From Context to Phenomenology in Grief Versus Major Depression

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“There is a sanity to grief…given to all, [grief] is a generative and human thing…it acts to preserve the self.”
— Kay Redfield Jamison, PhD, Nothing Was the Same

Mr. Smith is a 72-year-old retired businessman whose wife died of cancer 3 weeks ago. At presentation he says, “I feel down in the dumps and weepy every day, Doc — really lousy! I don’t get any pleasure out of anything anymore, even stuff I used to love, like watching football on TV. I wake up at 4 in the morning almost every day, and I have zero energy. I can’t keep my mind on anything. I barely eat, and I’ve lost 10 pounds since Mary passed away. I hate being around other people. Sometimes I feel like I didn’t really do enough for Mary when she was sick. God, how I miss her! I can still cook for my- self, pay the bills, and so on, Doc, but I’m just going through the motions. I don’t enjoy life at all anymore.”

Of course, you would want more detailed information regarding Mr. Smith’s mental status exam, personal and family history, etc, but how you would conceptualize his situation, knowing only the information provided might lead you to conclude that Mr. Smith merits a diagnosis of major depressive disorder (MDD); or that he has a condition “resembling” MDD, but “not really” MDD. Perhaps you would conclude he shows normal “non-disordered sadness” in the context of recent bereavement.

This hypothetical highlights the controversy surrounding the construct of depression and its relationship to the “normal” grief of bereavement after the death of a loved one. Notwithstanding the tragic blow Mr. Smith has suffered, experienced clinicians will be very concerned about a patient presenting with this picture. Mr. Smith easily meets symptom and duration criteria for MDD in both the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) and fifth edition (DSM-5). A previous bout of MDD in his history would strengthen the likelihood, as would several other clinical findings I have omitted.

And yet, according to DSM-IV criteria, Mr. Smith probably would not be diagnosed with a major depressive illness. He would simply be called “bereaved” because he is still within the 2-month period that allows for use of the bereavement...
exclusion (BE); and because, based solely on the facts presented, Mr. Smith lacks the features that would “override” use of the BE, such as severe functional impairment, suicidal ideation, psychosis, morbid preoccupation with worthlessness, or extreme guilt. Ironically, and paradoxically, if Mr. Smith’s wife had left him for another man 3 weeks prior to presentation, he would, in fact, meet DSM-IV MDD criteria.

Some might argue that whereas Mr. Smith’s clinical picture “resembles” an episode of MDD, it is, in some sense, “not really” MDD. But, absent empirical data, the notion that his picture merely “resembles” major depression amounts to a kind of metaphysical claim: it seems to posit an entity — let’s call it “not really MDD” — that “mimics” a major depressive episode but is, in some unspecified sense, another condition. A very rough analogy would be the relationship of the viceroy butterfly to the monarch butterfly. Both are orange-and-black butterflies, but are known to represent different species. For example, whereas the monarch butterfly feeds on milkweeds and thereby absorbs a toxin that is distasteful to birds, the viceroy butterfly lacks both these features; it “benefits” from its mimicry of the monarch butterfly because birds avoid eating it. In short, we can find differentiating features of these two similar entities that allow us to say that the viceroy merely “resembles” the monarch.

To be sure, this type of argument has merit in certain clinical situations. For example, a patient who develops manic-like symptoms shortly after snorting cocaine could rightly be said to have a condition that “resembles” or “mimics” mania, based on the “context” of recent cocaine use. It actually might be a legitimate example of a “false positive” for mania, but in this scenario, we have good and sufficient medical reasons, based on thousands of cases of cocaine-induced “manic-like” states, to say that the “context” is critically important in rejecting a diagnosis of bipolar disorder. Indeed, the cocaine use makes it quite “understandable” that the patient developed manic-like symptoms. However, that does not render the manic-like symptoms a “non-disordered” state; nor would any physician opine, “Well, anyone would have become manic under those conditions — that’s just normal!”

