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Research report

Bereavement and common mental disorders in middle-aged adults: Results from the Brazilian longitudinal study of adult health (ELSA-Brasil)

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ABSTRACT

Background: Although bereavement is accompanied with depression and anxiety symptoms, it is usually not associated with increased rates of mental disorders in North American and European samples. Data from low- and middle-income countries are, however, scarce. We therefore explored the prevalence of mental disorders after bereavement in Brazil.

Methods: The Clinical Interview Schedule-Revised (CIS-R) was used for psychiatric assessment of 15,105 participants from the Brazilian Health Longitudinal Study (ELSA-Brasil). We asked whether the participant suffered loss of a first-degree relative/spouse within 6 and 12 months prior to the interview.

Results: The prevalence within 6 and 12 months after bereavement for major depressive disorder (MDD, 4.3% for 6 and 12 months) and anxiety disorders (17.4% and 15.9%, respectively) did not differ compared to non-bereaved participants, except for panic disorder. Sociodemographic and clinical data were also similar. Conversely, we found increased 12-month prevalence of bereaved-related (vs. non-related) mixed anxiety and depressive disorder (15.7% vs. 12.5%, respectively) and common mental disorder (30.7% vs. 26.2%); diagnoses that are solely based on the number and severity of depression and anxiety symptoms.

Limitations: Although this was a cross-sectional study, the sample size was large.

Conclusions: Bereavement was associated with greater psychopathological burden but not with increased prevalence of MDD and anxiety disorder diagnoses, therefore highlighting the need of carefully monitoring subjects whom recently experienced bereavement. Our findings also support and provide a "cultural validator" for excluding bereavement as an exclusionary criterion for MDD diagnosis.

1. Introduction

Many people experience a period of deep sadness, hopelessness and loneliness after the death of a close relative. In this time period, usually referred as "mourning" or "grief", several psychic symptoms resembling a psychiatric disorder commonly arise, which poses the question of whether these symptoms, when sufficient for composing a clinical disorder, should be treated. In fact this issue has endured a long debate in psychiatry for almost one hundred years, and it has again led to controversy in the recent 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), in which the former exclusionary criteria of bereavement was excluded for the diagnosis of major depressive disorder (MDD) (APA, 2013).

The recent DSM-5 criteria contrast with early studies that support a clear-cut distinction between mourning and psychiatric syndromes. For instance, in the classic work *Mourning and Melancholia*, Freud (1917) pointed out that "mourning (…) never occurs to us to regard it as a pathological condition and to refer it to medical treatment", defending that mourning exists after the actual loss of a loved one; whereas melancholia's genesis comes from the unconscious, introjected loss of a love object. In the 1960s and 1970s, Clayton et al. (1968, 1972) reported high rates of a full depressive syndrome one month and one year after bereavement; results that led to the concept – later incorporated in the 3rd and 4th DSM editions – that depression after bereavement should not be treated as a psychiatric condition per se. This would also prevent over-diagnosis and thus over-medicalization of a specific type of depression syndrome in which the treatment could be unnecessary (Wakefield, 2013).

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On the other hand, the exclusion of bereavement adopted in the DSM-5 was based on data from more recent studies that did not distinguish bereaved-related vs. non-bereaved related depression. In a comprehensive review of nine large studies, Zisook et al. (2012) did not identify significant differences between bereaved and non-bereaved depression considering three validators: (1) antecedent validators; (2) concurrent validators; and (3) predictive validators (all validators were not necessarily present in each evaluated study). The authors concluded that, considering that bereaved vs. non-bereaved depression is roughly similar, the bereavement exclusion in DSM-5 was correct. Another compelling evidence is that no other type of losses or stressful life events are exclusionary criteria for depression – in fact, bereavement-related depression has many more similarities than differences compared to depression related to other stressful life events (Kendler et al., 2008, Zisook and Kendler, 2007).

However, Zisook et al. (2012) were not able to assess the impact of "cultural validators" since all studies except for Karam et al. (2009) used data from American and European samples. Even though, Karam et al. used data from a study carried out in 1989 and 1991 that was primarily designed to evaluate the impact of war on the mental health of adults in Lebanon (Karam et al., 1998). Thus, most of the current data in literature regarding depression and bereavement came from high-income countries, whose individuals might display distinct symptoms after bereavement as compared to individuals from low- and middle-income countries. For instance, Latin American populations are prone to somatization in stressful contexts (Tofoli et al., 2011) although it is not known whether bereavement in such populations leads to an increased prevalence of psychiatric symptoms and diagnoses.

