The Medicalization of Grief

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Abstract

Determining where normal human emotion ends and mental disorder begins remains one of psychiatry's most contested challenges. Grief, a universal yet deeply individualized response to loss, sits at the center of this debate. As medicalization increasingly frames everyday suffering as pathology, the boundaries of mental illness have expanded, running the risk of transforming ordinary emotional experiences into diagnosable conditions. While this process can legitimize distress and improve access to care, it also risks reducing complex, socially embedded experiences to clinical symptoms. The shifting classification of grief within the Diagnostic and Statistical Manual of Mental Disorders illustrates this tension. The removal of the bereavement exclusion in DSM-5 and the subsequent introduction of Prolonged Grief Disorder in DSM-5-TR reflect evolving and socially negotiated diagnostic criteria. These changes blur distinctions between natural mourning and more severe mental disorders, raising concerns about overdiagnosis and the imposition of rigid temporal and functional standards on an experience shaped by culture, relationship, and meaning. Grief varies widely in expression, duration, and intensity across individuals and societies. Pathologizing it risks reinforcing Western ideals of productivity, emotional restraint, and rapid recovery while neglecting communal, moral, and existential dimensions of loss. Although some individuals experience debilitating grief that warrants clinical intervention, most mourning is not a disorder to be cured but a meaningful process to be lived. A cautious, context-sensitive, and culturally attuned approach is essential to preserve the integrity of grief while still supporting

Where to draw the line between normal human emotion and mental disorder remains one of the most contested debates in psychiatry and modern culture, especially when some individuals' emotions are situated as excessive while others' emotions are not. Historically, Western society has struggled to define when clinical intervention becomes necessary, often blurring the distinction between natural human suffering and pathological disorder. Medicalization, the "process by which a mental or physical condition comes to be seen as a medical condition deserving medical attention," has increasingly expanded the boundaries of what counts as illness (Gosselin, 2019; Conrad, 2013).While this process can help some individuals access needed care for severe, persistent symptoms of mental dysfunction, it can also transform ordinary human experiences into pathologies. Grief exemplifies this tension: as a universal, existential, and socially mediated experience, it resists clear diagnostic categorization. Conceptualizing grief primarily as a pathology risks overdiagnosis, unnecessary treatment, and the imposition of unrealistic expectations for how individuals should process loss. Therefore, a more cautious, context-driven, and individualized understanding of grief, one that preserves the authenticity of human emotion while still supporting those whose suffering becomes debilitating, is essential.

Medicalization, though conceptually neutral, has become a pervasive lens through which psychiatry interprets emotional distress, as it is the practice of interpreting "everyday emotional suffering and behavior as a medical condition that can be treated with a particular drug" (Aho, 2008). As Gosselin (2019) notes, medicalization can provide legitimacy and resources to those in need, enabling access to treatment, insurance coverage, and social support. Yet it also has the potential to obscure the social, relational, and environmental factors that contribute to mental distress. Therefore, medicalization is also multi-dimensional; it acts on a continuum, as some disorders, illnesses, or conditions are more medicalized than others (Conrad, 2013). This further intensifies the difficulties in medicalizing mental difficulties, as it is challenging to determine which symptoms deserve treatment, and if treatment is necessary, to what degree. In addition, medicalization is not without bias, as it is a social process (Conrad, 2013). Physicians, pharmaceutical companies, consumer advocacy groups, and insurers all have vested interests in expanding diagnostic categories, often for profit rather than care (Conrad, 2013). Thus, medicalization reflects not only medical progress but also sociopolitical priorities, many of which privilege efficiency and pharmacological solutions over understanding human suffering in its broader context.

Before the codification of mental illness through the Diagnostic and Statistical Manual of Mental Disorders (DSM), Western conceptions of

mental health were inconsistent and largely moralistic. With the DSM's first publication in 1952, psychiatry gained a formalized diagnostic framework that became, as Conrad (2013) writes, the "official 'bible' for designating mental disorders in the United States." However, even these formalized categories are socially constructed rather than purely objective. Mental illnesses are not fixed biological entities but negotiated interpretations shaped by cultural and political values (Conrad, 2013). Granek (2011) similarly argues that psychiatry's reliance on the DSM has led to the pathologizing of reactions that were once considered normal, such as sadness or grief. Moreover, the DSM's continual revisions reflect the instability of diagnostic boundaries, as definitions change as societal norms and professional ideologies evolve. Nowhere is this more evident than in the shifting classification of grief.

