



## Is prolonged grief distinct from bereavement-related posttraumatic stress?

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### ABSTRACT

Prolonged grief disorder (PGD) (previously called complicated grief (CG)) is proposed as a distinct post loss syndrome, with its own core symptoms. A key issue concerning the diagnostic validity of PGD is whether it can reliably be distinguished from related psychiatric outcomes following bereavement. This study therefore sought to determine whether the core symptoms of PGD could be distinguished from those of bereavement-related anxiety, depression and posttraumatic stress disorder (PTSD). Data were derived from a community sample of 223 bereaved adults in Croatia. PGD symptomatology was measured using the Revised Inventory of Complicated Grief. Depression and anxiety symptoms were measured using the Beck Depression and Anxiety Inventories, respectively. The intrusion and avoidance symptoms of PTSD were assessed using the Revised Impact of Event Scale. The distinctiveness of the five symptom clusters was examined using principal component analysis (PCA). Symptoms of prolonged grief, depression, anxiety, PTSD-intrusion, and PTSD-avoidance clustered together into five distinct factors. These results support the phenomenological distinctiveness of prolonged grief symptoms, from those of bereavement-related anxiety, depression and, for the first time, PTSD.

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### 1. Introduction

Following the loss of a significant other, a period of acute distress is common. However, a notable minority of individuals so bereaved develop clinically disabling grief symptoms. At present, the Diagnostic and Statistical Manual of Mental Disorders (DSM) does not recognise such grief reactions as a separate disorder but lists bereavement as a “V” code condition that “may be a focus of clinical attention” (DSM-IV-The Current Version (TR)). However, there is a growing consensus that pathological grief reactions – variously called “complicated grief” (Boelen and van den Bout, 2008; Boelen, et al., 2007; Boelen et al., 2006; Prigerson, et al., 1995a; Prigerson, et al., 1996a), “complicated grief disorder” (Horowitz, et al., 2003), “Traumatic Grief” (Boelen and van den Bout, 2002; Boelen et al., 2003; Prigerson et al., 1997a,b; Prigerson, et al., 1999a,b) or, most recently, “prolonged grief disorder (PGD)” (Boelen and Prigerson, 2007; Goldsmith, et al., 2008; Prigerson et al., 2007) merit inclusion in the DSM as a distinct mental disorder that induces clinically significant distress associated with substantive disability. The current consensus criteria for PGD are presented in the Appendix.

One of several key criteria for establishing the validity of a putative psychiatric diagnosis is the distinctiveness of the clinical phenomenology (see Robins and Guze, 1970, for a fuller discussion). Distinctiveness is important because one wants to know that the disorder in question is not simply a different but overlapping expression of another condition. In the case of PGD, efforts to demonstrate distinctiveness have focussed on

delineating its core symptoms from those of anxiety, and depression surrounding the bereavement (Boelen and van den Bout, 2005; Boelen et al., 2003; Ogrodniczuk, et al., 2003; Prigerson et al., 1995a,b; Prigerson, et al., 1996a). The most persuasive empirical data in support of the distinctiveness of PGD phenomenology come from a series of innovative factor analytic (FA) studies on bereaved samples revealing that the core symptoms of PGD load on separate factors to the symptoms of anxiety and depression related to the bereavement using principal component analysis (PCA) and principal axis factoring (Boelen et al., 2003; Chen et al., 1999; Prigerson, et al., 1995a; Prigerson, et al., 1996a); using exploratory factor analysis (EFA) (Ogrodniczuk et al., 2003; Prigerson et al., 1995b) and using confirmatory factor analysis (CFA) (Boelen and van den Bout, 2005; Prigerson et al., 1996b). For example, in the prototypical study (Prigerson, et al., 1995a) on elderly, bereaved spouses who completed various measures of pathological grief and depression symptomatology, PCA revealed a two-factor solution including a prolonged grief factor that constituted symptoms of yearning, searching, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, feeling stunned by the death and lack of acceptance of the death. Critically, this grief factor was distinct from a bereavement-depression symptom factor (e.g., apathy, depressed mood). This work was extended to include an examination of bereavement-related anxiety symptoms revealing separable factors reflecting prolonged grief, anxiety and depression symptoms, associated with the bereavement, in bereaved elders (Prigerson, et al., 1996a) and a Dutch community sample (Boelen et al., 2003), and using both exploratory (Boelen et al., 2003) and confirmatory factor analysis (Boelen and van den Bout, 2005).