But now, returning to Mr. Smith: Are we justified in saying that his condition is a non-disordered state because it occurred in the entirely “understandable” context of bereavement? In short, does Mr. Smith fit the “viceroy” paradigm? To make that case, in my view, we would need convincing evidence that someone with Mr. Smith’s clinical picture will likely show, for example, a different degree of morbidity and mortality; a different level of functional impairment or clinical course; or a different response to treatment than someone with identical depressive symptoms arising outside the context of recent bereavement.

But notwithstanding some survey-derived data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) study,¹ there are few if any clinical studies of bereavement-related depression (BRD) that support the “viceroy” model (ie, that demonstrate that Mr. Smith’s picture merely “resembles” MDD but is in fact “something else.”) On the contrary, the preponderance of clinical data strongly suggest that BRD does not differ in any clinically important respects from non-BRD that meets DSM-IV symptom and duration criteria for a major depressive episode.²³

As to the claim that Mr. Smith is merely showing “normal, non-disordered sadness,” this, too, requires a demonstration that individuals like Mr. Smith show no greater morbidity or mortality than the average “sad” or grieving person who does not meet DSM-IV symptom and duration criteria for MDD, but, to my knowledge, no empirical studies have demonstrated this.

“DISORDER” IN PSYCHIATRY AND GENERAL MEDICINE

I believe these considerations lead to the conclusion that psychosocial “context” is not a reliable or veridical indicator of “disorder” versus normalcy. Indeed, as a rule, the recognition of “disease” or “disorder” in general medicine is not “context dependent,” once a certain threshold of suffering, impairment, and incapacity is crossed. Neither is knowledge of the condition’s etiology necessary in declaring it a “disorder.” Thus, a patient who experiences sudden, crushing substernal chest pain radiating to the jaw, accompanied by nausea, sweating, and irregular heart rate, usually receives a preliminary diagnosis of “ROMI” — rule out myocardial infarction — and is universally considered “disordered,” regardless of the “psychosocial context” of the complaints. If the patient says, “It all started when I opened a
letter from the IRS, telling me that I owed $50,000;” I doubt any competent physician would say, “Oh well, anybody would experience crushing chest pain, reading a letter like that,” and not treat the patient.

Some may object that, unlike in psychiatry, there are biological tests in general medicine that can confirm the presence of disease (eg, cardiac enzyme elevations in acute myocardial infarction). But this claim is only superficially and generally true. Many medical and neurological diagnoses such as fibromyalgia, migraine, tardive dyskinesia, and atypical facial pain, lack biological “tests” and yet remain recognized disorders.

Context is important when considering certain physiological responses to stress, which are generally transient, functional, and adaptive in nature. A patient experiencing persistent tachycardia while sitting in a chair is clearly different from one whose heart rate is 120 beats/minute while climbing the stairs of the Washington Monument. (To prefigure my later distinction between grief and major depression: ordinary grief may be understood as roughly analogous to the adaptive tachycardia related to normal exertion; major depression may be understood as roughly analogous to myocardial ischemia under such conditions).

Similarly, the etiology of a disorder (qua disorder) must indeed be subject to contextual scrutiny, as with treatment considerations. Proper medical care demands such scrutiny, including consideration of psychosocial context. For example, Italian cardiologists reported a case of a 76-year-old woman with mild-to-moderate mitral regurgitation who developed severe mitral regurgitation while undergoing transesophageal echocardiography (TEE), during which she experienced “deep anxiety.” A subsequent TEE under general anesthesia, and thus, “...without the emotional involvement of the patient,” did not provoke severe mitral regurgitation.

This change in psychological “context” has important etiological and management implications for the patient, but it does not render the initial worsening of her mitral regurgitation “normal” or “non-disordered.” By analogy: A major depressive syndrome that is “understandable” because it occurs in a stressful psychosocial context such as bereavement, job loss, etc, is not thereby rendered nonpathological.

