Against Hyponarrating Grief: Incompatible Research and Treatment Interests in the DSM-5

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> *"There is nothing more terrible, I learned, than having to face the objects of a dead man. Things are inert: they have meaning only in function of the life that makes use of them. When that life ends, the things change, even though they remain the same. They are there and yet not there: tangible ghosts, condemned to survive in a world they no longer belong to. What is one to think, for example, of a closetful of clothes waiting silently to be worn again by a man who will not be coming back to open the door? . . . Or a dozen empty tubes of hair coloring hidden away in a leather traveling case? – suddenly revealing things one has no desire to see, no desire to know. There is poignancy to it, and also a kind of horror. In themselves the things mean nothing, like the cooking utensils of some vanished civilization. And yet, they say something to us, standing there not as objects but as remnants of thought, of consciousness, emblems of solitude in which a man comes to make decisions about himself: whether to color his hair, whether to wear this or that shirt, whether to live, whether to die. And the futility of it all once there is death."*
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> (Paul Auster 1982, pp. 10–11)

Abstract The controversial debate on whether to remove the bereavement exclusion from the DSM's depression criteria has mostly focused on whether depression and grief related distress are in fact distinct. Those who argue for the removal provided scientific evidence for the truth of this claim, while those argue against it suggested that the cited evidence base is slim. Despite heated controversy, the change took place. In this article, I use a different argument to address the problems with this change in the DSM-5. Even if we assume that there is no meaningful difference between the properties of grief-related distress and depression symptoms, diagnosing the grieving individual with depression is not the best therapeutic approach to address their needs.

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Introduction

Suppose your colleague Steve has not been quite himself lately. He has not been stopping by your office as he usually does, to see how your weekend went. He keeps conversations brief. More than a few times, you have run into his students in the hallway waiting for him. They complain that they cannot find Steve during his office hours, and he does not respond to e-mails. They also tell you that he forgot to give the scheduled test last week. "He is lecturing like a robot," one adds. You are puzzled, as the person they are talking about does not sound like Steve at all. You meet him one day on your way to lunch and ask him to join you. Steve follows but seems disengaged, making you think the students are on to something. He is quiet, his eyes are red, and he has lost weight. During lunch he is spaced out and restless. When you ask if he'd like to go to the play being put on by the theatre students, he says "No," without explanation. When you ask him if he is okay, he says he did not sleep at all last night. You are worried and want to help. You send him an e-mail to follow up on your lunch, but he does not respond. A few days later you learn from your department chair that Steve lost his partner of 30 years a few weeks ago in a car accident, and since then, he has not been well. "Now it all makes sense," you think; you know how much Steve loved his partner.

Suppose Steve's situation gets worse and he is no longer able to meet the demands of his job. He even fails to fulfil the smallest tasks in his daily life. You encourage him to seek clinical support, and he goes to a family doctor. Because Steve's complaints, such as not being able to sleep or eat, losing interest in normally enjoyed activities, and being trapped in a depressed mood resemble the symptoms of Major Depressive Disorder (depression for short) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Steve's clinician may diagnose him with depression and address his complaints with antidepressants or other medications such as sleeping pills. Despite the obvious connections between Steve's loss and his experiences, he can be diagnosed this way because of the removal of the bereavement exclusion criterion from the depression diagnostic criteria in the most recent edition of the DSM, the DSM-5.

The rationale for removing the bereavement exclusion is that the observable and distressing experiences of grieving individuals and those in depression are similar. The argument is that there is no scientific evidence for characterizing bereavement related distress and depression as distinct conditions; hence, whatever treatment helps the latter will also help the former (Zisook and Kendler 2007; Zisook et al. 2001; APA 2011). I call the first premise of this argument grief erosion (GE) because it assumes that depression and grief related distress are not distinct.[1] GE is a conceptual assumption that equates grief and depression and thereby obscures, or even erases, the distinction between the two. It promotes a certain type of

[1]I use the word "erosion" because the DSM's removal of the bereavement exclusion criterion from the depression category has been an extended process, starting with the publication of the DSM-III (1980) and ending with the APA (2013). In other words, the "erosion problem" existed long before

therapeutic approach indicated in the conclusion of the argument above, which I call grief erosion therapy (GET), the therapy that treats grief in the same manner as depression.

Proponents of this change in the DSM-5 further argue that if those struggling with grief are not diagnosed with depression, they will not receive clinical support for coping with their loss even if they need it. For instance, the chair of the DSM-5 Task Force, psychiatrist David Kupfer, argues that without the change, a person who is suffering from severe depression symptoms 1 or 2 months after a loss can't be diagnosed as depressed and "may then not get the treatment they need" (Carey 2012). Some have even proposed there is an increased risk of suicide among those who suffer from bereavement-related distress and highlight the importance of early intervention (Shear et al. 2011).[2]

The controversial debate on whether to remove the bereavement exclusion from the depression criteria has mostly focused on GE, i.e., the assumption that depression and grief related distress are not distinct or the grief erosion assumption. Those who argue for the removal provide scientific evidence for the truth of GE (Zisook and Kendler 2007; Zisook et al. 2001; Carey 2012), but those arguing against it suggest the cited evidence base is slim (Horwitz and Wakefield 2007; First and Wakefield 2012; Kleinman 2012; Frances 2013; see also Wakefield's chapter in this volume). Despite heated controversy, the change took place.

