The Medicalization of Grief

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Abstract

Medicalization occurs when a phenomenon comes to be subject to medical study, diagnosis, treatment, or prevention. Whether a phenomenon ought to be medicalized should be decided on a case-by-case basis. Recent moves to remove "bereavement exclusions" from psychiatric diagnostic manuals and to introduce grief-specific medical disorders have elicited criticisms from skeptics about grief's medicalization, but these criticisms can largely be blunted. This article first clarifies the nature of disputes about medicalization, highlighting how these disputes do not concern whether a condition such as grief is clinically significant or whether it can generate illness, but whether the condition itself is rightfully categorized as potentially pathological. It then offers a stronger, philosophically grounded case against the medicalization of grief, resting on how medicalizing grief is likely to detrimentally alter the moral and political meanings attached to grief. Specifically, medicalizing grief will "normativize" a medical vocabulary for evaluating grief that may impede authentic engagement with grief, validate a

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T. Schramme, M. Walker (eds.), *Handbook of the Philosophy of Medicine*,
https://doi.org/10.1007/978-94-017-8706-2_106-1

suspect "time slice" model of human well-being that overlooks how grief can benefit a person's life as a whole, and impede desirable sympathy or solidarity with grieving persons.

Keywords

Grief · Bereavement exception · Medicalization · Kubler-Ross · Five-stage model of grief · Psychiatric nosology · Prolonged grief disorder · Well-being · Z codes · Looping effects · Sympathy

Introduction

A phenomenon is said to be "medicalized" when it comes to be subject to medical study, diagnosis, treatment, or prevention. Sociologists and historians of medicine have observed that while a few conditions have been de-medicalized (most medical communities, for example, no longer view homosexuality as an illness or disorder), the overall trend has been toward greater medicalization, especially within the domain of behavioral or mental health. Once medicalized, conditions that, in the past, were viewed as instances of normal and acceptable human variability (for example, learning disorders) are no longer seen as such. To medicalize a condition has practical implications, at both the personal and political levels. At a personal level, those whose conditions are newly medicalized may be treated more sympathetically because their conditions are no longer attributed to their character or choices. They are instead perceived as victims of the genetic lottery or of social circumstances not of their making. At a political level, institutions generally view medicalized conditions with a measure of urgency; illnesses or disorders require diagnostic criteria, treatment protocols, and prevention strategies at the individual or public health level.

There are important philosophical debates to be had regarding medicalization (see Illich [1976], Elliott [2003], and Parens [2013]). Should we think that the growing medicalization of human life is on balance desirable or not? On the one hand, medicalization could reflect our increasing scientific grasp of the bases of illness and a growing societal appreciation for the many forms that human suffering can take. Conversely, medicalization skeptics worry that more and more of human life is coming to be perceived as pathological, and there may be moral perils in handing over the management of human problems to medicine, itself a fallible and socially embedded institution with a spotty history in terms of respecting individual autonomy and treating individuals with equal dignity or concern. Medicalization also raises the specter of larger social maladies: Perhaps the trend toward medicalization is due less to growing scientific understanding or appreciation of human suffering than to the fact that our societies are suffering systematic breakdown. From this perspective, more people are sick because the communities they live in are getting sicker.

It might be assumed that this large-scale philosophical debate must be settled before we can reasonably determine whether a particular condition or phenomenon

should be medicalized. That is not so however. For aside from the most ardent opponents of medicalization, participants in these conversations largely agree that medicalization is value-neutral, neither inherently welcome nor unwelcome (Conrad 2007; Brinkmann 2020). Indeed, that there are controversies about the medicalization of specific conditions should not obscure the wide areas of agreement about medicalization: Some conditions (cancer) no doubt should be medicalized, whereas other conditions (having detached earlobes) should not be. Such consensus suggests that, in thinking about whether a specific condition or phenomenon ought to be medicalized, we can proceed on a case-by-case basis, asking both what facts regarding that condition or phenomenon speak in favor of medicalization and what facts speak against it, in the hope of arriving at an all-things-considered judgment on the matter.

