The many faces of depression following spousal bereavement

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Abstract

While it is becoming increasingly clear that mood disorders tend to be chronic, intermittent and/or recurrent conditions with different manifestations over time, little is known of the variability or course of mood disorders that are associated with severe psychosocial stress. This paper reports on the prevalence and course of major, minor, and subsyndromal depressions in 328 widows and widowers followed prospectively from 2 to 25 months following one of the most disruptive of all naturally occurring stressors, spousal bereavement. The results are consistent with the following conclusions: (1) past major depression (prior to the death) predicts an increased risk for major depression following bereavement; (2) membership in any of the unipolar subgroups, in turn, predicts future depression throughout the unipolar depressive spectrum; (3) subsyndromal and minor depression stand between major depression, on the one hand, and no depression, on the other, in terms of their effects on overall adjustment to widowhood. Thus, the results support the validity of subsyndromal depression, and that the three subgroups (major, minor and subsyndromal depression) are pleomorphic manifestations of the same unipolar depression disorder. © 1997 Elsevier Science B.V.

1. Introduction

Since depression often is precipitated or exacerbated by stressful life events (Paykel et al., 1969), prospectively following a large cohort of individuals exposed to the same severe stressor is an ideal way to identify a high risk cohort and to measure how depressive symptoms and syndromes evolve over time. Thus, spousal bereavement, a ubiquitous and highly disruptive life event (Holmes and Rahe, 1967), provides a suitable natural laboratory to study the pathophysiology of depression. This study will explore the relationship of prebereavement major depression to various postbereavement depressive syndromes, and will follow the course of postbereavement depressions. It will address the questions of whether subsyndromal manifestations are clinically benign events or significant syndromes; and whether major, minor, and subsyndromal depressions are best conceptualized as distinct disorders or as variable manifestations of a single disease process.

An abundant literature documents a high prevalence rate of depressive symptoms following bereavement (Breckenridge et al., 1986; Clayton, 1990; Zisook and Shuchter, 1993). Among the most frequently noted symptoms are crying spells, sleep disturbances, low mood, loss of appetite, fatigue and/or poor memory. Psychomotor retardation, feel-
ings of worthlessness and suicidal ideation are less often experienced unless a major depressive episode intervenes (Clayton et al., 1972; Zisook and Shuchter, 1993). While the somatic symptoms of depression tend to diminish in frequency over time, psychological symptoms are more tenacious (Blanchard et al., 1976; Clayton, 1982). Despite the overall decrease in frequency of symptoms over time, several symptoms—including loneliness, feeling blue, insomnia, diminished interests, thoughts of death or dying, and feeling hopeless about the future—are more often experienced by widows and widowers than by married men and women as long as 2 years after their spouse’s death (Lund et al., 1990; Zisook and Shuchter, 1991).

Similarly, several studies have documented high rates of major depressive syndromes following bereavement, ranging from 29 to 58% 1 month after the loss (Clayton et al., 1972; Clayton, 1979; Harlow et al., 1991), 24–30% at 2 months (Futterman et al., 1990; Zisook and Shuchter, 1991), 24–25% at 4–7 months (Clayton, 1979; Zisook and Shuchter, 1991), 16% at 13 months (Bornstein et al., 1973; Zisook and Shuchter, 1991), and 14–16% at 25 months (Harlow et al., 1991; Zisook and Shuchter, 1993). About 50% of all widows and widowers meet criteria for major depressive syndrome at some time during the first year of bereavement, and 8–13% are depressed for the entire year (Clayton, 1990; Zisook and Shuchter, 1991).

A small but emerging literature is beginning to document the existence and clinical significance of subsyndromal depression after bereavement (Pasternak et al., 1994; Zisook et al., 1994). So far, these few studies have suggested subsyndromal depressions are frequent manifestations of mood disturbance following spousal bereavement, are associated with impairment in work and decreased ability to experience pleasure, and have long lasting effects on recovery from bereavement. However, there is not yet published data on postbereavement minor depression or on the relationship between major, minor, and subsyndromal symptomatic depression. Thus, it is not clear whether these subgroups of depression are etiologically distinct conditions, or whether they represent varying clinical expressions of the same condition over time. By examining an existing database on individuals who have all encountered the same ‘depressogenic’ stimulus, spousal bereavement, this paper will measure the prevalence, course, clinical importance, and the relationship between these three syndromes.

