

Ph.D. Thesis of the Dissertation

**Depression and grief-reaction
Symptomatological comparison especially of suicidal
symptoms**

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I. INTRODUCTION

The manifestations of bereavement depend on cultural norms, expectations, and the circumstances of death. Mourners and their environment accept depressive mood as an appropriate reaction to loss. Duration varies culture by culture, but the main symptoms usually go away in 2-3 months and are not observable later. Most of the symptoms connected to loss are similar to the symptoms of depression; even a complete depressive syndrome can develop (Raphael and Minkov, 1999; Abraham, 1942; Bruce et al, 1990).

All the modern classification systems (DSM-III-R, DSM-IV, ICD-10) differentiate non-complicated bereavement from depressive episode (APA 1987, 1994; WHO, 1992). The distinction is based on timing (following loss) and on certain symptomatological differences. In bereavement, there is no expressed inhibition and feeling of worthlessness, but feelings of guilt and thoughts of death are well defined.

However, since grief-reaction can develop into major depression, Prigerson et al (1995a) introduced the term “complicated grief”, using their own Inventory of Complicated Grief. They have found that seven symptoms constituted complicated grief: searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, feeling stunned by the death, and lack of acceptance of the death. These symptoms appear to define a unique disorder, and may be distinct from depressive symptoms (Prigerson et al, 1995b). Horowitz et al (1997) also expressed that a new diagnosis of complicated grief disorder is indicated.

II. AIMS OF THE WORK

Specifying the symptoms of complicated grief can be helpful in differentiating it from other disorders associated with loss.

II./1. The aim of the present study was to analyze the specific symptoms of bereavement compared to major depressive episode in a random, representative sample of adult Hungarian population. The reason for this is that DSM criteria are based on depressive symptoms (feeling of worthlessness, suicidal thoughts, etc.) and not on symptoms connected to loss.

Our hypothesis was to find a specific syndrome, which can help in the separation of grief-reaction and depressive episode even when the symptoms of grief-reaction exist longer than two months. This way, the therapy of the two different conditions could be more appropriate.

II./2. Another aim was to see if the risk for complicated grief-reaction was higher when a major depressive episode had occurred previously.

II./3. On the other side it was a question if the risk was higher for major depressive episodes in patients having lifetime complicated grief-reaction.

III. METHOD

In this study, two Hungarian data sets, - one from a community health survey and another from a survey of primary care attendees - were combined.

III./1. The first survey, performed in 1995-1996, was designed to assess the prevalence of affective and anxiety disorders in a Hungarian adult population sample aged 18 to 64 years (Szádóczy et al, 1998; Rihmer et al, 2001). Respondents were selected at random from the lists of patients, regardless of their medical history, registered by 15 GPs in five different geographic areas of Hungary. Each of the selected GPs was responsible for the primary care of 1500-2000 inhabitants. A total of 3500 persons were visited in their homes, of which 2978 gave informed consent to be questioned (response rate 85%). Since 25 questionnaires were incomplete, the data of 2953 respondents were analyzed (Szádóczy et al, 1998; Rihmer et al, 2001).

III./2. The second survey was performed in 1998-1999 with the objective of assessing the prevalence of affective and anxiety disorders in 12 general practices of Budapest. Primary care attendees were interviewed in their GP's offices. Among the randomly selected 2000 patients between 18 and 64 years, 1798 gave written informed

consent to participate in the study (response rate 90%), and 1794 questionnaires were completed.

III./3. In both studies, trained lay interviewers (4th year university students at the Faculty of Psychology who had to take part in a one-week training procedure) conducted the DIS interviews.

The studies applied the Hungarian version of the Diagnostic Interview Schedule (DIS) (Szádóczy et al 1995; 1998), a fully standardized questionnaire developed by Robins et al (1981), which assesses the presence, duration and severity of symptoms and excludes symptoms due to physical illness or medication use. Since then, it has been revised according to DSM-III-R and DSM-IV criteria. We used the DIS, DSM-III-R version for constructing DSM-III-R lifetime and period (1-year and 1-month) diagnoses. Computer algorithms generated psychiatric diagnoses consistent with DSM-III-R, using the data from the DIS.

IV. RESULTS

In this study, the data of the first and second surveys were combined and only lifetime diagnoses were considered. Out of 4776 subjects, the data of 4747 respondents were processed, 717 subjects (15.1%) fulfilled the criteria of a DSM-III-R lifetime major depressive episode and 102 subjects (2.1%) the criteria of bereavement. (Table 1.)