This chapter applies this case-by-case methodology to a phenomenon—the grief and bereavement we experience in response to the deaths of those that especially matter to us—where there has been a lively discourse over the past decade or so regarding its potential medicalization (Konigsberg 2011; Kleinman 2012; Wakefield 2012; Pies 2014; Tekin 2015; Cacciatore and Francis 2022; Cholbi 2022: 166–185). Central to this discourse have been two recent developments within clinical psychiatry: (i) The removal of "bereavement exclusions" from diagnostic manuals. In the past, diagnostic manuals have usually stated that although grief strongly resembles mental disorders insofar as it causes psychological suffering and can sometimes interfere with daily life, it does not constitute a mental disorder nevertheless, since it is the normal and culturally sanctioned response to loss. Recently, diagnostic manuals such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have removed such exclusions, opening the door to grief being associated with a mental illness diagnosis. (ii) The introduction of grief-specific mental disorders into psychiatric taxonomies and practice. The most recent editions of both the DSM and the *International Classification of Diseases* (ICD) include the diagnostic category of "prolonged grief disorder," defined in terms of a grief response involving such symptoms as intense emotional pain, longing for the dead, impairments in functioning, etc. These diagnoses are not to be applied to those in the immediate aftermath of the death in question (only after 6 months under the ICD diagnosis and only after 1 year under the DSM diagnosis) and must recur regularly for a defined period (for example, at least 1 month).

These moves toward the medicalization of grief have been among the most intensively debated in the recent history of psychiatry and mental health care (Granek 2010; Prigerson et al. 2021; Wada 2022; Zachar et al. 2023). The case *for* medicalizing grief is, I take it, relatively straightforward: The grief we undergo when those that matter to us die induces mental pain or suffering. Although many people manage this pain and suffering well, some do not, with the result that it becomes distressing or interferes with their ability to carry on in day-to-day life. In this respect, grief can sometimes develop so as to resemble other recognized categories of mental disorder (depression or anxiety, for example). Medicine, particularly psychiatric medicine, has among its central therapeutic objectives the mitigation of suffering and the enhancement of individuals' ability to carry on in day-to-day life.

Hence, there is a principled basis for viewing grief as appropriately subject to medical intervention. Finally, there is some reason to expect that medical interventions directed at particularly acute or severe forms of grief could mitigate patient suffering and enable them to recover their ability to carry on in day-to-day life. Counseling or various forms of "talk therapy," as well as psychoactive medications, are likely to help patients whose grief has become distressing or unmanageable (Lichtenthal et al. 2004; Fox and Jones 2013; Zisook et al. 2013).

Critics of grief's medicalization have offered a number of objections in turn (Kleinman 2012; Wakefield 2013; Bandini 2015; Brinkmann 2020; Cacciatore and Francis 2022; Lutz et al. 2022). They propose that the diagnostic criteria for grief-related disorders put too much emphasis on the duration of grief episodes. Such critics claim that to assert that grief should subside within a specified time period overlooks ordinary variations among individuals and in the relationships they have with those whose deaths prompt their bereavement. What would plausibly count as unduly prolonged grief in one set of circumstances (a year or more of grief upon learning of the death of a childhood companion with whom one had long ago lost touch) would plausibly count as entirely apt in another set of circumstances (a year or more of grief by a widow happily married to her partner for several decades). Second, critics of grief's medicalization underscore that grief does not correspond to any underlying physiological or neurological dysfunction. While grief has wide-reaching effects on the body and brain, there does not appear to be a sense in which the grieving brain or body is misfiring or behaving abnormally. Grief may *feel* bad, but it is not a sign of anything disorderly in our bodies. In grief (medicalization's critics suggest), we merely exhibit an inherent, and perhaps beneficial, biological tendency, one that recent evidence indicates we may share with some other animal species (King 2013; Monsó 2024). Finally, some critics detect a political or socio-economic agenda in moves to medicalize grief. Grief's medicalization (they allege) represents the further encroachment of medicine on human affairs, as well as giving pharmaceutical manufacturers a golden opportunity to exploit grief for economic gain.

