**Bereavement At A Glance**

Adapted from: *Grief and Depression: Treatment Decisions for Bereaved Children and Adults* (Shear KM. Am J Psychiatry 166:746-748, July 2009)

The 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 and often struggle with whether, when, and how to treat bereaved people.

While 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 significant minority does not. These persons 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.

**Discussion**

Brent et al. (1) suggest that 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).

Clinicians frequently have difficulty identifying those bereaved persons in need of treatment because there is uncertainty about how to differentiate between acute grief and depression. Sadness is a hallmark 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 correctly 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 an essential characteristic 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 impede or slow the process of working through the loss, however, data do not support the veracity 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 pharmacological means must always be employed. Appropriate clinical management of milder forms of depression may involve psychoeducation, symptom monitoring, and support. 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.

Complicated grief often co-occurs with other psychiatric disorders, and 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).

**References**

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