Distinguishing Grief, Complicated Grief, and Depression

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Editor's Note: Depression, grief, and complicated grief can be difficult to distinguish from one another. However, a study[1]—recently published in JAMA Psychiatry—the first randomized trial to explore the treatment of complicated grief (CG) in an elderly population—emphasizes how important it is to recognize when grieving patients are also suffering from comorbid psychopathology, so that appropriate care can be delivered. Medscape contributor Ronald W. Pies, MD, professor of psychiatry at SUNY Upstate Medical University in Syracuse, New York, recently moderated an email discussion between lead author M. Katherine Shear, MD, program director for Columbia University's Center for Complicated Grief, and Sidney Zisook, MD, distinguished professor and director, Department of Psychiatry at the University of California San Diego, La Jolla, California, on what complicated grief is, how to treat it, and how to distinguish it from grief and depression.

Depression vs Grief vs Complicated Grief

Dr Pies: I'm delighted to have my colleagues, Dr Sid Zisook and Dr Kathy Shear, join me in a discussion of grief, depression, and some of the controversies surrounding these topics.

Sid and Kathy, as we know, the concepts of grief, complicated grief, and depression are sometimes tough for clinicians to sort out. This is especially true in the context of recent bereavement: that is, following the death of a loved one or significant other. Sometimes our colleagues in primary care—and in psychiatry, too—find it hard to tell whether a patient who has just suffered the death of a loved one is experiencing grief or depression, both, or neither. Unfortunately, these terms are often used in confusing ways, both in the popular media and in some of the professional literature.

So, to get the ball rolling, can we provide some brief, basic definitions or descriptions of the terms "grief," "complicated grief," and "depression"?

Dr Zisook: "Depression" is a broadly used term for the self-limiting and generally benign everyday blues that we all experience from time to time, as well as a catch-all for a group of serious, often quite malignant mental illnesses, herein grouped under the rubric "major depression." The latter, in turn, encompasses a group of important clinical conditions: major depressive episodes (MDEs) seen in bipolar mood disorders, major depressive disorder (MDD, or "unipolar" depression); and persistent depressive disorder, which may or may not have fewer or less intense symptoms than MDD, but is marked by its persistence (at least 2 years' duration).

Each of these clinical conditions are themselves heterogeneous, comprising a spectrum of severity from relatively mild to quite severe. And they may (but not necessarily) be associated with anxious, mixed, melancholic, atypical, or psychotic features, and may be in full bloom or in partial or full remission.

To help clinicians differentiate the nonclinical type of depression—sadness or the blues—from the clinical conditions, it is important to remember that none of these clinical conditions should be diagnosed absent three key characteristics:

• Severity (at least five of the characteristic symptoms);
• Duration (most of the day, nearly every day, for at least 2 weeks); and
• Pathology (clinically significant distress or impairment).

In keeping with the acknowledgment in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), that classification of mental disorders is a work in progress, and that the current classification system is intended to serve as a "practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders," we favor also adding clinical judgment and caution to the diagnostic menu.

Thus, if a person meets criteria for one of the clinical conditions, but it is a first episode and relatively mild (eg, only five or six symptoms are met and these do not include feelings of worthlessness or suicidal ideation), brief (less than 1 or 2 months) and only minimally impairing, it may make sense to delay making a formal or definitive diagnosis while more information is gathered and a tincture of time is allowed its due.

Just as it is important not to overdiagnose the blues of everyday life as major depression, it is every bit as vital not to overlook major depression when it is there. No disorder is more painful or has a more profound effect on the way a person relates to others, feels about themselves or their worth as a human being, functions in everyday activities, or maintains hope of a better future.

Here, I think a quote from Infinite Jest, by David Foster Wallace, beautifully describes severe major depression:

It is a level of psychic pain wholly incompatible with human life as we know it. It is a sense of radical and thoroughgoing evil not just as a feature but as the essence of conscious existence. It is a sense of poisoning that pervades the self at the self's most elementary levels. It is a nausea of the cells and soul.

Sometimes major depression seems to occur out of the blue, with no warning; sometimes its onset is gradual and almost unnoticeable; and sometimes it seems to be brought on, or intensified, by stressful life events, such as the death of a loved one. When that happens, a reverberating cycle sets in: The depression increases the stress, intensifies the grief, and may even interfere with grief’s resolution, setting the stage for a condition we call "complicated grief."

Whether or not triggered by adversity, major depression tends to be both chronic (at least 20% of all episodes last 2 or more years) and recurrent (at least 90% of acute episodes recur). In its more severe forms, the sufferer is withdrawn and inconsolable, and ongoing life may feel untenable. In short, it is a miserable state.