Table 1.

Lifetime prevalence of grief-reaction and DSM-III-R major depressive episode

	<u>Male</u>		<u>Female</u>		<u>Male/Female</u>		<u>OR (95% CI)</u>
	<u>N</u>	<u>(95% CI)</u>	<u>N</u>	<u>(95% CI)</u>	<u>N</u>	<u>(95% CI)</u>	
Grief-reaction	102	2,1	25	1,4	77	3,4	2,45 (1,55-3,86)
MD episode	717	15,1	186	9,7	531	19,5	2,27 (1,90-2,71)

The mean age of respondents was 37.8 years (SD: 13.4) (males 36.7 years, females 38.6 years). Considering each subgroup as 100%, females were over-represented either in MD or the bereavement group (74.1% and 75.5%, respectively). There is no data of persons over 64 years. In agreement with previous epidemiological data, depression is more frequent in females in every age-group (Pélissolo and Lépine, 1997), but the difference between genders was not that great as in grief reaction (female/male OR: 2.27 [1.90-2.71] vs. 2.45 [1.55-3.86]), respectively.

There is a tendency for depressive episode to be more frequent than bereavement in the age-subgroup 25-34 (23.6% vs 8.8% respectively; OR [CI 95%] = 1.70 (0.71-4.05)), however, between 55-65 years of age it is just the opposite and significantly so (12.3%, 32.4%, respectively; OR ([CI 95%] = 0.24 (0.12-0.47)

Our hypothesis was that the risk for complicated grief-reaction is higher if the patient had a major depressive episode in the past. Another question was if the risk was higher for major depressive episodes in patients having lifetime complicated grief-reaction. We have found very interesting data regarding these questions. (Table 2)

Table 2

Lifetime history of grief-reaction and major depressive episode in the total sample (N = 4747)

Lifetime history	Females		Males		Total	
	N	(%)	N	(%)	N	(%)
Neither GR, nor MDE	2185	(46.0)	1740	(36.7)	3925	(82.7)
GR, with or without grief-related MDE	77	(1.6)	25	(0.5)	102	(2.1)
MDE only	531	(11.2)	186	(3.9)	717	(15.1)
GR and MDE	2	(0.05)	1	(0.02)	3	(0.1)
TOTAL	2795	(58.9)	1952	(41.1)	4747	(100)

GR = Grief-reaction

MDE = Major Depressive Episode

Table 3 shows that there were only 2 persons having “GR+MDE” which means that the risk was not higher in our sample for being depressed if the patient was suffering from complicated grief before, or having complicated grief if the person had depressive episode in the past.

There were many similarities in the relative incidence of depressive symptoms during bereavement and depressive episode.

In spite of these we found that a statistically significant difference exists only in the following symptoms: thoughts of death were significantly more frequent in bereavement (84.3% vs 64.2%), while hypersomnia (33.9% vs 14.7%), feeling of guilt and worthlessness (56.6% vs 33.3% and 52.9% vs 21.6%), and low self-esteem (50.3% vs 23.5%) were more frequent in major depression, as well as suicidal thoughts (47.3% vs 20.6%) and suicide attempt (13.9% vs 5.9%) (Table 3).

Table 3

Differences in the frequency of DSM-III-R depressive symptoms during lifetime major depressive episode and in grief-reaction*

	Depressive episode n = 717 (100%)	Grief-reaction n = 102 (100%)	OR (95% CI)
Hypersomnia n (%)	243 (33,9)	15 (14,7)	2,92 (1,64-5,17)
Guilt n (%)	405 (56,6)	34 (33,3)	2,60 1,68-4,03
Worthlessness n (%)	379 (52,9)	22 (21,6)	4,07 (2,48-6,68)
Low self-esteem n (%)	361 (50,3)	24 (23,5)	3,29 (2,03-5,32)
Thoughts of death n (%)	460 (64,2)	86 (84,3)	0,33 (0,19-0,58)
Suicidal thoughts n (%)	339 (47,3)	21 (20,6)	3,45 (2,09-5,71)
Suicide attempt n (%)	100 (13,9)	6 (5,9)	2,59 (1,10-6,07)

* only symptoms that show significant difference (p<0.05) were listed

There was no significant difference in the relative incidence concerning the other symptoms. However, lifetime history of comorbid panic disorder was significantly more frequent in major depression than in bereavement (8.4% vs 3.9%; OR: 1.14 [0.43-3.00]).

