

Do Clinical Psychologists Extend the Bereavement Exclusion for Major Depression to Other Stressful Life Events?

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Background. In assessing potential cases of major depressive disorder (MDD), to what extent do clinicians interpret symptoms within the explanatory context of major life stressors? Past research suggests that when clinicians know a plausible life event cause for a person's disordered symptoms, they generally judge that person to be less abnormal than if the cause was unknown. However, the current, fourth edition of the Diagnostic and Statistical Manual of Mental Disorders specifies that only bereavement-related life events exclude a client from a diagnosis of MDD, and the upcoming fifth edition of the manual (DSM-V) is currently slated to eliminate this bereavement clause altogether. **Objective.** To systematically examine whether clinicians' judgments reflect agreement with either of these formal DSM specifications. **Method.** In a controlled experiment, 72 practicing, licensed clinical psychologists made judgments about realistic MDD vignettes that

included a bereavement event, stressful non-bereavement event, neutral event, or no event. **Results.** Bonferroni-corrected paired comparisons revealed that both bereavement and non-bereavement life events led MDD symptoms to be rated as significantly less indicative of a depression diagnosis, less abnormal, less rare, and less culturally unacceptable (all $P \leq 0.001$) relative to control conditions. **Limitations.** Clinicians made judgments of realistic, controlled vignettes rather than patients. **Conclusions.** The results suggest that practicing clinical psychologists assess symptoms within the explanatory context of bereavement and non-bereavement life stressors, indicating a departure from the DSM's recommendations, both current and proposed. Implications for diagnostic decision making and the clinical utility of the DSM's recommendations are discussed. **Key words:** clinical reasoning, judgment, diagnosis, depression. (*Med Decis Making* 2012;32:820-830)

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INTRODUCTION

Suppose that a person has been showing depressive symptoms following a catastrophic financial loss. Is this person any more or less disordered than another person showing identical symptoms with no significant precipitating life event? The diagnostic criteria for major depressive disorder (MDD) in the current *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revision; *DSM-IV-TR*)¹ and the in-progress proposal for the upcoming fifth edition of the manual² do not distinguish between these cases. In other words, the formal recommendation of the American Psychiatric Association is to treat both cases identically in diagnosis, without considering differences in explanatory life event context. This deliberate removal of explanatory context, primarily intended to increase diagnostic reliability between clinicians (including those of differing theoretical orientations¹), is characteristic of

the diagnostic criteria for the majority of disorders listed in the manual.³

Yet consider the introduction sections of the very same *DSM-IV-TR*¹ and proposed *DSM-5*,² in which the intended guiding philosophy of the manual is described.⁴ These explicitly state that significant life events that help explain behaviors *should* be taken into consideration when identifying behaviors corresponding to a mental disorder. Thus, the manual recognizes at a broader, more abstract level that distressed behaviors can be relatively normal when elicited by stressful circumstances.⁵ This apparent internal ambivalence between intended guiding philosophy and actual diagnostic criteria in the *DSM* is illustrative of a longstanding debate regarding the proper role of explanatory life events in assessment.

One major issue illustrative of this broader struggle concerns the status of the so-called *bereavement exclusion criterion*^{6,7} in the diagnosis of MDD. In the *DSM-IV-TR*, people otherwise meeting criteria for MDD may be excluded from diagnosis “if the symptoms begin within 2 months of the loss of a loved one and do not persist beyond these 2 months.”^{1(p352)} The bereavement exclusion in the *DSM-IV-TR*¹ is to be applied, assuming that the person’s condition does not meet criteria for complicated bereavement (e.g., “marked functional impairment or . . . morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.”^{1(p352)}). However, recent research has overwhelmingly demonstrated that the manifestation of MDD does not differ across life stressors (e.g., bereavement, divorce, job loss^{6,8–13}). Thus, it is widely acknowledged that changes to the bereavement exclusion criterion should ultimately be made. Several theoretical camps have drawn radically different conclusions regarding exactly *how* the bereavement exclusion criterion should be modified in the upcoming *DSM-5*.² These theoretical camps share the general goal of establishing consistent guidelines for consideration of explanatory life event context.

