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Validation of the Italian version Inventory of Complicated Grief (ICG): A study comparing CG patients versus bipolar disorder, PTSD and healthy controls

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Abstract

Background: A minority (9%–20%) of bereaved individuals experience symptoms of persistent intense grief associated with significant distress and impairment. This recently identified distinct post-loss syndrome has been variously named complicated grief, prolonged grief disorder, traumatic grief and persistent complex bereavement disorder. The Inventory of Complicated Grief (ICG) is a self-report instrument used to reliably identify this syndrome. We undertook a study to: 1) validate the Italian version of the ICG; 2) examine its performance in a clinical of bereaved individuals with complicated grief, post-traumatic stress disorder, bipolar disorder and healthy controls.

Methods: Study participants included 171 bereaved individuals clinically diagnosed with complicated grief (n=64); post-traumatic stress disorder (n=72); bipolar disorder (n=35) and 58 bereaved healthy controls. Assessments included the Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I/P) and the Italian version of the ICG.

Results: The mean total ICG score was significantly different among the study groups [$F(3.228) = 94.19$, $p < .001$]. Post-hoc Games–Howell comparisons indicated significantly higher scores in complicated grief patients with respect to the other three groups and significantly lower scores in healthy controls compared to all other participants. The scale demonstrated a high level of internal consistency: Cronbach's alpha value for the whole sample was 0.947. Factor analyses demonstrated a single-factor solution.

Conclusions: This study provides evidence of the validation of the Italian version of the ICG, tested in a large and well-characterized clinical help-seeking population. These data further support the existence of a unique grief-related syndrome different from bipolar and post-traumatic stress disorders.

1. Introduction

The loss of a loved one represents one of the most distressing life events that greatly affect physical and psycho-social well-being [1–4]. A number of studies have shown higher rates of disability and medication use in bereaved individuals compared to their non-bereaved counterparts, with the former being at a heightened risk of death [5–12]. This morbidity and mortality is likely related to acute grief, the initial response to bereavement, and its persistent form, variously designated as complicated, traumatic, prolonged or persistent complex grief. Most people adapt to loss without long term sequelae. However, a notable minority currently estimated between 7% and 20% of bereaved subjects, finds coping painful and difficult, and goes on to develop clinically disabling grief symptoms [13–20].

Within the last decades several studies have focused on the distinction between normal and "pathological" grief processes [12,16,21,22], attempting to establish the characteristics of "unresolved" grief [4,12,23–25] and leading to the definition of a new specific disorder, variously named "complicated grief" (CG), "traumatic grief", prolonged grief disorder, or persistent complex bereavement disorder [18,23,26–28]. In the absence of consensus about the best designation for this syndrome, we use the term complicated grief in this paper.

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Increasing evidence underpins CG as characterized by a specific set of symptoms that differ from other possible pathological reactions that occur in the aftermath of a loss, such as Major Depressive Disorder (MDD) and Post-Traumatic Stress Disorder (PTSD) [18,29]. While evidence in support of a unique syndrome of complicated grief was clearly sufficient to establish independent diagnosis in the DSM-5, uncertainties still remain regarding the best diagnostic criteria, the time frame in which the diagnosis should be made and the name for the condition. Given the lack of consensus in these areas, the DSM-5 work-group collocated the condition in adjustment disorders section and in Section 3 that includes those conditions for which criteria are in need of further research as *Persistent Complex Bereavement Disorder* (PCBD) [4,15,18,30–32]. For this reason, the use of validated measures to assess CG in clinical samples would be decisive in order to distinguishing it from other disorders such as depressive disorders or PTSD.

The Inventory of Complicated Grief (ICG), a 19-item questionnaire with good psychometric properties, has been used by a large number of studies to assess the presence of CG [24]. Criteria for identifying a clinically significant condition involving grief were unavailable until the development of the ICG [24]. The original study indicated an ICG total score of ≥25 as the top quartile and proposed this as a cut score for identifying CG [24]; however, in a treatment study funded by the National Institute of Mental Health (MH60783; MH70741; principal investigator MKS) we utilized an ICG score of 30 or higher [18] and demonstrated differential treatment response among individuals we identified as having CG. The ICG assesses the current presence of core CG symptoms that have been associated with impairment and poor outcomes [24] such as: intense yearning and preoccupation with the deceased; anger and bitterness about the death; shock and disbelief; enstrangement from others; hallucinations of the deceased; behavior change, including avoidance or proximity seeking behaviour [33]. Although still debated, most of these symptoms have been integrated in recently introduced criteria for PCBD in the DSM-5. A modified, shorter version of the original ICG is also available, named Inventory of Complicated Grief-Revised (ICG-R), consisting of 15 questions with a 5-point Likert-scale, a functional criterion and a duration criterion of six months [34].

Because ICG may be an outcome for international trials and studies on patients with these symptoms, there is an advantage in having it available in other languages including Italian. Therefore, we decided to validate the ICG for use in Italy, adopting the original version in order to have more informative data accordingly to the still on-going debate over the core symptoms of CG. This process we used entailed a formal translation as well as a cultural validation obtained by submitting the ICG questionnaire to a large group of Italian patients and condicting an assessment of its reliability and psychometric properties. The aim of the present study was to validate the reliability, factor structure and internal consistency of an Italian version of the ICG, besides providing additional empirical evidence of CG diagnosis through analysis of CG symptoms in a clinical data set consisting of bereaved individuals with CG, PTSD, bipolar disorder (BD) and healthy controls. In this same sample we also aimed at identifying the most discriminant ICG total score cut-off, and exploring possible underlying components of the same scale.

2. Methods

2.1. Sample

The study sample included 229 bereaved adults who had experienced the death of a significant other, either a relative or a close friend: 171 were psychiatric patients seeking treatment at the out-patient facilities of the Psychiatric Clinic of the University of Pisa and 58 (25.3%) were HCs (Healthy Controls). Among the 171 psychiatric patients 64 (27.9%) were consecutively enrolled from individuals seeking treatment for symptoms of continuing and disabling grief, who satisfied one of the criteria sets proposed for CG [18,33]; 72 (31.4%) reported a diagnosis of PTSD; 35 (15.3%) of BD. In all participants, the loss had occurred at least 6 months before enrolment [12,35]. Patients were enrolled in two prior clinical studies aimed at assessing the validity and reliability of a new spectrum assessment for trauma and loss related symptoms [36,37] and at comparing patients with CG to those with MDD and HCs [29,38]. In these studies, patients with a clinical diagnosis of CG, PTSD or BD were enrolled at six Italian University Departments of Psychiatry, among new and continuing patients referring to the in- or outpatient facilities of the same Institutes. CG diagnosis was performed prior to completing the ICG based upon clinical assessments by expert clinicians. The HCs were recruited from subjects presenting at the Department of Ophthalmology of the University of Pisa for a routine vision examination, including their friends and relatives, who did not present any current or lifetime psychiatric diagnosis, or a history of psychological or psychiatric treatment. All patients and healthy controls were assessed by means of a SCID-P [39] and comorbidities are reported in Table 1. Exclusion criteria were neurologic diseases, cognitive or psychotic symptoms that might compromise the ability to complete the questionnaires.

2.2. Procedure

The study was carried out in accordance with the Declaration of Helsinki. The Ethics Committee of the 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 an opportunity to ask questions. Subjects were