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Grief and Risk of Depression in Context: The Emotional Outcomes of Bereaved Cancer Caregivers

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Abstract
We investigated the relationships of grief and depression to cancer caregiving in early bereavement. We began with three expectations: (a) each outcome would reflect different situational predictors, (b) grief would be more directly related to such predictors, and (c) components of grief would relate differently to the caregiving context and depressed mood. We conducted telephone interviews with family caregivers of incurable cancer patients from two hospitals. A total of 199 family caregivers were interviewed at the time of the patient's diagnosis and reinterviewed 3 months after the patient's death. Results showed grief severity was predicted by caregiving circumstances, but bereavement depressed mood was largely unrelated to caregiving. Grief was the main predictor of depressed mood and mediated almost all other effects. We conclude that while grief may trigger depression, the dissimilar connection to context means that the two emotional states should not be equated based purely on similarity of expression.

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Grief and depression have long been recognized as separate yet overlapping emotions, with grieving individuals viewed as at risk of developing depression (Averill & Nunley, 1993; Bowlby, 1980; Freud 1917/1957). Caregivers of loved ones with serious or terminal illnesses have been shown to score high on depression inventories (Given et al., 1993; Kim & Given, 2008; Kissane et al., 2006; Neundorfer et al., 2001; Sherwood, Given, Given, & Von Eye, 2005), and the potential for serious psychological distress among such caregivers after bereavement has consequently been a topic of much interest (Aneshensel, Botticello, & Yamamoto-Mitani, 2004; Burton et al., 2008; Goodkin et al., 2005; Kim & Given, 2008; Kissane & Bloch, 2002). Some have argued that as many as 30% of bereaved caregivers suffer abnormal emotional outcomes such as depression or excessive grief after the death of their loved one (Schulz et al., 2008). With health care shifting increasingly to outpatient and home settings, the number of people caring for a sick or dying loved one continues to rise, making bereavement outcomes a growing concern. For this large and growing group of caregivers, the question of the relationship between the normal reaction of grief and the pathological outcome of depression is both relevant and important.

There are currently two competing models describing the relationship between grief and depression. A medical perspective argues that when the expression of grief overlaps with depression, grief should be diagnosed and treated as a form of depression. In this model, symptoms are definitive, and bereaved caregivers who meet *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-V*) criteria for major depression even in early bereavement should be viewed as suffering psychopathology (Kendler, Myers, & Zisook, 2008). By contrast, a social science perspective emphasizes the cultural, interactional, and contextual nature of emotion and argues that grief is a normal response to a distressing situation (Charmaz & Milligan, 2006; Wakefield, Schmitz, First, & Horwitz, 2007). In this model, the context is definitive, and bereaved caregivers should be viewed as normatively distressed, not medically ill. Based on the former perspective, the bereavement exclusion has recently been removed from the diagnosis of major depressive disorder (MDD) in the *DSM-V* (American Psychiatric Association, 2013). Supporters of this view assert that research has shown that even in early bereavement, there is little difference between grief and depression in either reported symptoms or antecedent factors such as family history of depression (Zisook & Kendler, 2007). Critics, however, point out that little research on early bereavement addresses the difference in context between grief and MDD (Wakefield et al., 2007), and such research needs to occur before the distinction between grief and depression can be discarded.

The current study attempted to address this identified gap in research on the context of grief. Due to the nature of our measures, we could not address the formal clinical concerns of complicated grief or MDD. Instead, we approached the topic from the perspective of the sociology of emotions and mental health, asking how the situational factors surrounding cancer caregiver bereavement affected the potential caregiver outcomes of grief and the risk of depression. In keeping with the social science perspective on grief, we expected that the circumstances of caregiving will affect caregiver grief and caregiver risk of depression in different ways. In particular, we had two hypotheses: first, we predicted that grief would have different situational predictors than risk of depression; and second, we predicted that severity of grief would be related more directly to these situational predictors (be more context dependent), and risk of depression would be largely independent of situational predictors (be more context independent). These hypotheses corresponded to our conception that grief is a normal reaction to loss and depressive symptoms are not. Finally, we analyzed the complexity of grief to explore how its different components may add to our understanding of the context of caregiving and bereavement.

The Context of Caregiving

Context, as used in this discussion, refers to the actual circumstances of the emotion-causing situation. Prior research on the relationship between bereavement-related depression and major depression has largely overlooked these elements of bereavement, focusing largely on *antecedent factors* of the person such as demographics and personal characteristics and history (Kendler, Myers, & Zisook, 2008; Lamb, Pies, & Zisook, 2010; Zisook & Kendler, 2007). While such individual features are certainly relevant, they do not adequately reflect the experience of the event and thus, as described earlier, do not permit a real assessment of how closely related the expressed emotion is to the milieu in which it occurred. In the case of bereaved cancer caregivers, understanding grief must encompass recognition of the circumstances of caregiving ending in the death of the patient from cancer.

The stressful nature of cancer caregiving has generated a great deal of research on consequences for the health and well-being of cancer caregivers. The literature on cancer caregiving and bereavement provides a wealth of information on the most influential factors for caregiver mental health outcomes. Unfortunately, the lack of conceptual clarity about what constitutes depression is reflected in much of the psycho-oncological research. Most of this body of work focuses on caregiver burden or depression before the patient's death (Francis, Bowman, Kypriotakis, & Rose, 2011; Francis, Worthington, Kypriotakis, & Rose, 2010; Given et al., 2006; Nijboer et al., 2000; Northouse, 2005) and provides little insight into subsequent adaptation. Thus, the relationship between caregiving and well-being in bereavement remains unclear. Indeed, various studies report that caregiving can lead to both an increase and decrease of postbereavement psychological symptoms (Boerner, Schulz, & Horwitz, 2004; Prokos & Keene, 2005; Stein, Folkman, Trabasso, & Richards, 1997), variations in length of recovery from grief (Chentsova-Dutton et al., 2002; Ferrario, Zotti, Massara, & Nuvolone, 2003), and outcomes of either relief from caregiving strain or complicated or prolonged grief (Bass & Bowman, 1990; Bernard & Guarnaccia, 2003; Jacobsen, Zhang, Block, Maciejewski, & Prigerson, 2010). Recent work that has attempted to specify the relationship more clearly has found that both depression and perceived burden during caregiving can predict depression in subsequent bereavement (Kim & Given, 2008; Kim, Carver, Schulz, Lucette & Panadi, 2013; Schulz et al., 2008). Taken together, this work highlights the consequences of caregiving on bereavement but does not clarify how the context of caregiving affects the course of grief and/or depression after the patient dies.