Proposals Regarding the Bereavement Exclusion Criterion in *DSM-5*

The first camp proposes that the bereavement exclusion criterion should be removed completely from the manual, so that MDD is diagnosed more purely with respect to the presence of current symptoms, marked distress, and impairment.^{9,10,14–16} The justifications in the literature for this change are complex and encompass a range of views, but one key

justification is that once the threshold for disordered symptoms, as defined by the *DSM*, is met, it indicates that a breakdown in functioning has occurred. From this perspective, there is no need to assess the behaviors with reference to life event context because the behaviors in and of themselves reflect dysfunction and suffering and thereby warrant clinical attention. In February 2010, the *DSM-5* task force² announced a working proposal to completely remove the bereavement exclusion criterion from the upcoming *DSM-5*. This plan is unchanged as of this writing.²

A second camp proposes that the bereavement exclusion clause should instead be expanded to include all major life stressors. In this proposal, no cases triggered by a life event would be diagnosed with MDD, assuming that they are not complicated cases or of extended duration. Overall, the general argument is that if a person experiences a major life stressor, then MDD symptoms may often be a normal response to that stressor and ought not to be artificially pathologized by clinicians.^{3,6} Historically, this etiologically-minded position was the norm within the field of psychiatry up until the advent of the *DSM-III*.^{17,18} Indeed, as noted by Granek,¹⁹ even prior to Freud, melancholia was described within the context of life events and was distinguished from similar behaviors occurring in the absence of any identifiable cause.

A third camp advocates maintaining the bereavement exclusion criterion in the *DSM-5*² as it currently stands.¹ Grief reactions to the death of a loved one may be widely considered universal, in that they are observed across many cultures.^{20,21} In contrast, it has been argued that depression-like behaviors in the wake of other life causes are less agreed-upon stressors.²² Some researchers, who would prefer to see the exclusion criterion expanded eventually, believe that it should *at minimum* be retained.^{6,18,23} Some research suggests that interrupting the normal grieving process with clinical interventions can have negative effects.³ Furthermore, Clayton’s classic research^{24–26} showed that a very high proportion of people in bereavement experience significant depressive symptoms in the first year following the death, suggesting that the conjunction of bereavement and MDD is statistically very common. One conclusion that might be drawn from such findings is that retaining the 2-month bereavement exclusion is a bare-minimum necessity. One practical justification for incorporating a short-term bereavement exclusion, as opposed to the first full year following the death, is the motivation to help ameliorate psychological distress and suffering in a reasonably

timely manner, rather than leave it untreated for so many months.^{27,28} Furthermore, very recent work suggested that clients experiencing brief (less than 2 months in duration), single episodes of depression were much less likely to experience follow-up episodes of depression if the initial episode was triggered by bereavement than by any non-bereavement cause.²⁹ In addition, antidepressant medications reduce MDD symptoms more than they do traumatic grief (e.g., preoccupation with the deceased; yearning).³⁰ Specifically, the latter are ameliorated more effectively by specialized psychotherapy treatments addressing the grief directly.³⁰

Clinicians' Beliefs and Judgments about the Bereavement Exclusion

The theoretical debate over the bereavement exclusion criterion thus far has been centered on identifying the most optimal and accurate way of making judgments about MDD as it exists in the world.^{22,31} However, it is also important to examine the beliefs and judgments of practicing clinicians in assessing cases of MDD. Official diagnostic criteria in nosologies of disordered behaviors, such as the *DSM-IV-TR*¹ and the proposed *DSM-5*,² are important, but it is clinicians' own judgments and beliefs that ultimately affect the degree to which they choose to apply those nosologies.

Whooley³² recently described the practical consequences of what he called a *sociological ambivalence* held by clinicians toward the *DSM-IV-TR*.¹ He found that even clinicians who intend to adhere to the *DSM-IV-TR*¹ routinely implement informal "work-arounds" to provide room for their own clinical judgment, altering its influence in practice. (The most common, according to Whooley³²: intentionally diagnosing a client with a more severe disorder than is actually present to ensure that the client's insurance company will cover the treatment, and diagnosing a client with a milder disorder than is actually present to help the client avoid stigma.) Such a finding is all the more striking given that deliberately upgrading a diagnosis to obtain insurance payouts for a client is a criminally prosecutable act.³³ In other words, clinicians' motivation to use their own clinical judgment is very strong, making it all the more important to examine how well clinicians' own beliefs compare with formal *DSM* recommendations for the diagnosis of MDD. As Shear and others³⁴ noted, the *DSM-5*² task force explicitly adopted several major principles in developing changes to the manual, such that "the highest priority is 'clinical

utility'—that is, making the manual useful to clinicians diagnosing and treating people with mental disorders." Therefore, our major goal was to take a first look at whether clinicians' assessments of MDD cases reflect a general agreement with the proposal to expand the bereavement exclusion criterion, with the proposal to completely remove the bereavement exclusion criterion, or with leaving the bereavement exclusion criterion as it currently exists and has existed in the *DSM* system for a number of years. We conducted a controlled vignette-based experiment, presenting practicing clinical psychologists with realistic case study vignettes of depression that included a bereavement life event, a stressful non-bereavement life event, a neutral life event, or no life event.