2. Methods

Sampling and instruments have been described in detail elsewhere (Zisook and Shuchter, 1991, 1993; Zisook et al., 1994). In brief, 350 widows and widowers were recruited from death certificate records filed with the San Diego County Department of Health Services. Subjects were interviewed in their own homes 7–8 weeks after their spouse’s death. The structured interview covered sociodemographics; present, past and family histories of depression based on DSM-III-R criteria; and global ratings of physical health, recent work performance and overall adjustment to widowhood. In addition, each subject completed a questionnaire that contained a number of self-report measures including the Hopkins Symptom Checklist (HSCL-54) (Derogatis et al., 1974), Zung Self-Rating Depression Scale (ZUNG) (Zung, 1975), and sets of additional questions assessing grief-specific feelings and behavior. Subsequent questionnaires were mailed to each subject at 7, 13, 19 and 25 months postbereavement. To provide a yardstick against which to measure outcome variables such as depression symptoms and syndromes, a modified version of the Widowhood Questionnaire was completed by 126 demographically similar but, married men and women. These men and women comprised our ‘comparison’ group (Zisook and Shuchter, 1991, 1993; Zisook et al., 1994).

Of the 350 widows and widowers who began the study, 259 (74%) completed the entire 2-year study. There were no significant differences between dropouts and completers in terms of gender, income, years of education or depression status at 2 months. On the other hand, completers tended to be older (62 vs. 58 years) ($F = 5.514$, df = 1.248; $p < 0.05$). Seven of the subjects were known to have died during the 2-year study and five remarried. Because this study relies on diagnostic categories derived from the HSCL and the ZUNG, only the 328 subjects who completed all relevant items on these scales at the intake session are included in the
results. There were no demographic differences between the 328 subjects with complete data sets and the 22 subjects who were excluded.

While this study was not designed to yield DSM-IV diagnoses of all depressive spectrum disorders, sufficient clinical information and symptom ratings were obtained to arrive at post-hoc diagnostic impressions. Specifically, both the HSCL and the ZUNG were used to collect information about depressive symptoms during the past month for the duration of the study. For example, 'depressed mood' was measured by using the response to the HSCL item 'feeling blue' and the ZUNG item 'I feel downhearted, blue and sad'; 'anhedonia' was measured by the HSCL item 'feeling no interest in things'. This methodology and the specific items used for each of the nine DSM-IV symptoms have been described previously (Zisook et al., 1994). For a symptom to be counted as present, at least one of the items representing the symptom had to have been scored a 3 or 4 (this equates to 'quite a bit' or 'extremely' troubled by the symptom over the past month on the HSCL, or experiencing the symptom 'a good part of the time' or 'most of the time' on the ZUNG). Since there are no items for increased sleep or appetite or for psychomotor retardation on these scales, it is likely this methodology under-represents 'depression', especially those with atypical features. Similarly, because of the recency of spousal bereavement, we elected to exclude the ZUNG item on decreased interest in sex as a possible indicator of decreased interest.

A subject is considered to have major depression (Maj Dep) if he/she has a total of at least five symptoms for the DSM-IV symptom list for a 'major depressive episode' and at least one of the symptoms is either depressed mood or loss of interest. Similarly, the study employed DSM-IV criteria to define minor depression. To meet the operational criteria for minor depression (Min Dep), subjects: (1) do not meet criteria for Maj Dep; (2) endorse either depressed mood or loss of interest; and (3) endorse a total of two to four DSM-IV symptoms for a major depressive episode. Since the DSM-IV does not include the category of subsyndromal depression, the criteria established by Judd et al. (1994) were utilized. To meet criteria for subsyndromal symptomatic depression (SSD), subjects: (1) do not meet criteria for either major depression or minor depression and (2) endorse any two depressive symptoms from the DSM-IV symptom list for a major depressive episode.