In this article, I use a different argument to challenge the change in the DSM-5. In my view, even if we consider that there is no meaningful difference between grief and depression, the GET is not the best therapeutic approach to address the needs of grieving individuals. We do not need to show the falsity of the assumption that grief and depression are similar in order to argue that grieving individuals may not necessarily benefit from a depression diagnosis.[3] What it takes for the bereaved to effectively cope with grief is more complex than envisioned by the proponents of the removal of bereavement exclusion criterion, and it is wrong to assume that diagnosing grief-related distress as depression will help the bereaved to cope. Receiving a depression diagnosis during a struggle with grief may help *some* individuals to develop effective coping strategies, but there are strong reasons to claim that a depression diagnosis may shrink grieving individuals' psychological

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the DSM-5 was published. Section "DSM Hyponarrativity and Grief Erosion" summarizes this process. Inspiration for this concept comes from Alan Horwitz and Jerome Wakefield's *Loss of Sadness* (2007).

[2]In a National Public Radio interview, Sidney Zisook said: "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" (Zisook 2010).

[3]I do not claim that all those in grief must be clinically treated. Rather, my focus is on those who have difficulty coping with their loss on their own, and who need clinical assistance. This is known as complicated grief in the medical literature, including the DSM-5. Throughout the essay, whenever I indicate "grief related distress" I refer to complicated grief.

resources for coping. More specifically, the DSM-5's symptom-based approach makes its mental disorder categories poor constructs for clinical purposes, even though they have arguable advantages in research contexts.

In the first part of the paper, I identify the source of GE as the symptom-based approach to mental disorders in the DSMs, also known as hyponarrativity (Sadler 2005). Next, I discuss how GE, because of the DSM hyponarrativity, might negatively influence individuals who struggle with grief because the DSM hyponarrativity has negative implications for both the clinical treatment of the grieving individual and her self-narratives about her loss. Finally, I offer a strategy to overcome these negative implications. I conclude with the more general point that research and treatment goals are incompatible in the DSM-5 and that the DSM must abandon the ambitious task of developing representations of mental disorders that are amenable to being used in both context. While it may be fruitful for research to explore whether grief related distress and depression are in fact similar, it is false to assume that they can be treated by receiving the same medical attention. Methodologically, the paper features first-person accounts of grieving individuals to balance the available literature on the removal of the bereavement exclusion criterion, which has downplayed or ignored the actual experiences of grieving individuals even though they were the target population for the DSM revisions.

DSM Hyponarrativity and Grief Erosion

Despite its ubiquity, there are many varieties of grief.[4] Some rely on their own cognitive and emotional resources, others welcome support from their friends, relatives, and pastors, and still others need clinical assistance. Addressing the needs of the latter group who struggle with coping has historically challenged medical practitioners. There are significant cultural, social, and individual differences in the way grief is experienced, and such variations constitute an obstacle for the development of a standard therapeutic approach. Starting in the late 1970s, the creators of the DSM have consistently entertained the possibility that grief may turn into a mental disorder, based on its frequently observed emotional, cognitive, and physiological features, including sadness, sleep disruptions, changes in appetite, fatigue, diminished interest or pleasure in previously enjoyed activities, and difficulties in concentration. The similarity between the features of grief-related distress and the symptoms and signs of depression has been highlighted to make clinicians aware of the risk of grief turning into a pathological condition, or complicated grief (Horwitz and Wakefield 2007; Jackson 1986; Zisook et al. 2007). The challenge has been to distinguish the cases in which the experiences of grieving individuals are within the range of appropriate response to loss from those in which they are manifestations of depression.

[4]Grief generating loss includes the death of a loved one, loss of home, property, employment, as well as losses due to a natural disaster. In this article, I limit my discussion to bereavement.

To avoid a possible false positive problem, where the distress associated with grief could yield a misdiagnosis of the grieving individual's condition as depression (First and Wakefield 2012; Frances 2013), the psychiatric community introduced the bereavement exclusion criterion into the depression diagnostic criteria. More specifically, the DSM-III (APA 1980) stated that if the depression-like symptoms of the individual in grief exceeded 1 year, a depression diagnosis could be made and the individual could receive appropriate treatment. In the DSM-IV (APA 1994), the length of appropriate grieving was reduced to 2 months. In the fifth and latest edition, as noted above, the bereavement exclusion criterion has been removed, based on the assumption that grief related distress and depression are not distinct. Clinicians can now diagnose those individuals who struggle with grief related distress, like Steve, with depression, if their grief is manifested in experiences resembling the symptoms of depression, as early as 2 weeks after the loss – the required time for those with depression symptoms to receive a clinical diagnosis.