One hypothesis, the *context-independence hypothesis*, is that in making assessments, clinicians are primarily concerned with the current symptoms and apparent distress exhibited by a client. That is, they prefer to designate such cases as MDD cases without reference to a life event context.¹⁵ If true, then clinicians' judgments would be in concert with the proposal to remove the bereavement exclusion criterion in the upcoming *DSM-5*.² If clinicians prefer to assess the psychopathology of symptoms and distress without reference to context, then we should not observe a strong influence of bereavement life events or of stressful, non-bereavement life events on diagnoses or related clinical judgments, as compared with control events.

Alternatively, a second hypothesis, the *context-dependence hypothesis*, is that clinical psychologists are less willing to diagnose cases with MDD (and show similar tendencies in making related clinical judgments) when presented in the context of any stressful, highly negative, explanatory life event, bereavement related or not, compared with cases in which such an event is not provided. Wakefield and colleagues³⁵ first showed that clinical trainees distinguished between conduct disorder cases in which symptoms were caused by internal dysfunction v. those in which symptoms were elicited by a negative environment (e.g., implying a normal response to an abnormal event). Psychiatrists and other practicing clinicians were similarly affected by context in assessing conduct disorder.^{36,37} Subsequent studies using hypothetical case vignettes with artificial disorders showed that having a plausible explanation for symptoms can make that person seem less psychologically abnormal (see Ahn and others,³⁸ following Meehl³⁹) and less in need of treatment.⁴⁰ The former finding has been empirically

demonstrated both in undergraduates and in expert and novice clinical psychologists.³⁸ However, a systematic and controlled investigation of the influences of bereavement v. stressful non-bereavement events on MDD assessment was not previously conducted.

A third and final hypothesis, which we will call the *bereavement-only hypothesis*, is that clinicians believe that bereavement is indeed a special kind of life stressor that explains MDD better than other life stressors. Such a belief could be driven by clinicians' opinions about the nature, severity, or universality of bereavement events; their years of experience applying the *DSM-IV-TR*'s bereavement exclusion criterion¹ in practice; or some combination of the above. If true, then clinicians will only perceive cases as less indicative of a MDD diagnosis when the symptoms were precipitated by bereavement life events but not when precipitated by stressful, non-bereavement life events. That is, their diagnostic judgments will adhere to the *DSM-IV-TR*.¹ Similarly, under this hypothesis, related clinical judgments would also show the same pattern of results (i.e., would only be influenced by bereavement events).

Study Overview

To our knowledge, the influence of life event explanatory context on a straightforward diagnostic judgment has never previously been tested with potential cases of depression. Again, previous work has examined the role of explanatory context in diagnosing other mental disorders (e.g., conduct disorder^{35-37,41}; posttraumatic stress disorder [PTSD]⁴²) and in assessing the overall abnormality of disorders^{38,43} and clients' need for treatment.⁴⁰ More broadly, nonexplanatory contexts such as stigma, insurability, and the attitudes of the patient's family members toward available treatments have also been shown to influence a wide range of judgments, including disease diagnoses (e.g., otitis media⁴⁴⁻⁴⁶), assessments in social work,^{47,48} and bail decisions.^{49,50} According to Baumann and colleagues,⁵¹ the kinds of diagnostic judgments we focus on in the current study are primary in the decision-making process. These other types of context also play a follow-up role in determining how to act upon diagnostic judgments once made,⁵¹ but will remain to be investigated in conjunction with explanatory context.

In the current study, we presented currently practicing, licensed clinical psychologists with realistic case vignettes and asked them to answer a diagnosis question for each case, which served as our key

dependent measure. We also asked clinicians to make 3 additional clinical judgments regarding the symptoms' abnormality, cultural unacceptability, and statistical rarity. This additional set of questions allowed us to cast a broader net for corroborating evidence. In particular, the abnormality judgment enabled us to more directly assess clinicians' own judgments about psychological abnormality, as opposed to their adherence to the definition of psychological abnormality as presented by the *DSM-IV-TR*.¹ Cultural unacceptability and statistical rarity judgments, which people commonly use as cues to psychopathology,⁵² were included to examine the scope of influence of contextual life event information.