To better understand the clinical impact of the various depression subtypes, subjects were questioned at each time point how well they felt they were adjusting to widowhood, ranking adjustment on a scale of 1 = poor to 4 = excellent. In previous studies, overall adjustment was found to be a reliable global assessment of social, interpersonal and vocational functioning (Zisook and Shuchter, 1991).

The aim of this investigation is to address the following questions. First, does a history of past personal major depression influence the likelihood of minor and subsyndromal depression, as well as of major depressive episodes, after spousal bereavement? Second, does membership in a depressive spectrum disorder predict future occurrence of a depressive episode within the spectrum? Third, do subjects with a depressive disorder 2 months after the loss of a significant other experience a depressive disorder over a significant portion of the follow-up period? Fourth, does depressive disorder 2 months after the loss predict significantly worse adjustment to the loss as a measure of psychosocial functioning during the follow-up period?

Based on recent findings from epidemiological samples (Pasternak et al., 1994; Zisook et al., 1994), we hypothesized that not only major depressive disorder, but all categories of the depressive spectrum, including subsyndromal symptomatic depression (SSD), would be experienced by recently bereaved men and women 2–25 months after their spouses’ deaths. Moreover, we hypothesized that a past history of major depression would increase risk for each category of depression within the full spectrum of disorders examined here. Further, we hypothesized each depressive spectrum disorder at 2 months post-loss would result in a significant increase in time spent in various depressive spectrum categories at follow-up. Finally, we hypothesized that each depressive spectrum disorder at 2 months post-loss would result in significant impairment of psychosocial functioning at follow-up.

The statistical tests used to determine differences between diagnostic groups were \( \chi^2 \) analyses for categorical variables (e.g., whether subjects belong-
ing to the different diagnostic groups differed in their probability of expressing a depressive disorder at follow-up) and analysis of variance (ANOVA) for continuous variables (e.g., whether the different diagnostic categories at 2 months differed with respect to the time spent in different diagnostic categories from months 7–25). Mann-Whitney ANOVA, Tukey Studentized Range Method, and Kruskal-Wallis post hoc analyses were used to determine statistical significance of differences between groups. Statistical tests were considered significant at \( P \leq 0.05 \) and were two-tailed.

3. Results

3.1. Subjects

Two months after bereavement, 160 of 328 (49%) widows/widowers were classified as ‘no depression’, 35 (11%) as subsyndromally depressed, 66 (20%) as minor depression, and 67 (20%) as major depression. The majority of subjects were widows (70%), elderly (mean age 61 years, range 25–85 years), white (95%) and moderately well educated (mean year of education = 14 years). There were no statistically significant differences between groups on demographic factors with the exception of age. The group with major depression was significantly younger than each of the other groups (No Dep = 62.7, SSD = 61.4, Min Dep = 62.6, Maj Dep = 55.5; \( F = 8.23; \) df = 3; \( P < 0.001 \)). For 65% of the subjects, the spouse’s death was described as the result of a chronic illness, while for 35% the death was sudden and unanticipated. There were no statistically significant differences between groups on the nature of the death. At no time were more than 8% of subjects taking antidepressant medication. At each time point, 22–24% of the subjects with major depression had been prescribed antidepressant medication, while 10–14% of subjects with minor and subsyndromal depression and 2–4% of subjects with ‘no depression’ had been prescribed antidepressant medication. There is no information on which medications were prescribed, dosages taken, or durations of treatment.

3.2. Depressive status over time

Table 1 describes the rate of each diagnostic category of depression from 2 to 25 months postbereavement. While the rate of subsyndromal depression remains fairly stable, the rates of minor and major depressive disorders decrease over time. After the first 7 months, the frequency of widows and widowers free of significant depressive symptoms progressively increases up to 70% by the 25th month postbereavement. Even then, however, the rate is substantially greater than in the married comparison group, as 94% of the married men and women were free from significant depressive symptoms.

