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Lifetime mood symptoms and adult separation anxiety in patients with complicated grief and/or post-traumatic stress disorder: A preliminary report

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ABSTRACT

A minority of bereaved individuals experiences symptoms of complicated grief (CG) that are associated with significant distress and impairment. CG is currently under consideration for inclusion in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) and a major issue is whether or not it can be differentiated from major depressive disorder (MDD) and post-traumatic stress disorder (PTSD). The purpose of this study is to compare the clinical features of CG with those of PTSD and CG + PTSD. A total sample of 116 patients (66 PTSD, 22 CG and 28 CG + PTSD) was recruited. Assessments included: Structured Clinical Interview for DSM-IV Axis-I disorders (SCID-I/P), Inventory of Complicated Grief (ICG), Adult Separation Anxiety Questionnaire (ASA-27), Work and Social Adjustment Scale (WSAS), and Mood Spectrum-Self Report (MOODS-SR) lifetime version. CG was strongly associated with female gender. MDD comorbidity was more common among patients with CG while bipolar disorder was highest among those with PTSD + CG. Patients with CG + PTSD reported significantly higher ASA-27 scores compared to patients with either CG or PTSD alone. Patients with CG + PTSD or PTSD alone reported significantly higher scores on the manic component of the MOODS-SR. No significant differences were reported in the WSAS scores. Our results support differences between CG and PTSD that are important for the consideration of including CG as a new disorder in the DSM-V.

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1. Introduction

Bereavement is one of the most distressing life-events and the loss of a loved one has been associated with significant morbidity and mortality (Schaefer et al., 1995; Schultz et al., 2001; Li et al., 2003; Stroebe et al., 2007) and with mood and anxiety disorders (Bruce et al., 1990; Onrust and Cuijpers, 2006; Kristensen et al., 2009; Dell'Osso et al., 2011a). There is considerable evidence that a minority of bereaved individuals experience symptoms of complicated grief (CG) that are associated with significant distress and impairment (Horowitz et al., 1997; Shear et al., 2007; Boelen and van den Bout, 2008; Prigerson et al., 2009; Dell'Osso et al., 2011b).

CG is currently under consideration for inclusion in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V), and the Internal Statistical Classification of Diseases and Related Health Problems, eleventh revision (ICD-11). One issue related to inclusion in DSM-V is whether or not CG can be differentiated from its "nearest neighbours", in this case major depressive disorder (MDD) and post-traumatic stress disorder (PTSD) (Prigerson et al., 1995a; Lichtenthal et al., 2004; Boelen et al., 2010; Shear et al., 2011). CG frequently co-occurs with MDD, with rates of MDD comorbidity ranging from 52 to 70% (Melhem et al., 2001; Simon et al., 2007). High rates (24%) of CG comorbidity have also been found in individuals with bipolar disorder (Simon et al., 2005, 2007) with the presence of CG associated with additional psychiatric comorbidity, greater bipolar disorder severity and functional impairment, and lifetime suicide attempts. These observations could raise the question of the nosologic independence between CG and mood disorders. In this respect the study of the relationships between lifetime mood symptomatology and CG may provide useful information.

CG is characterized by continued severe separation distress and by dysfunctional thoughts, feelings or behaviours that are related to the loss that complicate the grief process (Prigerson et al., 2009; Zisook and Shear, 2009; Shear et al., 2011). In particular, CG differs from MDD and PTSD in having prominent symptoms of separation distress (e.g., preoccupation with thoughts and images of the deceased, yearning and searching behaviours, excessive loneliness and frequent intense pangs of grief and sadness) (Shear and Shair, 2005; Shear et al., 2007). Other complicating features include feelings of disbelief, ruminating about circumstances or consequences of the loss, intense physical or emotional reactivity to reminders, intrusive images, avoidance behaviour and loss of sense of security and trust, anger or

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bitterness, social estrangement, feeling lost and unfocused. Although the latter resemble some of the symptoms of PTSD, the separation distress component is unique. In more recent conceptualizations of CG, the original distinction suggested between symptoms of separation and traumatic distress is no longer made and increasing effort has been devoted to identifying the core symptoms of CG loaded into a single construct (Prigerson et al., 2009; Zisook et al., 2010; Shear et al., 2011).

Traumatized individuals are typically anxious about the threat related to the traumatic event; whereas individuals with CG experience separation anxiety and the hallmark of CG is sadness and yearning (Lichtenthal et al., 2004; Prigerson et al., 2009; Shear et al., 2011). Recent studies have suggested that the vulnerability to CG may be rooted in insecure attachment styles developed in childhood (Vanderwerker et al., 2006), while previous work showed an association between insecure attachment styles and elevated traumatic grief symptoms but not depression in bereaved spouses (Van Doorn et al., 1998). Adult separation anxiety and CG are phenomenologically alike and therefore it is relevant to examine their distinctiveness. Assuming the perspective of insecure attachment (as a trait) to be a vulnerability factor, adult separation anxiety and CG might be different aspects of the same psycho(patho)logical dimension. In a previous study, we first reported significantly higher adult separation anxiety symptoms in patients with CG with respect to healthy control subjects (Dell'Osso et al., 2011c).

