

Grief Reactions and Depression in Family Practice: Differential Diagnosis and Treatment

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To make a differential diagnosis between depression, normal grieving, and pathological grief reactions is a common problem for family physicians. Patients often present to the family physician with physical symptoms, such as pain, headache, dizziness, fatigue, and disturbances of digestion and sleep, rather than psychological symptoms. Treatment modalities and effectiveness differ depending on specific diagnosis. The family physician is in a unique position to influence prevention, early detection, and morbidity of these disorders.

The family physician is in a unique position to observe the evolution of disease processes and clinical syndromes and to provide early detection and prevention. This is especially true of psychosocial problems encountered in medical practice.

The recognition of depression and grief syndromes is especially important in family practice. It is important to distinguish whether depression is a symptom of a psychiatric or medical illness, of normal grieving, or of a pathological grief reaction. As is true of medicine in general, sophisticated differential diagnosis is essential because proper and effective therapy is based upon proper diagnosis.

The treatment modalities for depression, grieving, and pathological grief reactions are specific, effective, and vary depending upon diagnosis.

Grief and Grieving

Grief and grieving are normal aspects of the human condition. They result from experiencing a loss and are a consequence of the human capacity to develop significant attachments. Normal grieving is characterized by intellectual and emotional awareness of the loss, acute onset, psychic pain,

physiological somatic distress, preoccupation with the image of the lost person, feelings of guilt, anger, and hostility, and changes in normal conduct.¹ Most people who experience and acknowledge a loss grieve to completion with family and friends and do not seek psychiatric help.²

Unresolved grief reactions include delayed, incomplete, and pathological grief syndromes. These syndromes may include a persistent memory of the events surrounding the loss; an anniversary grief experience; persistence of intense affect, such as anger or sadness, when discussing the loss; a splitting of the cognitive and affective recognition of the loss, often manifested by verbalizations, as if the lost person were still present; an inability to cry; emotional and irrational hanging on to linking objects; the presence and persistence of a variety of physical complaints, such as headache, fatigue, dizziness, and increased susceptibility to real injury,³ illness,⁴ morbidity, and death; and flooding with intense disproportionate emotion at the time of subsequent loss or crisis.

Depression

In a discussion of depression as a counterpoint to the discussion of grief, it is important to review the medical and social meaning attached to the word depression.

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Table 1. Causes of Secondary Depression

Medical	Medications	Psychiatric
Major surgery	Reserpine	Schizophrenia
Childbirth	Birth control pills	Schizoaffective disorder
Hypothyroidism	Cortisone	Alcoholism
Cushing's syndrome	Alcohol	Borderline syndrome
Carcinoma of the lung	Marijuana	Personality disorders
Carcinoma of the pancreas	Barbiturates	
Presenile dementia (Alzheimer's disease)		
Viral disease		
Mononucleosis		
Influenza		

Depression is a normal human affect; it is a feeling of sadness. Depression serves as a signaling device to alert the depressed person and his or her loved ones that there is a disruption in the usual homeostatic state, either physical, psychological, or social.

Depression is an existential state, a normal part of the life experience of normal people, usually transient and often accompanying anger, conflict, and disappointment.

Depression is also a symptom. If the physician can recognize the presence of depression as a symptom beyond a normal transient range of affect, it may be a symptom of an illness. Depression can be a symptom of either a psychiatric or a medical illness.

Depression as a clinical syndrome includes (1) dysphoric mood changes of sadness, (2) behavioral changes of psychomotor retardation or agitation, (3) multiple vague physical symptoms, and (4) specific physical symptoms from diencephalic disturbances, which include appetite and digestive disturbance, diminution of general energy levels and specific loss of sexual interest, and energy and sleep disturbances, usually frequent awakening, difficulty returning to sleep, and early morning awakening.

Depression as an illness is a major affective disorder, whether a major depressive episode in a recurrent depressive illness, a single episode of a major depressive disorder, or an episode of depression in the bipolar disorder, manic-depressive illness.⁵

As a primary illness, depression is characterized by a positive family history,⁶ no other underlying illness, and a positive response to tricyclic and tetracyclic antidepressants, monamine oxidase inhibitors, lithium, or electroconvulsive therapy.

Etiology

Normal grief and pathological grief syndromes, as well as depressive symptoms or illness, may follow crisis events in the life of the individual, his social system, or family, which can include, but are not limited to, pregnancy, miscarriage, abortion, birth, birth of an ill, injured infant or a premature infant, any episode of illness in the person or loved one (especially myocardial infarction, stroke, or sudden unexpected illness), amputation, diagnosis of cancer, divorce, job loss or change, or death of child, spouse, friend, or loved one.

If the loss is anticipated, as in the case of prolonged illness, anticipatory grieving can occur.

Many, but not all, cases of pathological grief occur when the loss is sudden and unexpected, when the loss is not recognized by the individual or others,^{4,7} or when permission to grieve is denied to the grieving person, either by others or by the grieving person himself.

