Grief and depression

A PSYCHIATRIST'S VIEW

What is grief?

Grief is a natural response to loss, but is a painful emotional experience.

The more significant the loss, the more intense the grief is likely to be.

Grief is expressed in many ways and it can affect every part of your emotions, thoughts and behaviour, beliefs, physical health, your sense of self and identity, and your relationships with others.

Everyone experiences grief differently. Some people may grieve for weeks and months, while others may grieve for years.

The process of grief can lead to beginning to create new experiences and habits that work around your loss.

When does a normal mood state become 'abnormal'?

Mood is too intense and/or too long lasting in relation to the trigger

Mood is inappropriate to the trigger

People with clinical depression lack the capacity for spontaneous remission.

Is it depression?

Grief is something that takes time to work through.

Grief and depression can appear similar as they can both lead to feelings of intense sadness, insomnia, poor appetite and weight loss.

Depression more persistent, with constant feelings of emptiness/despair and difficulty feeling pleasure or joy, poor self esteem, feeling slowed down.

When compared to depression, an episode of grief is less likely to involve impairment in functioning, ruminations of self-blame, worthlessness.

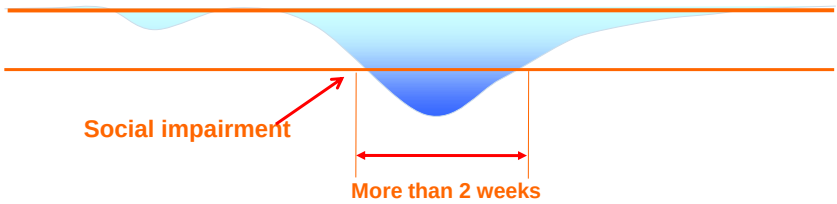
However, grief can be 'complicated', 'prolonged' and 'persistent', which can overlap with clinical depression.

Normal mood swings

'Normal depression'

" Do you feel depressed, have lost your sense of self-worth, feel hopeless and helpless, self-critical and feel like giving up?"

"Clinical" Depression



Key features: decline in self-esteem, self-criticism, depressed mood
Common nonspecific features: sleep/appetite ↑ or ↓, libido ↓, fatigue, pain, anhedonia

Clinical Depression

Key features

- ↓Self-esteem
- Self-criticism
- Depressed mood

Nonspecific features

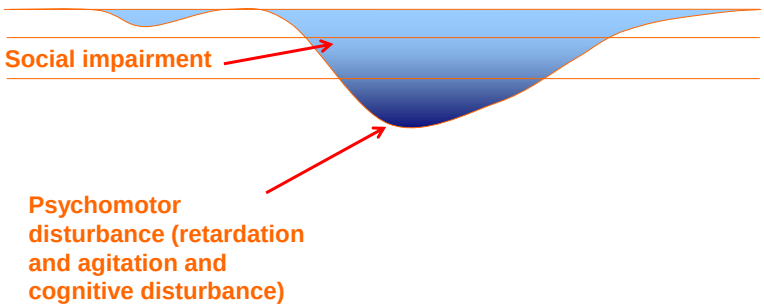
Insomnia
Libido changes
Fatigue
Anxiety
Poor concentration
Appetite/weight changes

Concerning features

- Anhedonia
- Amotivation
- Nonreactive mood
- Rumination
- Hopeless/helplessness
- Diurnal variation and
- Early morning waking
- Psychomotor retardation
- Cognitive changes
- Suicidality
- Agitation
- Psychosis

Past history of bipolar disorder/ major depression +/-panic / vascular disease/hypertension diabetes/cancer

Melancholic Depression



Melancholic Depression

Symptoms

Anhedonia

Nonreactive mood

Profound, uncharacteristic inanition – 'emptiness' and inactivity (unable to get out of bed/have shower)

Mood/energy worse in am

Sleep pattern, early morning wakening

Individuals may fluctuate over the day.

Psychomotor Disturbance

Cognitive processing problems: poor concentration, inattention 'pseudo-dementia' picture

Retardation, and/or agitation

Based on observation

Family members report CHANGE in behaviour

Functional Melancholia

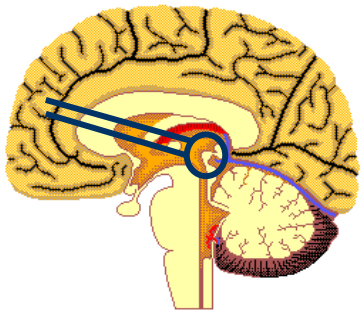
Younger onset (<60 yrs)

Often strong family history of depression and/or bipolar Δ

Check drug use

Structural abnormalities rare on imaging

Good response to antidepressants and ECT



Mechanism: Functional shut-down of circuits linking basal ganglia and pre-frontal cortex.