THE FALLACY OF MISPLACED EMPATHY

The fallacy of misplaced empathy is predicated on the notion that, in a manner of speaking, “If I can readily understand why someone is depressed, particularly on the basis of my own experience, then, all things being equal, the depression does not represent a disorder.” This is no less fallacious when applied to “perfectly understandable depression” than when applied to pain in the context of abdominal surgery. A patient who complains of intense pain around the wound site after abdominal surgery is not denied a diagnosis of “postoperative pain,” much less denied pain-relieving medication, because we “understand the context” of her pain. As one of my professors used to teach, no physician would say of such a patient, “You’d be in pain, too, if you just had abdominal surgery!”

Of course, context is clearly important in working therapeutically with the depressed patient. But even in psychotherapy, the issue of “context” must be carefully and critically scrutinized, and not confused with causality or etiology. Indeed, the very concept of “cause” proves to be complex and elusive, when considering the patient with depressive complaints.

PATIENTS’ NARRATIVES AND THE PITFALLS OF “CAUSALITY”

Some have argued in favor of classifying depression based on the criterion, “with or without cause.” They argue that this has been the traditional approach of physicians for centuries, and that only in recent decades, roughly beginning with DSM-III, have psychiatrists taken a disastrous turn away from this model toward one of “decontextualized” diagnosis. Actually, this argument is dubious on historical grounds, since physicians in earlier centuries probably did not adhere to a “with or without cause” paradigm in identifying disease or disorder. According to medical historian H. Erik Midelfort, PhD:

“...for ancient and early modern physicians, there was no clear bright line between disease and health. They did not, generally, decide that someone was suffering an understandable and proportionate sadness and was not therefore ‘ill.’ They generally decided that if one were suffering, for whatever reason and whether proportionate or disproportionate, they would do what they could to help: suggest music, friendship...less ‘dry food,’ and more ‘moistening’ foods, more or less alcohol...etc.”. But these remedies did not depend upon a strict decision that so and so was...
fundamentally ‘ill’ while someone else was merely sad for good, sufficient, and proportionate reasons.” (personal communication, 11/1/08)

Even more centrally, “causality” is itself a problematic construct when applied to MDD, and the patient’s own “theory of the case” may prove to be misleading or incomplete; eg, the patient may be unaware of, or ignoring, the presence of an underlying medical disorder; unresolved intrapsychic conflicts; or environmental stressors not related directly to recent bereavement. Physicians in other medical specialties seem aware that the patient’s narrative, in so far as it posits “causes” for the presenting illness, must be evaluated respectfully, but not credulously. And this is precisely where the “depression with and without cause” argument comes off the rails. For example, James R. Roberts, MD, a professor of emergency medicine, notes that:

“Patients with many conditions tend to lead physicians astray by overemphasizing diet, injury, ‘sleeping on it wrong,’ or other temporal or circumstantial scenarios. They scour the past and their environment for a layman’s cause. The young woman with acute gonococcal arthritis of the knee will often relay bogus trauma; the elderly man with a thoracic dissection always seems to have picked up a heavy object the day before; and most patients with appendicitis remember eating some bad tuna. While few clinicians would allow the pepperoni pizza or beer history deter an investigation for myocardial ischemia in a high-risk patient with ‘indigestion,’ it’s quite easy to relate extremity pain to a patient-proffered, albeit erroneous, etiology.”

There are instances in which the “obvious” cause of a patient’s depression also turns out to be the actual, or at least, the proximate or principle, cause of the depression. This seems almost self-evident, after, say, the death of spouse or family member. But sometimes, what seems self-evident is simply wrong. (After all, for hundreds of years, it was “self-evident” that the sun moved around the earth!) When it comes to assessing the depressed patient, there are often multiple, overlapping causes or concomitants, and the patient’s recollection of temporal sequencing is not always reliable. As Gabbard has observed,

“...often the stressor identified by the patient (or therapist) is retrospectively assumed to be the cause [of the depression] because it fits a particular intrapsychic narrative — often one involving victimization. It’s rarely that simple. Often there are multiple stressors; issues involving adult developmental phases; dashed fantasies and hopes; and failures to live up to the expectations of internalized parents...” (Gabbard G: personal communication, 12/31/08).