President Abraham Lincoln said of being depressed:

I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on the earth. Whether I shall ever be better I cannot tell; I awfully forebode I shall not. To remain as I am is impossible; I must die or be better, it appears to me.

In such a state, it is no surprise that thoughts of death or dying are core features of major depression and that suicide is an all-too-frequent tragic outcome, especially when the depression is unrecognized or untreated.

Treatments and Terminology

Dr Pies: And yet, as bad as the illness is, we have effective treatments for major depression; wouldn't you agree, Sid?

Dr Zisook: Although treatments are imperfect—and there is ample room for better, more rapidly acting, safer, and more sustainable therapies—there is strong evidence that both antidepressant medications and depression-focused psychotherapies work. They reduce symptoms, enhance functioning, improve well-being, reduce suicide risk, and can reduce relapse and recurrence. For many individuals with major depression, combining antidepressants with psychotherapy is more effective than either alone.

There also is a role for exercise, light, good nutrition, and a host of other health-promoting behaviors, but these may become feasible only after the darkest periods begin to lift.

*For those who have dwelt in depression's dark wood...their return from the abyss is not unlike the ascent of the poet, trudging upward and upward out of hell's black depths and at last emerging into what he saw as "the shining world."

Dr Shear: Terminology is used inconsistently, so I will start by defining how we use key terms.

"Bereavement" is the situation of having experienced the death of someone close, not the response to the loss. "Grief" is the response to loss, not simply an emotion. The word "grief" is a simple shorthand for a complex, multifaceted experience that changes over time and varies from loss to loss. Grief is an automatic reaction, presumably guided by brain circuitry activated in response to a world suddenly, profoundly, and irrevocably altered by a loved one's death.

At any given time, grief symptoms are a manifestation of ongoing psychobiological processes as modified by an evolving process of adaptation. Adapting to an important loss often entails reevaluation of one's self-concept, and revising expectations and predictions of self and others, especially the deceased. Adaptation entails understanding the meaning of the finality and consequences of the loss and re-envisioning life goals and plans. As adaptation progresses, the frequency and intensity of grief symptoms attenuate.

Death is permanent, and so too is the response to the loss, though the manifestations of grief usually evolve and change over time. Grief can be considered as the form love takes when someone we lose someone we love. Like other forms of love, grief can be an avenue for personal change and growth.

Dr Pies: Kathy, what about the notion that people can and should "get over" grief?

Dr Shear: As Wortman and Silver[2] have argued, return to a prior state after a significant loss does not occur. They suggest that the idea of resolving grief is one of a number of common misconceptions not supported in survey studies of bereaved people. Another is the idea that successful adaptation means "letting go" or "saying goodbye" in order to "move on."

Another misconception is the belief that experiencing and expressing strong emotions is the key to successful adaptation and that those who do not experience and express their emotions right after someone dies will pay later, or the corollaries of this—that the more intense a person's emotions, the more effectively she or he is grieving and that once you have grieved effectively, you never have to grieve again.

Many clinicians believe that problems with grief are seen primarily in people who have an ambivalent relationship to the person who died. However, complicated grief is seen primarily in people who have enjoyed a very rewarding and loving relationship with the deceased.

Acute grief is the initial response to a painful loss that usually entails painful emotions; a sense of disbelief about the finality of the loss; preoccupation with thoughts, images, and memories of the deceased; and an inclination to social withdrawal. Longing, yearning, and sorrow are the most prominent emotions, often accompanied by a sense of disbelief even though the bereaved person knows that their loved one has died.

As time passes, the disbelief wanes; acute grief is reshaped, and its dominance subsides. As the finality and consequences of the loss are understood, grief is integrated into memory systems, emotional reactivity (both positive and negative) to reminders of the deceased is extinguished, and ways are discovered to use this relationship to foster continued psychological growth. Though grief is more than a feeling state, emotions form an important component of the response to bereavement.

**Dr Pies:** What, then, characterizes the person's emotions in grief?

**Dr Shear:** Grief is not a single emotion, but rather contains a compendium of emotions, both negative and positive. Yearning and sorrow are the emotions that define grief. In addition, almost everyone experiences some anxiety, guilt, anger, or shame in response to a significant loss.

Most grieving people are anxious about the meaning of the loss, the experience of grief, or the shape of the future without their deceased loved one. Some people are afraid that they will never stop feeling wrenching pain, anxious about whether they can ever be happy again, or whether they can ever feel comfortable with themselves without the person they lost.

Many bereaved people experience some remorse or guilt about how they treated their loved one. Many feel some survivor guilt because they get to live and enjoy life when the person they loved can no longer do this.

Anger is also common. It is easy to feel cheated, to think it is unfair that the person died, or that someone failed in caring for the person who died. Sometimes anger is directed toward the person who died.