3.3. Relationship between past history and depression status at 2 months postbereavement

It has been shown previously that a past history of major depression is a strong predictor of postbereavement depression (Zisook and Shuchter, 1993). To test whether a past history of major depression also is related to the likelihood of developing minor or subsyndromal depressions, sub-

<table>
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<tr>
<th>Diagnosis at month 2</th>
<th>% within each subtype of depression at month:</th>
<th>% in married comparison group (n = 126)</th>
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<tbody>
<tr>
<td></td>
<td>2 (n = 328)</td>
<td>7 (n = 284)</td>
</tr>
<tr>
<td>No depression</td>
<td>49</td>
<td>50</td>
</tr>
<tr>
<td>Subsyndromal depression</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Minor depression</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Major depression</td>
<td>20</td>
<td>15</td>
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jects were divided into three groups: those who stated at the intake session that they had never previously had symptoms of major depression (n = 242), those who had one previous major depressive episode (n = 30), and those with two or more previous episodes (n = 56). As Table 2 shows, the relationship between past history and the likelihood of developing a depression spectrum disorder after the stress of bereavement is significant. While less than half (108/242) the widows and widowers who had never previously experienced a major depressive episode met criteria for a depressive spectrum disorder after their loss, 75% (42/56) of those who had two or more previous major depressive episodes developed a depressive spectrum disorder after the loss (χ² = 12.31, df = 1, P > 0.001). Although much of the difference was accounted for by the increase in major depressive episodes for those with positive past histories, 41% (24/59) of the widows and widowers with positive past histories who experienced depressive spectrum disorder 2 months after their loss had either a subsyndromal (n = 9) or minor (n = 15) depressive episode.

Table 2 also shows that only 9% (14/160) of widows and widowers who were depression-free after bereavement had experienced recurrent major depressive episodes prior to bereavement compared to the 17% (6/35) of those with subsyndromal depression (χ² = 2.197; df = 1; NS), 18% (10/66) of those with minor depression (χ² = 2.016; df = 1; NS) and 46% (26/67) with major depression (χ² = 29.37; df = 1; P < 0.001). Fig. 1 demonstrates the increased likelihood of having a past history of at least one depressive episode as one goes from the group with no depression to those with either subsyndromal or minor depression, and finally to those with major depressive episodes at month 2.

3.4. The relationship between depression status at 2 months and subsequent depressive subtypes

To determine whether membership in a depressive spectrum disorder 2 months after bereavement predicts future occurrences of depression subtypes, the diagnostic category for each subject was determined at 2 months and then for each of the four follow-up periods. If, at any of these follow-up periods, the subject belonged to one of the depressive spectrum disorder categories, the subject was coded as having a future occurrence of this particular depressive disorder. Subsequently, group-wise comparisons were performed using χ² analyses to determine whether subjects belonging to the different diagnos-

<table>
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<tr>
<th>Diagnosis at month 2</th>
<th>Past history of MDE</th>
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<tbody>
<tr>
<td></td>
<td>No previous MDE (n = 242)</td>
</tr>
<tr>
<td>No depression, n (%)</td>
<td>133 (55)</td>
</tr>
<tr>
<td>Subsyndromal depression, n (%)</td>
<td>26 (11)</td>
</tr>
<tr>
<td>Minor depression, n (%)</td>
<td>51 (21)</td>
</tr>
<tr>
<td>Major depressive episode, n (%)</td>
<td>32 (13)</td>
</tr>
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Overall, χ² = 29.67; df = 6; P < 0.0005. No Depression vs. depressive spectrum, χ² = 12.33; df = 2; P < 0.005
tic groups differed in their probability of experiencing a depressive disorder at follow-up. As hypothesized, subjects beginning with any depressive spectrum disorder were significantly more likely to experience another depressive spectrum disorder at follow-up than were subjects with ‘no depression’ at baseline.

As can be seen in Table 3, subjects with major depression at 2 months are least likely to be free of depression throughout the next 2 years, subjects who are not depressed at 2 months remain most likely to stay nondepressed over the next 2 years, and subjects with either minor or subsyndromal depression appear intermediary. Indeed, only 37% of subjects who begin with major depression become free of depression at any point over the next 2 years, while only 7% of subjects who begin with no depression subsequently develop major depression. While 60% of subjects who start out with a major depressive episode will have at least one more major depressive episode during follow-up, they also are at risk for minor and subsyndromal episodes over follow-up. In turn, subjects with minor or subsyndromal depression are more likely to develop major depression over follow-up than are subjects who begin with no depression.