These worries about grief's medicalization are not without merit. Nevertheless, they can to some extent be answered by those in favor of medicalization. Diagnostic criteria evolve over time. So too, we might expect, for the criteria for grief-related mental disorders. These criteria can be fine-tuned to be more accurate or reliable, and, indeed, have been changed in response to criticism (most notably, the "waiting period" after death for a diagnosis of prolonged grief disorder has been extended from several weeks to at least 6 months). In addition, all such criteria require the careful application of clinical judgment, and clinicians may sometimes conclude that a prolonged or complicated grief episode is nevertheless not detrimental to a bereaved person and hence not the appropriate locus of therapeutic attention. As to the diagnostic criteria's emphasis on the duration of grief, defenders of medicalization point out that duration is not an independent "symptom," but merely a way in which the severity of adverse grief responses can be measured. As to grief not representing a physiological or neurological dysfunction, it should be acknowledged that grief has far-reaching bodily effects, including effects on cognition, attention,

memory, appetite, sleep, etc. (Shulman 2018; Cholbi 2022: 172–174). Viewed in this light, grief appears to be a global stress reaction, which (in particularly severe or prolonged cases) can get out of hand, much in the way that hyperventilation, prompted by the need to breathe, ends up leaving someone gasping. Hence, even though grief is not dysfunctional in the way that (say) a broken bone or a clogged artery is a bodily dysfunction, it can be understood as a generally adaptive response that sometimes ends up harming a bereaved person. Lastly, medicalization will likely have beneficiaries beyond those who might receive medical treatment for their pathological grief. But whatever objectionable nonmedical benefits might flow to the former, including pharmaceutical companies, should at least be weighed alongside the medical benefits that would accrue to the latter.

The case for medicalizing grief is (I noted above) easy enough to discern. Yet given the limitations of the arguments discussed in the previous paragraph, the case *against* the medicalization of grief has not, to my eye, been adequately prosecuted. Hence, my purpose here is to advance a more principled philosophical case for opposing the medicalization of grief, including the introduction of a grief-related mental disorder. This case will be less reliant upon specifics of medical practice, physiology, etc., and more on the larger moral and political meanings of medicalizing grief. In so doing, my aim is not to convince readers that grief ought not be medicalized. I instead intend that readers, once exposed to the philosophical case for opposing grief's medicalization, will be better situated to draw more reasonable conclusions about grief's medicalization, taking all relevant factors into account.

The chapter proceeds first by clarifying the nature of the dispute regarding grief's medicalization. Then, in sections "Debating Medicalization: Grief as Disorderly," "Normativizing Grief," and "Grief's Benefits and Human Flourishing," I offer a trio of arguments against grief's medicalization, arguments that emphasize how medicalization would likely alter the personal and social experience of grief for the worse. Medicalizing grief would change the subjectivity—and intersubjectivity—of grief in ways that could be unwelcome. My conclusion is that these arguments need to be weighed against the clinical benefits of medicalizing grief if we are to reach a reasoned conclusion about the merits of grief's medicalization.

Debating Medicalization: Grief *as* Disorderly

Medicalization is a subtle phenomenon, so debates about whether a condition should be medicalized are accordingly subtle. This is true with respect to the medicalization of grief. On its face, it might seem that those disputing grief's medicalization are divided over the question of whether some individuals ought ever to seek (and receive) medical attention for suffering related to their grief. This misunderstands the dispute at hand, however.

Suppose an individual S has been undergoing grief for several months and has become worried that their grief is "unhealthy." Should S seek out and receive medical help for their grief? Proponents of grief's medicalization may answer "yes," and in particular, they may argue that S should be treated as having a grief-

based disorder if S meets the relevant diagnostic criteria for it (the designated symptoms at the right time and for an adequate duration, etc.). Surprisingly though, opponents of grief's medicalization may well *agree* that S should seek out and receive medical attention. But their justification will differ from that of medicalization's proponents: S, according to medicalization's opponents, is suffering from some other condition (for example, depression, anxiety, sleeplessness, etc.) caused by or *due to* S's grief, and it is this other condition that warrants medical attention, not S's grief *as such.* The disputants in this case thus disagree about the conceptualization of S's suffering and hence on the *rationale* for S's seeking out and receiving medical attention. For proponents of medicalizing grief, S could be suffering *from*, or be sick *with*, grief. But for opponents, S is suffering from the *consequences* of grief.