In summary, the *DSM-IV-TR*¹ states that only a bereavement life event should downgrade the perceived appropriateness of a diagnosis of depression, whereas the proposed *DSM-5*² states that no life events should do so, and previous research suggests that any plausible, stressful life event may be judged to do so. The critical question is what clinicians themselves actually believe when considering cases of MDD. This study provides the first experimental test of this question.

METHOD

The Northeastern University Institutional Review Board formally approved all study protocols.

Participants

Seventy-three clinicians participated in response to a mailed postcard invitation to participate online. Because we described it only as "a study on expert clinicians' opinions," any self-selection of clinicians particularly interested in the status of the bereavement exclusion criterion was not possible. Postcards were sent to 350 clinical psychologists randomly selected from national and state psychology board databases and from *The Directory of Ethnic Minority Professionals in Psychology*.⁵³ Of these, 35 postcards were returned to us by the postal service because the clinician had moved, yielding a voluntary response rate of 23.2%, which is comparable to similarly conducted studies (e.g., Rottman and others⁵⁴). We pre-verified that each invited clinician had completed a PhD in clinical psychology, was currently practicing in the United States, and held a current license in good standing. Participants were offered a \$25 gift card to a major online retailer upon completion.

Table 1 Sample Vignette (“Andrew”)

Component	Text
Background	Andrew has been married to Karen for 5 years, and they have a son together named Eric. Although they did occasionally get into arguments during their first few years together, Andrew and Karen generally got along well and were a happily married couple.
Event type	<p>Cause: bereavement One day, while at work, Andrew received a call from the hospital, informing him that his wife had gone into cardiac arrest. The doctors tried their best, but she passed away in the emergency room.</p> <p>Cause: non-bereavement One day, they got into a verbal argument, during which Andrew was stunned to discover that Karen had been having an affair. A few days later, Karen filed for divorce.</p> <p>Control: filler There is a small community center, located down the street from their house. Andrew and Karen often take turns bringing Eric there to participate in a variety of activities.</p> <p>Control: no event (No additional text)</p>
Current behaviors	For the past several weeks, Andrew has been feeling really down. He has lost interest in his weekly golf matches and makes excuses to avoid attending any social activities. These days, Andrew listlessly picks at his food. As a result, he has lost quite a bit of weight. His coworkers report that he constantly fidgets with his hands, picking his fingernails, seemingly unable to hold still.

One participant did not complete a number of the key dependent measures and was excluded from analysis. The 72 remaining participants' demographics are fully described in the Results.

Materials

We created 4 case study vignettes, 2 male and 2 female, in a style similar to cases of depression in the *DSM-IV-TR Casebook*.⁵⁵ Each vignette consisted of 2 full paragraphs. Table 1 depicts a complete set of materials for a sample vignette.

The first paragraph provided background information about a person. For each vignette, we created 3 different events (2 causal, 1 control) that could be interchangeably placed in this paragraph. The first type of causal event (cause—bereavement, henceforth) involved experiencing the death of a close family member or friend. The second type of causal event (cause—non-bereavement, henceforth) involved divorce, job loss, or serious injury or illness suffered by the person or a loved one. The control event (control—filler, henceforth) consisted of neutral information that matched the causal events in length but did not explain the person's behaviors. We also created a second control, in which no event of any kind was added to the background information (control—no event, henceforth).

In each vignette, the second paragraph described the person's current behaviors and was held constant across events. We described each person as

experiencing 4 symptoms of depression from both the *DSM-IV-TR*¹ and proposed *DSM-5*.² One of those symptoms was always *depressed mood*, as it is widely considered the hallmark of depression and is one of the required symptoms for diagnosis. The time course of symptoms as stated in the paragraph always exceeded *DSM-IV-TR*¹ and proposed *DSM-5*² requirements for diagnosis (over 2 weeks) while also remaining within the allowable time frame for applying a bereavement exclusion (under 2 months).

Procedure

Participating clinicians completed the task online via Qualtrics, an Internet-based survey software package.⁵⁶ Each clinician saw all 4 vignettes. All 4 event types were also seen by all participants, 1 event type per vignette. Event type was rotated across vignettes and between participants, such that each of the 4 vignettes was presented equally frequently with each of the 4 event types overall. Furthermore, each event type and vignette were presented equally frequently in the first, second, third, and fourth positions (regarding presentation order) across participants.

