



# Adult separation anxiety differentiates patients with complicated grief and/or major depression and is related to lifetime mood spectrum symptoms

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## Abstract

**Background:** Increasing literature has been focused on complicated grief (CG) and its distinctiveness from other potentially loss related mental disorders such as major depression (MD). In this regard, symptoms of separation distress seem to play a key role. The aim of this study was to compare the clinical features of CG to those of MD and of CG + MD, with particular attention to separation anxiety.

**Methods:** Fifty patients with CG (26 with and 24 without MD) and 40 with MD were consecutively recruited. Assessments included: SCID-I/P, Inventory of Complicated Grief (ICG), Adult Separation Anxiety Symptom Questionnaire (ASA-27), Work and Social Adjustment Scale (WSAS), Mood Spectrum-Self Report (MOODS-SR)-lifetime version.

**Results:** Patients with MD reported significantly higher ASA-27 scores than patients with CG either alone or with MD. In all groups, ASA-27 total scores were significantly correlated with the MOODS-SR total scores and with those of its depressive component and rhythmicity domain. No significant differences were reported in the WSAS scores.

**Limitations:** Major limitations are the small sample size and the use of lifetime instruments.

**Conclusions:** Our results suggest a correlation between adult separation anxiety symptoms and lifetime mood spectrum symptoms both in patients with CG and MD. Further studies are needed to better understand the role of adult separation anxiety in the development of these disorders and for their nosographic autonomy as well.

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## 1. Introduction

Increasing literature has been focused on bereavement related conditions with particular attention to a new, unique syndrome variously referred to as “complicated grief”, “prolonged grief disorder” or “traumatic grief”. In the recently released DSM-5 [1], this syndrome has been classified in Section III (Conditions Requiring Further Research) as “Persistent Complex Bereavement-Related Disorder”. However, we will use “complicated grief” (CG) in this paper because this definition is more widely used in the existing literature.

CG is characterized by a specific onset after the loss of a significant other and includes dysfunctional thoughts, feelings or behaviors that are related to the loss that

complicate the grief process, including disbelief and preoccupation with the deceased, intense yearning and searching, distressing memories and difficulties moving on [2–5]. CG is typically associated with significant distress, impairment and a heightened risk of suicide beyond concomitant depression and anxiety [2,6–12]. Despite consistent evidence in support of a unique syndrome of CG as an independent diagnosis, the lack of consensus regarding the best diagnostic criteria led to the inclusion of CG among disorders requiring further study in DSM-5.

In order to acknowledge CG as a distinct syndrome, several studies have examined the distinctiveness from its “nearest neighbors” that can also occur in the wake of a loss, in particular major depression (MD) and post-traumatic stress disorder (PTSD) [7,13–21].

Severe grief increases the risk of major depressive episodes [22] and there is evidence that CG frequently co-occurs with mood disorders [23]. Rates of MD comorbidity ranging from 52 to 70% have been reported in CG patients

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[24,25]. Conversely, two recent studies found high prevalence of CG (respectively 18.6% and 25%) in bereaved patients with depression [23,26]. Similarly, CG comorbidity has been detected in about 24% of patients with a diagnosis of bipolar disorder facing a loss [25,27]. These observations suggested the potential usefulness of exploring the relationships between lifetime mood symptomatology and CG [28].

Studies investigating the differential clinical correlates of CG and MD highlighted the former to be characterized by prominent symptoms of separation distress (e.g., preoccupation with thoughts and images of the deceased, yearning and searching behaviors, excessive loneliness and frequent intense pangs of grief and sadness) with respect to the latter [8,29–31]. Recently, insecure attachment styles have also been suggested as potential risk factors for CG [32–34]. Previous work showed an association between insecure attachment style and elevated traumatic grief symptoms but not depression in bereaved spouses [35]. If so, separation anxiety may be uniquely associated with CG, however there are little data to examine this possibility [28,36,37].

