› **Narrative review articles** based on the author's own experience and a discretionary selection of articles.

What distinguishes prolonged grief disorder from depression?

Prolonged grief disorder, which is proposed as a new diagnosis in ICD-11, and depression share some similarities but also several key differences. In order to provide the correct help and treatment, it is important for doctors to be able to ascertain whether a person is struggling with prolonged grief or has become depressed following the loss of a loved one

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The loss of a close and loved person through death is regarded as one of life's most stressful events. Most people are nevertheless able to handle the pain inflicted by this loss and adapt to a new life without the deceased. Some, however, develop mental afflictions as a result of their loss. The most common ones include prolonged grief disorder (in the following referred to as prolonged grief) and depression (1).

Studies have shown that prolonged grief and depression share some similarities, but that they also have some key differences (2, 3). For reasons of diagnosis and therapy it is crucial to distinguish between these two conditions. The purpose of this article is thus to provide a detailed overview of the main differences between prolonged grief and depression.

The evidence is based on literature searches in PubMed and PsychInfo, as well as the authors' own experience from work with bereaved persons. The article is restricted to grief and depression after deaths. The term «depression» primarily refers to the most common types (depressive episode/recurrent depressive disorder).

What is grief, what is prolonged grief and what is depression?

There is no simple definition of normal grief, but some main points can be noted. Grief after the death of a loved one includes a number of different reactions that are of an affective, cognitive, behavioural and somatic nature (4). There are major individual differences in how people react and adapt to the loss of a loved one. This depends on a number of factors such as who has been lost, the closeness in the relationship, the way in which the death occurred, the support provided by others, and personality factors (5).

Grief often comes in waves, with sudden, intense reactions (pangs of grief) that can be triggered by internal or external reminders. At a relatively early stage after a loss, many bereaved persons may experience positive emotions in addition to the painful grief, for example when talking about happy memories or relating anecdotes from the life of the deceased (1). With time, the waves of grief will come more rarely, and the sadness and feelings of unreality will gradually recede, although large and dramatic losses, such as the loss of a child and loss caused by sudden, violent death will often progress differently from losses that could be expected (6). Grief reactions often intensify around anniversaries and holidays.

Prolonged grief is the most common form of complicated grief in adults (5). It is different from normal grief in that the immediate grief reactions persist over time with more or less undiminished strength, causing a considerable loss of everyday functioning (2). One may also observe little change or flexibility with regard to the way in which this grief is handled (2, 4).

Prolonged grief is primarily characterised by an intense longing for or persistent preoccupation with the deceased person (2, 3). Other characteristics include difficulties in accepting the death, the feeling of having lost a part of oneself, difficulties in continuing with life, emotional numbness and avoidance of things/places/activities that serve as reminders of the deceased. Others also emphasise rumination over how the death could have been avoided, blaming of others and self-blame as typical of persons who struggle with prolonged grief (2).

While many laypersons and professionals would say that normal grief lasts through the first year until all major anniversaries have passed, the proposal in ICD-11 states that prolonged grief can be diagnosed six months after the bereavement (3). The intensity and duration of the grief reactions must go beyond what is expected in light of cultural and religious norms. Studies indicate that approximately 7 % of those who lose someone to death are affected by prolonged grief (2), but far higher figures have been found among parents who have lost a child and

MAIN MESSAGE

A key assessment to distinguish between prolonged grief and depression is whether the content of thoughts and emotions in the bereaved continues to circle around the deceased (prolonged grief) or whether these are more free-flowing and generalised and to a lesser extent associated with the loss itself (depression)

While intense and persistent longing for the deceased person is a core symptom of prolonged grief, a generally reduced interest in or ability to enjoy everyday matters is a core symptom of depression

In depression, the patient will often harbour feelings of worthlessness and self-contempt, which are not found in prolonged grief

Grief-specific psychotherapy has proven effective for prolonged grief, while a combination of psychotherapy and drugs (depending on the degree of severity) is recommended for depression

those who have been bereaved through sudden, violent death (6). It is important to point out that grief can be intense and last for more than six months without automatically being deemed abnormal. The central issue in prolonged grief is its considerable impact on daily functioning.

Depression is a heterogeneous diagnostic group and among the most common mental afflictions that we know (7). It is estimated that 6–12 % of the Norwegian population suffer from depression at any one time (8). The most common symptoms include low mood and lack of interest in and enjoyment of normal activities, as well as fatigue and reduced energy (9). In addition, difficulty in concentrating, poor self-esteem, self-accusations or feelings of guilt, hopelessness, suicidal thoughts, sleep disturbances and loss of appetite, as well as psychomotor agitation or retardation are common. Depressions are frequently graded into mild, moderate and severe forms, and the symptoms must have persisted for more than two weeks before a diagnosis can be made (9).