Grief creates feelings of extreme vulnerability, and people who pride themselves on being strong and capable can feel ashamed of the weakness that accompanies grief. People who value emotional control might be ashamed of uncontainable anguish.

Sometimes people also feel guilt or shame about having positive emotions. However, grief usually contains positive feelings interspersed with the negative ones, even in the early period of bereavement. Susan Folkman and her colleagues found that bereaved people reported positive emotions.

emotions as frequently as negative ones as early as 1 month after the death of someone very close. It feels good to recall happy memories, tell funny anecdotes, feel pride in honoring the person who died, or feel warmth in recollecting closeness to a loved one.

If the person who died was ill and burdensome, it is very natural to feel relief when they die. People might feel relief after the death of a person who was difficult to live with.

In addition to evoking strong emotions, bereavement presents major cognitive and behavioral challenges. Bereaved people need to change the ways in which they think about themselves, other people, and the world at large. Behavioral changes may be needed to achieve new roles or to form new relationships.

Overall, many complex and varying emotional, cognitive, and behavioral changes are entailed in making the adaptation needed to come to terms with the loss and to re-envision the future after bereavement.

Coming to Terms With Loss

Dr Pies: Can you say what helps the grieving person adapt and come to terms with the loss?

Dr Shear: Adaptation is largely a learning process. Bereaved people need to assimilate information about the finality and consequences of the loss into long-term memory and learn new ways to envision their own lives without the deceased person.

The process of adaptation to a death has been described by Bowlby[4] as one in which we must change a mental model, and he points out that such a change is always resisted. Bowlby asserts that our minds mercifully move toward and away from acknowledging the painful reality, providing bouts of grief interspersed with periods of respite. In other words, adaptation typically progresses in fits and starts, in which we oscillate between confronting and reflecting on painful information about the loss, and then setting it aside. Stroebe and Schut[5] point out that loss brings dual coping challenges related to dealing with the loss on the one hand, and restoring a meaningful life on the other.

Different feelings associated with acute grief can guide and motivate changes that help people adjust to the death. At the same time, preoccupation with the person who died helps weave into adaptation ways to stay connected to the person who died, and to feel their presence as the bereaved begin to engage in their own lives again.

For example, if there is a chore to be done, memory of how the deceased did this chore is likely to be easily accessible. This is useful for the bereaved person, who can then consider whether this would be a good way to do it or not. If not, it will help to see why not. If there is no idea how the person actually did the chore, easily accessible memories might still make it possible to recall what advice the deceased might have provided. Many people make it a habit to “talk” to a loved one who has died, especially when they are solving a problem or making an important decision.

**Dr Pies:** What about complicated grief, Kathy? What context does that occur in?

**Dr Shear:** Sometimes, maladaptive feelings, thoughts, or behaviors can get a foothold during grief. A person might become caught up in troubling thoughts about the circumstances or consequences of the death, or about aspects of their relationship with the deceased. Sometimes, reminders of the loss are so painful that the bereaved person goes to great length to avoid these, and thoughts about the death are so intensely painful that it is difficult to reflect on it and make peace with the loss. Or there may be an external situation: hostility or severe neglect by other people, devastating financial consequences, or other highly stressful changes in a bereaved person’s situation.

Complicated grief occurs when something interferes with learning that is the core process of healing. The result is a situation in which the bereaved person seems "stuck" in acute grief, trying to deal with the complications that block acceptance and adaptation to the loss. Initially identified using a 19-item self-report questionnaire called the Inventory of Complicated Grief, complicated grief can be a disabling problem. Complicated grief is best understood as a severe form of grief, similar in many respects to the experience almost everyone has when a loved one dies.

**Bereavement Doesn't "Immunize" Against Depression**

**Dr Pies:** Thanks to you both for these excellent descriptions.

One of the most controversial decisions the DSM-5 made was to drop the so-called "bereavement exclusion" when diagnosing an MDE. Essentially, the DSM-IV had instructed clinicians not to diagnose major depression within the first 2 months after the death of a loved one, unless certain putative markers of severity were present, such as suicidal ideation, marked functional impairment, psychomotor retardation, sense of worthlessness, or psychosis.

The DSM-5, in contrast, tells us that the subset of persons who meet the full symptom/duration/severity criteria for major depression within the first few weeks after bereavement should not be excluded from the set of all persons with major

To put it more simply: The DSM-5 recognizes that bereavement does not "immunize" the grieving person from major depression, and is in fact a frequent precipitant of major depression.[6]

Despite some guidance in the DSM-5 regarding the differences between grief and major depression, many clinicians remain puzzled or uncertain as to how the two are distinguished.