It appears from Table 3 that subsyndromal depression is sometimes relatively stable, sometimes a forerunner of major depressive episodes, and occasionally a residual of major depression. To more closely examine the relationship between subsyndromal and major depressive episodes, Fig. 2 demonstrates that compared to ‘no depression’, subsyndromal depression predicts major depression at some point in the future. Fig. 3 demonstrates that

![Graph showing percentages of subjects with major depression at 7.1-12.19 and/or 25 months]

Table 3
Depression status at 2 months and subsequent depressive subtypes

<table>
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<tr>
<th>Status at 2 months</th>
<th>Likelihood of subtype at some point in future</th>
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<tbody>
<tr>
<td></td>
<td>No depression, n (%)</td>
</tr>
<tr>
<td>No depression (n = 160)(^a)</td>
<td>142 (89)</td>
</tr>
<tr>
<td>Subsyndromal depression (n = 35)(^a)</td>
<td>26 (74)</td>
</tr>
<tr>
<td>Minor depression(^a) (n = 66)</td>
<td>47 (71)(^c)</td>
</tr>
<tr>
<td>Major depression (n = 67)(^a)</td>
<td>25 (37)(^c)</td>
</tr>
</tbody>
</table>

\(^a\)Sum of category > total n because subjects can meet criteria for more than one category over various time points.

\(^b\)Significantly different from no depression: \( P < 0.05 \).

\(^c\)Significantly different from no depression: \( P < 0.01 \).

\(^d\)Significantly different from no depression: \( P < 0.001 \).
compared to 'no depression', major depression predicts subsyndromal depression.

3.5. The relationship between initial depression status and subsequent time being depressed

In order to assess the relationship between the depression category at 2 months and the subsequent time spent in each depression category, the duration of belonging to a depressive spectrum disorder was estimated by summing the depressive spectrum categories over the follow-up period. Specifically, the number of times within each diagnostic category, including missing observations, was determined for each subject. This number was averaged across all subjects belonging to the different diagnostic categories at time 1. Finally, this number was expressed as percent time observed belonging to a specific diagnostic category. Subsequently, a one-way ANOVA was performed to determine whether the different diagnostic categories at time 1 differed with respect to the time spent in different diagnostic categories at follow-up. Mann-Whitney ANOVA and the Tukey Studentized Range Method were performed to determine the significance.

Table 4 depicts the percentage of time spent in each category of depression based on initial membership. The percentages are given only for those subjects who had no missing data. There were no significant differences between groups in terms of the percentage of time with missing data (ranges from 16 to 24% of the time for the four categories). Table 4 demonstrates that subjects who initially were free of major depression spent the majority of the next four time points (84%) nondepressed and were in a major depressive episode only 2% of the time. On the other hand, subjects who began with a major depression ended up spending more time in a major depressive episode (38%) than in any of the other categories (14–24%). Subjects who had a subsyndromal depression 2 months after their spouse’s death spent significantly more time over the next 2 years in some depression category than did subjects with no depression initially, although they spent less time in depressive categories than did subjects who began with a major depressive episode. In all, subjects who began with subsyndromal depression at 2 months experienced some form of depression 39% of the time over the subsequent 2 years. Fig. 4 demonstrates the increased percentage of time spent in any depression category based on whether the subject began with no depression, subsyndromal depression, minor depression or major depression. The Tukey Studentized Range method

![Bar chart showing percentage time spent in any depression category from 7 to 25 months based on 2-month status.](image)