This illustrates a neglected point in debates regarding medicalization: To claim that some condition should not be medicalized is not to deny that it can be medically significant or to be indifferent to its medical effects. If grief is precluded from serving as the basis of a diagnosis of mental illness, this does not entail that grief can never result in conditions that merit medical attention all the same. When it does so, patients can be conceptualized and treated in terms of these medically significant conditions (anxiety, depression, sleeplessness, etc.) instead of in terms of their being sick with grief (Cholbi 2022: 174). Opponents of grief's medicalization cannot, therefore, be fairly charged with ignoring cases in which grief is in fact harmful to the bereaved. They part ways with their opponents chiefly in terms of whether such harm represents disordered grief or instead struggles with the effects of grief.

As we shall see, how we conceptualize the suffering arising within grief will matter a great deal to whether its medicalization is warranted. For now, it is worth noting that the vast majority of mental disorders (and especially those related to the emotions or affect) are defined by reference to their symptoms rather than to their causes. Take generalized anxiety disorder, for example. This disorder is defined in terms of the magnitude, frequency, and persistence of a person's anxiety or worry, where this anxiety proves difficult to control and results in at least three of six problematic symptoms (restlessness, being easily fatigued, difficulty concentrating, etc.). Crucially, *why* a person is anxious—its causes, or whatever personal or social facts are behind the anxiety—plays no role in the diagnosis. That a person's anxiety is due to academic stress, strain in a romantic relationship, etc. does not determine if a person is clinically anxious, nor are there distinct diagnoses corresponding to these causes (academic anxiety disorder, relationship anxiety disorder, etc.). In contrast, to medicalize grief is to assign the sources of grief's "symptoms" a key role in its status as pathological. Many of the diagnostic criteria offered for grief disorders in the DSM-5-TR (identity disruption, intense emotional pain, difficulty in management of relationships, emotional numbness, etc.) and ICD-11 (intense emotional pain, including emotions such as sadness, guilt, and anger; inability to experience positive mood; disruption to social or occupational functioning; etc.) fit the aforementioned diagnostic pattern: emotional or psychological manifestations of suffering. But other criteria explicitly locate the source of these symptoms in the experience of another's death: In the DSM-5-TR, longing for the deceased, avoiding reminders of the

deceased, and disbelief regarding the death, and in the ICD-11, longing for or preoccupation with the deceased, etc. The dispute about grief's medicalization can therefore be seen as a dispute regarding how the latter set of facts, facts arising from the individuals' awareness of another's death, factor into their diagnosis. For medicalization's proponents, they are an intrinsic part of a grief-based disorder. For its opponents, they belong to some other disorder, not tethered to death or grief per se, to which death or grief is extrinsically related. From the standpoint of medicalization's opponents, to link these affective facts to grief makes a grief-related mental disorder a nosological outlier, akin to supposing that we need "complicated unemployment disorder" to capture the suffering associated with unemployment or "prolonged breakup disorder" to capture the suffering associated with breakdowns in romantic relationships. No need for such categories, nor for a grief-specific mental disorder either, medicalization's opponents will argue.

Again, opposition to grief's medicalization does not entail that clinicians should pay grief no heed. Clinicians should be cognizant of how grief can shape a person's experience, including how it may increase the risk of behaviors such as suicide. In so doing, clinicians can draw upon grief's status as a "Z-code,' a clinically significant fact that impacts the diagnosis, development, or treatment of a disorder but that is not itself "disorderly." In viewing grief as a Z-code, a clinician rightfully takes stock of how a patient's distress is shaped by its origins in grief (much in the way that a clinician should take stock of the specific fears that underlay a patient's phobia). But still, the patient is to be treated for the complications grief generates, rather than for "complicated" grief or its diagnostic cousins.

A compelling case against the medicalization of grief is therefore not likely to turn on whether grief (or its effects) can *ever* warrant medical interventions. It must instead rest on the implications of viewing grief as a potential locus of human dysfunction. We will now proceed to articulate three arguments of that kind. What links these arguments is a concern for the ways in which medicalizing virtually any phenomenon, grief included, invites a remapping of human experience and of the categories used to account for that experience. The medicalization of grief would not leave grief, an important dimension of human subjectivity, untouched. More specifically, grief would increasingly be seen as a human malady instead of a human predicament. If the arguments of sections "Debating Medicalization: Grief as Disorderly," "Normativizing Grief," and "Grief's Benefits and Human Flourishing" are sound, then at least some of the ways in which medicalization would alter the experience of grief, both for the bereaved and for others, may prove harmful.