Loss of a loved one through death is a known risk factor for development of depression (1). International studies have shown that approximately 15 % of all widows/widowers suffer from depression one year after the loss of their spouse, and approximately 12 % two years later (1). The figures vary depending on who has been lost and the circumstances in which the loss occurred. A Norwegian study shows that 25 % of the bereaved who survived the tsunami disaster in 2004 suffered from depression two years after the incident (10). Furthermore, studies show that up to 50–70 % of those who endure prolonged grief also suffer from depression (1). Having had depression prior to a death increases the risk of developing both depression and prolonged grief after the loss of a loved one (1).

Prolonged grief disorder versus depression

A key assessment to distinguish prolonged grief from depression involves whether the thoughts and emotions continue to circle around the deceased (prolonged grief) or whether these are more free-floating and generalised and less associated with the loss itself (depression) (11, 12). For example, a low mood (dysphoria) in prolonged grief will be associated with the separation from the deceased, while depression will involve a more persistent and pervasive dysphoria, often in combination with pessimistic rumination and a sense of hopelessness (12).

Other core symptoms also differ. In prolonged grief, intense and persistent longing for the deceased person is a core symptom, which is not associated with depression. In depression, the patient will experience a generally lowered interest in or ability to enjoy everyday activities, while prolonged grief will involve a persistent preoccupation with the deceased, often accompanied by positive emotions or an intense longing. It is also common for the bereaved to seek sensory experiences that bring them closer to the deceased, for example by using their clothes to feel their smell or listening to the voice of the deceased on a mobile telephone (2).

In depression, the patient will often express a more global feeling of guilt and a sense of worthlessness, even self-contempt and a feeling of being a burden on others, none of which feature in prolonged grief (11, 12). In prolonged grief, the patient may instead have feelings of guilt for things they have said or done or failed to say or do with regard to the deceased. Brooding, such as «if only», «if only I had» done something different, this person would still be alive (counterfactual thinking), is also common.

These two conditions also differ in terms of avoidance behaviour (2). While persons with prolonged grief will often tend to avoid specific places, things and activities that remind them of the reality of the loss, people with depression will often engage in more general avoidance behaviour and social withdrawal.

Sleep disturbances are common in both prolonged grief and depression (1). However, pronounced weight loss, slowness in thinking, speaking and moving (psychomotor retardation) and difficulty in making decisions are prominent in depression, but absent in prolonged grief (1).

Suicidal thoughts occur in both prolonged grief and depression (12, 13). In prolonged grief, this will often be associated with a wish to be reunited with the deceased. In depression, thoughts of ending life will commonly be more associated with notions of not deserving to live and a wish to put an end to an intolerable situation or the idea that others will be better off if the sufferer disappears for good.

Diagnosis and treatment

Some screening tools are available (e.g. Inventory of Complicated Grief and Prolonged Grief Disorder-13) (3), but because the criteria have not been finally defined in ICD-11, no single questionnaire is yet available to establish whether a person is struggling with prolonged grief. However, extensive research is being undertaken in this area.

The doctor's assessment should primarily be based on a clinical interview or a conversation with specific questions related to reactions to the loss. As regards examination and diagnosis of depression, the national guidelines provide a good basis for medical assessments by healthcare workers in the primary and specialist health services (7). Considering that prolonged grief and depression often occur in parallel, both conditions ought to be identified, and if so, which of them presents the patient with most difficulty.

Many who struggle with prolonged grief tend to keep the deceased more or less constantly in their thoughts and behaviour. Our clinical experience indicates that it might be useful to cautiously advise mourners who struggle with this to reduce the number of visits to the grave, sort out the personal belongings of the deceased, steer their thoughts of the deceased towards defined periods of time and gradually resume activities that have been avoided (14).

Numerous studies have shown that grief-specific psychotherapy can be effective in treatment of prolonged grief (15, 16). As yet there is no psychopharmacological treatment of prolonged grief with a documented effect, although some drugs (e.g. citalopram) have been shown to reduce comorbid symptoms of depression (16). The treatment of depression secondary to a loss is not different from other depression therapies and may include both psychotherapy and drugs, depending on the degree of severity (1, 7).

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