**Fig. 4.** Percentage of time spent in any depression category from 7 to 25 months based on 2-month status.

<table>
<thead>
<tr>
<th>Diagnosis at month 2</th>
<th>% time in each category at months 7–25</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>No depression</td>
</tr>
<tr>
<td>No depression (n = 160)</td>
<td>83.6&lt;sup&gt;a,b,c,d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Subsyndromal depression (n = 35)</td>
<td>61.4&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Minor depression (n = 66)</td>
<td>46.8&lt;sup&gt;a,d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Major depression (n = 67)</td>
<td>23.6&lt;sup&gt;b,c&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Significantly different from no depression (P < 0.05).
<sup>b</sup>Significantly different from SSD (P < 0.05).
<sup>c</sup>Significantly different from minor depression (P < 0.05).
<sup>d</sup>Significantly different from major depression (P < 0.05).
revealed that each depressive spectrum group was significantly different from the no depression group \((P < 0.05\) for SSD; \(P < 0.01\) for Min Dep and Maj Dep). In addition, the group with major depression was significantly different from the minor depression group \((P < 0.05)\) and the SSD group \((P < 0.01)\).

3.6. Overall psychosocial adjustment

As a measure of overall psychosocial functioning, we used the self-rated Adjustment to Widowhood score (measured on a scale of 1 = poor to 4 = excellent). A one-way ANOVA (depression status at 2 months) was performed to determine whether subjects who rated their overall adjustment as 1 (poor) or 2 (fair) differed by diagnostic category. Moreover, to assess how long lasting the consequences of each depression subtype at month 2 are, one-way ANOVAs were performed on adjustment at months 7, 13, 19 and 25 on the basis of depressive status at month 2.

As can be seen from Table 5, the majority of subjects with major depression rated their adjustment to widowhood as fair–poor at 2 months, over 50% of those with minor depression rated it as fair–poor, over one-third with subsyndromal depression rated it as fair–poor, and less than one in five with no depression felt their adjustment was either fair or poor. However, differences in overall adjustment between ‘no depression’ and ‘subsyndromal depression’ were significant only at 2 months \((\chi^2 = 5.826, \text{df} = 3, \ p < 0.05)\), with a statistical trend at 19 months \((\chi^2 = 2.505, \text{df} = 3; \ P = 0.1)\). On the other hand, differences between ‘no depression’ and both minor and major depression were statistically significant at all the points.

3.7. Validity of diagnostic categories

The validity of the three diagnostic categories of unipolar depression are partially validated by the results thus far presented. Thus, both subsyndromal and minor depression stand between no depression, on the one hand, and major depression, on the other in terms of: past history of recurrent depression, likelihood of predicting future episodes of depressive spectrum disorders, time spent in a depression spectrum disorder during 2 years follow-up, and association with poor adjustment. As further confirmation of their validity, mean ZUNG-SDS Index scores were calculated for each category and compared using ANOVA. The results \((\text{No Dep} = 41 \pm 7; \ \text{SSD} = 50 \pm 8; \ \text{Min Dep} = 54 \pm 8; \ \text{Maj Dep} = 65 \pm 9; \ F = 146.63; \ \text{df} = 3; \ P > 0.001)\) demonstrate significant differences between groups. Furthermore, Kruskal Wallis post-hoc analyses revealed that each of the depressive spectrum groups were significantly different than the no depression group at \(P > 0.01\).

4. Discussion

The results of this paper support the growing conceptualization of unipolar depression as a heterogeneous group of disorders, with the various subgroups being pleomorphic manifestations of a single disease process. Major depressive episodes are the most severe forms. They are associated with a

<table>
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<tr>
<th>Diagnosis at month 2</th>
<th>% with fair/poor overall adjustment to widowhood at month:</th>
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<tbody>
<tr>
<td></td>
<td>2(^{a}) ((n = 328))</td>
</tr>
<tr>
<td>No depression</td>
<td>17</td>
</tr>
<tr>
<td>Subsyndromal depression</td>
<td>35</td>
</tr>
<tr>
<td>Minor depression</td>
<td>55</td>
</tr>
<tr>
<td>Major depression</td>
<td>75</td>
</tr>
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\(^{a}\)Overall, \(\chi^2\) at 2 months = 76.030; \text{df} = 3; \ P < 0.000.
\(^{b}\)Overall, \(\chi^2\) at 7 months = 41.505; \text{df} = 3; \ P < 0.000.
\(^{c}\)Overall, \(\chi^2\) at 13 months = 37.543; \text{df} = 3; \ P < 0.000.
\(^{d}\)Overall, \(\chi^2\) at 19 months = 31.467; \text{df} = 3; \ P < .000.
\(^{e}\)Overall, \(\chi^2\) at 25 months = 32.624; \text{df} = 3; \ P < 0.000.
greater likelihood of both past and future major depressions, and carry a more malignant psychosocial burden than either minor or subsyndromal depressions. However, even these milder subtypes by no means should be considered benign. Rather, they are clinically meaningful manifestations of unipolar depression. Like major depressive episodes, they are frequently observed after a severe stressor, such as spousal bereavement, and they stand between major depressive episodes and no depression in their severity, association with further episodes, and adverse psychosocial consequences. In addition, both minor and subsyndromal depressions may be chronic or recurrent in their own rights, and may also exist as either prodromal or residual symptoms of major depressive episodes. Thus, even in the face of spousal bereavement, the presence of subthreshold depressive symptoms may be a clinically important manifestation of a serious unipolar depressive disorder.

