

## Issues in Bereavement: Preparatory Grief vs. Depression

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In end-of-life care, distinguishing grief associated with advanced illness from symptoms of clinical depression can be difficult. The complex physical and psychological symptoms seen at the end of life pose challenges to those caring for patients with severe, life-threatening illness. The distinction between preparatory grief and depression has been debated in the literature. Overlooking depression in the patient facing end of life can lead to absence of treatment. The task of differentiating depression from the normal grief associated with end of life is important. In this article, we identify the rationale for differentiating grief from depression and how to identify these two entities. The key differences will be identified and approaches to treatment will be discussed.

Preparatory (anticipatory) grief is a normal reaction experienced by patients who are dying. Usually, patients have a progression through the physical, psychological, emotional, spiritual, social, cognitive and behavioral changes necessary to move toward acceptance of their loss. At times, the patient can experience “waves of intense grief,” requiring them to process their loss again.<sup>1</sup> It is common to go through this type of grief, and it frequently leads the patient toward acceptance of their situation. This acceptance prepares the patient for the final separation that death brings to them. Symptoms associated with grief can include somatic distress, loss of appetite and sleep disturbance. Emotional and spiritual distress may lead to social withdrawal.<sup>1,3</sup>

Depression is characterized by a negative self-image, lack of self-worth, anhedonia, persistent dysphoria and hopelessness. Thoughts of suicide and desire for early death can be an indicator of depression. Physicians caring for this group of patients should have a high index of suspicion for depression. Evidence of neurocognitive symptoms in the elderly can be an indication of depression. According to the DSM-IV-R, criteria for major depression include five of the above listed symptoms lasting for more than two weeks duration. In addition, at least one of the symptoms must be depressed mood or anhedonia. In palliative care, the use of somatic symptoms as an indicator of depression may result in misdiagnosis of the patient who is truly experiencing physical decline from his or her terminal disease. These patients should not be confused with patients who are

depressed and exhibiting somatic symptoms. The distinction of somatic symptoms that are part of the patient’s disease and its co-morbidities from those associated with depression can be difficult. Use of standardized tools such as the Edmondton Symptom Assessment Scale (ESAS) can be helpful in making this distinction. Uncontrolled symptoms can lead to depression, and this underscores the importance of palliative care for patients that have terminal disease.

Clinical depression is experienced by 22 to 75 percent of people who are dying. Depression is not an inevitable part of dying. Attention to the presence of depression and timely introduction of antidepressant therapy is the key to reducing the incidence of depression. The treatment of depression may also include non-pharmacologic approaches such as psychotherapy and psychosocial intervention.<sup>3</sup>

Clinically, depression and grief frequently coexist. Clinical assessment is essential. Approaching the patient and asking “are you depressed?” or “do you feel that you are better off than many other people in this situation?” has proved to be a valid method to obtain diagnostic information about the patient’s frame of mind. Some patients and family members are readily able to identify depression, while others do not have this introspection. Validated depression screening tools are helpful in the diagnosis of depression.<sup>7</sup> In the patient with cancer, it has been shown that a single-question screen is more effective in identifying patients with depression in comparison to more complicated psychiatric screening tools. It is the responsibility of the physician or interdisciplinary team to distinguish clinical depression from grief in patients with life-threatening and chronic, progressive illnesses. Once identified, depression can be treated more quickly, allowing improved quality of life. Note Table 1, which compares and contrasts preparatory grief and depression.

Pharmacotherapy in association with psychosocial intervention can lead to significant improvement in depressed patients at end of life. A risk of undesirable side effects from antidepressants exists; therefore, careful identification of depression before initiating pharmacotherapy is prudent.<sup>1</sup> Lack of treatment of depression in this group of patients may lead to social withdrawal from friends and family leading to worsening of the depression as well as delaying

**Table 1.**  
**Comparison between preparatory grief and depression in end-of-life care**

<b>Preparatory Grief</b>	<b>Depression</b>
<ul style="list-style-type: none"> <li>• Normal Self-Image</li> <li>• Absent anhedonia</li> <li>• People process through grief and it diminishes in intensity over time</li> <li>• Maintain sense of hope</li> <li>• Thrive with social interaction</li> <li>• Brief period of agitation, then acceptance</li> <li>• Patients frequently cope with grief on their own</li> <li>• Improved with symptom control</li> <li>• Positive attitude toward the future</li> </ul>	<ul style="list-style-type: none"> <li>• Negative Self-Image</li> <li>• Anhedonia</li> <li>• Pathological Process, patient may become “stuck” without treatment</li> <li>• Loss of sense of hope</li> <li>• Withdrawal, isolation</li> <li>• Agitation and sense of discomfort</li> <li>• Treatment is necessary for patient to improve</li> <li>• Active desire for early death</li> <li>• No hope for future</li> </ul>

adequate assessment and treatment of other physical symptoms.<sup>3</sup> Patients who have adequate support for their grief and treatment of depression, if present, are more able to do the emotional work of saying good-bye to family members. This is a source of improved quality of life for the patient as well as the family. Assisting the patient in dealing with grief includes taking the time to reflect, empathize, educate and validate the patient's experience.<sup>6</sup> Educating the family leads to improved coping with the stress of a family member's illness and subsequent death. These supportive interventions are key in the care of patients with life-threatening disease.

The approach to the terminally ill patient with psychological stress is well delineated by the ACP-ASIM End-of Life Care Consensus Panel,<sup>4</sup> which eloquently discusses the reasons for identifying and treating the patient with psychological stress. Psychological distress is common, and many patients and their families (as well as their caregivers) believe it is necessary at end of life. This represents a barrier to effective therapy of depression. Early diagnosis allows the introduction of pharmacologic agents in a timely manner, thus allowing them to have time to be effective. Diagnosis of depression later in the course of their disease requires a different pharmacologic approach.

The standard agents used for the treatment of depression in terminally ill patients are the selective serotonin reuptake inhibitors (SSRIs) or tricyclic antidepressants. Choosing paroxetine or sertraline in this patient population may decrease side effects because of fewer active metabolites. Tricyclic antidepressants have autonomic side effects and are sedating. The use of tricyclic antidepressants should be accompanied by judicious dosing and close observation. It is important to reassess and adjust medication to achieve the desired response. Referral to psychiatry should be considered if the patient is not responding to treatment. Other indications for referral to psychiatry include history of or

active mental illness, requests for assisted suicide, or if the patient is suicidal.<sup>4</sup>

The patient in whom depression is noted at the very end of life may not have time to respond to the traditional approach of SSRIs. It is in this population that psychostimulants may be effective. Use of methylphenidate or dextroamphetamine in this group of patients may bring about improvement because they take effect quickly. These drugs are indicated in the patient with depression that has a relatively short life span.<sup>4</sup>

Caring for patients at the end of life requires the practitioner to have skill in diagnosis and treatment of physical and psychosocial issues. The absence of high-quality interdisciplinary care can lead to patient and family suffering due to lack of attention to issues in symptom management and emotional needs. Grief is a common occurrence and supportive care is helpful in teaching the patient and family to cope. Recognizing the presence of depression and treating it appropriately leads to improved quality of life and, therefore, improved quality of care.

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