Taken together, these studies provide compelling evidence that, despite overlap in the symptom criteria of PGD and anxiety and

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depressive reactions following bereavement, the different syndromes are not isomorphic and the core symptom clusters are empirically dissociable.

Notably absent from these PCA/EFA/CFA studies, however, is the examination of posttraumatic stress symptoms in the wake of bereavement. There is considerable debate as to whether PGD itself can be conceptualized as a form of posttraumatic stress disorder (PTSD) with the setting event as the bereavement, as opposed to a severe threat-related trauma (Bonanno, 2006; Bonanno, et al., 2007; Dalgleish and Power, 2004; Prigerson et al., 1997a,b). There is currently gathering evidence in favour of distinguishing PTSD and PGD, with the emergence of data showing that the two conditions are not 100% concordant (Barry et al., 2002; Melhem et al., 2001; Simon, et al., 2007), and that they have differential predictive validity as regards later psychosocial functioning (Bonanno, et al., 2007; Prigerson, et al., 1999b; Silverman, et al., 2000). Nevertheless, demonstrating the distinctiveness of the phenomenology of PGD and PTSD symptomatology using techniques such as PCA remains a key challenge in establishing the diagnostic validity of the syndrome (Robins and Guze, 1970).

To date, only one study has used the FA approach described above to examine the distinctiveness of PGD symptoms from the hallmark PTSD symptom dimensions of intrusion and avoidance (Ogrodniczuk, et al., 2003). However, unlike earlier studies which have used samples selected on the basis of bereavement itself rather than on the basis of diagnosis or symptom profiles, this study was restricted to a cohort of psychiatric patients almost all of whom were classified as meeting the criteria for “complicated grief” (i.e., not the current PGD criteria) and almost 90% of whom met the criteria for an existing DSM Axis I disorder. The results showed that for this psychiatric sample a number of the core symptoms of CG/PGD (e.g., yearning, searching, disbelief) and the intrusive symptoms of posttraumatic stress (e.g., involuntary intrusive thoughts, images and feelings associated with the traumatic experience of the bereavement) loaded on the same factor, while other core symptoms of CG/PGD loaded onto a separate factor. However, these two factors were distinguishable from bereavement-related avoidance and bereavement-related depression.

These findings provide some support for a distinction between PGD symptoms and bereavement-related avoidance – one of the principal symptom dimensions of PTSD – and thus potentially strengthen the case for PGD as a distinct syndrome. However, some caution is warranted. The results from this study revealed two separable PGD symptom factors, as opposed to the single factor in the previous studies (Boelen and van den Bout, 2005; Boelen et al., 2003; Prigerson, et al., 1995a; Prigerson, et al., 1996a). These two factors comprised PGD symptom items from two different grief measures and interestingly all of the items from one measure loaded onto one of the factors, while the items from the second measure loaded onto the other factor, despite considerable overlap in the range of symptoms assessed by the two measures. Closer inspection reveals that the two measures actually assessed grief symptoms in different ways: by eliciting symptom reports over the previous week, on the one hand; and by asking how the person felt at that moment, on the other hand. Given the differential factor loadings for the two measures, it seems likely that this key psychometric difference between the measures significantly accounts for the factor structure in this particular study. Other potential issues are the restricted range of scores on the various measures and the skewing of the symptom profile in favour of grief symptoms, given that this was a psychiatric patient sample selected on the basis of a primary CG diagnosis. Finally, the study failed to include items assessing bereavement-related anxiety.

Given these concerns it seems imperative to examine the distinctiveness of PGD symptoms from anxiety, depression and posttraumatic stress symptoms surrounding the bereavement in a community sample, selected on the basis of bereavement rather than

psychiatric diagnosis, akin to those used in the earlier PCA/EFA/CFA studies (Boelen and van den Bout, 2005; Boelen et al., 2003; Prigerson, et al., 1995a; Prigerson, et al., 1996a). Such community samples include a broader and more balanced spread of symptoms than a psychiatric sample by a single diagnosis. This breadth will provide a less skewed context within which the relevant factors can be identified. It is also important to ensure that all of the measures index symptomatology in psychometrically similar ways. This approach was the aim of the present research.

