Grief and Depression: Treatment Decisions for Bereaved Children and Adults

It is common knowledge, and probably instinctively understood, that loss of a close attachment ushers in a period of acute grief characterized by intense emotional distress, intrusive thoughts, and withdrawal from ongoing life. Within the framework of these commonalities, no two people grieve in the same way or for the same period of time. Many people experience intense uncontrollable emotions as foreign and the difficulty connecting with others or being interested in usual activities as disconcerting. Consequently, bereaved people may worry about whether their experience is normal. Clinicians do not always know the answer. Psychiatrists often struggle with whether, when, and how to treat bereaved people. There is a critical need for research that can help answer these questions.

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The carefully designed study reported in this issue by Brent and colleagues (1) makes a major contribution to understanding mental health consequences of bereavement in children. Loss of a parent during childhood can have long-term effects. Yet family, friends, and relatives are often focused on comforting bereaved adults, leaving children to manage on their own. There is an urgent need for research to understand the course and consequences of childhood bereavement in order to guide interventions. Brent et al. report on the incidence and prevalence of psychiatric sequelae among 154 bereaved individuals ages 7–25 years, compared to illness rates in a matched group of 100 offspring with two living parents. Study participants were assessed 9 and 21 months after the bereaved group lost a parent to suicide, accident, or sudden natural death. Findings from the 9-month assessment were published previously and showed higher rates of depression and posttraumatic stress disorder (PTSD) in bereaved offspring than in comparison subjects (2).

The current report extends these findings by examining outcomes of bereavement at 21 months. Results show that the rates of depression and anxiety remain elevated, relative to the rates in comparison subjects, and bereaved offspring show greater functional impairment and more alcohol or substance abuse. History of depression prior to study onset predicts depressive illness in both bereaved children and comparison subjects; however, the increased rate of major depression in bereaved offspring at the 21-month assessment is largely attributable to incident depression during the first 9 months after the death.

Within the bereavement group, an earlier episode of depression and higher scores on complicated grief conferred greater risk for depression, as did losing a parent to suicide and maternal death. Not surprisingly, those with more problems coping and lower self-esteem were more likely to be depressed. Blaming others for the death, commonly seen with complicated grief, was also a risk factor for depression in the second year.

Brent et al. conclude that their results suggest treatment of depression and complicated grief in the first 9 months of bereavement may prevent longer-term impairment. This recommendation makes good sense and holds for adults as well as children. Adults have similar rates of depression (3) in the aftermath of bereavement and similar risk for enduring illness (4). However, clinicians frequently have difficulty discerning those bereaved individuals in need of treatment. Much of the confusion arises because of uncertainty about how to differentiate between acute grief and depression. Sadness is a hall-

mark of both grief and depression, so it can be difficult to decide whether a bereaved person is experiencing a normal response to a painful loss or an episode of major depression. In fact, this confusion led the authors of DSM-IV to conclude that we should not diagnose major depression, even in someone with a past history of depression, until at least 2 months after the death of a loved one. Grief is rightly understood as a natural reaction to loss; however, grief differs importantly from depression. Only a minority of bereaved individuals meet criteria for major depression, and those who do have a past history and illness course that do not differ from those of individuals who seek treatment of depression without having lost a loved one (5).

Yearning is the sine qua non of grief (6) and is not seen in depression. Yearning is the experience of wanting, a component of the brain reward system (7) thought to be deactivated in depression (8). By contrast, even during the initial period of acute grief, bereaved people retain the ability to experience positive emotions. Positive emotions may be evoked in a bereaved person when recalling pleasant experiences with the deceased or when expressing pride in the loved one or telling amusing anecdotes. Moreover, sadness is not usually pervasive during grief; rather, it occurs in waves or pangs of emotion. Acute grief is associated with preoccupation with thoughts and memories of the deceased, while depression is associated with self-critical or pessimistic rumination.

Some clinicians fear that treatment of depression with antidepressant medication might block the process of working through the loss. However, data do not support the legitimacy of this concern (9, 10). To the contrary, it is very likely that untreated depression increases the likelihood of complicated grief. For example, among a clinical population of patients with complicated grief, 80% had a current or past history of major depression (11). It is important for clinicians to diagnose and treat major depression, even (or maybe especially) in the context of bereavement.

Treatment of depression does not mean that medication treatment must always be employed. Good clinical management of milder forms of depression may entail psychoeducation, symptom monitoring, and support. This approach may be appropriate for some episodes of depression following bereavement, just as it is for some episodes that occur in other contexts. Psychotherapy may also be very helpful to bereaved individuals who are depressed. In any case, as Brent et al. suggest, depression should be appropriately treated early in the course of bereavement in order to prevent enduring symptoms. The bereavement exclusion for major depression in DSM-IV is an impediment to this practice. Eliminating this exclusion would be an important advance in DSM-V.

It is also important for clinicians to recognize the syndrome of complicated grief, a form of prolonged acute grief that is clinically significant and occurs in about 10% of bereaved individuals. Key features of complicated grief include persistent intense yearning and longing for the person who died, disruptive preoccupation with thoughts and memories of this person, avoidance of reminders that the person is gone, a range of negative emotions that include deep relentless sadness, self-blame, bitterness, or anger in connection with the death, and an inability to gain satisfaction or joy through engaging in meaningful activities or relationships with significant others. A recent study documented increased activation of brain reward centers in women with complicated grief on exposure to stimuli that were reminders of the deceased loved one (12), supporting the difference between complicated grief and depression.

Complicated grief often co-occurs with other psychiatric disorders, but studies have shown that it contributes to psychological and functional impairment, including suicidality, independent of comorbidities (13, 14). Complicated grief needs to be treated and is refractory to standard treatment for depression (15, 16). A targeted treatment may be required. Failure to include complicated grief in DSM-IV is an impediment to recognition and treatment, and including it in DSM-V would be an important advance.

In summary, studies of adults as well as children indicate that most bereaved people experience a painful period of acute grief and go on to make a good adjustment and to

restore their ability to attain joy and satisfaction in their ongoing lives. A clinically significant minority do not enjoy this positive outcome and instead experience psychiatric sequelae, the most common of which are major depression, PTSD, alcohol or substance abuse, and complicated grief. Each of these conditions needs to be recognized as early as possible and treated appropriately to prevent the development of enduring disruptive illness.

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