V. DISCUSSION

These rates, the higher number of women, and the low number of persons with grief-reaction and major depressive episode are similar to the findings of Bruce et al (1990), where bereaved respondents were more likely to be women, and none of the bereaved reported a prior depressive episode.

In spite of the overlaps between depressive symptoms during bereavement and a major depressive episode, there is a characteristic pattern in both conditions, which makes a difference between a depressive episode and complicated bereavement. The cognitive symptoms were significantly different between the two groups, which shows that mainly the symptoms of depressive cognition differentiate between depression and bereavement and not additional symptoms, which were not statistically different, except hypersomnia. Similarly, Breckenridge et al (1986) pointed out that although bereaved people report several features, which are associated with depression, the likelihood of self-deprecatory cognition was no greater among them than among control participants.

In bereaved and depressed patients the different rates of suicidal thoughts (20.6% vs 47.3%) and suicide attempts (5.9% vs 13.9%) showed that patients with depressive episode are at a higher risk for suicidal behavior – as it has already been reported by Bornstein et al. (1973).

The reason for this might be that people with bereavement are often thinking of death, but it usually does not concern themselves, but the dead person. Thoughts of death relate to the death of the close relative/friend or to death in general in case of bereavement, and do not mean that they have suicidal thoughts or are at a higher risk for suicide attempts, which is connected rather to major depression.

The finding that lifetime history of comorbid panic disorder was significantly more common in major depression than in grief reaction can be one of the consequences of the fact that the rate of lifetime history of panic disorder is much more common in patients with a major depressive episode than those with no lifetime history of mood disorders (Rihmer et al., 2001).

In other words, because of the very frequent comorbidity of panic disorder and major depression –either unipolar or bipolar type (Rihmer et al, 2001)-, panic disorder can also be a good marker of major depression but not for grief reaction.

VI. CONCLUSIONS AND USING THE RESULTS IN CLINICAL WORK

Bereavement is generally considered as a common psychological reaction to loss, i.e. death of a loved person and involves many depressive symptoms. Our findings show that in spite of the overlap in the symptomatology between bereavement and depression, some symptoms can help in the separation of the two conditions.

In addition, these symptoms (thoughts of death, hypersomnia, feeling of guilt and worthlessness, low self-esteem, suicidal thoughts) and prior history of panic disorder and suicide attempt indicate a syndrome different from “complicated grief” (Prigerson et al, 1995a; 1995b), and can be good predictors of future major depression among persons with grief-reaction.

Recently bereaved persons are well-known targets of suicide prevention efforts (Rihmer et al., 2002). Our findings can help in the identification of particularly vulnerable persons for major depression among the relatives of suicide victims too.

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VIII. PRESENTATIONS ON THE TOPIC OF THE DISSERTATION

VIII/1. Publications

Kiss K., Szádóczy E., Rózsa S., Rihmer Z., Belső N., Füredi J.
Mourning and melancholy: symptomatological differences and overlaps between depression and grief-reaction.
Psych Res 2003,(in press)

Kiss K., Rihmer Z.
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Strategies for suicide prevention. Current opinion in psychiatry 2002, 15:83-87.

Balázs J., Kiss K., Szádóczy E., Bolyós Cs., Laczkó K., Szabó J., Bitter I.

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Possible effect of gender and season on the length of hospitalization in unipolar major depressives – *J Aff Dis* 2003, 73:279-282.

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VIII/2. Presentations

Kitty Kiss

Gyász és depresszió: eltérések és átfedések a depresszió és a gyász-reakció tüneti képében. MPT, Sopron, 2003

VIII/3. Posters

Kitty Kiss, Erika Szádóczky, Sándor Rózsa, Zoltán Rihmer, Nóra Belső, János Füredi: Mourning and Melancholy: Symptomatological differences and overlaps between depression and grief-reaction. AEP epidem., 2002

Zoltán Rihmer, Kitty Kiss, Nóra Belső, Erika Szádóczky: Changing suicide rates in Western and Eastern Europe: The possible causes. AEP epidem., 2002

István Kecskés, Zoltán Rihmer, Kitty Kiss: The seasonal distribution of admissions and the duration of hospitalization in depressed patients. ECNP- Munich, 2000