Several methodological limitations of this study are important to keep in mind. First, the study was not designed to identify subsyndromal or minor depression. Indeed, these concepts and present operational criteria were not well defined until after the study was well under way. Thus, criteria for these syndromes are post-hoc, imperfect, rest upon items taken from two self-report questionnaires that use 4 rather than 2 weeks for duration, do not encompass several important symptoms of depression such as reversed neurovegetative symptoms, and only approximate other DSM-IV criteria. While the close agreement of subjects identified as having a major depressive episode using these criteria with other diagnostic systems support the validity of this methodology, further study based on structured interviews and reliable criteria would be helpful to confirm this paper's observations. Second, the dropout rate of 26% may have compromised the results. While there are few demographic differences and no differences in terms of initial depression between dropouts and controls, it is possible that other, unidentified, features may have biased the results. Finally, the psychosocial outcome measure—adjustment to widowhood—was based on subjective assessments which were not validated by observations of others or by standardized questionnaires. While this subjective measure does correlate with several other outcome measures (Zisook and Shuchter, 1991) and appears to have face validity, future studies will be well served to use psychometrically validated and reliable instruments such as the Social Adjustment Scale (Weissman and Sholomskas, 1981), MOS Short Form General Health Survey (Stewart et al., 1988), Quality of Well Being Scale (Kaplan and Anderson, 1993), and/or Longitudinal Interval Followup Instrument (Keller et al., 1987).

Despite these limitations, the results suggest answers to the four questions raised in the Section 2. First, while we were not able to demonstrate an increased risk for minor or subsyndromal depression in individuals with a past history of major depression, such a history did predict an increased risk for major depressive episodes following bereavement. Second, membership in any of the depression categories at 2 months, in turn, predicted future depression in all categories for at least the next 2 years. Thus, there appears to be continuity of the depressive spectrum from before bereavement to immediately after, through at least the following 2 years; and the fluidity of depressive subtypes within this spectrum over time supports the concept that the three depressive subtypes studied here are pleomorphic manifestations of a single disease entity—unipolar depression. Third, subjects responding to bereavement with minor or subsyndromal depression spend significantly more time over the next 2 years being depressed than subjects who do not experience any initial depression, but less time than those initially meeting criteria for major depression. Finally, subjects in each depression category have a worse adjustment to widowhood than subjects without any depression.

From the above, it is clear that subsyndromal, minor and major depression all should be taken seriously after major life stress. The DSM-IV recognizes minor depression only in the appendix—as a disorder that may be an example of Depressive Disorder NOS, and as a disorder worthy of future study. It does not recognize subsyndromal depression at all. Yet, in this study, the importance of subsyndromal depression is supported by its close temporal relationship to major depression, its prediction of substantial amounts of subsequent time spent in various depression categories, and its association with poor psychosocial outcome. This is consistent
with a growing body of literature that has found subthreshold symptoms of depression to be associated with disability, poor physical and social functioning (Wells et al., 1989; Broadhead et al., 1990; Judd et al., 1994), increased lifetime suicide attempts (Johnson et al., 1992), and increased risk for future major depressive episodes (Horwath et al., 1992). Each of these three subgroups of the depression spectrum likely represent alternative manifestations of the same disorder, perhaps representing, more than anything else, different intensities of depression over time. Future studies that further delineate these depression subtypes biologically, phenomenologically, and pharmacologically clearly are in order.