Some important studies have, however, shown the effects of particular aspects of the caregiving context for bereavement outcomes. Bass, Bowman, and Noelker (1991), for example, found that good social support aided in bereavement adjustment, while Kissane and Bloch (2002) discovered that family conflict and dysfunction during caregiving can lead to complicated grief after the patient's death. This body of literature also considers demographic differences in outcomes (Fitzpatrick & Bosse, 2000; Gaugler et al., 2008; Nijboer, Tempelaar, Triemstra, Sanderman, & van den Bos, 2001) and emphasizes the essential contribution of patient quality of life to the caregiver's experience (Given et al., 1992; Kim & Given, 2008; Kimberlin, Brushwood, Allen, Radson, & Wilson, 2004). Although the relationship between caregiving, grief, and depression remains unclear in this literature, the contribution of caregiving circumstances to caregiver emotional outcomes has been well established. The first contribution of this study, therefore, is to clarify the consequences of cancer caregiving and the relationship of such caregiving to both grief and risk of depression. This will serve as the basis for our argument on the distinction between grief and MDD after bereavement.

Grief and Depression in Context

The challenge to the bereavement exclusion for MDD is supported largely by research demonstrating considerable overlap between grief and depression in symptoms, sufferer characteristics, and family history (Kendler, Myers, & Zisook, 2008; Lamb et al., 2010; Zisook & Kendler, 2007). The fact that grief also responds to antidepressant medication is also frequently cited as support for treating severe grief as MDD (Zisook, Shear, & Kendler, 2007; Zisook, Shuchter, Pedrelli, Sable, & Deaciuc, 2001). This view puts primary focus on the manifestation of the emotional states to the exclusion of source of the emotion. Yet researchers and clinicians have long recognized the similarity in the expression of grief and depression. Indeed, observations to this effect date back to Hippocrates (U.S. National Library of Medicine, 2011). This similarity in experience has constituted much of the reason that the bereavement exclusion in the *DSM* specifies the *context* of the symptoms—recent loss of a significant other—as central to the diagnostic process.

Context is an inextricable component of all emotions. Indeed, context is often the defining feature as to whether we define emotional reactions as normal or pathological. A person who frequently laughs for no perceptible reason or at highly inappropriate moments is liable to have his or her sanity questioned. The same holds for a person who rages without cause or one who cries when the situation does not merit tears. Context is what we use to define emotion; to judge its manifestation without considering the surrounding circumstances is to omit half the picture. Based on research from sociology, psychology, and anthropology, Thoits (1985) makes the case that there are actually four cues or sources of information individuals use to interpret their own emotions: situational cues, cultural labels, physical cues, and expressive gestures. From this perspective, the social and cultural context comprises the key source from which we are able to attribute meaning to our physical symptoms and expressions.

According to the sociology of emotions, therefore, the recognition, expression, and even experience of grief are embedded in a social and cultural milieu that defines its appropriateness (Charmaz & Milligan, 2006; Lutz & White, 1986). Grief is a normative emotional response to loss—extreme sadness appropriate to the situation. In this sense, grief is a cultural construct (Lofland, 1982; Lutz & White, 1986) whose definition and legitimacy must be endorsed by others in order for its expression to be condoned in any given situation (Charmaz, 1997; Clark, 1997; Francis, 1997a, 1997b). Thus, emotion is inextricable from environmental, contextual, and interpersonal factors (Aneschesel et al., 2004; Carr, 2003; Charmaz & Milligan, 2006; Lofland, 1982; Rosenblatt, 2001).

This focus on context is reflected as well in the social stress literature. Stress theory considers the death of a loved one as a severe negative life event (Lin, Dean, & Ensel, 1986), something that puts heavy strain on the emotional and psychological resources of the sufferer. Psychological distress after bereavement, therefore, is a function of the degree of demand a person experiences on their psychological, emotional, social, and structural resources, both due to the death and to all other causes (Aneshensel et al., 2004; Carr, 2004). Following the stress literature, then, some degree of distress after a negative stressor such as bereavement is normal and expected to be proportional to the stressfulness of the event. Note, however, that emotional or psychological distress should not be confused with depression. Distress is a generic term encompassing a number of negative emotions that occur in response to negative events or situations. It is, in that sense, normative and expected in the context of events in a way that MDD is not.

This is not to imply that context and events are irrelevant to the development of depression. On the contrary, widespread research has made it clear that many, if not most episodes of depression have an environmental trigger (Dohrenwend, 2000; Pearlin, Aneshensel, & LeBlanc, 1997; Prigerson et al., 2009). However, seminal work by Brown and colleagues (Brown, 2002; Brown & Harris, 1978; Brown, Lemyre, & Bifulco, 1992) clarifies that a single event or strain such as bereavement is unlikely itself to propel a person into depression. Rather, an episode of depression is a product of a lifetime, not a single event. Specifically, Brown argues that the likelihood of developing a true depressive episode after experiencing stress is greatest when a person who has developed few protective psychological and social resources suffers a severe loss in an area of personal importance and that loss involves either humiliation or a sense of entrapment (Brown, 2002). Thus, depression may be triggered by circumstances, but in actuality has much deeper roots and ultimately transcends the immediate context.

This pattern of disconnection of depression from the context also appears in Karp's (1996) study of people suffering from major depression. The turning point for his subjects was the moment when they realized that their emotional pain was not due just to stress or difficult circumstances but was somehow inside the individuals themselves. Even when things were going well, the expected relief from depression did not occur. Karp refers to this key moment as the recognition that "something is really wrong with me," (p. 57) locating the problem in the person, not the environment.