The push to remove the bereavement exclusion criterion must be understood in the historical context of psychiatry's attempts to establish itself as a scientific discipline. In the DSM this manifests itself in a shift from the etiological approach to classification in the DSM-I and DSM-II, to a symptom-based approach in the DSM-III (APA 1980) onwards.[5]

The DSM-I and the DSM-II were grounded in the psychoanalytic approach to understanding human psyche. Mental disorders, also called "reactions," were represented in relation to the causal factors thought to underlie them. These causal factors were taken either as a dysfunction in the brain or a general adaptational difficulty to environmental stressors due to unresolved sexual conflicts of childhood. For example, psychotic disorders were defined as "disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain" (APA 1952; Gruenberg et al. 2005). As such, theoretical presuppositions about the human mind underlay the descriptions of mental disorders, including for example, the unresolved sexual tensions of childhood causing adult psychosis. As these presuppositions were not grounded on the observable features of psychopathology, they were criticized as lacking scientific validity and reliability (Beck 1962; Katz et al. 1968; Schwartz and Wiggins 1987a, b). A scientifically valid category of mental disorder requires external validators, such as symptoms (experienced by the patient), signs (observed by others), and neurobiological markers (Robins and Guze 1970; First et al. 2004), not simply theories. In addition, research showed that psychiatric diagnoses differed markedly between Europe and the USA (Cooper et al. 1969). Because the diagnosis of mental disorder relied on theoretical presuppositions about the mind, as opposed to observable and measurable evidence, it was difficult to individuate a set of behaviors expressing the same mental disorder across settings, throwing the validity of the DSM's categories into question.[6]

[5]The symptom-based approach is also known as "atheoretical" or "purely descriptive."

[6]See also Tsou's chapter in this volume for a detailed discussion about the theoretical and descriptive views of psychiatry.

For many, focusing on the observable aspects of mental disorders, i.e., symptoms and signs, could overcome these problems of scientific validity and reliability. Thus, scientific psychiatrists sought to ground descriptions of mental disorders in scientific data derived from studies in the natural sciences,[7] and starting with the DSM-III, emphasis shifted from the theoretical explanations of the causes of mental disorders, to the observable and measurable features of psychopathology such as signs and symptoms. Under the symptom-based schema, categories of mental disorders, such as depression, became individuated through a list of criteria identifying the symptoms (observed by the patient) and signs (observed by others).

As a result, mental disorders are now represented through a list of observable properties, i.e., the physical or psychological experiences of the patient.[8] Polythetic criteria sets, as opposed to monothetic criteria sets, are used to determine the boundaries of a disorder category. Monothetic classifications are based on the characteristics that are both necessary and sufficient for the identification of members of a class; each member of a class must have at least one property shared with all members of the class. In polythetic classifications, each individual member of a class shares a large proportion of its properties with other members but all members do not necessarily share any one property (Sokal 1974; Guze 1978). For instance, according to the criteria for depression in the DSM-5, at least five symptoms have to be present during a 2-week period and must represent a change from the patient's previous functioning: either "depressed mood" or "diminished interest in and pleasure from daily activities" must be among the five. Additional symptoms include: significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation; fatigue or loss of energy; feelings of worthlessness or inappropriate guilt; and diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death, and suicidal ideation (APA 2013, 125).

There are also clauses that attempt to prevent misdiagnosis. If the symptoms are accounted for by the direct physiological effects of a substance or by a general medical condition, a depression diagnosis cannot be made. Until the publication of the DSM-5, bereavement was one of these conditions (e.g., APA 1994, 327).

Symptom-based descriptions of mental disorders are thought to enhance both the scientific and the clinical utility of the DSMs because they constitute both valid and reliable scientific categories (APA 2013, xli; APA 1994, xv). Consider first the scientific utility. A diagnostic category based on symptoms is believed to have validity because the diagnosed individual exhibits behaviors or feelings that are typical of depression (insomnia, loss of interest in previously enjoyable activities, etc.). It also has reliability because the same set of observable behaviors

[7]This move was influenced by the rise of logical positivism and the development of computer assisted diagnosis, i.e., DIAGNO by Robert Spitzer and Jean Endicott (1968).

[8]Among the examples for psychological symptoms comes depression as mood related; obsessive thoughts as thought related; memory problems as related to cognitive functioning. Symptoms of anxiety (e.g., palpitation) and disturbances of vegetative functions (e.g. appetite loss, weight gain) are included among physical symptoms (APA 1994; Fulford et al. 2006;).

will be individuated as the same mental disorder regardless of the context. Thus, the symptom-based approach, by simplifying a complex target such as mental disorder, helps validate the mental disorder constructs by identifying common signs and symptoms, and creates reliable categories across different settings. In addition, a focus on the observable features of mental disorders helps further research into the genetic and neural underpinnings of mental disorders, by, say, performing imaging studies on the brains of depressed individuals who suffer from insomnia. All these are believed to ensure the scientific utility of the DSM.