Causes of secondary depression can include nearly all medical, surgical, and psychiatric illness (Table 1).

A major psychological stress can often cause a primary depression. The stress can be associated with a major loss and concomitant prolonged or

incomplete grieving. Major affective disorders, especially the bipolar disorder, are more common among family members than in the general population.^{5,6}

Incidence

Approximately 20 percent of women and 10 percent of men in the adult population have had a major depressive episode. About 1 percent of the adult population has had bipolar disorder, which is equally common in men and women.⁵ Incidence studies report that affective disorders are among the top ten diagnoses in primary care.⁸

Widmer and Cadoret⁹ describe a follow-up study of 43 patients previously diagnosed as depressed who had 59 subsequent episodes of depression. They emphasized that while psychiatric criteria for diagnosis of depression emphasize psychological symptoms, the depressed patient presents to the family physician with somatic symptoms of pain, anorexia, weight loss, fatigue, headache, symptoms of respiratory illness, gastrointestinal complaints, and other functional complaints due to weakness, fatigue, and dizziness. They also noted that the patients were unable to recognize the development of depression in spite of their previous experience.

Reifler et al¹⁰ reviewed the literature to determine incidence and prevalence of depression in primary care practice and found reported incidence between 0.2 percent to 1.5 percent, and they reported an incidence of 4.5 percent of 1,321 total adult patient visits.

Raune³ reported a case of repeated trauma as the presenting symptom of a pathological grief reaction. Corney and Horton¹¹ reported a case of pathological grief following a spontaneous abortion, and Stack⁴ presented a number of cases of unresolved grief reactions following spontaneous abortion.

It is important to emphasize that the majority of patients presenting to family physicians with these clinical conditions do not usually recognize their symptoms or illnesses as depression or grieving.

Morrison¹² reported on a review of records of 176 patients with an isolated diagnosis of fatigue in which a specific physical or psychological diagnosis could be made. He observed that 72 of the 176 (41 percent) diagnoses were psychological. Depression was diagnosed in 43 percent of the cases, with

anxiety, stress, adjustment reaction, and alcoholism making up the remainder.

Whenever the patient's symptoms are vague or the physician suspects a diagnosis of depression or grieving, it is important to pursue this diagnosis early by reviewing the history and inquiring about past depressive illness, previous manic episodes, family conflict, or loss. The patient will often be able to acknowledge rapidly the psychosocial aspects of his present concern. Usually not deeply repressed, these issues are often preconscious and easily accessible to the patient if the physician inquires.

An accurate diagnosis is important because proper therapeutic planning is dependent upon it. In fact, the process of obtaining the diagnosis is often therapeutic in itself, as reported by Brody and Waters.¹³

Treatment

Treatment of normal grieving should allow some degree of distress, allow and encourage questions and talking about the loss, avoid excessive sedation, and be alert to the one family member who may be taking care of everyone else. In cases such as miscarriage, stillbirth, and sudden death, the physician can alert the patient and family to the need to grieve, to talk about the loss, to cry together, and to hold the bereaved person.

The grieving person should be assured that illusory experiences, dreams, and episodes of unexplained sadness or crying are signs not of mental illness but of the normal grieving process. To allow these experiences to occur will facilitate healing and the pain will subside. The endpoint of grieving is not to forget the loved lost person but to be able to remember without pain.

To treat the unresolved grief reaction is essentially to recognize it, to identify it as the underlying cause of the patients' complaints, and if possible, to encourage normal grief work with family and friends. The treatment by professionals is always psychotherapy, usually short-term time-limited therapy.

The treatment of the pathological grief reaction, in which the patient may exhibit severe dissociative, behavioral, or psychiatric symptoms, consists of more intense psychotherapy, often requiring hospitalization. In cases of grief work, medications may be of little help and may be contra-

indicated because of sedation and suppression of dreams. If the grief syndrome includes the diencephalic signs of depression, antidepressant medications may be of help.

To treat depression as a symptom (ie, secondary depression) is to treat the underlying condition, whether medical, surgical, or psychiatric. It is important to remember that depression, when it is a symptom of other psychiatric conditions (borderline syndromes, a character disorder, alcoholism, or schizoaffective disorder), will often not respond to the usual treatment for the illness depression.¹⁴ Frequently these patients complain bitterly of the side effects of the medication or experience a worsening of their illness, as when a psychosis is precipitated in the schizoaffective patient who is treated with tricyclic antidepressants.