Normativizing Grief

For many, grief is a bewildering or disorienting experience. Despite grief being a nearly universal human experience, we are often caught off guard by its intensity or by the specific emotions we undergo within grief episodes (Cholbi 2022; Ratcliffe 2023). The renowned theologian and children's author C.S. Lewis, for example, reported in his memoir *A Grief Observed* (1976) that he was not prepared for the

ways in which grief involved emotions such as fear or would lead him to neglect daily activities like shaving. Though we generally know why we grieve, we often do not know how best to grieve. It is therefore understandable that individuals will seek help in understanding or addressing their grief. And given the prominence of medicine as a social institution—I would argue that in many societies nowadays, medicine is almost exclusively entrusted with addressing intricate personal problems such as grief—the medicalization of grief would likely lead people to look first and foremost to medicine for that help. What would the likely consequences of this be for our relationship to grieving? In a pragmatic spirit, enthusiasts for grief's medicalization may argue that it will lead individuals in need of medical attention for their grief to come forward when they otherwise would not.

The actual consequences of grief's medicalization would be more complex than this, I propose.

First, to medicalize a phenomenon is to "normativize" it, i.e., to appraise manifestations of it by reference to putatively healthy manifestations of that phenomenon. Though grief has some common features across individuals and episodes, it nevertheless varies significantly in its duration, emotional content, dynamics, resolution, etc., thanks to variations both among bereaved individuals (their personalities, life situations, etc.) and among the relationships bereaved individuals bear to the deceased persons that they grieve for. "Everyone grieves differently," it is often said. But medicalizing grief represents certain grief experiences as "healthier" than others without due regard for such variations. Coarse-grained diagnostic practices are thus likely to lead to both significant overdiagnosis and underdiagnosis: Some individuals may seek medical attention for grief episodes that do not stand to benefit substantially from it or which will subside and resolve without medical attention. Other individuals (especially men) will shun medical attention precisely because their own self-conceptions are at odds with such help seeking. (As the popular meme has it, men would rather do virtually anything else besides go to therapy.)

But the worries regarding how medicalization would normativize grief extend further. Again, in the midst of grief, bereaved individuals can struggle to grasp the experience and its significance. They are thus vulnerable to having their understandings of their grief shaped by narrative frameworks that are authoritative within the wider culture (Kofod 2017), and in some cases, these narratives are false to their own experiences or discourage an authentic engagement with their grief. For example, likely thanks in part to its simplicity, the Kübler-Ross five-stage model of bereavement has become a common therapeutic tool, as well as a cultural trope. But the model itself is true only of a handful of grief episodes (Maciejewski et al. 2007; Konigsberg 2011), and many now complain that its prominence compels individuals to try to understand or represent their grief in the terms set by the five-stage model even when it is awkward or misguided to do so. In addition, one of the central challenges of bereavement concerns emotional fluency and adaptation: Grief is best managed by those with strong emotional fluency, i.e., those able to recognize, describe, and become accommodated to strong, and in many cases unfamiliar, emotions. The Kübler-Ross model provides a template for this task (denial-anger-bargaining-depression-acceptance) that many bereaved people find alien to their

own experiences. Hence, by serving as a "master narrative" for grief experiences, the Kübler-Ross model has, unfortunately, distorted or interfered with many people's grief experiences.

The medicalization of grief would pose a similar hegemonic threat. Given the esteem with which medicine is held in many societies, the availability of a "grief as illness" narrative would lead this to become the dominant narrative frame at the expense of enabling individuals to relate to their grief as their own circumstances and perceptions befit. The conceptual duality of "grief as illness" versus "grief as medically healthy" neglects the diversity of grief experience, particularly within the latter category. No doubt, an illness narrative for grief would be true and beneficial for some, but we should be wary of signing on, even with good intentions, to a narrative framework for experiences that are universal but highly variegated, as grief is. To be clear, the objection to grief's medicalization is not that it offers a narrative framework at all. After all, individuals need frameworks of concepts, etc., by which to make sense of any of their experiences, grief included. Furthermore, successful grief seems to depend on our ability to be open to new experiences. Those with personalities that are uncomfortable with new experiences are more likely to find the powerful emotions associated with grief threatening or destabilizing (Stevens 1987; Robinson and Marwit 2006). Such individuals benefit from having narratives within which to comprehend their grief, but it is vital that these narratives encompass the wide array of grief experiences.