The validity and reliability of diagnostic categories afforded by symptom-based approach are also considered useful for clinical treatment by easing the diagnostic process, allowing a clinician to evaluate the patient's complaints against a list of symptoms. In addition, the clinician may aid the management of some symptoms, say, by recommending certain types of psychotherapy or drugs. Finally, the patient would be given the same diagnosis and treatment plan regardless of the context in which they are diagnosed.

In short, the DSMs are intended to serve as a "practical, functional, and flexible" guide for both research and treatment (APA 2013, xli). Starting with the DSM-III, the DSM creators committed themselves to establishing diagnostic classificatory systems that emphasize descriptions (as opposed to causal explanations), remain atheoretical with respect to etiology, and operationalize terminology so that communication is facilitated across various contexts that require a diagnostic label (Poland 2001; Sadler 2005; Tekin 2010, in press).[9]

GE is a manifestation of the DSM's symptom-based approach to mental disorders. The proponents of the removal of bereavement exclusion have argued for the similarity of grief-related distress and depression based on the similarity of the observable experiences of individuals in the two groups: "evidence does not support separation of loss of loved one from other stressors" (APA 2011).[10] If the DSM categories relied on a psychoanalytically oriented causal etiology, as in the DSM-I and the DSM-II, these two conditions would not be considered the same. What

[9]Another argument for a symptom-based approach is to model mental disorders following physical diseases. For instance, from a nosological point of view it does not matter if someone has lung cancer because he smokes too much, or because he lives in a polluted city, or because he is unlucky. Whatever the cause, his disease is lung cancer. A similar reasoning is at play with depression and the DSM-5: the cause of the symptoms does not matter; a disease is not defined by its cause, but by its symptoms and signs. Context does not dissolve disorder, even if it seems to explain it. In fact, to further research into the genetic and neural underpinnings of mental disorders, it might be necessary to isolate the content from the context, and focus exclusively on the observable properties of mental disorders. I thank Steeves Demazeux and Patrick Singy for their helpful input on this point.

[10]The "evidence" is *one* review paper (Zisook and Kendler 2007) which purports to show that bereavement-related experiences are generally similar to the symptoms of standard depression; including extreme sadness, disturbed sleep, disturbed appetite and energy, agitation, difficulty concentrating, etc. Some have taken issue with the vagueness of the notion of "similarity" and the slim evidence provided, but their concerns have not affected the DSM outcome (First and Wakefield 2012).

follows GE is the grief erosion therapy (GET): since depression and grief related distress are similar, grief related distress can be better addressed therapeutically if labeled as depression.

I argue that even if there may be grounds to believe the truth of GE, the effectiveness of GET can be challenged: while the symptom-based approach has advantages for scientific research, its utility in clinical contexts is arguable, especially in the context of addressing the needs of the bereaved (e.g., Sadler 2005; Tekin, in press). In his evaluation of how the symptom-based approach is used in treatment related contexts, Sadler coins the term hyponarrativity (Sadler 2005). A DSM category of a mental disorder is a hyponarrative, when we consider it in the larger schema of an individual's unique and rich life narrative. Even though mental disorders are sensitive to an individual's life story, including developmental history, biological and environmental risk factors, interpersonal relationships, race, gender, and other important aspects of personal identity, these elements of the story are not included in mental disorder categories. In other words, the DSM categories abstract (or bracket) the self-related and context-specific aspects of the encounter with mental disorders. By saying little about how the illness experience is integrated to the patient's life as a whole, they become nothing more than a "repertoire of behavior" (Cohen 2003). Hence, the symptom-based approach makes the DSMs hyponarrative.[11]

Though it is important for scientific purposes to be wary of descriptions that are too subjective to be generalizable, stripping away these self- or context-related aspects of the encounter with mental disorder may prevent an effective addressing of a patient's concerns in treatment contexts (Sadler 2005; Tekin in press). As I show in the rest of the chapter, even if we were to agree that grief-related distress and depression are similar or even identical, there are grounds to argue that diagnosing grief-related distress as depression may have negative implications to therapeutically addressing grieving individuals' distress, due to the DSM hyponarrativity.

Negative Implications of Grief Erosion on the Bereaved

Diagnosing grief-related distress as depression has implications for grieving individuals not just in the clinical context, where they seek help from health practitioners, but also in the personal context, where they try to adjust to a new life without the loved one by creating self-narratives about their loss. It is an empirical matter whether and how the new depression description in the DSM-5 will affect grieving individuals who need help. There will be individual and cultural variations in the way they may respond to receiving a depression diagnosis, and some may benefit

[11]It is beyond the scope of this paper to discuss whether re-appraising the self-related aspects of encounter with mental disorder is even possible within the framework of the DSM project.

from it. My intention is not to make an overarching claim about how depression diagnosis may cause harm, but rather, to identify potentially problematic implications of diagnosing a grieving individual with depression, and more generally to explore the problematic implications of the DSM's symptom-based strategy.