Horwitz and Wakefield (2007) address this issue directly, arguing that MDD is a true medical dysfunction that becomes disconnected from environmental causes. They argue that grief and other forms of situation-dependent distress are *normal sadness*, and not true mental disorders. They call into question the practice of medically labeling emotional responses to distressing circumstances as depression. Indeed, Horwitz and Wakefield argue specifically that a key distinction between MDD and grief is the tie of the latter to distressing events, as described by stress theory. MDD, on the other hand, is not a direct and proportionate response to events but seems overblown or even entirely disconnected from the nature of the sufferer's circumstances. As they describe it:

> [S]ymptoms in themselves do not distinguish depressive disorders from normal sadness; the symptoms themselves are not qualitatively different from what an individual might naturally experience after a devastating loss.... Instead, it is the absence of an appropriate *context* for symptoms that indicates a disorder.... [C]ases either emerged in the absence of any loss event or developed after the occurrence of a positive event.... Their severity was of grossly disproportionate intensity to the sufferer's actual circumstance. Finally, symptoms persisted independently of any stressful contexts, took on a life of their own, and were immune to changes in external conditions. The fact that the literature emphasizes such examples can mislead us into overlooking the fact that the DSM diagnostic criteria themselves are not limited to such conditions and invalidly encompass a great range of intense normal reactions. (Horwitz & Wakefield, 2007, p. 14, italics in original)

Following these authors, therefore, MDD is a dysfunction of the emotional system, a true disorder or disease. To confuse it with normal sadness is to both unnecessarily medicalize people undergoing normal reactions and to distract attention from those truly in need of intervention. On this basis, Wakefield and colleagues have taken issue with the elimination of the bereavement exclusion from major depression diagnoses in the *DSM-V* (Horwitz & Wakefield, 2007; Wakefield & First, 2012). Unfortunately, as Wakefield and First (2012) point out there is a dearth of early bereavement studies that include data on the context of both grief and depression.

In this study, we addressed this issue directly. Specifically, we sought to demonstrate the connection (or lack of it) of grief and risk of depression to the contextual circumstances of caregiving in early bereavement. Drawing on the arguments of Horwitz and Wakefield (2007), we expected grief severity to be directly related to the context of caregiving, reflecting the fact that it is a normal response to circumstances. Depressed mood (or risk of depression), on the other hand, would have a much more tenuous connection to the context of caregiving, reflecting its nature as a disproportionate and dysfunctional emotion. This was the second—and the key—contribution of this study.

Grief as a "Compound" Emotion

Finally, we sought to explore the nature of grief and its relation to risk of depression. Part of the difficulty in illuminating bereavement outcomes lies in the complexity of grief. As Charmaz and Milligan (2006) point out, grief is, in fact, a compound emotion made up of multiple overlapping and sometimes conflicting feelings. These emotions include those identified by traditional stage models: disbelief, denial, depression, anger, and acceptance (Maciejewski, Baohui, Block, & Prigerson, 2007), as well as guilt and blame (Guarnaccia & Hayslip, 1998), yearning (Stroebe, Schut, & Stroebe, 2007; Van der Houwen et al., 2010), and sadness (Horwitz & Wakefield, 2007; Stroebe et al., 2007). To make things yet more complicated, recent research on bereavement has demonstrated that such emotions do not progress in orderly stages as long believed (Holland & Neimeyer, 2010). Rather than a lockstep progression of grief recovery, for most people, deviation from a straight path is the norm, not an aberration. Work by Maciejewski, Prigerson, and colleagues, for example, demonstrate how the emotions of grief tend to overlap and blend, with acceptance gradually dominating. The authors concluded that the emotional *stages* of recovery might be better conceptualized as emotional *states* that make up the complex emotion of grief (Maciejewski et al., 2007; Prigerson & Maciejewski, 2008).

Stroebe and her colleagues also argue for a more complex nonlinear understanding of grief. (Stroebe, Schut, & Boerner, 2010; Stroebe et al., 2007). Rather than reaching stages or accomplishing tasks, these authors find that the mourner oscillates between loss-oriented and restoration-oriented activities. This oscillation is characterized by multiple changing emotions and perceptions and thus reflects a more dynamic view of grief recovery as a process. Such research recognizes that mourners attend to separate aspects of bereavement at different times and that some aspects of the context of bereavement may produce divergent emotional reactions. An accurate understanding of the similarities and distinctions between grief and depression, therefore, must acknowledge the compound nature of grief and its complex connection to bereavement. This is a third goal of this article.

Research Questions

With these ideas in mind, it is unsurprising that severe grief would have substantial similarity to depression at bereavement, as shown both by research showing overlap in symptoms and historical observations that bereavement increases risk of depression. However, in this study, we propose what we feel are important distinctions. Before we address those, however, we want to make clear the range of our claims. Because our measure of depression has no clinical cut point, we could not speak directly to MDD but rather referred to a high number of depressive symptoms as depressed mood or risk of depression. Correspondingly, because our data were collected 2 to 5 months after bereavement, we could not make a case about complications of bereavement, or complicated grief, but rather refer to severity of grief in early bereavement. As a result, the research questions to be tested in this study focused on grief severity and depressed mood/risk of depression.

Our research questions were threefold. First, we expected that grief and depressed mood/risk of depression at bereavement would each reflect different predictors in the caregiving situation. This research question reflects the social science orientation that emotions are inherently embedded in and driven by context. Second, based on prior research defining grief as a normative and depression as a nonnormative emotional reaction to the situation, we anticipated that severity of grief would be more context dependent, that is, more directly related to contextual factors than would be depression. Third, we took the complexity of grief into account, investigating whether different components of grief were influenced by caregiving factors and whether the components varied in their relation to risk of depression. Note that the first two of these three research questions could be considered predictive hypotheses and the third as an open-ended exploration. All three, however, address the fundamental question of the relationship of grief and depressed mood to the context of caregiving among bereaved cancer caregivers.

Data and Methods

These analyses utilized data from two time points: early caregiving, approximately 2 months after the patient's diagnosis of incurable cancer and early bereavement, about 3 months after the patient's death. Study data came from a large randomized controlled trial evaluating the longitudinal effects of a coping and communication support intervention for advanced cancer patients and their caregivers (Bowman et al., 2009; Rose et al., 2008; Radziewicz et al., 2009). The study was conducted in two cancer clinics in large urban tertiary care hospitals caring for disadvantaged and underserved patients in the Midwest. Both hospital institutional review boards approved and monitored the study. Recently diagnosed late-stage cancer patients were enrolled and randomized into intervention and control groups. Eligible patients were diagnosed with Stage IV [or Stage III lung, pancreatic, or liver] cancer within the past year, were 40 years or older, cognitively intact, and English speaking. Average time between diagnosis and recruitment was under 90 days. Patients completed a baseline interview and then identified the person they most depended upon for assistance with care and gave contact permission. Caregivers completed a baseline telephone interview. All enrolled respondents gave informed consent. Of a total of 514 primary caregivers identified, 462 agreed to participate in the study. Caregivers who could be located were contacted 2 to 5 months (on average 3 months) after the death of the care recipient and reconsented for another telephone interview. A total of 199 caregivers had complete data from both time points. This study used data from both patient and family caregiver interviews.