For each vignette, participants made 4 judgments: 1) a diagnosis judgment (“should [Andrew] be diagnosed with depression?” on a scale of 1–9, where 1 = *definitely no* and 9 = *definitely yes*), 2) an abnormality judgment (“how normal or abnormal are [Andrew]’s current behaviors?” on a scale of 1–9,

where 1 = *very normal* and 9 = *very abnormal*), 3) a cultural unacceptability judgment (“how acceptable or unacceptable are [Andrew]’s current behaviors in US culture?” on a scale of 1–9, where 1 = *completely acceptable* and 9 = *completely unacceptable*), and 4) a statistical rarity judgment (“how common or rare are [Andrew]’s current behaviors in the US population?” on a scale of 1–9, where 1 = *very common* and 9 = *very rare*). We chose to use Likert scales rather than all-or-nothing response choices, given that researchers across camps,^{6,7} as well as the *DSM-5*² draft itself, suggest that subsyndromal depression and minor depression may lie along a single continuum between major depression and normality.

The study was presented in 3 sections. Vignettes were presented sequentially, and each vignette was presented on a new page within each section. In the first section, half of the participants were asked to make the diagnosis judgment below each vignette, whereas the other half made the abnormality judgment. In the second section, the vignettes were presented again, this time with the question (abnormality or diagnosis) that was not presented in the first section for that participant. In the third section, the vignettes were presented again, and participants were asked to make both the cultural unacceptability judgment and statistical rarity judgment below each vignette (order counterbalanced between participants). People could edit their responses only before they advanced to the next vignette; this was clearly stated in the instructions. Finally, clinicians were asked about their clinical background and experience (see above).

RESULTS

Study Sample Characteristics

As described above, all 72 participating clinical psychologists had completed clinical psychology PhD degrees and held licenses in good standing, and all were currently in practice. They had a mean (SD) of 24 (12) years of experience and spent a mean (SD) of 22 (11) hours seeing patients weekly. Thirty-seven identified their primary theoretical orientation as cognitive, behavioral, or cognitive-behavioral; 13 psychoanalytic or psychodynamic; 16 eclectic; and 6 “other.” Thirty-eight were women (1 declined to report gender). Six were Hispanic or Latino/a (5 declined to report ethnicity). Sixty-two were white, 3 Asian, 2 African American, 1 Native

American, 1 both Native American and white, and 2 both Asian and white (1 declined to report race). The mean (SD) age of their patients was 34 (15) years, with a mean (SD) of 84% (26%) of patients having an Axis I diagnosis and 26% (26%) having an Axis II diagnosis. Individual disorder diagnoses on Axis I (clinical disorders) and Axis II (personality disorders) need not be mutually exclusive and comprise the full set of possible *DSM* mental disorder diagnoses.

Overview of Main Analyses

We conducted the analyses at the $\alpha = .05$ level, except where otherwise specified, and collapsed the data across vignettes. All paired comparisons were 2-tailed and Bonferroni corrected. There were no effects or interactions involving task order, so factor is not discussed further. Mean ratings by condition, broken down by vignette, mimic the direction of the overall results in all cases except the following: In 1 of the 4 vignettes, the direction of means is reversed (nonsignificantly) between the filler control event and the non-bereavement event for the diagnosis, statistical, and cultural ratings; in a second vignette, the same (nonsignificant) reversal is obtained in the cultural ratings only. However, please note again that the design is fully counterbalanced to avoid confounding due to content.

Diagnosis Judgments

A repeated-measures analysis of variance (ANOVA; condition: cause—bereavement, cause—non-bereavement, control—filler, and control—no event) revealed a main effect of condition, $F(3, 213) = 24.61$, $MSE = 3.91$, $P < 0.001$, $\eta^2 = .26$ (Table 2). A set of 6 Bonferroni-corrected paired-sample t tests ($\alpha = .01$) was conducted to test whether the presence of life events influenced diagnosis judgments and to determine whether clinicians’ ratings differed between the 2 cause conditions (bereavement or non-bereavement) or between the 2 control conditions (filler or no event). In all 4 pairwise comparisons between cause conditions and control conditions, clinical psychologists reliably advocated a diagnosis of depression more strongly in the control conditions than in the cause conditions (all $t(71) \geq 3.72$; all $P < 0.001$; all $\eta^2 \geq .16$), in support of the context-dependence hypothesis.