In propounding the objection that medicalization will result in the embrace of unduly restrictive norms regarding the experience of grief, I am not claiming that no bereaved individual would benefit from such norms. But for every individual who benefits from grief's medicalization, there could well be one or more individuals who are made worse off insofar as their grief experience is left unaddressed, or is even distorted, by the medicalized conception of grief that is likely to prevail over time. Highly prescriptive social norms surrounding grief (for instance, the mourning norms associated with the Victorian era) now strike us as quaint. It would thus be an error to reintroduce similarly prescriptive norms regarding grief even under the benevolent auspices of medicine.

Grief's Benefits and Human Flourishing

A second philosophical objection to grief's medicalization arises from how psychiatric medicine in particular relies upon a suspect notion of well-being. Mental health theorizing and practice often present mental disorder in terms of three "dis"-ses: Mental disorders are mental *dis*turbances that give rise to *dis*tress or *dis*ability. The duration of a disorder is thus indexed to the time period in which the distressing or disabling disturbance occurs. During this time period, a patient is badly off because they are undergoing suffering that has proven overwhelming or unmanageable.

One limitation of this picture of mental disorder is that it treats disorders in abstraction from patients' larger biographies, and in so doing neglects the possibility that the disturbances, etc. might prove beneficial to the patient in the longer run. In

the case of grief, even though it may be distressing, etc., during its occurrence, it may nevertheless have value that exceeds the disvalue of this distress. Indeed, grief seems paradoxical in just this way: In and of itself, its painfulness and emotional strain give little reason to recommend it, but at the same time, quashing or avoiding grief altogether is imprudent precisely because it provides us with important personal goods. In particular, grief has a larger role in enabling us to grasp the significance of our personal relationships, to craft ongoing identities in light of changes in those relationships, and to understand and refine our own values and commitments (Parkes 1996; Attig 2010; Cholbi 2022: 65ff; Lutz et al. 2022). Grief's relationship to a person's well-being overall (how well a person's life goes biographically or as a whole) therefore cannot be captured by focusing solely on the degree of distress or disability it causes within the temporal confines of a grief episode. To represent grief as potentially diseased or disorderly is to focus exclusively on its felt qualities in the moment to the exclusion of the part it plays in our well-being across our lifetimes (Tekin 2011; Tekin 2015; Tekin and Mosko 2015).

Grief thus serves as an important counterexample to the time slice or "snap shot" conception of well-being that underlies most conceptions of psychiatric illness or disorder. The medicalization of grief would contribute to decontextualizing the negative affect, etc. found in grief from the wider contribution that grieving can make to well-being across our lifetimes. After all, from a medical perspective, there can be no good diseases or disorders, even taking their overall impact on our lives into account. Note that this objection does not assume that grief's medicalization would be universal, i.e., that all grief episodes would eventually be classified as disordered or diseased. Nor does it assume that medical interventions can never be valuable to bereaved individuals. It instead asserts that medicalization validates a picture of grief's significance wherein it is inherently bad for us, sometimes bad enough to be disordered or pathological. This picture thus overlooks how grief is a critical ingredient of a meaningful and well-lived human biography.

Sympathy and Solidarity with Human Need

As observed earlier, medicalizing a phenomenon can sometimes lead it to be viewed more sympathetically within the population at large. After all, individuals are not usually castigated or held responsible for a condition when that condition is perceived as an illness. Proponents of medicalizing grief may argue that medicalization will have a similar effect, leading to cultural change where grief is viewed more sympathetically and given wider berth. It could even contribute to a sense of human solidarity: A shared appreciation for the difficulties of grief could lead to a deeper interpersonal sense that, at least in grief, "we are all in this together."

Medicalization does not operate in homogenous ways on social attitudes though. In determining that grief is sometimes diseased or disorderly, we would introduce a medically legitimated division within experiences of grief and among bereaved persons. And try as we might, such a division might in fact *inhibit* sympathy or solidarity. Every human being eats, but the medicalization of eating disorders seems

to have done little to reduce stigma around such disorders (Guy et al. 2022). There is thus no assurance that grief's medicalization would not lead to a tacit division between those viewed as capable, resilient, etc., able to manage grief well, and grief patients, who lack the fortitude, etc. to withstand the throes of grief.