Prior to the DSM-5, major depressive disorder (MDD) included a "bereavement exclusion," which prevented clinicians from diagnosing depression within the first months following the death of a loved one. This exclusion recognized grief as a normal, if painful, human experience rather than a psychiatric disorder. However, when DSM-5 was published, the bereavement exclusion was excluded (Kofod, 2015). \ Criticisms of this change rose quickly, as researchers subsequently warned that one-third to one-half of bereaved individuals might meet criteria for MDD within the first month of loss due to the natural intensity of grief symptoms (Kofod, 2015). This change blurred the line between normal grief and clinical depression, opening the door to overdiagnosis and overmedicalization (Brinkmann, 2017). Later, DSM-5-TR, an edit to DSM-5, introduced Prolonged Grief Disorder to distinguish between ordinary and pathological mourning. Prolonged grief disorder is described as "intense and persistent grief symptoms which are not only distressing in themselves but also associated with problems in functioning." Prolonged Grief Disorder requires that symptoms persist for at least one year in adults and cause significant impairment in functioning, however functioning itself is inherently difficult to classify (APA, 2025). While this temporal criterion acknowledges grief's natural duration, it still risks imposing rigid timeframes and normative expectations on an experience that varies widely across individuals and cultures.

An experience as nuanced and individual as grief is extremely difficult to pathologize, as it manifests differently in terms of symptoms, duration, and severity. Kofod (2015) describes grief as a "border diagnosis," a condition located at the margins of psychiatry, constantly negotiated between medical and nonmedical understandings. Pathologizing grief ignores its complexity and diversity, reducing an existential experience to a checklist of symptoms. While some individuals do develop severe or prolonged distress that warrants intervention, a universal diagnostic model cannot capture the moral, spiritual, and communal dimensions of mourning. In medicalizing grief, psychiatry risks oversimplifying a deeply human process that defies linear recovery or uniform expression.

Western psychiatry's tendency to treat grief as a disorder reflects broader cultural assumptions about normality, productivity, and emotional control. As Aho (2008) argues, experiences like grief must be understood as embedded within "the sociohistorical situation in which we grow." Symptoms of distress are not always indicators of illness; they may instead express culturally learned ways of processing loss. For example, in many non-Western cultures, extended mourning periods, public displays of sorrow, or continued relationships with the deceased are understood as natural and even necessary components of healing, rather than symptoms of pathology. Grief exists "in a gray area between an objective state of loss and social 'feeling rules' that dictate how emotion should be expressed" (Brinkmann, 2017). Western societies, in particular, often privilege quick recovery and emotional restraint, treating prolonged sadness as dysfunction rather than depth. Medicalizing grief under these assumptions risks imposing Western ideals of efficiency and self-control onto global and diverse mourning practices, erasing cultural variation and moral meaning.

While medicalization can sometimes facilitate healing by legitimizing suffering and connecting individuals to resources, its expansion into the realm of grief represents a troubling overreach. Pathologizing experiences like grief risks "trying to medicalize not only psychiatry but the human condition itself"

(Chodoff, 2002). This blurs the lines between disorder and life experience, as grief is simply part of being human. Grief, though painful, is neither abnormal nor pathological. By labeling it as such, psychiatry discourages emotional vulnerability and casts natural sorrow as something to be cured. This pathologization not only undermines personal meaning-making but also diminishes the moral and relational dimensions of love and loss (Kofod, 2015; Cacciatore, 2022). When grief becomes a diagnosis rather than a dialogue, in which individuals are given the time and space to grieve in the way that feels best for them, the focus shifts from understanding to correction. This effectively undermines the relationships that cause the painful experience of grief in the first place.

The impacts of this pathologization are profound. By imposing normative expectations about how individuals should grieve, medicalization implicitly suggests that recovery must be quick, linear, and measurable (Granek, 2011). Those unable to meet these expectations may feel shame or inadequacy, internalizing a sense of failure for not "healing correctly." This can drive individuals toward medical treatment, such as antidepressants, anti-anxiety medications, or sleep aids, that may not address the relational and existential dimensions of their suffering. As Granek (2011) notes, grief often requires time, presence, and community rather than pharmacological suppression. When natural sorrow is miscast as dysfunction, the process of mourning is reduced to a clinical problem rather than recognized as a vital aspect of human experience.