Structural Melancholia

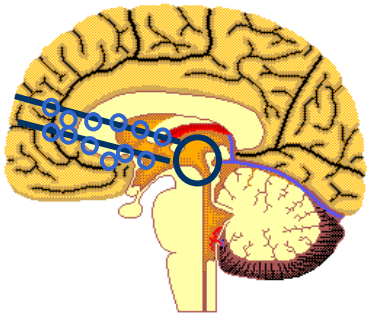
Older onset (eg. 60+ years)

Cerebrovascular disease more common

Poorer response to antidepressants/ECT

Risk of delirium

Mechanism: Structural disruption of circuits linking basal ganglia and pre-frontal circuits, presaging full dementia in months or years



Cognitive processing problems: ↓ concentration, inattention, 'pseudo-dementia' picture
Retardation and/or agitation Based on observation: Family members report CHANGE in behaviour

Suicide risk assessment

Is there a history of alcohol/tobacco? analgesics? sedatives? stimulants?

Is there a depressive episode? panic? agitation?

Any previous Hx of suicidality?

When did ideas start in relationship to grief, depression?

What do they have to live for?

Have they plans? Have they acted on them? What access do they have?

Who can they talk to?

Are they concerned about this?

What is the trajectory?

Initially doing well despite grief but then becomes depressed (illness factors, substance use, growing isolation, vulnerability)

Initial grief continues and gradually turns into depression

Continuing depression (personality style, difficulty coping, being in new role) and just continues and compounded by grief

Addressing different trajectories

Trajectories	Questions	Management issues
Normal grief has become complicated by new events, new or continuing illness COMPLICATED GRIEF	What has led to change? Any reversible factors? Is there depression? What type? Will ADM help? Which one?	If clinical depression, aim to improve symptoms to be able to continue to deal with grieving process
Grief not resolving, in person previously functioning well PROLONGED GRIEF/ Possible ONSET OF DEPRESSION	Has pattern changed over time? How is person functioning? What does s/he make of this?	Ensure that what started as unresolved grief has not become depression Keep a watching brief and decide when to change course
Depression present 'for as long as I can remember': grief has compounded this or grief is persisting for years without resolution PERSISTENT GRIEF	Are there features of longstanding personality vulnerability and/or trauma? Has s/he any superimposed mental/physical conditions? What does s/he have to look forward to?	Likely to have personality style vulnerable to complicated grief; unresolved issues from past may complicate the grieving process/counselling

Management: what I would use

Understand and education

Expressive writing

Referral for specific grief counselling

Improving lifestyle (sleep, diet, exercise, substance use)

Antidepressants, other medications, where appropriate

Specific strategies/therapy for underlying issues, where present

Interpersonal therapy

Using as an opportunity to promote emotional growth

Interpersonal therapy

PEER REVIEWED FEATURE

Interpersonal therapy in the general practice setting

KAY WILHELM
ROBERT MAY

Interpersonal therapy is a useful tool for the treatment of patients with depression and other mental disorders. A shorter version is available for GPs, which offers a more tailored intervention and greater treatment options.

KEY POINTS

- Interpersonal therapy (IPT) has a strong evidence base for the treatment of depression.
- IPT offers a short-term, unique approach that differs from cognitive behavioural therapy (CBT).
- Interpersonal counselling (IPC) is a shorter, manual-based version of IPT that is readily adapted to the general practice setting.
- IPT and IPC formulate a patient's mental illness in the context of their social environment.
- IPC can be delivered by GPs and practice staff with an interest in psychological therapy with the aid of available manuals.
- IPT works well with the medical model and the use of antidepressant medications and lends itself more adaptively to some patient circumstances than CBT.
- IPT has been expanded to a wide range of mental disorders including anxiety, substance use and depression related to medical illness.
- An awareness of IPT and IPC allows a more tailored intervention and greater treatment options for GPs and patients.

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How did interpersonal therapy (IPT) originate?

Interpersonal therapy (IPT) was originally designed about 40 years ago in a research setting as a time-limited psychotherapy, and its effectiveness was compared with amitriptyline and 'treatment as usual' unstructured supportive psychotherapy. The two main investigators were Myrna Weissman, a social worker, and Gerald Klerman, a psychiatrist. They proposed a brief interpersonally-based treatment specific to each of four interpersonal domains – grief, interpersonal dispute, roles transition and interpersonal sensitivity – which, they hypothesised, precipitated and maintained depressive episodes (Table 1).[1] In the trial, the patients in the arms receiving IPT or antidepressant medication showed similar rates of improvement, but the combination of IPT and antidepressant medication had the greatest impact on acute symptom improvement and delaying further episodes. Klerman and Weissman went on to write the original textbook on IPT.[2]

A multicentre trial in the USA was conducted to test the efficacy of the antidepressant imipramine either with or without psychotherapy as maintenance treatment for depression.[3] The two short-term psychotherapies selected for the trial were cognitive behavioural therapy (CBT) and IPT. The patients in both psychotherapy arms showed similar rates of improvement, although manifested in different ways. The imipramine plus CBT group improved in dealing with depressogenic cognitions (thoughts) whereas the imipramine plus IPT group improved in interpersonal function. The interest in IPT as an active treatment in its own right was further informed by a growing interest in attachment behaviour (an important theory underpinning IPT).

What is IPT?

IPT is a time-limited manual-based psychotherapy. It is based on the premise that depression arises in an interpersonal context and that relationship problems (such as disrupted relationships or expectations of those relationships) play a part in precipitating and maintaining depressive episodes.

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