First Edition (DSM-I). Washington DC: American Psychiatric Association; 1952.

42. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder. Second Edition (DSM-II). Washington DC: American Psychiatric Association; 1968.

43. Grob GN. The forging of mental health policy in America: World War II to new frontier. Journal of the History of Medicine and Allied Sciences. 1987;(42)4:410-446. doi: 10.1093/jhmas/42.4.410.

44. Mayes R, Horwitz AV. DSM-III and the revolution in the classification of mental illness. Journal of the History of the Behavioral Sciences. 2005;41(3):249-267. doi: 10.1002/jhbs.20103.

45. Kendler KS. Historical precedents for the DSM-III: Bereavement exclusion criteria for major depression. Psychological Medicine. 2018;48(16):2794-2803. doi: 10.1017/S0033291718000533.

46. Freud S. Duelo y Melancolía. In: Sigmund Freud, Obras Completas: Contribución a la historia del movimiento psicoanalítico, trabajos sobre metapsicología y otras obras (1914-1916). Vol. 14. Buenos Aires: Amorrortu; 2008.

47. Clayton P, Desmarais L, Winokur G. A study of normal bereavement. American Journal of Psychiatry. 1968;125(2):168-178.

48. Frances A. Opening pandoras box: The 19 worst suggestions for DSM-5. Psychiatric Times [Internet]. 11 feb 2010 [cited 13 may 2019]. Available from: https://tinyurl.com/yyug4r3k.

49. Paris J. The ideology behind DSM-5. In: Paris J, Phillips J, (eds.). Making the DSM-5: Concepts and controversies. New York: Springer; 2013.

50. Muñoz F, Jaramillo LE. DSM-5: ¿Cambios significativos? Revista de la Asociación Española de Neuropsiquiatría. 2015;35(125):111-121. doi: 10.4321/S0211-57352015000100008.

51. Rose NS. Molecular biopolitics, Somatic ethics and the spirit of biocapital. Social Theory & Health. 2007;5:3-29. doi: 10.1057/palgrave.sth.8700084.

52. Rose NS, Abi-Rached JM. Neuro: The new brain sciences and the management of the mind. Princeton NJ: Princeton University Press; 2013.

53. Wakefield JC. The DSM-5 debate over the bereavement exclusion: Psychiatric diagnosis and the future of empirically supported treatment. Clinical Psychology Review. 2013;33(7):825-845. doi: 10.1016/j.cpr.2013.03.007.

54. Pies RW, Zisook S. Drs Pies and Zisook respond. In: Wakefield JC, Horwitz AV. Depressive

symptoms after loss. Psychiatric Times [Internet]. 13 may 2009 [cited 13 may 2019]. Available from: https://tinyurl.com/yymxvqrq.

55. Wakefield JC, Horwitz AV. Depressive symptoms after loss. Psychiatric Times [Internet]. 13 may 2009 [cited 13 may 2019]. Available from: https://tinyurl.com/yymxvqrq.

56. Wakefield JC, Demazeux S. Introduction: depression, one and many. In: Wakefield JC, Demazeux S, (eds.). Sadness or depression?: International perspectives on the depression epidemic and its meaning. Dordrecht: Springer; 2016.

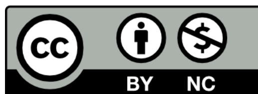
57. Rose NS. Politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century. Princeton: Princeton University Press; 2007.

58. Kass L. Beyond therapy: Biotechnology and the pursuit of happiness. New York: Dana Press; 2003.

59. Foucault M. El poder psiquiátrico: Curso en el Collège de France, (1973-1974). México: Fondo de Cultura Económica; 2005.

CITATION
Pizarro Obaid F, De La Fabián Albagli R. A critical analysis of the debates on grief and depressive disorder in the age of the Diagnostic and Statistical Manual of Mental Disorders. Salud Colectiva. 2019;15:e2319. doi: 10.18294/sc.2019.2319.

Received: 16 May 2019 | Modified: 19 Jul 2019 | Accepted: 27 Sep 2019



Content is licensed under a Creative Commons Attribution-NonCommercial 4.0 International.
Attribution — you must attribute the work in the manner specified by the author or licensor (but not in any way that suggests that they endorse you or your use of the work).
NonCommercial — You may not use this work for commercial purposes

https://doi.org/10.18294/sc.2019.2319

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English< >Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by Carolina López and Vanesa Martínez under the guidance of Victoria Illas, reviewed by Nora Windschill under the guidance of Julia Roncoroni, and prepared for publication by Lucas Moccia under the guidance of Vanessa Di Cecco. The final version was approved by the article author(s).