The treatment of primary major depression, whether a single episode or recurrent or bipolar, includes tricyclic and tetracyclic antidepressants, monamine oxidase inhibitors, lithium, and/or electroconvulsive therapy. Supportive psychotherapy is also of help during the episodes of illness.¹⁵

Case Reports

Case 1

A 36-year-old mother of two children complained of a generalized nonspecific headache of two months' duration. Her medical review and neurological and funduscopic examinations were normal. She was told that her headache was probably not of physical origin, and she was asked whether she was having any family or emotional problems or whether she had experienced any recent loss. She immediately began to talk about the sudden death of a woman with whom she worked in a church guild. Although these women were of different educational and social backgrounds, she had been invited to the woman's home and considered this woman, who was very kind to her, to be her best friend. The patient attended the funeral, as did many others in the community. She felt a sadness and a need to cry and to talk about the woman, but her husband told her not to talk about it, that it would not help bring her friend back.

On relating these events, the patient experienced considerable sadness and did cry. It was pointed out to her that the duration of her headache was the same as the interval since the

woman's death. Her family physician suggested that she share with her husband her new awareness of the link between the headache and the unmet need to grieve and ask him to allow her to talk about her friend, to allow her to cry, and to hold her. This entire exchange, history, neurological examination, and elicitation of the nature of the loss and its relationship to the headaches, took 20 minutes of the family physician's time. The patient reported one month later, at the time of an office call for one of her children, that she had done as suggested, her husband had been responsive to her, and she had not had a headache since her visit.

This case demonstrates the value of immediately asking questions about conflict or loss, the value of the family physician knowing the patient and her family, the easy availability of the grief-provoking episode, the role of the care giver in facilitation of grieving, and the role of the family in blocking or allowing normal grief work in normal people.

Case 2

A 30-year-old mother of two children complained of increased susceptibility to illness, fatigue, cough, and nasal discharge since an early miscarriage four months previously. Examination revealed a purulent nasal discharge, x-ray evidence of maxillary sinusitis, and a labile, weepy, and angry affect. When asked to describe how she felt about her miscarriage, she wept and described the starkly clear recurring memory of the events of that day. She acknowledged her ambivalence about the pregnancy, her denial of this miscarriage, and her unfulfilled need to be comforted and to be allowed to assume the role of a grieving person. In addition to proper treatment of her sinusitis, she was seen weekly for four weeks for re-grief work with psychotherapy. She did significant grief work with family and friends and in therapy.

Her labile affect subsided, the details of the memory of the miscarriage began to blur, and she could talk about her experience without pain. Her chronic fatigue and susceptibility to illness resolved, as did her sinusitis.

This case demonstrates the role of unresolved grief in susceptibility to real physical illness, rather than presenting with vague symptoms, and the role of family, friends, and care givers in facilitation of normal grief or in re-grief work.

Other important points in this case were the sudden nature of the loss, the ambivalence about the loss, and the lack of recognition by the patient or others as to whether a loss had occurred.

Case 3

A 25-year-old mother of two children complained of excessive fatigue of vague duration, perhaps between two and four months. She wondered if she needed thyroid supplement or an iron shot. She was clinically and chemically euthyroid and not anemic. When asked, she denied any family problems or any recent loss and requested further workup. Throughout the interview and examination she had been tense and sighing. She was advised that further workup could be done but that it was the physician's impression there was something more psychologically involved than she was able to acknowledge. She began to cry and talk with considerable difficulty about her loss of interest in sex with her husband, her lack of energy, wanting to be alone, and not being happy. She admitted to a poor appetite, a four-pound weight loss, and increasing sleep. The physician was aware of the basic stability of her marriage but was also aware of her own family background, with considerable characterological problems in her sister and parents and episodic depression in her mother. It was suggested to her that she was experiencing a primary depression and that her problems with her husband were secondary and not causal. She was given imipramine to be taken at bedtime and was advised not to make any major decisions such as separation and to explain to her husband the nature of the illness.

This case demonstrates the vague onset of depressive illness as contrasted with the sharply marked onset of symptoms in grief reactions. Although the physical symptoms are similar, the diencephalic signs of disturbance of appetite, sleep, general energy, and sexual energy are often much more distinct and prominent in the depressive illness. The roles of family history and biologic therapy are also demonstrated.

Comment

The family physician is often in a position to prevent the serious sequelae of disruption of normal grieving because he or she is often attending the person or family when the loss occurs. It is not

necessary for the patient to develop full-blown psychiatric illness to turn to the family physician for assistance. Facilitation of normal grieving and diagnosis of early signs of depression and/or of unresolved grief reactions can be done in the daily family practice.

Depression may be an early signal to the family physician that the patient is experiencing a medical or psychiatric illness. Depression as an illness can be lethal when it leads to suicide. Undiagnosed or untreated depression can lead to considerable family disruption. Unresolved grief can result in illness and even death. The poet often suggests that people die of broken hearts. Shakespeare¹⁶ in *Macbeth* wrote: "Give sorrow words; the grief that does not speak, whispers to the o'erfraught heart and bids it break."

What the poet tells us, the pathologist often confirms. Family physicians are in a position to intervene in a timely and effective manner in the prevention, diagnosis, and treatment of these common human maladies.

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