The purpose of the current study was to explore the distinctiveness vs. overlap between CG and MD in terms of clinical correlates. In particular, our aim was to compare patients with CG with those with MD and CG + MD paying attention to symptoms of adult separation anxiety and lifetime mood spectrum comorbidity.

## 2. Materials and methods

Eligible patients included new and continuing patients with a diagnosis of CG ( $N = 24$ ), MD ( $N = 40$ ) or both ( $N = 26$ ), seeking for treatment for these conditions. Patients with CG had been consecutively recruited in a multicenter Italian study, coordinated by researchers of the Psychiatric Clinic of the University of Pisa (Italy), aimed at assessing the validity and reliability of a new structured clinical interview for trauma and loss spectrum and its self-report version (SCI-TALS and TALS-SR respectively [38,39]). Forty patients with a diagnosis of MD without CG, age and gender matched with patients with CG, were consecutively recruited at the Psychiatric Clinic of the University of Pisa, Italy.

All patients with a diagnosis of CG had experienced the loss of a close relative or of a friend at least 6 months before entering the study. All patients were taking psychotropic medications (SSRIs, mood stabilizers and/or benzodiazepines). Exclusion criteria were: severe medical illnesses, neurological diseases or presence of psychotic symptoms.

The ethics committee of the coordinating center (University of Pisa) approved all recruitment and assessment procedures. Eligible subjects provided written informed consent after receiving a complete description of the study and having the opportunity to ask questions.

The assessments included: the Structured Clinical Interview for DSM-IV Axis-I disorders (SCID-I/P) [40], the

Inventory of Complicated Grief (ICG) [41], the Adult Separation Anxiety Symptom Questionnaire (ASA-27) [42], the Work and Social Adjustment Scale (WSAS) [43], and the Mood Spectrum Self-Report (MOODS-SR) lifetime version [44]. A specific checklist also collected demographic data including: gender, marital status, education level, and employment status.

### 2.1. Assessment instruments

The SCID-I/P was administered by psychiatrists trained and certified in the use of all instruments in this study, for the assessment of current or lifetime diagnoses.

The ICG is a self-report instrument used to identify CG [41]. At the time of our study, most of the literature indicated an ICG total score  $\geq 25$  as the threshold for CG diagnosis [3,6,13]. In the present study we adopted this threshold in order to detect a diagnosis of CG. More recent reports, including the DSM-5 anxiety disorder-working group, suggested an ICG total score  $>30$  as the threshold for CG diagnosis [2,5,45,46].

The ASA-27 is a 27-item self-report measure with items rated on a scale from 0 (this never happens) to 3 (this happens all the time) developed to rate symptoms of adult separation anxiety. In a previous study [42] on the psychometric properties of this instrument, the measure was compared with a semi-structured clinical interview (the Adult Separation Anxiety Semi-Structured Interview), modeled on the SCID [42]. A cut-off score of 22 was used to identify individuals with clinically significant levels of adult separation anxiety as it has been shown to maintain sound levels of sensitivity (81%) and specificity (84%) [42]. In the present study we used such cut-off score.

The MOODS-SR is an instrument developed and validated by an international collaborative group of clinicians and researchers under the name of the Spectrum Project, which is aimed at assessing lifetime mood spectrum symptoms [47,48]. The MOODS-SR consists of 140 items coded as present or absent for one or more periods of at least 3–5 days throughout the subject's lifetime. The items are organized into manic and depressive components as well as into a section that assesses disturbances in rhythmicity and vegetative functions, yielding a total of seven domains. Both the manic and the depressive components, in fact, are subtyped into three domains exploring mood, energy and cognition symptoms respectively. The number of the mood-, energy- and cognition-manic items endorsed by subjects makes up the "manic component" (62 items) while the sum of the mood-, energy- and cognition-depressive items constitutes the "depressive component" (63 items). The rhythmicity and vegetative functions domain (29 items) explores alterations in the circadian rhythms and vegetative functions, including changes in energy, physical well-being, mental and physical efficiency related to the weather and season, and changes in appetite, sleep and sexual activities. The reliability of the questionnaire proved to be excellent

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