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

2. Methods

A consecutive sample of 116 outpatients ($N=103$) and inpatients ($N=13$) was recruited in a multicentre Italian study 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, Dell'Osso et al., 2008, 2009). The original study, which was a multicentre study carried out at six Italian University Departments of Psychiatry (Pisa, Cagliari, Milano, Napoli, Sassari, and Siena), correlated these new instruments on established measures of similar constructs such as the Inventory of Complicated Grief (ICG) (Prigerson et al., 1995b) and the Impact of Event Scale (IES) (Horowitz et al., 1979). In the present study we did not adopt either the SCI-TALS or the TALS-SR.

Eligible patients for the present study included new and continuing patients with a diagnosis of PTSD ($N=66$), CG ($N=22$) or both ($N=28$), seeking for treatment for these conditions. 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 (selective serotonin reuptake inhibitors, mood stabilizers and/or benzodiazepines). Exclusion criteria were: severe medical illnesses, neurological diseases, alcohol or drug abuse or presence of psychotic symptoms.

The Ethics Committee of the coordinating centre (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 assessment included: the Structured Clinical Interview for DSM-IV Axis-I disorders (SCID-I/P) (First et al., 1995), the ICG (Prigerson et al., 1995b), the Adult Separation Anxiety Symptom Questionnaire (ASA-27) (Manicavasagar et al., 2003), the Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002), the IES (Horowitz et al., 1979) and the Mood Spectrum Self-Report (MOODS-SR) lifetime version (Dell'Osso et al., 2002). Demographic data were also collected by means of a specific checklist 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 (Prigerson et al., 1995b). In the present study we confirmed a high internal consistency of this instrument with a Cronbach's α in our sample of 0.931. At the time of our study, most of the literature indicated an ICG total score ≥25 as the threshold for CG diagnosis (Prigerson et al., 1995a; Horowitz et al., 1997; Zisook et al., 2010). Thus, in the present study we adopted this threshold in order to detect a diagnosis of CG. More recent reports, including the DSM-V anxiety disorder-working group, suggested an ICG total score >30 as the threshold for CG diagnosis (Prigerson et al., 2009; Shear et al., 2011).

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 (Manicavasagar et al., 2003) on the psychometric properties of this instrument, the measure was compared with a semi-structured clinical interview (the Adult Separation Anxiety Semi-Structured Interview), modelled on the SCID (Manicavasagar et al., 2003). 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%) (Manicavasagar, et al., 2003). In the present study we used such cut-off score.

The IES is a 15-item self-report instrument, developed to assess patients' stress levels referred within the last week, to a specific traumatic event such as the death of a loved one. Its two-factor structure (including an intrusion and an avoidance subscale) is stable over different types of events and it can discriminate between stress reactions at different times after the event (Horowitz et al., 1979).

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 (Frank et al., 1998; Cassano et al., 1999). 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. In fact, both the manic and the depressive components 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 function 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 and the inter-rater reliability of domains ranged between 0.79 and 0.92.

The instrument can be downloaded from the web site www.spectrum-project.net.

2.2. Statistical analyses

Analyses to examine familial, epidemiological, clinical, and course characteristics of subgroups were conducted using one-way analysis of variance (ANOVA) followed by the Scheffé F-test for dimensional variables and chi-square analysis for categorical ones. Considering the number of comparisons and the number of subjects in each group, our results are prone to both type I and type II errors. However, given the exploratory nature of our study, we decided to set a two-tailed significance level at $p<0.01$. Pearson's correlations between the scores of the scales adopted were also calculated.

All statistical analyses were carried out using the Statistical Package for Social Science (SPSS Inc., Chicago 2006), version 15.0.

3. Results

Patients with CG, either alone ($n=18$; 81.8%) or with PTSD ($n=25$; 89.3%), were more frequently females and widows or widowers in comparison with patients with PTSD alone ($n=33$; 50%). Details on the demographic characteristics of the study sample are reported in Table 1.

Patients with CG reported the loss of a spouse/partner ($N=10$, 45.5%), brother/sister ($N=3$, 13.6%), child ($N=2$, 9.1%), parent ($N=3$, 13.6%), or close friend ($N=4$, 18.2%). Among patients with both CG and PTSD, in nine (32.1%) cases the loss reported had occurred in the framework of the traumatic event and, in particular: 4 (44.5%) patients had lost their spouse/partner, one (11.1%) a child, two (22.2%) a parent and two (22.2%) a close friend.

Lifetime MDD comorbidity, as assessed by means of the SCID-I/P, was more common among patients with CG compared to those with PTSD alone. Bipolar disorder comorbidity was highest among patients with PTSD + CG ($n=8$, 28.6%) compared to those with PTSD or CG alone. There was no difference in lifetime anxiety disorders comorbidity. (See Table 2 for details.)

Table 3 shows the clinical characteristics of the study sample. Patients with both CG and PTSD reported higher scores on most measures. In particular, patients with CG + PTSD presented significantly higher ASA-27 ($p=0.008$) scores than patients with either CG or PTSD alone. Moreover, a significantly ($p=0.05$) higher proportion of patients with CG + PTSD scored above the ASA-27 cut-off than patients with either CG or PTSD alone. Patients with both diagnoses

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