Judgments also differed between the 2 cause conditions ($t(71) = 2.68$; $P < 0.01$; $\eta^2 = .09$), perhaps

Table 2 Results: Mean Ratings

Judgment	Event Type			
	Cause—Bereavement	Cause—Non-bereavement	Control—Filler	Control—No Event
Diagnosis	3.85 (2.68)	4.64 (2.76)	5.88 (2.36)	6.39 (2.17)
Abnormality	3.17 (1.93)	3.79 (2.15)	6.49 (1.43)	6.56 (1.50)
Cultural unacceptability	3.44 (2.16)	4.04 (2.17)	5.36 (2.00)	5.36 (1.99)
Statistical rarity	3.08 (2.01)	3.38 (1.88)	4.35 (1.79)	4.33 (1.77)

Note: All ratings were made on a 1 to 9 scale. Higher ratings indicate judgments of stronger affirmation of depression diagnoses, greater abnormality of the behaviors, greater unacceptability of the behaviors in US culture, and greater statistical rarity of the behaviors, respectively. Standard deviations are in parentheses.

either because of practice with the *DSM-IV-TR*¹ or because our clinical psychologists truly found bereavement to be a more compelling explanation for depression than the stressful non-bereavement events in our study. However, clinicians made lower diagnosis ratings in *both* cause conditions relative to both control conditions. That is, the bereavement-only hypothesis would only have been supported if ratings in the non-bereavement condition did not differ from those made in the control conditions, which was not the case. Clinicians' judgments did not differ between the 2 control conditions ($t(71) = 2.32$; $P = 0.02$; $\eta^2 = .07$).

Abnormality Judgments

Identical analyses were conducted for the abnormality judgments. There was a main effect of condition, $F(3, 213) = 121.52$, $MSE = 1.88$, $P < 0.001$, $\eta^2 = .63$ (Table 2). Pairwise comparisons indicated that clinicians judged behaviors to be less abnormal in the cause than in the control conditions (all $t(71) \geq 10.37$; all $P < 0.001$; all $\eta^2 \geq .60$). Furthermore, bereavement events made depression symptoms seem even less abnormal than did non-bereavement events ($t(71) = 3.02$; $P < 0.01$; $\eta^2 = .11$). Ratings in the 2 control conditions did not differ from one another ($t(71) = 0.46$; $P = 0.65$; $\eta^2 < .01$). In sum, patterns of responses for abnormality judgments paralleled those for diagnostic judgments.

Cultural Unacceptability Judgments

For cultural unacceptability judgments, there was again a main effect of condition, $F(3, 213) = 30.13$, $MSE = 2.23$, $P < 0.001$, $\eta^2 = .30$ (Table 2). Clinicians judged behaviors to be less acceptable in US culture in the control than in the cause conditions (all $t(71) \geq 4.87$; all $P < 0.001$; all $\eta^2 \geq .25$). In addition, bereavement events rendered depression symptoms

more culturally acceptable than did non-bereavement events ($t(71) = 2.95$; $P < 0.01$; $\eta^2 = .11$). Clinicians' ratings did not differ between the 2 control conditions ($P = 1.00$). These findings, as well as the statistical rarity results below, should be interpreted with some caution because these judgments were always measured after the diagnosis and abnormality judgments. However, these data do provide a preliminary indication of the broader scope of contextual effects on clinical judgment.

Statistical Rarity Judgments

There was a main effect of condition for statistical rarity judgments, $F(3, 213) = 17.25$, $MSE = 1.78$, $P < 0.001$, $\eta^2 = .20$ (Table 2). Clinicians judged behaviors to be more statistically rare in the control than in the cause conditions for all 4 paired comparisons (all $t(71) \geq 3.96$; all $P \leq 0.001$; all $\eta^2 \geq .18$). Ratings did not reliably differ between the 2 cause conditions ($t(71) = 1.36$; $P = 0.18$; $\eta^2 = .03$) or the 2 control conditions ($t(71) = .07$; $P = 0.95$; $\eta^2 < .01$).

