

## ***Silencing Sorrow: When Grief Becomes a Diagnosis***

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### **Introduction**

In a world where every emotion seems to require a diagnosis, grief has become medicine's most misdiagnosed form of suffering, not ignored but absorbed into clinical categories like depression that obscure its meaning. This paper applies a historical lens to evaluate how diagnoses function as both medical conditions and cultural constructs. The analysis examines how grief-related suffering, particularly chronic sorrow, is still routinely misclassified as clinical depression despite the DSM-5 TR's 2022 addition of prolonged grief disorder (PGD) as a distinct diagnosis,<sup>1</sup> and its role in society and culture. While the DSM-5-TR (2022) now recognizes prolonged grief disorder as distinct from major depressive disorder, this paper argues that a broader category of grief-related suffering—chronic sorrow—remains unaddressed by either diagnosis and continues to be mislabeled as depression in clinical practice.<sup>2</sup> Drawing on the concept of diagnostic logic, the reflex to read all suffering as a symptom, what is often identified as depression in social and clinical contexts, can be better defined as chronic sorrow, a subtype of grief. Chronic sorrow comes from losses that continue to affect a person over time and can be clinically recognized without being framed as a disorder. This paper does not argue that grief should be excluded from diagnostic frameworks, nor that it should be universally pathologized; rather, it argues that clinicians need narrative competence<sup>3</sup> to interpret grief-based suffering contextually rather than defaulting to pharmaceutical intervention.

### **Diagnostic Systems and Power**

Economic, institutional, and cultural powers shape modern psychiatry's diagnostic system, medicalizing depression while excluding grief, unless it is prolonged.<sup>4</sup> The DSM-5-TR's inclusion of prolonged grief disorder in 2022 was a significant development, classifying it under trauma- and stressor-related disorders rather than depressive disorders.<sup>5</sup> Yet PGD applies only to grief following death that persists beyond twelve months; it does not address chronic sorrow arising from ongoing, nonfinite losses such as disability or caregiving.<sup>6</sup> Insurance systems and pharmaceutical development impact diagnostic symptom checklists. Scientific clarity does not solely determine diagnosis.<sup>7</sup> The "sick role" is granted to individuals who suffer from depression through exemptions and expectations of recovery.<sup>8</sup>

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### **Chronic Sorrow Versus Clinical Depression**

Clinical depression is a mood disorder characterized by ongoing low energy, lack of interest, and difficulties in functioning.<sup>9</sup> Its symptoms are broad and may persist beyond any specific precipitating event, even when a clear cause is present. In contrast, chronic sorrow arises from ongoing loss, causing exhaustion from repeatedly coping with it.<sup>10</sup> The feelings are directly linked to the loss and typically do not improve with medication.<sup>11</sup> Chronic sorrow often arises in the context of illness, disability, or other enduring conditions that repeatedly reopen emotional wounds for patients or caregivers. Loss may take the form of identity, independence, social role, status, or imagined futures.<sup>12</sup> Mislabeling chronic sorrow as depression risks trapping patients in cycles of misunderstanding and ineffective treatment.

Scholars have linked symptoms of depression, including nervousness and exhaustion, to modern urbanization, capitalism, and alienation, with depression often described as a “disease of civilization.”<sup>13</sup> Grief, however, is frequently overlooked within this framework and treated as depression despite its capacity to build community through rituals, religion, and shared meaning. While the global expansion of depression diagnoses has helped many sufferers, it has also displaced cultural grief practices.<sup>14</sup> Unlike depression, grief and mourning often affirm love, loyalty, and meaning through social recognition rather than medication.

### **Grief and Medicalization**

Grief itself is a natural response<sup>15</sup>, and when society frames it as pathological, ethical concerns arise. Such distress can be psychological, physical, and psychosomatic,<sup>16</sup> yet the experience remains nonfinite and evolving, affecting individuals and those around them.<sup>17</sup> Although grief may resemble illness in its social effects, it does not comfortably fit within a biomedical disease model. It should be resistant to medicalization. However, bureaucratic and pharmaceutical forces influence what is formally recognized as a disease.

### **Disenfranchised Grief and Institutional Failure**

At a systems level, the failure to distinguish between chronic sorrow and clinical depression, a distinction the DSM-5-TR addresses for prolonged grief but not for ongoing nonfinite losses, reflects the problem of disenfranchised grief in medicine, where grief is acknowledged not through diagnosis, but through appropriate clinical support and referral.<sup>18</sup> When grief is overlooked or misdiagnosed, patients’ rights to appropriate support are undermined,<sup>19</sup> leading institutions to rely on medication rather than adaptive, relational forms of care.<sup>20</sup>

### **Narrative Competence and Ethical Diagnosis**

Critiques of diagnostic logic emphasize the need for greater attention to contextual meaning in clinical practice.<sup>21</sup> In this paper, I am critiquing diagnostic logic rather than arguing that sorrow should be diagnosed as a disorder by default. Through training in narrative competence, clinicians can read patient stories holistically rather than as symptom lists, incorporating cultural variation and moral reflection before assigning psychiatric diagnoses.<sup>22</sup> With this framework, clinicians can better recognize grief-based suffering without reducing it to pathology, and support patients by referring them to social supports when diagnosis is not the best fit. This approach encourages ethical awareness in the use of diagnosis and treatment.<sup>23</sup>

### **Counterargument: Access to Care**

A common counterargument is that diagnosing grief as depression facilitates access to existing medical and insurance systems. While access concerns are significant, diagnostic inaccuracy risks inappropriate treatment<sup>24</sup> and further marginalization of grief. Ethical care requires institutional reform that expands support without reducing grief to pathology.

Medicine often treats depression pharmaceutically at the individual level, while chronic sorrow reflects a systems-level condition rooted in ongoing relational and social loss. Improved screening and training can help clinicians recognize this distinction and avoid unnecessary medication, supporting patients in ways that promote autonomy, beneficence, and justice.

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