Measures

Independent variables

The Functional Assessment of Cancer Therapy—General Version (FACT-G). FACT-G (Cella, 1994; Weitzner et al., 1995) measured cancer patient quality of life ($0 =$ *not at all* to $4 =$ *very much*). Two scales were included in these analyses: emotional well-being (5 items, $\alpha = .75$); and physical well-being (7 items, $\alpha = .76$).

The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being. The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being incorporates spiritual well-being inpatient quality of life (12 items, $\alpha = .87$; Brady, Peterman, Fitchett, Mo, & Cella, 1999), scored similarly to the FACT-G.

Patient Behavior Problems. Problematic behavior has long been an important variable in caregiving for dementia (Neundorfer et al., 2001) and in recent years has been applied successfully in cancer caregiving research as well (Ferrario, Cardillo, Vicario, Balzarini, & Zotti, 2004; Sherwood et al., 2007; Tsigaroppoulos et al., 2009). Based on its predictive importance in caregiver distress (Pearlin et al., 1997), we drew one item on Patient Behavior Problems from the *Caregiver Load* scale (Oberst, Thomas, Gass, & Ward, 1989): time spent by caregivers managing patient behavior problems (1 = *little or no time* to 5 = *a great deal of time*).

Living Together. Living Together was an indicator of whether or not the caregiver lived with the patient (1 = *yes*, 0 = *no*).

Employment. Employment is an indicator of whether or not the caregiver has paid employment outside the home [1 = *yes*, 0 = *no*].

The Functional Difficulties Index. The Functional Difficulties Index (Nagi, 1976) measured caregiver's ability to perform a series of 11 functions such as standing, lifting, and walking (0 = *no difficulty* to 3 = *unable to do*).

The Caregiver Reaction Assessment. The Caregiver Reaction Assessment (Given et al., 1992) measured subjective caregiver burden (1 = *strongly agree* to 5 = *strongly disagree*, higher scores indexing more burden) and reflected the perceived loss or wearing down of resources for caregiving. The model included the four (out of five) subscales directly measuring burden: Family Abandonment (five items, $\alpha = .85$), the sense of being left by other family members to provide all caregiving tasks; Impact on Health (four items, $\alpha = .90$), perceived health deficits due to caregiving; Impact on Schedule (five items, $\alpha = .82$), the perceived difficulty of managing health care needs and related arrangements; and Impact on Finances (three items, $\alpha = .81$).

Social Support. One item measured a caregivers' number of close friends and relatives they have that "they feel at ease with and can talk to about what is on their minds." This variable was recoded at the 95th percentile (a maximum of 25 people) to eliminate outliers.

Demographics. Caregiver characteristics included the following: age (in years), gender, race (African American vs. White), annual income (seven ordinal categories from 1 = *$0–$9,999* to 7 = *$50,000+*), and employed outside home (yes/no). The description of the sample is found in Table 1.

Measures: Dependent Variables

The Short Form of Profile of Mood States. The Short Form of Profile of Mood States (Shacham, 1983) is a subscale of Depression-Dejection (eight items, $\alpha = .91$, 0 = *Not at all* to 5 = *Very much*). Lacking a clinical cut point, more depressive symptoms were considered as indication of depressed mood or risk of depression. Questions included: "In the past week have you felt: [unhappy, discouraged, worthless, blue, etc.]."

Table 1. Description of Sample ($N = 199$).

Caregiver demographics	*N* (%)
Gender	
Female	162 (81.4)
Male	37 (18.6)
Age (years)	54.8 (23–86)
Income	
$0–9,999	19 (9.5)
$10,000–14,999	21 (10.6)
$15,000–19,999	15 (7.5)
$20,000–29,999	40 (20.1)
$30,000–39,999	19 (9.5)
$40,000–49,999	19 (9.5)
$50K or more	58 (29.1)
Employed	86 (43.2)
Race	
African American	50 (25.1)
White	149 (74.9)
Live w/Patient	82 (41.2)
Disability/impairment [0–13]	
No impairment	70 (35.2)
1–2 impairments	46 (23.1)
3–4 impairments	34 (16.6)
5–6 impairments	13 (6.5)
7+ impairments	34 (17.1)
Caregiving context (range)	Mean (*SD*)
Caregiver variables	
Health burden [4–20]	8.02 (2.65)
Scheduling burden [5–25]	14.23 (4.39)
Financial burden [3–15]	7.85 (2.89)
Family abandonment [5–25]	10.6 (4.17)
Perceived social support [0–25]	8.33 (6.31)
Patient variables	
Patient behavior problems (0–4)	2.4 (1.31)
Emotional well-being (0–24)	18.01 (4.91)
Physical well-being (0–28)	19.88 (5.33)
Spiritual well-being (0–48)	29.32 (7.52)

(continued)

Table 1. (continued)

Caregiver demographics	*N* (%)
Outcome variables (range)	Mean (*SD*)
Grief severity (1–4)	1.64 (0.42)
Bereavement depressed mood (0–32)	6.85 (6.75)

Abbreviation: SD, standard deviation.

The Bereavement Experience Questionnaire. The Bereavement Experience Questionnaire (Guarnaccia & Hayslip, 1998; 24 items, $\alpha = .91$) had three subscales. (A) Existential Loss/Emotional Needs (nine items, $\alpha = .86$) included questions like "Since the death of my relative/friend: I felt life has no meaning; I lost interest in my work; I felt a need to be emotionally close to someone; (B) Guilt/Blame/Anger (9 items, $\alpha = .83$) included items such as: Since the death...: I felt that some person was responsible for the death; I felt guilty about things I did/said before the death; I felt angry at the deceased; and (C) Preoccupation with Thoughts of the Deceased (six items, $\alpha = .81$) included such items as: Since the death...: I yearned for the deceased person; I felt the deceased was/is guiding me; I spent time looking at the deceased's pictures, clothing, belongings." Items were summed and averaged with high scores indicating more severe grief.