Sid, this is an area you have explored deeply. Can you give the primary practice physician, and psychiatrists as well, four or five key features that you look for when distinguishing grief from major depression, in the context of recent bereavement? And, then, Kathy, can you add a bit on how complicated grief differs from major depression?

**Dr Zisook:** The first step is to remember precisely what grief and major MDD represent. The death of a loved one almost always triggers grief; but, an exquisitely stressful and sometimes traumatic life event may also precipitate a number of adverse health consequences, including (but not limited to) MDD.

Grief is the normal, expected, generally adaptive psychological, biological, interpersonal, and social response to loss. MDD, on the other hand, is a serious, sometimes malignant, life-threatening, mental disorder marked by intense, persistent and pervasive sadness or anhedonia. MDD generally is a recurrent condition and often is quite chronic.

Thus, I would rephrase the question I was asked to discuss. The more meaningful question is not so much, "How can grief and MDD be differentiated?" as it is, "How can an MDE be diagnosed when it occurs in a recently bereaved person who is still actively grieving?" That can be a challenging and tricky clinical conundrum, even for the most experienced clinician.

The DSM-5 does a good job in helping clinicians to understand when grief may be complicated by a co-occurring MDE. In the footnote for the diagnostic criteria of an MDD, the DSM-5 notes:

- **Key issue:** The predominant affect in grief that is not complicated by an MDE is a sense of emptiness and loss. When there is also an MDE, persistent and pervasive
depressed mood and the inability to anticipate happiness or pleasure predominate, even in the absence of reference to the deceased.

- **Nature of dysphoria:** In grief that is not complicated by an MDE, the dysphoria tends to decrease in intensity over days to weeks and occurs in waves that are associated with thoughts or reminders of the deceased—so-called "pangs of grief." When an MDE intervenes, the dysphoria tends to be more persistent and not tied to specific thoughts or preoccupations.

- **Positive emotions:** In grief, the pain may be accompanied by positive emotions, such as humor, relief, warmth, and even pleasure in the closeness with significant others. In contrast, when a MDE also is present, more pervasive unhappiness and misery are likely to leave no room for warmth, joy, or humor.

- **Preoccupations:** Thoughts and memories of the deceased predominate in grief. When the grief is accompanied by a coexisting MDE, thoughts also are focused on oneself being bad, undeserving, or unworthy.

- **Self-esteem:** In grief, self-esteem is generally preserved. When grief is accompanied by an MDE, thoughts of worthlessness and self-loathing also are common.

- **Consolability:** Grieving individuals often feel supported and comforted by friends and relatives sharing time and conveying condolences. When an MDE intervenes, people are far less consolable or approachable.

- **Suicidal thoughts:** In grief, thoughts of death or dying are generally focused on the deceased and possibly about joining them. In a bereaved person who is also suffering from an MDE, thoughts may be more focused on ending one's life because of feeling undeserving of life, feeling unable to withstand the seemingly unending torture of depression, and/or mistakenly believing that others would be better off without them.

Even with these guidelines, it is not always easy to diagnose an MDE in the context of bereavement. It is clear that a symptom checklist is not enough. Rather, a more nuanced assessment, taking into account some of the features and phenomenology noted above, combined with the unique history, beliefs, and social/cultural

dimensions of the person and their environment, must be weighed into the diagnostic process.

Sometimes it is useful to wait before making a definitive diagnosis. This is especially true in someone who does not have a previous history of MDD, and if symptoms are relatively mild and not life-threatening. When in doubt, past history and family history, as well as a tincture of time, may help inform clinical judgment and decisions.

More on Parsing Complicated Grief and MDD

Dr Pies: That's extremely helpful, Sid, and you remind us once again that grief and major depression are not mutually exclusive—that one can be grieving a death and also be experiencing an MDE.

Kathy, how about your take on what differentiates complicated grief from major depression?

Dr Shear: Complicated grief is at the high end of the grief spectrum in both intensity and duration. People with complicated grief are often caught up in ruminations, avoidance, or maladaptive proximity-seeking. Complicated grief ruminations are usually focused on counterfactual accounts of the death—for example, "If only I had made him go to the doctor sooner" or "If only I had not left the room right before she died."

Depressive rumination is different. Depressed people get caught up in thoughts about being worthless or being a bad person or thoughts that nothing good ever happens in the world, etc. With depression, people may become withdrawn and not want to go out or socialize.

With complicated grief, avoidance is more specific, focused on not wanting to confront reminders of the person who died. People with complicated grief are desperate to feel close to their deceased loved one and may spend hours looking at photos, touching or smelling their clothes, or daydreaming about times they were together. These times are usually pleasurable until the person "wakes up" and remembers that the person is gone.

Dr Pies: I want to thank my colleagues, Dr Zisook and Dr Shear, for helping us understand this complex and difficult area of diagnosis.