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Research report

# Clinical features distinguishing grief from depressive episodes: A qualitative analysis

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ABSTRACT

*Background:* The independence or interdependence of grief and major depression has been keenly argued in relation to recent DSM definitions and encouraged the current study.
*Methods:* We report a phenomenological study seeking to identify the experiential and phenomenological differences between depression and grief as judged qualitatively by those who had experienced clinical ($n$=125) or non-clinical depressive states ($n$=28).
*Results:* Analyses involving the whole sample indicated that, in contrast to grief, depression involved feelings of hopelessness and helplessness, being endless and was associated with a lack of control, having an internal self-focus impacting on self-esteem, being more severe and stressful, being marked by physical symptoms and often lacking a justifiable cause. Grief was distinguished from depression by the individual viewing their experience as natural and to be expected, a consequence of a loss, and with an external focus (i.e. the loss of the other). Some identified differences may have reflected the impact of depressive "type" (e.g. melancholia) rather than depression per se, and argue for a two-tiered model differentiating normative depressive and grief states at their base level and then "clinical" depressive and 'pathological' grief states by their associated clinical features.
*Limitations:* Comparative analyses between the clinical and non-clinical groups were limited by the latter sub-set being few in number. The provision of definitions may have shaped subjects' nominated differentiating features.
*Conclusion:* The study identified a distinct number of phenomenological and clinical differences between grief and depression and few shared features, but more importantly, argued for the development of a two-tiered model defining both base states and clinical expressions.
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## 1. Introduction

In this report we pursue the phenomenological distinction of depression and grief. As summarised by Shear (2012), grief's hallmarks are yearning and sadness which emerge from the loss of the "other" and with self-esteem generally preserved, and in contrast to depression where the person views their own self as empty or impoverished —as differentiated by Freud (1917). A similar distinction is provided in a DSM-5 sub-script (p 161), where it is noted that the predominant affect in grief involves "feelings of emptiness and loss" while, in depression, it is a "persistent depressed mood and the inability to anticipate happiness or pleasure". Further, the sub-script states that the preoccupying thought content in grief involves "memories of the deceased" rather than the "self-critical or pessimistic ruminations" integral to depression, and that self-esteem is generally preserved in grief whereas in major depression "feelings of worthlessness and self-loathing are common".

Differentiation is nevertheless often difficult as individuals and patients may not define their emotional states quite so pristinely. Further, the two states may co-occur, making their formal differentiation even more difficult. Definitional and differentiation issues between grief and clinical depression have been wrestled with since DSM-III introduced the "major depressive disorder" (MDD) category, and with researchers and clinicians subsequently raising concerns that an episode of grief could manifest symptoms making an individual eligible for a MDD diagnosis (e.g., Clayton, 1990; Zisook and Shuchter, 1991). During the initial stages of an acute grief reaction, it might be expected that the presence of distinctive "depressive" symptoms would not be interpreted as necessarily indicative of a depressive disorder if the bereavement context is taken into consideration. The DSM-IV formalised this

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nuance by including bereavement as an exclusion criterion for a major depressive episode—unless depressive symptoms persist for more than two months after the bereavement, are gravid and uncharacteristic of normal grieving (e.g., suicidal ideation, psychotic symptoms, or psychomotor retardation) or are associated with marked functional impairment. This exclusion criterion sought to avoid pathologising normal grief responses in the estimated one-third to one-quarter of individuals who would otherwise meet MDD criteria if assessed within two months of bereavement (Zisook and Shuchter, 1991; Clayton et al., 1972).

The DSM-5 notes that responses to a significant loss such as bereavement "may resemble a depressive episode", with overlapping symptoms usually including insomnia, appetite and weight loss, rumination about the loss, and intense sadness, therefore somewhat blurring distinction. In contrast to DSM-IV, DSM-5 does not state that responses to significant loss are exclusion criteria for major depressive episodes, but instead instructs practitioners to "exercise clinical judgement" in determining whether a grief response is accompanied by a MDD depressive episode, and by evaluating what would be expected to be the "normal response to a significant loss" given the individual's history and consideration of cultural norms. DSM-5 also allows that "responses to a significant loss" are not limited to grief caused by a break in a social bond (bereavement), but also lists financial ruin, losses from a natural disaster, serious medical illness and disability as exemplars, and risks some conjoining of the two states. The controversy generated by the DSM-5 classification (Maj, 2012; Parker, 2013; Wakefield, 2013; Wakefield and First, 2012) contributed to undertaking the present study, which seeks to identify phenomenological points of distinction.