Additionally, the lines between normal grief and grief that requires medicalization, diagnosis, and treatment are quite blurred. In fact, evidence suggests that boundaries between healthy and pathological grief are culturally constructed. Granek (2011) argues that the growing tendency in Western psychology and psychiatry to pathologize grief reflects an individualistic, efficiencydriven cultural paradigm, which privileges rapid recovery and emotional control over communal or ritualized expressions of mourning. Aho (2008) supports this critique philosophically, noting that experiences such as grief must be understood as embedded in sociohistorical and relational contexts rather than reducible to neurochemical dysfunction. Together, these perspectives show that efforts to medicalize grief often reflect Western cultural values, particularly individualism, productivity, and emotional restraint, rather than universal features of human psychology. Recognizing the cultural and historical variability of grief underscores the need for caution when defining it as a medical disorder and reinforces the argument that grief should remain understood as a socially and existentially meaningful experience, not merely a pathology.

Ultimately, the challenge lies in supporting those whose grief becomes disabling without pathologizing ordinary human sorrow. For some, grief may overlap with depressive or anxiety disorders, and compassionate clinical intervention can be lifesaving. Yet for most, grief is not a symptom to be treated but a process to be lived through. Clinicians should therefore adopt a cautious, individualized approach that recognizes grief as both a psychological and moral experience. As Brinkmann (2017) writes, grief itself "is not a pathology, but rather an existential condition that may lead to mental disorder." A humane approach must honor this distinction by acknowledging grief as potentially painful and destabilizing, yet simultaneously profoundly meaningful and necessary.

Recognizing the variability and cultural embeddedness of grief calls for a broader social response. Societal investment should not be limited to pharmaceutical or psychotherapeutic interventions but extended to community-based supports, public rituals of mourning, and compassionate acknowledgment of loss. Research should explore how social connection, ritual, and collective care influence healing compared to strictly medical interventions. Arguably, this is further complicated at this point in human history, as the community environment and social framework becomes increasingly fragmented and unstable. However, reintegrating grief into the social fabric affirms its role as a shared moral and existential experience rather than a pathology to be cured.

Grief, though undesirable and often agonizing, is a central feature of human life, as it is an expression of love, attachment, and the meaning we ascribe to others. To medicalize it indiscriminately is to deny part of what makes us human. The task for psychiatry,

then, is not to eliminate grief but to understand it, by distinguishing suffering that requires intervention from the suffering that simply requires witness. In striking this balance, society can preserve the integrity of grief as both a deeply personal and profoundly communal experience.

References

Aho, K. Medicalizing Mental Health: A Phenomenological Alternative. J Med Humanit 29, 243– 259 (2008). https://doi-org.proxy.library.vanderbilt.edu/10.1007/s10912-008-9065-1

Brinkmann, S. (2017). Could grief be a mental disorder? Nordic Psychology, 70(2), 146–159. https://doi.org/10.1080/19012276.2017.1381038

Cacciatore, J., & Frances, A. (2022). DSM-5-TR turns normal grief into a mental disorder. The Lancet Psychiatry, 9(7). https://doi.org/10.1016/s2215-0366(22)00150-x

Chodoff, P. (2002). The medicalization of the human condition. Psychiatric Services, 53(5), 627– 628. https://doi.org/10.1176/appi.ps.53.5.627

Conrad, P., Slodden, C. (2013). The Medicalization of Mental Disorder. In: Aneshensel, C.S., Phelan, J.C., Bierman, A. (eds) Handbook of the Sociology of Mental Health. Handbooks of Sociology and Social Research. Springer, Dordrecht. https://doi.org/10.1007/978-94-007-4276-5_4

Gosselin, Abigail. 2019. "'Clinician Knows Best'? Injustices in the Medicalization of Mental Illness." Feminist Philosophy Quarterly5(2). Article 2.

Granek, L. (2017). Is grief a disease? The medicalization of grief by the psy-disciplines in the twenty-first century. In N. Thompson & G. R. Cox (Eds.), Handbook of the sociology of death, grief, and bereavement: A guide to theory and practice (pp. 264–277).

Routledge/Taylor & Francis Group. Kofod, E. H., M.Sc. (2015). Grief as a Border Diagnosis. Ethical Human Psychology and Psychiatry, 17(2), 109-124. http://proxy.library.vanderbilt.edu/login?url=https://www.proquest.com/scholarlyjournals/grief-as-border-diagnosis/docview/1727434556/se-2

Prolonged grief disorder. Psychiatry.org - Prolonged Grief Disorder. (2025, August). ttps://www.psychiatry.org/patients-families/prolonged-grief-disorder

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