Grief Erosion in the Clinic

DSM hyponarrativity has disadvantages when addressing the therapeutic needs of patients in a clinical context. For one, this schema, insofar as it defines what to look for in a patient, turns the clinician's attention away from the "self" as a more or less integrated multidimensional unity (Tekin 2014), to her symptoms (Sadler 2007). This type of therapeutic intervention is geared towards symptom management; it is not an integrated approach seeking to address the individual's concerns in the larger context of her life. Although the DSM does not advise the clinician to "ignore the patient's story" (Sadler 2005), it guides clinical practice by directing the clinician's interest towards the symptoms, rather than encouraging the development of an integrated approach to improve the individual's condition by relating her complaints to the larger historical, cultural, social, and personal context of her life. In this sense, the DSM exhibits "a redirection, a marginalizing, a setting aside in lieu of something else" (Sadler 2005, 177). What it sets aside are the patients' stories that play an important role in their encounter with mental disorder (Sadler 2005; Tekin, in press; 2011; 2010).

Consider how Steve, who presents with experiences such as depressed mood, sleep disruptions, etc., may be affected by the DSM hyponarrativity. We can imagine scenarios where he is diagnosed with depression by a clinician who does not know about or inquire into his significant loss, as he meets the diagnostic criteria for depression. Unfortunately, this diagnosis may not provide him with the help he may need because the DSM-5's individuation of grief as a cluster of symptoms fails to align with the true complexity of grief. Focusing on complaints that can possibly be manifestations of a mental disorder may fail to guide the clinician's therapeutic attention to the right place in understanding and helping Steve. A more integrated approach is crucial.

Grief is an emotional, physical, cognitive, behavioral, social response to the loss of someone to whom the individual has a strong attachment. It is an adjustment process that involves lamenting for the deceased and for the self. The individual is distressed about the loss of an inherently and independently valuable person who can no longer participate in life and engage in the completion of certain projects. The age of the deceased, the way he died (e.g., sickness or accident), and his character, all influence how the individual grieves. She must recognize and negotiate with the fact that the deceased will not be returning back to life. For example, Paul Auster notes the "kind of horror" involved in making decisions about what to do with the "closetful of clothes waiting silently to be worn again by a man who will not be coming back to open the door" (Auster 1982, 10).

William James suggests that a person's self includes "not only his body and his psychic powers, but... his wife and children, his ancestors and friends... and if they dwindle and die away, he feels cast down" (James 1890/1983, 279–280). A key dimension of grief is to salvage one's own identity. However, this is not an automatic process. As Sigmund Freud writes, grieving individuals have to reclaim the energy invested in the deceased (Freud 1917). The more their identity was wrapped up with the deceased, the more difficult it will be to adjust to the loss and redesign their lives. Consider how Michel de Montaigne illustrates his feelings following the loss of his dear friend Étienne de la Boétie by citing Gaius Valerius Catullus:

> What shame or limit should there be to grief for one so dear?... How wretched I am, having lost such a brother! With you died all your joys, which your sweet love fostered when you were alive. You, brother, have destroyed my happiness by your death: all my soul is buried with you. Because of your loss I have chased all thoughts from my mind and all pleasures from my soul. (Catullus as quoted in Montaigne 2003/1580, 217–218)

Grief process requires decoupling one's self from the lost person, and recreating a life with new joys without that person in it. Arthur Kleinman, a psychiatrist and an anthropologist, explains that with his wife's death a part of him "was gone forever":

> In March, 2011, my wife died and I experienced the physiology of grief. I felt greatly sad and yearned for her. I didn't sleep well. When I returned to a now empty house, I became agitated. I also felt fatigued and had difficulty concentrating on my academic work. My weight declined owing to a newly indifferent appetite. This dark experience lightened over the months, so that the feelings became much less acute by around 6 months. But after 46 years of marriage, it will come as no surprise to most people that as I approach the first anniversary of my loss, I still feel sadness at times and harbor the sense that a part of me is gone forever. I'm not even sure my caregiving for my wife, who died of Alzheimer's disease, ended with her death. I am still caring for our memories. Is there anything wrong (or pathological) with that? (Kleinman 2012)

The potential failure of clinicians to engage with the deceased-related and self-related dimensions of grief which are missing from the DSM-5 individuation of grief related distress may present an obstacle to the development of effective therapeutic strategies. In these kinds of situations, if a grieving individual were to seek clinical help, a clinician must recognize the details of the individual's loss, and what that relationship meant to her, to best address her needs. It may be important for the clinician to know that Steve's partner died in a car accident to help him process his loss. Or that Steve used to co-author articles with his partner; even his academic identity was enmeshed with hers. As George Graham has recently discussed, "solidarity with the beloved does not evaporate just because or when the beloved dies and the love can no longer be shared" (Graham 2013, 168). One must actively work on recreating the self. In fact, as philosopher and psychiatrist Hanna Pickard writes, a narrative self-understanding achieved in the psychotherapeutic context enables self-creation and enhances self-autonomy which are both central for the recovery process (Pickard, in press).