There are several characteristics of this sample that are important to note. First, it is heavily skewed toward female respondents. This reflects the nature of caregiving, however, nationally, on average, 77% or more of caregivers are women (Salmon et al., 2003). Our caregiver sample is 81.4% women; this slightly high percentage probably reflects the fact that half of our patient sample was recruited from a VA hospital that serves mostly male patients (who tend to have female caregivers). Second, our median household income for caregivers was $35,000, below the average of $38,000 for the state (Kaiser Family Foundation, 2007). However, as lower income people are more at risk of developing cancer, the lower income of this study is a useful contrast to the higher income groups reflected in most research. The employment rate of only 43.2% is the result of the low-income sample, the high median age (54.8) with many respondents at or above retirement age, and the fact that caregiving itself is so time-consuming that managing paid employment simultaneously is difficult. Drawn from a Midwestern, urban population, our sample shows a higher than average percentage of African American respondents (25.1%). Finally, we included living with the patient as an indicator of degree of involvement in caregiving. Our low-income sample had very low rates of actual marriage, and relationships were so varied and complex (e.g., ex-wife, grandniece, stepsister, cousin, roommate, etc.) that kinship measures proved to have little predictive value. However, many caregivers lived with the patient during their illness and provided daily assistance.

Analysis

Data came from a randomized controlled trial, and for the purposes of this study, all analyses controlled for the effect of the intervention (not shown, intervention status did not alter the findings). Twenty-seven cases were missing data on at least one variable, but no single case was missing more than two items. We used mean substitution to manage missing values on independent variables. Twenty-one cases had missing data on one of the two outcome variables, and these cases were excluded from the analyses. There were no significant differences between the excluded and the included groups. The first analysis, structural equation modeling with Mplus Version 6 (Muthén & Muthén, 2010), model regressed bereavement depressed mood on overall grief (intervening) and the baseline independent variables. Grief and bereavement depressed mood were measured at the same time point, but including the predictor baseline depressed mood as a control (not shown in tables) assessed the influence of grief on the change in depressed mood from baseline to bereavement. Chi-square showed a well-fitting model ($\chi^2 = .40$, $p = .53$), confirmed by comparative fit index (CFI) and Tucker–Lewis index (TLI) scores of 1 [not shown in tables]. The second model replaced the overall grief scale with its three component subscales. Residual errors of the grief subscales were allowed to correlate. Chi-square showed a well-fitting model ($\chi^2 = 3.61$, $p = .45$), which was confirmed by CFI and TLI scores of 1. Significance for both models was set at $p < .05$. Coefficients in Table 3 are unstandardized, but coefficients in Table 4 are shown standardized to permit comparison of findings across the grief subscales. Table 2 shows correlations between grief and bereavement depressed mood.

Results

Effects on Overall Grief and Depressed Mood in Bereavement

Direct effects on overall grief. Column 1 of Table 3 shows seven baseline variables with significant direct effects on grief: being employed (.169, $p < .01$), living with the patient (.176, $p < .001$), disability/impaired functioning (.018, $p < .05$), time spent managing patient behavior problems (.079, $p < .001$), and all measures of patient quality of life (emotional, −.014, $p < .05$; physical, .016, $p < .01$; spiritual, .010, $p < .01$). Of these, all but emotional well-being were positively related to grief, indicating they contributed to more severe grief.

Direct effects on bereavement depressed mood excluding grief. Column 2 of Table 3 shows five baseline variables with direct effects on bereavement depressed mood: living with the patient (2.685, $p < .001$), caregiver disability/impaired functioning (.309, $p < .05$), patient's physical well-being (.252, $p < .01$), impact on caregiver health (.493, $p < .05$), and impact on the caregiver's schedule (−.290, $p < .01$).

Table 2. Bereavement Outcome Variable Correlations: Overall Grief, Grief Subscales A–C, and Depressed Mood.

Outcome variables	Depressed mood at bereavement	Overall grief	Grief subscale A: Existential Loss/Emotional Needs	Grief subscale B: Guilt/Blame/Anger	Grief subscale C: Preoccupation with Thoughts of Deceased
Depressed mood	1				
Overall grief	.772**	1			
Subscale A	.772**	.889**	1		
Subscale B	.504**	.669**	.475**	1	
Subscale C	.514**	.772**	.543**	.216**	1

**Pearson correlations with two-tailed significance of .01.

The last two were the only variables that predicted only depressed mood and not grief, and only scheduling burden decreased the severity of the outcome variable.

Direct effects on depressed mood including grief. Column 3 of Table 3 shows a mediation effect of grief on bereavement depressed mood, with three variables, living with the patient, having impaired functioning, and the patient's physical well-being, no longer predicting depressed mood directly. New significant effects included: being African American (1.731, $p < .01$), patient's spiritual well-being (−.082, $p > .05$), and overall grief (11.270, $p < .001$). Grief, in a standardized model (not shown), had the largest effect of any variable ($\beta = .703$), more than 3 times the size even of baseline depressed mood ($\beta = .222$). Only the two burden variables (health: .378, $p < .05$; schedule: −256, $p < .001$) did not change significance with the addition of grief.

Indirect effects on depressed mood through grief. In column 4 of Table 3 all of the predictors of grief severity in column 1 had indirect effects on bereavement depressed mood: being employed (1.904, $p < .01$); living with patient (1.984 $p < .001$); having impaired functioning (.204, $p < .05$); time spent managing patient behavior problems (.894, $p < .001$); and patient's emotional (−.158, $p < .05$), physical (.176, $p < .01$), and spiritual (.118, $p < .01$) well-being. These variables either had no prior direct effects on depressed mood or had their direct effects disappear when grief was added to the model.

Results

Effects on Grief Subscales and on Depressed Mood in Bereavement

Direct effects on depressed mood. In the second analysis, we presented standardized coefficients for the purpose of making effect sizes comparable. Table 4 shows

Table 3. Unstandardized SEM Coefficients of Baseline Variables on Overall Grief and Bereavement Depressed Mood (Direct and Indirect Effects).