Previous study findings have variably reported substantive and minimal differences between the two states. For example, one US longitudinal epidemiological study reported that episodes of grief were prototypically different from standard major depressive episodes in being less likely to involve impairment in role functioning, fatigue, hypersomnia, feelings of worthlessness or suicide ideation (Mojtabai, 2011). In addition, bereaved individuals did not demonstrate an increased risk to future depressive episodes and were less likely to need medication or psychological therapy for depression and so differed from those with non-bereavement-related major depressive episodes. In relation to differing treatment responses, Reynolds et al. (1999) reported that, while depressive symptoms decreased with nortriptyline medication and interpersonal therapy, bereavement intensity was not impacted on by either treatment modality. By contrast, other studies have identified more similarities than differences between bereavement-related depressions and MDD. For example, Kendler et al. (2008) compared large sub-sets of those with confirmed bereavement-related depression and confirmed depression following non-bereavement stressful life events. The two sub-sets did not differ by age at onset of major depression, number of prior episodes, duration of index episode, number of endorsed DSM "A criteria" or the proportion meeting criteria for "normal grief". Research by Zisook and Kendler (2007) suggested that both individuals with bereavement-related depression and standard MDD responded favourably to antidepressant treatment and showed a similar trend toward recurring depressive episodes. This led the authors to conclude that, as bereavement-related depression resembled typical MDD, it should therefore be considered a form of MDD.

Many limitations emerge from the lack of identified or agreed on parameters that might distinguish between a grief response and a depressive episode, particularly when they co-occur—and which may reflect the bereaved individual already having an independent depressive state, being vulnerable to depressive episodes or because the context of the bereavement and its consequences are depressogenic. The DSM-IV duration criterion specified for the "normal" grief response (i.e., $\leq$ two months) is alone not a reliable indicator as to when normal grief has developed into pathological grief or represents an MDD episode. In fact, research has demonstrated that differentiating bereavement-related depressions from true MDD cases cannot be reliably determined by time alone until approximately one year following the loss (Wakefield et al., 2011) and when only 16% will be depressed (Zisook & Shuchter, 1991). Over that immediate loss period, clinicians and researchers require other valid and reliable guidelines for distinguishing between a grief reaction and a depressive condition—and it is here that phenomenological distinction may provide key information. Such disparate findings argue again for a phenomenological approach to differentiating grief and depression before examining for clinical differentiation in more pristinely defined comparison groups.

We reported a quantitative analysis within a sample of 200 outpatient and community participants (Parker et al., 2015) and now report qualitative analyses of the same sample. Sample characteristics (i.e. there being clinical and non-clinical sub-sets) allowed us to also determine if clinical status might be salient to definitional differences between depression and grief.

## 2. Methods

We sought to interview those who had experienced either non-clinical or clinical depressive episodes so as to examine a broad spectrum of depressive experiences. Thus, we advertised for volunteers who were between the ages of 18 and 65 years, fluent in both written and spoken English and prepared to take part in "an interview about sadness and depression" or who would describe themselves as never having "experienced depression". Exclusion criteria were memory or cognitive deficits which would disallow participation in an interview, primary schizophrenia or other non-affective psychotic disorder and current psychosis. Participants were recruited via newspaper and web advertisements as well as placing flyers and posters in the Depression Clinic at the Black Dog Institute, Sydney. In order to assist participants in identifying and distinguishing between different emotional experiences, and to ensure that all participants were referring to the same emotional constructs, definitions were provided at the beginning of the interview for (i) a depressed mood state, (ii) sadness, (iii) grief and (iv) stress. A "depressed mood state" was positioned as "feeling both depressed and experiencing a drop in self-esteem or self-worth, perhaps following being taken down a peg, unfairly criticised or bullied, or sometimes even coming out of the blue without a trigger". "Sadness" involved "feeling downhearted or sorrowful (but not experiencing any distinct drop in self-esteem or self-worth) when experiencing some rather temporary 'loss' (e.g. a partner going overseas for an extended period and being missed; leaving your family to move overseas; your sporting team loses when you had all your hopes in them winning)". "Grief" involved "feeling heartache, distress and the anguish of loss but without any drop in self-esteem or self-worth when a painful and seemingly permanent break in a social bond is experienced (e.g. the death of a partner, relative or even a favoured pet)". "Stress" involved "feeling stressed, insecure, fearful and unsettled but again without any distinct drop in self-esteem or self-worth (e.g. loss of a passport or running out of money or accommodation while overseas; being unable to meet necessary requirements at work or at school and which are likely to have painful consequences)." At interview, only participants who affirmed having ever experienced a depressed mood state episode were later asked "did it feel different to grief?" and, if affirmed, were asked to describe how their experience of depression differed from grief. Participants who judged there to be no difference were also asked to elaborate. Classification of clinical or non-clinical depressive episodes was made according to DSM-IV criteria imbedded into the research

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