References


Discussion of ‘The spectrum of depressive disorders following spousal bereavement’: Discussion led by Paula J. Clayton, M.D., from University of Minnesota

This is an interesting paper that exemplifies the strengths and weaknesses of using criteria to define
illness. Although all the comparisons are statistically significant between no depression, subsyndromal depression, minor depression and major depression, it still is not clear that subsyndromal and minor depression represent clinical entities. The one validating piece of evidence, previous history of depression, actually speaks against that. Unfortunately, they did not look at family history to validate outcome.

The criteria for subsyndromal depression are: no depressed mood or anhedonia, but at least two DSM-IV depressive symptoms at any point. The widowed were examined. Given the plethora of consistent data on the numbers and frequency of symptoms seen in recently widowed, it is amazing that 49% of these widowed are essentially free of depressed mood and any symptoms by the second month after the stress. What I thought to be a bell-shaped curve of responses to such a severe stress with the tails representing the very healthy and the other groups diminishing in frequency as the severity of the illness increases. Those with no depression represent 40% of the group at 2 months after widowhood and then increase substantially to 70% by 26 months. Subsyndromal depression remains relatively constant throughout the 26 months, although it may represent different individuals. Minor depression decreases gradually but stabilizes and becomes the most frequent depressive syndrome, whereas major depression gradually decreases over time until it is the least frequent of the defined depressive disorders. Major depression is clearly related to a past history of depression in the individuals, whereas minor and subsyndromal depression occur in equal frequency in those who never had a depression, and those who had one or two or more previous episodes. This leads me to believe that perhaps these other syndromes represent a more general response to the stress of a significant loss, whereas major depression even after the stress represents clinical depression. Is this labeling a legitimate and appropriate concern in illness? All three states certainly predict an increased likelihood of developing major depression and therefore identify a vulnerable population worth following.

I am proposing looking at bereavement as a response also to stress, as an example of external effects on the organism, which is supported by animal models that is not species specific. The prevalence in America for the loss of a first-degree family member is eight million/year, which means that 10% of bereaved individuals develop chronic depression, which contributes to 800 000 new clinical depressions per year. However, Dr. Hagop Akiskal questioned whether these individuals were going to develop chronic depression inevitably despite their bereavement. He also pointed out that a family history of depression does not predict response 1 or 5 years later, suggesting a more reactive than a biological component in bereavement. Despite greater rates of major depressive disorder in females, rates of bereavement occur equally amongst males and females. More females, however, lose their spouse. Yet a significant proportion of bereaved men who are less than 45 years of age develop suicidal thoughts, and a majority meet the criteria for major depressive disorder in the first 7 months. In the second year, the symptoms decrease. Young people in response to bereavement have more severe symptoms in the immediate grieving period. Symptoms often include crying (90 vs. 14% controls), sleep disturbances (29 vs. 35% in controls), sadness, loneliness, restlessness, appetite disturbances, fatigue and memory difficulties. More severe symptoms include psychomotor retardation, thoughts of death, suicidal ideation without attempts. Feelings of being a burden, hopelessness, worthlessness and guilt that Freud described as part of melancholia, not grief, are not common.

Our research has shown that at 1 month, 35% of bereaved individuals met the criteria for major depressive disorder (MDD). At 4 months, 25% did, at 13 months 16% did, and at 25 months 14% met MDD criteria. Most of the bereaved people described themselves as being what they would have expected given the circumstances of the bereavement vs. depressed patients who identify themselves as being different. We have found that the same clinical phenomenology (i.e., depressive subtypes) are found in terms of stress responses of patients with bereavement vs. those with post-traumatic stress disorder and major depressive disorder. There is usually a trauma with intense recollections in post-traumatic stress disorder. However, in major depressive disorders, in contrast, there often are no stressors but, similar to bereavement, there are good and bad dreams, compared with the nightmares of PTSD. In my opinion, this re-experiencing of the trauma is not pathological and with time, the intrusiveness of these recollections decrease.