Independent and intervening variables	Overall grief (direct effects)	Depressed mood excluding grief (direct effects)	Depressed mood including grief (direct effects)	Depressed mood through grief (indirect effects)
	β (*SE*)	β (*SE*)	β (*SE*)	β (*SE*)
Caregiver characteristics				
Age	−.002 (.002)	−.005 (.031)	.020 (.022)	
Gender (F)	−.061 (.064)	−1.537 (1.019)	−.700 (.715)	
Race (AA)	−.092 (.060)	.757 (.945)	**1.731**** (.664)	
Income	−.023 (.014)	−.342 (.219)	−.109 (.154)	
Disability/impairment	**.018*** (.007)	**.309*** (.117)	.102 (.083)	**.204*** (.085)
Employed	**.169**** (.058)	.970 (.926)	−.875 (.661)	**1.904**** (.668)
Caregiver context				
Lives w/patient	**.176***** (.052)	**2.685***** (.814)	.641 (.587)	**1.984***** (.597)
Health burden	.012 (.013)	**.493*** (.197)	**.378*** (.138)	
Schedule burden	−.003 (.007)	−**.290**** (.106)	−**.256***** (.074)	
Family abandonment	.011 (.007)	.070 (.109)	−.057 (.077)	
Financial burden	−.012 (.009)	−.176 (.149)	−.066 (.105)	
Social support	.003 (.004)	−.047 (.059)	−.080 (.040)	
Patient context				
Patient behavior problems	**.079***** (.021)	.605 (.329)	−.316 (.239)	**.894***** (.242)
Emotional well-being	−**.014*** (.006)	−.117 (.093)	.043 (.066)	−**.158*** (.068)
Physical well-being	**.016**** (.006)	**.252**** (.088)	.089 (.063)	**.176**** (.064)
Spiritual well-being	**.010**** (.004)	.040 (.057)	−**.082*** (.041)	**.118**** (.041)
Grief	NA	NA	**11.270***** (.787)	
	$R^2 = .412$	$R^2 = .433$	$R^2 = .724$	

Abbreviations: SEM, structural equation modeling; SE, standard error; NA, not applicable.
*$p < .05$ **$p < .01$ ***$p < .001$.

Table 4. Standardized SEM Coefficients of Baseline Variables and Grief Subscales on Bereavement Depressed Mood (Direct and Indirect Effects).

Independent and intervening variables	Bereavement depressed mood	Subscale A: Existential Loss/Emotional Needs		Subscale B: Guilt/Blame/Anger		Subscale C: Preoccupation w/Thoughts of Deceased	
	Direct β (*SE*)	Direct β (*SE*)	Indirect β (*SE*)	Direct β (*SE*)	Indirect β (*SE*)	Direct β (*SE*)	Indirect β (*SE*)
Caregiver demographics							
Age	.047 (.042)	−.079 (.068)		−.093 (.072)		.014 (.071)	
Gender	−.057 (.039)	−.012 (.063)		−.128* (.066)	−.015 (.010)	−.047 (.065)	
Race (AA/W)	.113** (.041)	−084 (.065)		−.065 (.069)		−071 (.068)	
Income	−045 (.043)	−067 (.070)		−.075 (.074)		−106 (.073)	
Disability/Impairment	.074 (.043)	.095 (.069)		.204** (.072)	.024* (.012)	.114 (.071)	
Employed	−066 (.046)	.182* (.072)	.107* (.044)	.133 (.076)		.152* (.075)	.019 (.012)
Caregiver context							
Lives w/patient	.074 (.041)	.133* (.063)	.079* (.038)	.049 (.067)		.294*** (.064)	.038* (.016)
Health burden	.103 (.052)	.172* (.083)	.101* (.049)	.020 (.088)		−047 (.086)	
Schedule burden	−.184*** (.046)	.018 (.074)		−.101 (.078)		−.015 (.076)	
Family abandonment	−.015 (.044)	.053 (.072)		.200** (.075)	.024* (.013)	.025 (.074)	
Financial burden	−.046 (0.43)	−.036 (.007)		−.053 (.073)		−.080 (.073)	
Social support	−.056 (.038)	.061 (.062)		−.017 (.065)		.142* (.063)	.018 (.011)
Patient context							
Patient behavior problems	−.038 (.044)	.168* (.068)	.099* (.041)	.144* (.072)	.017 (.011)	.282*** (.069)	.036* (.016)
Emotional well-being	.044 (.045)	−.176* (.072)	−.109* (.043)	−.071 (.076)		−.121 (.074)	

(continued)

Table 4. (continued)

Independent and intervening variables	Bereavement depressed mood	Subscale A: Existential Loss/Emotional Needs		Subscale B: Guilt/Blame/Anger		Subscale C: Preoccupation w/Thoughts of Deceased	
	Direct β (*SE*)	Direct β (*SE*)	Indirect β (*SE*)	Direct β (*SE*)	Indirect β (*SE*)	Direct β (*SE*)	Indirect β (*SE*)
Physical well-being	.057 (.046)	.186* (.072)	.107* (.044)	.158* (.076)	.019 (.012)	.118 (.075)	
Spiritual well-being	−.076 (.042)	.136* (.066)	.080* (.040)	.119 (.070)		.178* (.068)	.021 (.012)
Grief subscales							
A: Loss/Needs	.589*** (.050)						
B: Guilt/Blame/Anger	.121** (.044)						
C: Preoccupation	.128** (.048)						
	$R^2 = .758$	$R^2 = .345$		$R^2 = .270$		$R^2 = .299$	

Abbreviations: SEM, structural equation modeling; SE, standard error.
*$p < .05$ **$p < .01$ ***$p < .001$.

only two baseline variables remaining as significant predictors of bereavement depressed mood: being African American (.113, $p < .01$) increased depressed mood and impact on schedule (−.184, $p < .001$) decreased it. All grief subscales were positively associated with bereavement depressed mood (Subscale A, .589, $p < .001$; Subscale B, .121, $p < .01$; Subscale C, .128, $p < .01$).

Direct effects on grief subscales. Seven baseline variables predicted Subscale A (Existential Loss/Emotional Needs): employment (.182, $p < .05$), living with the patient (.133, $p < .05$), impact on health (.172, $p < .05$), patient behavior problems (.168, $p < .05$), and the three patient quality of life variables (emotional well-being, −.176, $p < .05$; physical well-being, .186, $p < .05$; spiritual well-being, .136, $p < .05$). Only two variables that predicted Subscale A also predicted B (Guilt/Blame/Anger): patient behavior problems (.144, $p < .05$) and patient's physical well-being (.158, $p < .–5$). Being female (−.128, $p < .05$), disability/impaired functioning (.204, $p < .01$) and perceived family abandonment (.200, $p < .01$) were unique predictors of Subscale B. By contrast, four of the five variables predicting Subscale C (Preoccupation with Thoughts of the Deceased) overlapped with the predictors of Subscale A: employment (.152, $p < .05$), living with the patient (.294, $p < .001$), patient behavior problems (.282, $p < .001$), and patient's spiritual well-being (.178, $p < .05$). Only social support (.142, $p < .05$) was unique to Subscale B. Subscales B and C overlapped only on patient behavior problems.