But even assuming that grief's medicalization would increase sympathy, it may not increase solidarity precisely because it changes the basis of our sympathy. Grief's medicalization would encourage our sympathy for grief to have a medical basis, but supplanting ordinary nonmedical sympathy with this "medical" sympathy may not be welcome in all quarters. For sympathizing with a grieving person differs phenomenologically from sympathizing with a grieving patient. The latter are more likely to be seen as feeble or helpless, and many individuals who would wish to have their grief socially acknowledged or who want assistance in managing their grief may have good reason to reject being seen in such a light. After all it matters to us not merely that others sympathize with our suffering; it also matters *why*. Many individuals will prefer not to have to play the "sick role" (Parsons 1951) in order to receive acknowledgement of, or help for, their grief. To medicalize feels (for some) like a diminishment of their agency or humanity instead of a validation of their suffering.

I concur with proponents of grief's medicalization that grief merits greater sympathy and that the needs of bereaved people should be taken more seriously. But there is no simple inference from the medicalization of grief to greater sympathy for bereaved persons or greater social solidarity surrounding grief, and whatever increases in sympathy or solidarity result from grief's medicalization may be of a kind that some experience as unwelcome, even disrespectful. We should thus be cautious about medicalizing grief, lest it displace desirable forms of sympathy or solidarity with or among the bereaved with medicalized versions of these at odds with the needs and interests of bereaved individuals.

Conclusion

If correct, the arguments of sections "Debating Medicalization: Grief as Disorderly," "Normativizing Grief," and "Grief's Benefits and Human Flourishing" strengthen the philosophical case against grief's medicalization. All of these arguments draw upon the observation that medicalization would not simply superimpose a regime of medical diagnosis and treatment upon some grief episodes. Disease classifications, as Ian Hacking (1995) observed, generate new "human kinds," classifications that have "looping effects" wherein we change our attitudes and behaviors in response to our being placed in these new pathological human kinds. Grief, I have argued, would be especially susceptible to these changes, and these changes would not be benign. Medicalization would likely catalyze a society-wide transformation in our attitudes toward grief, altering how we categorize, experience, or value grief in ways that threaten our ability to relate to grief authentically, to benefit from grief, and to relate to one another's grieving. Whether these considerations are compelling enough to overcome the likely clinical benefits of medicalizing grief is a question I leave to readers' judgment.

Definitions of Key Terms

Grief: the totality of individuals' responses, emotional and otherwise, to meaningful losses (when the loss in question is the death of another person, this is often called *bereavement*).

Kubler-Ross model: a popular five-stage model of bereavement according to which it conforms to a pattern of denial/anger/bargaining/depression/acceptance, developed by the Swiss psychiatrist Elisabeth Kubler-Ross

Looping effects: changes in individuals' attitudes or behaviors regarding themselves as a result of being placed in a "human kind" (for example, how someone perceives themselves differently after a personal difficulty is traced to a disease instead of a personal failing)

Medicalization: the phenomenon wherein a trait or behavior previously viewed as "ordinary" comes to be perceived as an illness and subjected to medical treatment or intervention

Z-code (or V-code): a fact or feature of an individual patient that, while not in itself an illness or disorder, is clinically significant and should therefore be taken into account in treating that patient (for example, a history of trauma is not itself an illness or disorder but is relevant to determining the best courses of treatment for many other mental disorders)

Summary Points

- Disputes about whether a condition is appropriately medicalized are best addressed on a case-by-case basis.
- In the case of grief's medicalization, moves to eliminate "bereavement exclusions" from psychiatric diagnostic manuals and to introduce a grief-specific mental disorder have elicited many criticisms from skeptics about the medicalization of grief.
- But these criticisms, that
  - they overemphasize the duration of grief
  - grief does not represent a physiological dysfunction
  - medicalization reflects the socioeconomic agenda of the pharmaceutical industry

can largely be answered, so a compelling philosophical case against grief's medicalization has heretofore not been made.

- A stronger philosophical case against grief's medicalization is more likely to rest on how it would alter the moral and political meanings of grief, more specifically
  - by "normativizing" a medical vocabulary for evaluating grief that may impede authentic engagement with grief
  - by validating a suspect "time slice" model of human well-being that overlooks how grief can benefit a person's life as a whole
  - by impeding desirable sympathy or solidarity with grieving persons.

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