One might oppose this argument by suggesting that the DSM-5 offers guidelines to the clinician about the appropriate way to approach the individual. After all, the definition of depression includes the following caveat:

> Note: 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... 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.* The 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, 161, my emphasis)

Even though the note mentions the likelihood of encountering certain kinds of distress during grief, it fails to offer guidelines on how to discriminate these from symptoms of depression. Rather, it prioritizes a definition of grief as a symptom-cluster involving "feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss," encouraging the clinician *to look for* a possible *mental disorder*, as opposed to developing an integrated approach to understand the patient's distress.

In effect, by prioritizing the definition of grief as a symptom-cluster, the DSM-5 fails to embrace the individual-context-sensitive nature of grief. One can easily imagine scenarios in which the overworked family doctor, within the 15 min he is allotted for each patient, may diagnose a grieving individual with depression, basing his diagnosis on the similarity of the complaints to the symptoms of depression and failing to recognize that the underlying stressor of those complaints is the loss of a loved one. Thus, by slotting grief under depression, the DSM-5 erases the therapeutic import of distinguishing the two. It does not actively guide the clinician to engage with the personal details of the individual's particular loss. In addition, given that the DSMs are used for teaching purposes in medical schools, the more hyponarrative the mental disorder descriptions are, the less likely it will be for psychiatry residents to receive special training in psychotherapy and other narrative treatment techniques, as the symptom-management approach lends itself naturally to a medication based treatment strategy.

These problems can be compounded when grieving people demand medications to manage their symptoms. My suggestion is not that medications will not help these individuals, but rather that prioritizing medical treatment in lieu of psychotherapy may delay the adjustment process following the loss by masking the bereaved person's authentic feelings (Tekin 2013b).

Hence, even if we were to agree that there is no distinction between grief-related distress and depression, the DSM hyponarrativity makes the DSM-5 be a poor guide for clinically addressing the needs of grieving individuals.

Grief Erosion in Self-Narratives

DSM hyponarrativity also has negative implications for an individual's understanding of, and response to, her mental illness (Tekin 2010, in press).[12] The DSM's neglect of the "self" leaves mental disorder descriptions irreconcilable with subjective experiences and directs an individual's attention away from her own understanding of her mental disorder to rely on what the DSM says. It becomes a challenge for those with mental disorders to understand their condition and its significance,[13] severely limiting their ability to develop coping strategies. In this respect, grief erosion may negatively affect a grieving individual's self-narratives.

I define self-narratives as selective representations of the states of affairs in an individual's life, which are organized in a more or less sequential, coherent and meaningful manner (Tekin 2013a, 2011). Important work on the relationship between the self and self-narratives in philosophy of cognitive science, as well as feminist philosophy, attests to the ways self-narratives are used by individuals to make sense of the states of affairs in their lives, including experiences of mental disorders, the loss of a loved one, or experiences of violence (Tekin 2010, 2011, 2013a; Flanagan 1996; Lindemann Nelson 2001; Baylis 2011; Lumsden 2013; Jopling 2000). These self-narratives are not mere expressions of an individual's conception of an experience, but tools for developing self-understanding, forming self-concepts, and shaping appropriate responses to the encountered states of affairs. In this sense, self-narratives shape the self.

Self-narratives, as cognitive representations of the states of affairs in an individual's life, regulate that person's responses to these states of affairs. For instance, following a break-up, a college student may reiterate the series of events that led to the break up, re-examine the role played by each partner, identify potential reasons for the break-up, etc. These self-narratives, incomplete and selective by nature, have varying degrees of connection with the states of affairs that have actually occurred: they may be veridical or far removed from the reality. In this respect, they are plastic;

[12]The limitations of the symptom-based approach are acknowledged in the introduction to DSM-5, which emphasizes that a categorical approach to classifications works best when all members of a class are homogeneous, when there are clear boundaries, and when the different classes are mutually exclusive. It acknowledges that this is not the case in mental disorders. Patients, even if they share a diagnosis, form heterogeneous classes, as each has a unique encounter with mental disorder, due to the contingencies of her own life. Further, using the categorical system does not assume clear boundaries between different mental disorders (APA 2013, 19–20). Despite these shortcomings, the DSM is considered able "to assist trained clinicians in the diagnosis of their patients' mental disorders as part of a case formulation assessment that leads to a fully informed treatment plan for each individual" (APA 2013, 20).

[13]I am not suggesting that a symptom-based approach to mental disorder is completely wrong, I am suggesting that it is incomplete, i.e., it only captures some aspects of a mental disorder, and leaves out the subjective aspects. This may have some advantages, but when it comes to individual's reflection on her condition, a symptom-oriented approach, as opposed to a more integrated one, has negative implications.

they are influenced not only by the actual states of affairs, but also by the social, cultural, and scientific norms that evaluate these experiences. Upon reading a book about male-female power dynamics in relationships, the college student may create another version of her self-narrative. Creating one that makes sense of the break-up through an understanding of power relations may help her adjust better to the break-up, and overcome negative experiences, such as abuse, in a more resourceful way.