Indirect effects of baseline variables on depressed mood via grief subscales. All variables directly affecting Subscale A (Existential Loss/Emotional Needs) also had significant indirect effects on depressed mood through Subscale A: employment (.107, $p < .05$), living with the patient (.079, $p < .05$), impact on health (.101, $p < .05$), patient behavior problems (.099, $p < .05$), and all three measures of well-being (emotional, −.109, $p < .05$; physical, .107, $p < .05$; spiritual, .080, $p < .05$). For Subscale B (guilt/blame/anger), however, only two of the four direct predictors had indirect effects: disability/impairment (.024, $p < .05$) and perceived family abandonment (.024, $p < .05$). Finally, only two of the four direct predictors of Subscale C had indirect effects on depressed mood: living with the patient (.038, $p < .05$) and patient behavior problems (.036, $p < .05$).

Discussion

We began with assumption that grief and depression are distinct emotions and therefore would be related to different aspects of caregiving and bereavement. We confirmed this assumption; only two contextual variables remained predictive of depressed mood at bereavement through both analyses and neither was related to grief. Correspondingly, the contextual variables predicting overall grief and the grief subscales did not predict depressed mood. These findings accord with current research on grief that views grief as a normal reaction to loss (Horwitz & Wakefield, 2007; Stroebe, Abakoumkin, & Stroebe, 2010; Wakefield & First, 2012). These findings do not support the older psychodynamic assumption that grief is closely related to depression (Maciejewski et al., 2007). The similarity in expression of the two emotional states, as Thoits (1985) points out, is insufficient to conclude they are the same when situational cues and cultural labels for the two diverge.

We also confirmed our expectation that grief would be a more context-dependent emotion than would be depression. Specifically, we found that very few contextual variables had a direct influence on the risk of depression among bereaved cancer caregivers. Only health and scheduling burden affected depressed mood directly without reference to grief. Of those, scheduling burden predicted a decrease in depressed mood consonant with a "relief model" of caregiver bereavement (Bass & Bowman, 1990; Bernard & Guarnaccia, 2003). Such a model speaks more to caregiving than it does to bereavement, as it indicates a distress response to the unrelenting commitment of 24-hr care for a dying cancer patient. "Relief" is the response when the overwhelming exhaustion of end-of-life caregiving lifts with the patient's death. In this, we see some implications for Brown's (2002) theory of "entrapment" being a core risk factor for depression. It is very common for caregivers to complain of feeling trapped, tied to the patient's side, unable to take a break for days, weeks, or even months because of their complete responsibility for the well-being of the patient (Given, Given, & Kozachik, 2001). Ironically, then, it is the death of the patient that provides the release from the entrapment and thereby reduces rather than increases the caregiver's risk of depression. Nonetheless, the amelioration upon release indicates a distress that may be less severe than MDD, given the rapid emotional resolution in early bereavement.

Two additional variables, being African American and patient's high spiritual well-being, showed a suppressor effect of grief, where their direct influence on depressed mood was only evident when controlling for grief. This combination of variables seems significant in and of itself, as spirituality and religiosity are frequently associated with African Americans (Dilworth-Anderson, Williams, & Gibson, 2002; True et al., 2005). The two effects, however, are in opposite directions, with African American caregivers having more depressed mood, but caregivers of patients with high spiritual well-being reporting less depressed mood. Perhaps these findings generally indicate the protective effects of faith on psychological well-being (Balboni, 2007), especially given that high patient spiritual well-being was also associated with more grief (a normal reaction) and less depressed mood. As for the higher risk of depression for African Americans, possible explanations may include African Americans' negative associations with the health care system (Francis et al., 2011; Halbert et al., 2009; Kennedy, Mathis, &Woods, 2007; Phipps et al., 2003;), avoidance of formal support (Kosloski, Schaefer, Allwardt, Montgomery, & Karner, 2002; True et al., 2005), or overall allostatic load and cumulative stress (Dilworth-Anderson, Williams, & Gibson, 2002; Pinquart & Sorensen, 2005). Interestingly, all of these explanations cohere with Brown's (2002) argument that vulnerability to depression may be a life span phenomenon, with those living in long-term disadvantage having the greatest number of risk factors. In this sense, the correlation of race and poverty in the United States (and in this sample), combined with the long-term effects of inner city living may find expression in the disproportionate psychological sequelae of cancer bereavement on African American caregivers.

Turning to grief, we see that many more contextual variables have important influence on this emotion. Six of the ten significant variables in the first model predicted grief severity and affected depressed mood only indirectly through grief. For these variables, then, risk of depression is clearly mediated by grief, and the only connection of depressed mood to these contextual factors is through the emotion of grief. We did not anticipate this pattern of mediation of depressed mood by grief, although in hindsight we probably should have as it follows logically from the hypotheses we initially framed. Specifically, we expected in our second hypothesis that grief would be more context dependent than depressed mood, and we knew from prior research and that grief severity would correlate with depressed mood at bereavement. By extension, then, it should have come as no surprise to find that the effects of the situation on depressed mood come through severity of grief. That severity of grief itself had so profound an effect on depressed mood indicates that severe grief itself may comprise the greatest risk for depression among the bereaved. This lends credence to Horwitz and Wakefield's (2007) assertion that depression is a dysfunction of the emotional system whose trigger may lie in emotion itself rather than the situation producing it.

When dividing grief into its component subscales, we get an even clearer picture of the ways in which the caregiving situation influences grief much more heavily than it does risk of depression. In this model (Table 4), the direct effects on depressed mood from both patient's spiritual well-being and of caregiver's health burden have disappeared, to be replaced by direct effects of those variables on grief subscales alone. This leaves only two of the contextual factors discussed earlier, race and scheduling burden, as predicting risk of depression. All other significant contextual variables either directly affect one or more grief subscales but have no effect on risk of depression or their effects on the latter are entirely mediated by grief. Figure 1 illustrates this pattern of mediation clearly.

