How do doctors distinguish grief from depression?

By CHRISTINE STAPLETON

Grief intrigues me. I've been there and despite counseling, self-help books and prayer, I don't understand it.

A few years after my divorce, my father died. Sixteen months after my father died, my mother died. Eight months later, my dog died. Several years passed and a long-term relationship ended. Then I crashed, slipped into a deep depression.

Compound grief – that's what I call it. At some point, all that grief piled up and morphed into depression. There was a tipping point. Despite the time I've spent rubbernecking my own grief, I don't know when or where I reached that tipping point but I sure as hell did.

Even with all the self-awareness and knowledge I have today, I doubt I would be able to identify that moment should I experience another loss and slide into – God forbid – a deep depression. So, how do doctors distinguish between grief and depression?

Apparently, it's not easy. According to a study recently published in JAMA Psychiatry, there is grief, complicated grief and depression. This was the first randomized trial to explore the treatment of complicated grief in an elderly population and it emphasized the importance for doctors to distinguish the differences between grief, complicated grief and depression.

I normally don't understand articles in JAMA. The articles look and sound like English but they are beyond my comprehension. Even the headlines baffle me. But I found this article on Medscape – essentially an email discussion about the JAMA article – that even I could understand.

http://blogs.psychcentral.com/depression/2015/01/how-do-doctors-distinguish-grief-from-depression/

Among the many problems facing clinicians – besides the fact that there is no blood or urine test that quickly confirms a diagnosis – is the terminology. There is bereavement, grief, complicated grief, depression and major depression.

Bereavement is the situation of having experienced the death of a loved one – not the response to that loss, according to Dr. M. Katherine Shear, program director for Columbia University's Center for Complicated Grief. Grief is the response to loss. It is "simple shorthand for a complex multifaceted experience that changes over time and varies from loss to loss."

Simply put: "Grief can be considered as a form the love takes when we lose someone we love." There are a lot of misconceptions about resolving or "getting over" grief, Shear wrote. Those include the belief that successful adaption to the death of a loved one means "letting go" or "saying goodbye" as a pre-requisite to "moving on."

There is also the misconception that experiencing and expressing strong emotions is the key to moving on and that those who do not do so right after a loved one has died will pay for it later, Shear wrote. It's like saying the more intense a person's emotions, the more effective their grief and once you have grieved effectively, "you never have to grieve again."

According to Shear, "grief is not a single emotion." It creates "feelings of extreme vulnerability" which is why the pull-yourself-up-by-your-bootstraps kind of people, like me, feel ashamed of their grief.

"Bereaved people need to change the ways in which they think about themselves, other people and the world at large," Shear wrote.

Now we come to "complicated grief." That happens when something interferes with learning and adapting to the loss and the person becomes "stuck" in acute grief. It can be caused by the circumstances and consequences of the death or about a person's relationship to the deceased. There can be devastating financial consequences or hostility or neglect by others, Shear wrote.

For clinicians, complicated grief can by identified using a 19-item, self-report questionnaire called the Inventory of Complicated Grief, Shear wrote. Then there is the recently published DSM-V, which dropped the "so-called "bereavement exclusion" when diagnosing a major-depressive episode," Shear wrote.

http://blogs.psychcentral.com/depression/2015/01/how-do-doctors-distinguish-grief-from-depression/

"Essentially, the DSM-IV had instructed clinicians not to diagnose major depression within the first two months after the death of a loved one, unless certain putative markers of severity were present," Shear wrote.

Those include suicidal thoughts, functional impairment, sense of worthlessness, psychosis and psychomotor retardation – the visible slowing of thoughts and emotional reactions that can interfere routine skills, such as bathing, eating or shopping for groceries.

But the DSM-V tells clinicians not to exclude a diagnosis of major depression within the first few weeks after a loss when the bereaved person meets the full criteria for major depression.

"The DSM-V recognizes that bereavement does not "immunize" the grieving person from major depression, and is in fact a frequent precipitant of major depression," Shear wrote. Thankfully, the DSM-V does a good job in helping clinicians identify when grief is accompanied by major depression, Shear wrote.

Here is where I realized that the job of a clinician trying to help someone who has lost of loved one must be terribly difficult. Shear lists a half-dozen states of mind that a clinician must examine, such as consolability, preoccupation, self-esteem, positive emotions and suicidal thoughts.

"The predominant affect in grief that is not complicated by (major depression) is a sense of emptiness and loss," Shear wrote. "When there is also (major depression), persistent and pervasive depressed mood and the inability to anticipate happiness or pleasure predominate, even in the absence of reference to the deceased."

Here are some examples cited by Shear:

- In grief, the pain may be accompanied by positive emotions, such as humor, relief and warmth from others. When depression is also present, pervasive misery leaves no room for positive emotions.
- Thoughts and memories predominate in grief. In grief complicated by depression the thoughts also are focused on "oneself being bad, undeserving or unworthy."
- Self-esteem is usually preserved in grief. In depression, the grief is accompanied by "thoughts of worthlessness and self-loathing."
- Grieving individuals are capable of feeling the support of friends and family. When depression intervenes, the grieving individual is less consolable or approachable.

Good Lord. These are the tools that clinicians use in deciding how to treat patients at the absolute worst time of their patients' lives? Is that really how rudimentary brain science still is today? There is no MRI, blood test or biopsy they can use to confirm their diagnosis?

I never looked at my depression from the shoes of my clinician. I never considered what it must look like to her or how she gauged the severity of my symptoms and decided how to treat me. I never realized how much of it was a judgment call and how vulnerable a clinician must feel and how easy it would be to second-guess your diagnosis.

Sad woman image available from Shutterstock.

http://blogs.psychcentral.com/depression/2015/01/how-do-doctors-distinguish-grief-from-depression/

Doctor pointing to x-ray image available from Shutterstock.