DISCUSSION

In this controlled examination of the influence of explanatory life event context on perceptions of depression symptoms, we found that currently practicing, experienced clinical psychologists were strongly influenced by life event context in making diagnostic, abnormality, cultural unacceptability, and statistical rarity judgments. Specifically, across the board, our results supported the context-dependence hypothesis and not the context-independence hypothesis or the bereavement-only hypothesis. Knowing that a stressful life event preceded a person's depressed behaviors led clinical psychologists to downgrade the appropriateness of a depression diagnosis and to perceive the behaviors

as less abnormal, less culturally unacceptable, and less rare. In conjunction with previous work examining the influence of explanatory life event context on assessments of conduct disorder and artificial disorders,^{35–38,40,41} clinical psychologists are consistently influenced by explanatory context across disorders in assessment, even when the *DSM* is inconsistent in its treatment of explanatory context between disorders (e.g., between MDD and PTSD, in which a traumatic life event is one of the formal criteria for diagnosis⁴³). As argued in previous work,⁵⁷ although the *DSM* is often predominantly descriptive, clinical psychologists seem to push beyond the surface and incorporate causal factors into their assessments. In particular, they appear to be considering the *relationship* between life events and clients' responses to them⁴³ rather than focusing exclusively on the responses in isolation.

Perhaps of greatest practical importance is our finding that stressful non-bereavement events and bereavement events *both* reduced clinicians' endorsement of a depression diagnosis, which is inconsistent with both *DSM-IV-TR* and proposed *DSM-5* specifications.^{1,2} We submit that our participating clinical psychologists' diagnostic judgments may reflect, to some degree, a possible eschewing of the system, although whether such findings were the result of a deliberate strategy remains to be tested more directly in future work. Because the *DSM* serves as the core basis for communication among researchers (facilitating studies on common research cohorts and the efficacy of treatments) and clinicians in a number of countries, and at least in the United States is considered the authoritative basis for diagnoses by health insurance companies, there are practical and real-world consequences for failing to adhere to the *DSM*.⁵⁸

That clinical psychologists' judgments of abnormality (regardless of task order) followed the same pattern supports our interpretation of the diagnosis judgments, given that diagnostic criteria for disorders are essentially formalized specifications of abnormality. Cultural unacceptability and statistical rarity, of course, are not formal judgments in the *DSM* system. However, clinicians are routinely trained to take these factors into account in assessment, given that high acceptability and commonality of behaviors are strong indicators of the absence of abnormality (e.g., the *DSM-IV-TR*¹ instructs clinicians to interpret behaviors in terms of cultural norms). Such judgments also have practical relevance; for example, they may assist in inferring likely societal responses to the person's behaviors, which would affect the person's adjustment and quality of life. Taken together,

our findings suggest that explanatory life event context influences both direct diagnostic judgments and a range of related clinical judgments that may influence the assessment.

We also found that bereavement events made MDD symptoms seem less in need of diagnosis than did stressful non-bereavement events. Similar effects were found for the abnormality and cultural unacceptability judgments. This finding does not diminish the main findings above, but may be worth noting. It could be driven by familiarity with the *DSM-IV-TR*¹ or because clinical psychologists truly find bereavement to be a more compelling explanation for depressive symptoms than, for example, the loss of a limb. Differences in specific content besides the intended manipulation in the bereavement v. stressful non-bereavement event scenarios were possible, given our choice to use relatively realistic stimuli (i.e., we used content-laden scenarios as opposed to highly controlled artificial scenarios such as "bereavement event X"). Thus, we cannot definitively pinpoint whether any additional factors (e.g., overall perceived severity of events) contributed to the differences in clinical psychologists' judgments. This was not the main purpose of the current study, and future investigations may further illuminate the micro-factors driving this difference.

Conversely, a key advantage of our approach is that we were able to maintain a relatively high degree of experimental control in our materials. One concern might be with respect to the artificiality of any study in which such control is possible; however, we believe our results can be generalized. Although the case vignettes were not real-life case files, they were written in a style approximating that of the *DSM-IV-TR Casebook*⁵⁵ and included detail. We used a single stressful life event in each causal scenario; future work may be needed to examine perceptions of depressive behaviors that arise after a succession of events over time, as is thought to occur in some cases.⁵⁹ Although we did not directly test such scenarios, under the context-dependence hypothesis, a confluence of events could certainly provide context for explaining a current set of behaviors in the same manner as a single event. Thus, we would predict the same results.