Our third research question asked whether the various components that make up the complexity of grief act differently from one another. Specifically, we explored whether each component is related in a unique way to either contextual variables or to depressed mood at bereavement. Figure 1 shows that indeed there

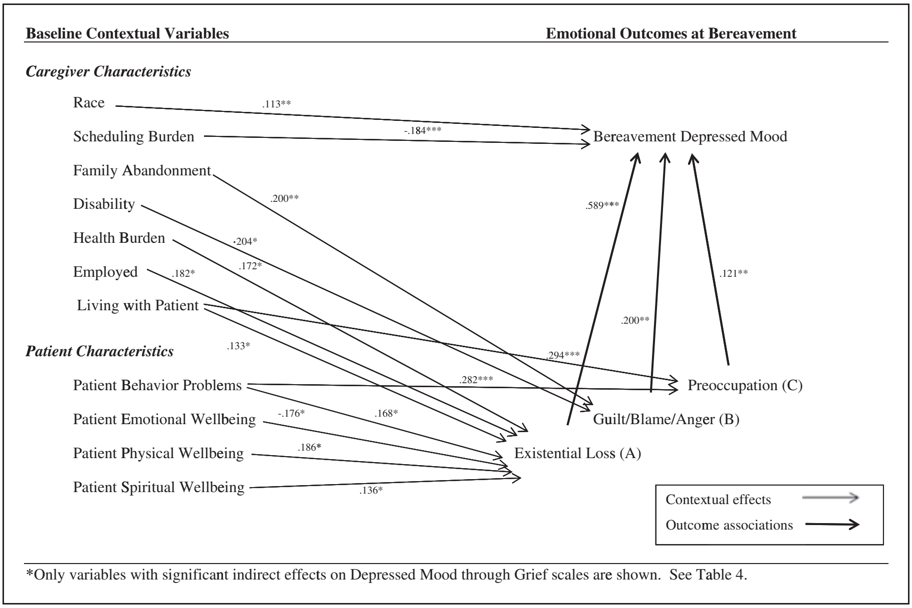

Figure 1. Significant standardized effects of contextual factors of the caregiving situation on caregiver grief and depressed mood in early bereavement.

Note. Only variables with significant indirect effects on depressed mood through grief scales are shown. See Table 4.

are key distinctions between the subscales of grief. Most apparently, it is clear that Subscale A (Existential Loss/Emotional Needs) is the primary component of grief predicting depressed mood. It has both the greatest effect on depressed mood, and it has the largest number of situational predictors. Subscales B (Guilt/Blame/Anger) and C (Preoccupation with Thoughts of the Deceased) each only have two predictors that go on to influence depressed mood. This pattern is clear in Table 4 as well. Unfortunately, at this point, it is hard to explain these findings unambiguously. The strong correlation of Existential Loss/Emotional Needs to bereavement depressed mood could be interpreted in at least three ways. First, it could indeed be the case that people whose severe grief takes this form are at greater risk of developing MDD. However, it could also be the case that the effect flows in the other direction as well and that people at risk of MDD are more likely to express their grief this way. Finally, this correlation could merely indicate that this is the aspect of grief whose expression is most similar to the symptoms of depression. Moreover, the only really clear message that can be obtained from this particular correlation is that grief and depressed mood have extremely similar expressions in early bereavement and potentially the only way to distinguish them is based on connection to context.

This point returns us to the original premise of this study: that grief and depression in early bereavement are distinct emotions that should not be equated purely based on similarity of expression. Our confirmation of this premise lends support to the argument that the bereavement exclusion to MDD is valid and important. At least among bereaved cancer caregivers, individuals who have undergone the burdensome and painful process of being primary caregiver for a dying loved one, their experience is predictive of grief severity only. It does not directly predict risk of depression at bereavement. Instead, it is almost entirely grief severity that predicts depressive symptoms. This finding is congruent with the contention that depression is a dysfunction of the emotion regulation system, a true disease or disorder, as argued by Horwitz and Wakefield (2007). Contrary to the current trend to focus only on surface similarity, then, this study argues that context may be one of the *most* important indicators in deciding whether a person is suffering from normative grief or actual psychopathology.

Limitations

This study is not without limitations. First, the sample size restricted the number of variables that could be used in the analysis and still maintain statistical power, so not all possible effects were considered. Second, some variables used only a single item, which makes them less than ideal measures of complex concepts. Third, this study assumes depressed mood as the ultimate outcome variable, but it is measured at the same time point as grief. By controlling for baseline depressed mood, we accounted for the influence of grief on change in depressed mood from baseline to bereavement. However, direction of effect between these two outcome variables cannot be assured. Finally, the measures of bereavement outcomes are only two possible measures of these states. However, both measures used are validated, reliable scales often used with cancer patients and their families, and the rigorous methodology of the sample lends force to their results. Arguably, then, this study lays the groundwork for future research to clarify these issues.

Conclusion

The death of a close family member is widely recognized as one of the most stressful experiences a person can undergo (Adler & Page, 2008). With about 70% of deaths occurring as a result of chronic conditions, many, if not most deaths, follow some degree of informal caregiving (Schulz et al., 2008). Thus, the stress of bereavement is frequently complicated by the preceding strains of informal care (Pearlin et al., 1997; Pearlin, Schieman, Fazio, & Meersman, 2005; Stroebe, Schut, et al., 2010). This study clarified the impact of the context of cancer caregiving influences both grief and risk of depression. In particular, this analysis resulted in three findings. We found support for our first hypothesis that grief and depressed mood in bereavement do not overlap in contextual predictors, and therefore, in accordance with much of the literature on emotion, should be considered distinct and separate emotions. Second, our second hypothesis stated that grief would be much more context dependent than depressed mood, and we supported that, showing that depressed mood has very little direct connection to the caregiving situations. Moreover, we found severity of grief to be the single largest influence on depressed mood, potentially suggesting that it might be strong emotion that triggers depression, not circumstances. Finally, in exploring the compound emotion of grief, we showed that a severe profound sense of detachment and hopeless in grief was highly correlated with depressed mood, indicating the greatest overlap with depressed mood, but distinguishable from it by its connection to the context of caregiving. These findings have evidence for the recent change in the DSM regarding the bereavement exclusion for MDD, in that this study provides evidence for the inappropriateness of equating grief and depression based purely on symptoms and the necessity of including context as a key factor in identification.

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