Furthermore, there are immense practical difficulties in applying the notion of depression “with” or “without cause,” as Lars V. Kessing, MD has noted:

“...it is difficult in clinical practice to discriminate between different categories of depression on the basis of presence or absence of a psychic trauma or a stressful life event...the inherent problem may be that it is difficult to decide whether a present life event...constitutes a psychic trauma for the individual patient or not.”

TOWARD DEVELOPMENT OF A SCREENING TOOL

The conundrum we are discussing is often summarized as, “It’s hard to know where to draw the line between grief and depression” or, “it’s all a matter of degree.” But that view is challenged by many mood disorder specialists. I suspect the misconception arose because of psychiatry’s overemphasis on symptom checklists, at the expense of understanding the patient’s frame of mind or “world view” — what philosophers call, phenomenology. This superficial diagnostic orientation has been exacerbated by the belief — misguided, in my view — that it is “disrespectful” or “devaluing” to tell a recently bereaved patient that he or she has a depressive disorder; and that doing so “medicalizes” a perfectly normal and adaptive human response to loss. And yet, based on the best available, albeit imperfect, data, the patient who meets MDD criteria in the context of recent bereavement is probably not experiencing a “normal” and “adaptive” response. Withholding a diagnosis of MDD seems an odd way of “respecting” a patient who may be at risk for further decompensation or suicide; indeed, in my view, doing so would be unethical.

Furthermore, when we explore the substantive differences between ordinary grief and major depression, we are led to the conclusion that they are fundamentally different constructs and states of being, notwithstanding some overlap in symptoms such as sadness, insomnia, and social withdrawal. I have hypothesized
4 principle domains in which grief and major depression differ phenomenologically: the relational, temporal, dialectical, and intentional.

In relational terms, during ordinary grief, the individual is usually able to maintain an emotional connection with significant others; in major depression, the severely depressed patient is typically on an “emotional island” and feels outcast and alone. Furthermore, as Dr. Kay Jamison has noted, the normally grieving person is capable of being consoled by significant others, whereas the severely depressed person is usually inconsolable.10

In temporal terms, the grieving individual usually feels that the “bad times” will eventually pass, and that the future contains some hope; the severely depressed person often feels as if time itself has “slowed down,” and that the depression will never end.11,12 As Jamison described her own experience with grief and depression: “Time [spent] alone in grief proved restorative; time alone when depressed was always dangerous.”13 Ordinary grief may also be understood in dialectical terms, in that the grieving person engages in a kind of “inward dialogue” between hope and despair; in contrast, the severely depressed person typically remains “hopeless” most of the time. Lastly, grief may be understood in intentional terms; that is, we usually give ourselves over to grief, by, for example, participating in various mourning rituals. In contrast, we typically experience severe depression as an involuntary state — one that seizes or overwhelms us.

Recently, my colleagues and I developed a potential screening ques-
tionnaire called the Post-Bereavement Phenomenology Inventory (PBPI), which expands these domains by means of targeted, dichoto-
mouse questions.14 A predominantly left-sided response on the PBPI is hypothesized to be more common with MDD; a predominantly “right-
sided” response, with ordinary grief. It should be stressed that the PBPI is still in need of field-testing and validation, and is referenced here chiefly for heuristic purposes.

CONCLUSION
The psychosocial context of a patient’s depressive symptoms is undeniably important in understanding one component of the depression’s etiology, and in structuring psycho-

erapeutic treatment. However, the etiology of a depressive episode is often complex and richly over-de-
termined; hence, the patient’s nar-

rative vis-a-vis psychosocial stressors should be viewed with respect, but not credulity. Furthermore, the presence or absence of disordered mood should not be determined by psychosocial context; rather, by the nature, degree and duration of the patient’s suffering and incapacity. Grief and depression are distinctly constructed, with fundamentally different phenomenology. Further research aimed at refining these distinc-
tions should prove helpful in distinguishing “proper sorrows of the soul”15,16 from the potentially lethal disorder of major depression.

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