In sum, the key aim of the current study was to examine the distinctiveness of PGD symptoms from symptoms of anxiety, depression and posttraumatic stress following a loss of a loved one in a community sample from Croatia.

## 2. Methods

### 2.1. Subjects

Data were available for 223 bereaved individuals recruited from the community in Croatia in response to advertisements placed in community centres, libraries, universities, shops, markets, health centres and hospitals. In the advertisements participants who had experienced an upsetting bereavement were invited to take part in a larger research programme examining trauma, grief, loss and related emotions and cognitions and were asked to complete a set of questionnaires at their own convenience.

The inclusion criteria were being older than 18 years and having lost someone close and important at least 6 months previously. Exclusion criteria were evidence of organic brain problems, psychosis or severe physical health problems. These criteria were applied by contacting each individual and asking appropriate screening questions. Individuals with non-psychiatric medical problems that were successfully controlled with medications without known psychotropic effects were accepted in the study. Written informed consent to participate was obtained from all participants after the procedure had been fully explained.

Participants' mean age was 35.49 years (S.D. = 13.82; range 18–78). Most participants (70%;  $n = 156$ ) were female. The deceased significant other was a parent for 33.6% ( $n = 75$ ) of participants, a child for 1.8% ( $n = 4$ ), a sibling for 5.4% ( $n = 12$ ), a spouse for 4.9% ( $n = 11$ ), a grandparent for 22.4% ( $n = 50$ ), a friend for 26.9% ( $n = 60$ ) and a cousin for 4.9% ( $n = 11$ ). A median of 6.00 years had passed since the loss (ranging from 6 months to 37 years).

### 2.2. Materials

The study was designed as an extension of the previous PCA/EFA/CFA studies (Boelen and van den Bout, 2005; Boelen et al., 2003; Ogrodniczuk, et al., 2003; Prigerson, et al., 1995a; Prigerson, et al., 1996a) and consequently the protocol for the present study closely followed that of the earlier research. As with these earlier studies, items reflecting CG/PGD symptoms were taken from the Revised Inventory of Complicated Grief (ICG), a 17-item self-report questionnaire developed for measuring bereavement-related symptomatology in order to discriminate between nonpathological grief and CG/PGD. Throughout the last decade, the criteria for diagnosing PGD/CG have undergone several minor changes. However, the items of the ICG remain a robust and valid reflection of the core diagnosis despite these shifting parameters. Consequently, for reasons of continuity with past PCA/EFA/CFA studies, the present study also used the ICG as its source of items to assess PGD. ICG questions thus cover the separation distress (Criterion A) and traumatic distress (Criterion B) symptom clusters of CG (Prigerson et al., 1995a) that were used in the original PCA/EFA/CFA studies (Prigerson et al., 1995b; Prigerson et al., 1996a,b) and the symptoms of PGD (Prigerson et al., 2007) used in more recent study (e.g., Boelen and Prigerson, 2007). The Croatian version of the ICG (Golden et al., 2007) was used as an initial screen for PGD and it has robust psychometric properties and evidenced good reliability in the present sample, Cronbach's alpha = 0.94.

Items assessing depression and anxiety were taken from the Croatian versions of the Beck Depression Inventory (Anic and Zivic, 1992) and Beck Anxiety Inventory (Loncar et al., 2006) – widely used and psychometrically robust self-report inventories of depression and anxiety symptoms. Cronbach's alphas for the present sample were 0.89 and 0.92, respectively, attesting to the reliability of these instruments.

Following the one previous study on bereaved adults looking at the distinctiveness of PGD and PTSD (Ogrodniczuk, et al., 2003), items assessing posttraumatic avoidance and intrusion were taken from the Croatian version of the Impact of Event Scale-Revised (Ljubotina and Muslic, 2004) which has separate subscales measuring the intrusion and avoidance symptom dimension of PTSD as they pertain to an identified distressing event, in this case the bereavement. The IES-R is also widely used, with good psychometric properties. Reliability in the current sample was good (alpha = 0.87 for both intrusion and avoidance). The items on these three measures closely relate to the depressive, anxious and posttraumatic stress states as described in the DSM-IV-TR. All four of the above measures assessed symptoms over the previous 1–4 weeks, rather than symptoms only at the time of testing (cf. Ogrodniczuk, et al., 2003). Specifically, the IES-R, BDI and BAI asked about symptomatology in the last week, whereas the ICG asked participants about symptomatology in the previous month.

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