Others' narratives of the states of affairs in an individual's life can be made part of that person's own self-narratives (Tekin 2011, 2013a). Depending on their quality, they may help or hinder her adjustment, shaping her available cognitive and social resources (Jopling 2000). There are salient examples throughout human history of dominant groups shaping the narratives of certain underrepresented groups through socially shared narratives, "damaging" their identity so that they cannot exercise their moral agency freely (Lindemann Nelson 2001). Others' narratives shape moral agency in individual contexts as well. For example, if the college student's self-narrative highlights her partner's insistence on her negative personality traits and posits these as the sole reason for the break-up, she may develop feelings of insecurity that hinder adjustment and deprive her of self-understanding.

Sciences of mental disorder, in addition to offering methods of treatment, also serve as epistemic sources for individuals to create self-narratives of their illness (Tekin 2010, 2011). In other words, the individual may be inclined to use the causal framework offered by psychiatry to shape her narratives of her own disorder, affecting her experience of and response to that disorder. A DSM diagnosis of a mental disorder informs an individual's self-narrative via the clinician's description of the mental disorder to her patient and the DSM culture, i.e., the cultural context in which information and speculations about mental disorders are disseminated (Tekin 2010, 2011, in press; Hacking 1995). Used as cognitive tool, a DSM-based self-narrative helps the individual make sense of her otherwise unfathomable mental distress. Yet because of an absence of self in the DSM's depression category, she may be less inclined to rely on the subjective life context in which she encounters mental disorder and more inclined to use available DSM-based explanations and typical treatment strategies, e.g. drug therapy.[14]

The following is a good example of a DSM-based self-narrative. Elyn Saks writes about browsing through the DSM and reading the definition of her diagnosis of schizophrenia:

> I had discovered the DSM.... I read it cover to cover. Knowledge had always been my salvation, but with my immersion into the DSM, I began to understand that there were some truths that were too difficult and frightening to know.... And now, here it was, in writing: The Diagnosis. What did it mean? Schizophrenia is a brain disease which entails a profound loss of connection to reality. It is often accompanied with delusions, which are fixed yet false beliefs—such as you have killed thousands of people—and hallucinations, which are false sensory perceptions-such as you have just seen a man with a knife. Often

[14]The "self" is introduced in the DSM for the first time via the general definition of personality disorders in the DSM-5 (APA 2013). My focus here is on mood related disorders.

> speech and reason can become disorganized to the point of incoherence. The prognosis: I would largely lose the capacity to take care of myself. I wasn't expected to have a career, or even a job that might bring in a pay check. I wouldn't be able to form attachments, or keep friendships, or find someone to love me, or have a family of my own—in short I'd never have a *life*.... I'd always been optimistic that when and if the mystery of me was solved, it could be fixed; now I was being told that whatever had gone wrong inside my head was permanent, and from all indications, unfixable. Repeatedly, I ran up against words like "debilitating," "baffling," "chronic," "catastrophic," "devastating" and "loss." For the rest of my life. *The rest of my life*. It felt more like a death sentence than a medical diagnosis. (Saks 2007, 167–168; italics in original)

This self-narrative reflects the formal definition of schizophrenia in the DSM and the speculative and unverified knowledge about schizophrenia disseminated in the DSM culture. For instance, the DSM does *not* say that schizophrenia is a brain disease, but the substantive literature on schizophrenia, including research articles, pharmaceutical studies, neuroscientific literature, not to mention popular literature, refers to it as such. Some terms, including "permanent," "debilitating," "catastrophic" are *not* found in the DSM.

This particular self-narrative is constraining, as it accounts for Saks's experiences with hallucinations and delusions superficially, without engaging with how these states are lived out in different contexts of her life. For instance, it is relevant in the development of Saks's understanding and response to her illness that she know the times she is more disposed to certain hallucinations, for example, the highly stressful situation created by examinations at Oxford, so that she can develop ways to deal with them; however, a symptom-oriented narrative does not engage with those factors.

The kind of narrative that disengages Saks' symptoms from her larger life context might shut down other, more integrated accounts of her experience with schizophrenia. In fact, Saks has a fulfilling life despite her illness, demonstrating her ability to create alternative, more integrated self-narratives in which she is not a collection of symptom-clusters, but an individual person with a meaningful life. Saks writes in her memoir that she has flourished by replacing the above narratives with more resourceful ones where she engages with the meaning of her illness and its significance in her life (Saks 2007). Not relying on the DSM-based narratives has helped her.

Thus, given the self-narrative shaping power of a DSM diagnosis, receiving a depression diagnosis for grief-associated distress may influence the individual's emotional and cognitive responses to her loss. For instance, Steve's self-narratives about his distress in the wake of his loss might present his experience as a psychopathological condition, as opposed to an appropriate response to loss. Making sense of his grief as an abnormal condition could alienate Steve from his own feelings. More specifically, he may be inclined to think of his experiences as a cluster of medical symptoms rather than engaging with the deceased-related and self-related aspects of his grief. However, full engagement with his personal feelings and experiences may help Steve create a meaningful self-narrative that will allow him to develop cognitive and emotional coping strategies.