Therefore, our aim is to explore the prevalence of depression and other psychiatric syndromes after bereavement in a large Brazilian sample – the Brazilian Longitudinal Study of Adult Health (ELSA-Brasil). Our study can contribute to the ongoing debate of whether the bereavement exclusion in DSM-5 was appropriate by examining a "cultural validator" (bereavement in Brazil, the largest country in Latin America), which, to the best of our knowledge, has not yet been explored in this field. Our study is also of interest for mental health policies in high-income countries, especially the US, which receive many emigrants from Latin America.

2. Methods

2.1. Overview and study design

ELSA-Brasil is a cohort study enrolling 15,105 civil servants (54% women; mean age of 52 ± 9 years) from 6 sites located in different regions of Brazil (corresponding to the metropolitan areas of São Paulo, Rio de Janeiro, Salvador, Porto Alegre, Belo Horizonte and Vitoria) (Aquino et al., 2012). Its main aim is to investigate the risk factors associated with the development and progression of diabetes and cardiovascular diseases. All active or retired employees of the 6 institutions aged 35–74 years were eligible for the study. Exclusion criteria were current or recent (< 4 months) pregnancy, intention to quit working at the institution, severe cognitive or communication impairment, and living outside the metropolitan area of the corresponding study center.

Baseline characteristics of the sample are described elsewhere (Aquino et al., 2012). The data here presented is a cross-sectional analysis using information of the first examination of ELSA, which occurred from August 2008 to December 2010. Data from participants were collected in 2 phases. The first, lasting approximately 1 h, included obtaining informed consent and conducting the initial interview at the participant's job site. The second, comprising additional interviews and examinations, lasted approximately 6 h and was conducted at a study clinic.

2.2. Assessments

2.2.1. Sociodemographic characteristics

For the present study, we considered the following variables: gender, age (categorized in 35–44; 45–54; 55–64 and 65–74 years-old), skin color (White, Brown, Black and other – Asian and Indian), years of schooling (categorized in less than completed high school, i.e., < 11 years of schooling; completed high school and incomplete college, i.e., 11–15 years of schooling and more than completed college, i.e., > 15 years of schooling), monthly income (categorized in lower, middle and upper tertiles) and partner status (living with partner vs. single).

2.2.2. Clinical comorbidities

We assessed the following 14 self-reported conditions: hypertension, diabetes melito, dyslipidemia, myocardial infarction, chronic heart failure, previous cardiac surgery, Chagas' Disease, rheumatic fever, asthma, chronic obstructive pulmonary disease, kidney disease, thrombosis, liver disease, cancer and we thereafter created a binary variable "clinical comorbidity" (dichotomized in "none or one clinical condition" and "two or more clinical conditions").

2.2.3. Psychotropic use

All participants were asked regarding use of antidepressant and benzodiazepine medicines that respectively totalized 6.9% and 3.9% of the sample. The most common (> 65%) antidepressant drugs were sertraline, paroxetine, citalopram, amitriptyline and fluoxetine, while clonazepam, alprazolam, bromazepam and diazepam were the most common (> 85%) benzodiazepines (for a complete review of psychotropic use in ELSA see Brunoni et al. (2013)).

2.2.4. Common psychiatric disorders

Mental diagnoses were assessed by trained interviewers using an adapted Brazilian-Portuguese version of the Clinical Interview Schedule-Revised (CIS-R). The CIS-R is a structured interview for measurement and diagnosis of non-psychotic psychiatric morbidity in community. It was developed by Lewis et al. (1992) specifically to be used in community and primary care, being a short and straightforward questionnaire. Importantly, lay interviewers are as reliable as psychiatrists in using CIS-R for performing mental diagnosis, being a suitable instrument to be used in our cohort.

The complete CIS-R version includes 14 sections covering symptoms of depression and anxiety: obsessions, compulsions, panic, phobias, anxiety, worry, worry about physical health, depression, depressive ideas, irritability, fatigue, concentration, sleep and somatic symptoms. Each symptom cluster present scores ranging from 0 to 4, except for depressive thoughts that range from 0 to 5. Therefore, the CIS-R can yield a score ranging from 0 to 57. As proposed by Lewis et al. (1992), the case threshold at 11/12 defines "common mental disorder" – this variable was used to explore whether bereavement was associated with increased number of psychiatric symptoms, although not fulfilling criteria for a psychiatric diagnosis.

The CIS-R also yields ICD-10 diagnoses. First, each abovementioned symptom is considered clinically relevant if participants score two or more on the corresponding sub-scale. The relevant symptoms are then grouped together to form, with accessory questions, ICD-10 diagnoses. We further classified these groups in "depressive episode" (all types and severities) and "anxiety disorders" (general anxiety disorder, panic disorder, social anxiety disorder, all phobias and obsessive compulsive disorder). All these ICD-10 diagnoses were used to explore the relationship between bereavement and psychiatric diagnoses.