At the end of the task, we asked all our clinical psychologist participants if they would like to volunteer any open-ended comments on any aspect of the study. In our experience, clinicians are typically candid if they feel that the materials are too artificial or that the task was not pertinent to clinical practice. None of our participants made any such complaint

in the current study. One clinical psychologist pointed out that he or she would normally also consider the results of psychometric tests. To the extent that such tests influence diagnoses across individual clinicians, we offer the caveat that, ultimately, additional factors such as this should be taken into account. However, we would argue that test results will not generally be taken as the sole indicator of a diagnosis and that clinical judgment is more likely to be the primary driving force behind diagnostic decisions; a recent meta-analysis supports this notion.⁶⁰

In future work, it will be necessary to consider exactly how clinicians would address information about explanatory life event context during a face-to-face interview. For example, clinicians may uncover other indicators of internal dysfunction while probing for additional information, which could effectively cancel out the normalizing influence of explanatory life events. Although such a finding would not negate the current findings, we would certainly expect that there exist multiple influences on any diagnostic judgment that are likely to come into play during a real face-to-face interview.

Finally, further research will be needed to determine whether and how different health care professionals (e.g., primary care physicians, psychiatrists, social workers) take into account explanatory life event context for this disorder, as MDD is frequently seen in a variety of health care settings, and demands on different professionals may systematically differ. For example, psychiatrists who often prescribe antidepressant medications may not require the same amount of insurance coverage for face-to-face time with the client as do health care professionals who conduct psychotherapy sessions. Thus, psychiatrists might be expected to pay less attention to explanatory life event context, perhaps relying more on quick rules of thumb and context-free symptom checklists.⁴² On the other hand, all health care professionals are faced with the problem of considering ramifications for the client's future ability to obtain affordable health coverage, potential stigma experienced by the client when applying for jobs, and other consequences for the client whenever an MDD diagnosis is recorded. When such factors are made salient, clinicians of all types may be driven to even more strongly consider the client's MDD symptoms within their explanatory life event context.

For clarity and to highlight the most vocal camps in the debate, we have reviewed the general positions of 3 different camps regarding the appropriate status of the bereavement exclusion criterion. Of course, additional practical proposals have been offered

that largely sidestep the issue of consideration of stressful life event context in assessment of MDD while still addressing the potential issue of overdiagnosis should the bereavement exclusion criterion be removed. For example, Chouinard and colleagues¹⁴ proposed that the exclusion should be removed, but the criteria should be revised to require at least 7 out of 9 symptoms instead of the current 5 out of 9. To increase overall diagnostic accuracy, Gopal and Bursztajn⁴² more broadly recommend a complete reformatting of the *DSM* system to integrate symptom weights, narrative descriptions, and dimensional scales with the "checklist" rule-based style of the current *DSM* (e.g., "x symptoms out of y"), although such proposals would remain to be systematically tested against the current system.

An outstanding question of interest is how clinicians would respond in practice if the bereavement exclusion criterion is removed from the *DSM-5*, as is currently slated to occur.² Our results, taken together with related past work,^{35,57} suggest that clinicians will to some degree follow their own intuitions, regardless of what exclusions exist in the *DSM*. Furthermore, we speculate that the currently planned removal of the bereavement exclusion clause will have a different impact than, for example, adding a clear statement that bereavement is now to be ignored. That is, the complete absence of any statement on what to do in cases of bereavement might leave newly trained clinicians with the perception that there is wiggle room. For example, they might proactively look for guidance to the introduction section of the *DSM*, which, again, does state more generally that precipitating life events should be considered. Future research will be needed to further uncover exactly how this difference might unfold in clinicians' actual reasoning processes. In the meantime, clearer instructions in the *DSM* itself regarding how to apply its criteria will be necessary to increase uniformity of use across clinicians.

In conclusion, we showed that clinical psychologists' diagnostic and related judgments overwhelmingly reflected agreement with the idea that the bereavement exclusion criterion should be expanded to include other stressful life events, in direct opposition to the current *DSM-5* plan.² Although, of course, the opinions of practicing clinicians do not necessarily warrant a change to the *DSM*, the fact remains that clinicians' responses to the *DSM* system have important implications for clinical epidemiology. As we have suggested, clinical judgment may play an important role in shifting the apparent prevalence of MDD, regardless of its

ultimate *DSM-5*² definition. Given our results, we predict even greater future circumvention of the *DSM-5*² than previously reported for the *DSM-IV-TR*^{1,32} in the diagnosis of MDD. If the *DSM-5* moves forward as currently planned, a proactive communication outreach effort to clinicians implemented by the American Psychological Association seems warranted. Our data raise questions about the clinical utility (if not the validity) of a context-free diagnostic system and indicate the importance of further research on how clinicians incorporate context into clinical judgments.

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