Some research supports the intuition that it matters whether the grieving person engages with the subjective features of her grief response by using her own language, rather than the psychiatric language of depression.[15] James Pennebaker's work in cognitive science supports the claim that if the subject is able to connect her symptoms to her specific life experiences, she will develop adaptive cognitive responses. Pennebaker demonstrates that when individuals write about traumatic experiences by deeply engaging with the associated emotional difficulties in their lives, significant physical and mental health follows. This is referred to as the disclosure phenomenon. Further, talking and writing about emotional experiences yield comparably higher biological, mood and cognitive effects than talking or writing about superficial subjects (Pennebaker 1997).[16] While some of the positive outcomes of the disclosure phenomenon are due to a reduction in inhibition, researchers argue that basic cognitive and linguistic processes during writing are more significant factors. There is a connection between language used and health outcomes (Pennebaker 1993). More thoughtful writing, it is suggested, leads to better health outcomes, as does the use of positive emotion words.[17]

Similar forces might be at play in grief-related distress. Perhaps the individual will better cope with the loss of a loved one if she is encouraged to explore her feelings connected to his presence in her life, the sadness that comes with her loss, how she feels about living in the world without him, and so on. If she establishes causal and insightful relationships between her symptoms and the deceased-related and the self-related dimensions of her grief, she may develop rich insights into her grief. Active engagement with the components of her grief may give her an enhanced ability to cope with it.

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[15]Research in psychology indicates the positive influence of a detailed language of emotion on subjects' responses to traumatic life experiences. For instance, in a study conducted among families with preadolescent children, Robyn Fivush et al. found that family narratives in which *specific* emotions were expressed and explained in a collaborative fashion, while acknowledging especially the negative emotions, were positively related to preadolescents' reported competencies and self-esteem. However, family narratives expressing very *general* positive emotions and neglecting negative emotions were negatively related to preadolescents' competencies (Marin et al. 2008). These studies support the idea that a detailed understanding of subjective experience of mood disorders has a significant influence on an individual's ability to cope with her mood disorder.

[16]Pennebaker et al. write: "When individuals write or talk about personally upsetting experiences in the laboratory, consistent and significant health improvements are found. The effects are found in both subjective and objective markers of health and well-being. The disclosure phenomenon appears to generalize across settings, most individual differences, and many western cultures, and is independent of social feedback" (Pennebaker et al. 1997, 164).

[17]Pennebaker et al.'s analysis of data from six writing studies found three linguistic factors reliably improved physical health. First, the more that individuals use positive emotion words, the better their subsequent health. Second, a moderate number of negative emotion words predicted health. Both very high and very low levels of negative emotion words correlated with poor health. Third, an increase in both causal and insight words over the course of writing was strongly associated with improved health (Pennebaker et al. 1997, 165).

Looking Forward

The DSM seeks to represent mental disorders in a way that will serve both research and treatment. But as seen in the example of grief, research and treatment interests are not automatically compatible. A particular feature of a DSM category – hyponarrativity – can yield positive outcomes in some research contexts and undesirable outcomes in clinical and personal contexts. Isolating depression like symptoms from the individual as a more or less integrated unit may lead to the DSM's failure to adequately address the needs of individuals in grief. Even if grief erosion is a viable assumption, it does not follow that diagnosing grieving individuals with depression will help improve their condition.

One way to look forward is to challenge the fundamental ambition of the DSM to serve disparate purposes and to use different constructs of mental disorder (with more or less self-related features) depending on our interests in using these constructs. As seen in the grief case, the details that need to be abstracted from a mental disorder description to guide scientific research may also be required to address the therapeutic needs of the individual. The DSM's schema for grief related distress is not useful in the clinical context, as it neglects the important properties of grief required in an effective therapeutic approach. The following statement is misguided:

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide variety of contexts. DSM has been used by clinicians and researchers from different orientations . . . all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients (APA 2013, xli).

It is a mistake to assume one representation of mental disorders can be useful for a wide variety of contexts, including research, treatment, and various administration related affairs. Similar incompatibilities may be found in the other contexts where the DSMs are used (e.g., insurance related interests and treatment interests).[18] For example, what looks like a *prima facie* useful feature of the DSM for research purposes, i.e., hyponarrativity, may have negative implications in treatment contexts. The best way for psychiatry to move forward might be to determine the primary purpose of the DSM categories and develop models of mental disorders that will fit that purpose. If it is solely used as a clinical treatment guide, it must abandon hyponarrativity. If it is to be used for research purposes, some hyponarrativity can remain, depending on the purposes of a particular research area.

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[18]Similar points in favour of pluralism in assigning roles for a psychiatric taxonomy can be found in the chapters by (Tsou 2015; Faucher and Goyer 2015) in this volume.

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