Comorbidity of Axis I Disorders in Patients With Traumatic Grief

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Background: Traumatic grief has been found to be a distinct disorder from both depression and anxiety; however, there is no information in the literature regarding comorbidity of traumatic grief with other psychiatric disorders.

Method: Twenty-three bereaved subjects who presented for treatment of traumatic grief symptomatology were included in this study. The Inventory of Complicated Grief (ICG) was used to confirm the presence of traumatic grief and assess its severity. In addition, the Structured Clinical Interview for DSM-IV was performed.

Results: Most subjects met criteria for a current or lifetime Axis I diagnosis. Fifty-two percent (N = 12) met criteria for current major depressive disorder, and 30% (N = 7), for current posttraumatic stress disorder (PTSD). ICG scores and functional impairment were higher among patients with more than one concurrent Axis I diagnosis.

Conclusion: Comorbid major depressive disorder and PTSD may be prevalent in patients presenting for treatment of traumatic grief.

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Research in the area of bereavement has distinguished between normal and pathologic grief. The former is considered to be self-limited and relatively benign, and the latter is frequently a chronic state associated with adverse health consequences and requiring intervention.[1] Pathologic grief has been distinguished from normal grief by the nature, duration, and severity of symptoms.[2] It has often been referred to as "complicated," "pathologic," "atypical," "neurotic," or "unresolved" grief. We prefer to use the term *traumatic grief* for this syndrome because of the similarity of its symptoms to those of posttraumatic stress disorder (PTSD) and the fact that it is a stress response syndrome.[3,4] Symptoms of disbelief, avoidance, numbness, and intrusive thoughts are common in both traumatic grief and PTSD. In PTSD, however, the traumatic event involves "an actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and the patient's response involves "intense fear, helplessness, or horror."[5(p424)] The trauma in traumatic grief is different in that it entails the loss of the relationship with the deceased and includes separation distress symptoms that are not included in PTSD criteria, such as yearning and searching for the deceased and excessive loneliness.[3]

Prigerson and colleagues[6–8] were the first to provide evidence of the distinctiveness of traumatic grief from both depression and anxiety. Traumatic grief was not only distinct from depression but also a significant predictor of depressed mood at 18 months after loss among a sample of 82 bereaved subjects 60 years or older with no previous psychiatric history.[8] Traumatic grief also did not respond to the antidepressant nortriptyline.[9] Patients treated with nortriptyline showed an improvement of their depression; however, their grief scores did not differ from those of the untreated group. This observation suggests that traumatic grief is a distinct disorder from depression and requires a different type of intervention.[9] These data and the need for standardized diagnostic criteria led a panel of experts to convene and propose diagnostic criteria for traumatic grief.[3]

Subjects with high levels of traumatic grief have been found to be at higher risk of many adverse mental and physical health outcomes, including suicidal ideation and behavior.[10,11] The presence of traumatic grief at 6 months

after the loss has been found to predict suicidal ideation at 13 and 25 months in a community-based sample of 150 bereaved elders.[10] Individuals with high levels of traumatic grief have been found to have higher rates of cancer and heart diseases, as well as an increase in rates of health care utilization.[10] Traumatic or complicated grief has also been found to be a significant predictor of low levels of global functioning.[6] Whether these adverse mental and physical health outcomes can be attributed to traumatic grief only or to the comorbidities that may exist with traumatic grief is unclear. The comorbidity of traumatic grief with other psychiatric disorders has not been previously reported.

This study examines the rate of DSM-IV Axis I disorders in a sample of subjects with traumatic grief symptomatology participating in a pilot study assessing the effectiveness of a therapeutic intervention for traumatic grief.

METHOD

The study group included 23 patients participating in a pilot study of an exposure-based psychotherapy for traumatic grief. Psychiatrists and psychologists at the Western Psychiatric Institute and Clinic, Pittsburgh, Pa, were asked to refer patients that they suspected were suffering from unresolved grief to the Anxiety Disorders Prevention Program. Twenty-one patients were referred as such, and 2 were self-referred. Patients were informed about the purpose of the study and completed a written informed consent form prior to full assessment. The Inventory of Complicated Grief (ICG),[12] a 19-item scale in which each item is scored from 0 = never to 4 = always, was administered to determine eligibility for the study and to assess traumatic grief severity. Screening for eligibility for the study was done over the phone, and only patients with ICG scores of 25 or above were invited to come in for an assessment. Patients endorsing this level of symptoms 6 months after a loss have been found to be at risk for poor mental and physical health outcomes at 18 months.[10,12] The ICG includes items that cover the symptoms of traumatic grief, such as loneliness, yearning and searching for the loved one, numbness, disbelief, distrust, anger, a sense of hopelessness about the future, and avoidance of reminders of the deceased. The internal consistency of the ICG is 0.94, and its test-retest reliability is 0.80. Concurrent validity with grief scales such as the Texas Revised Inventory of Grief and the Grief Measurement Scale is high.[12]

Our study group consisted of 6 men and 17 women with a mean ± SD age of 52.6 ± 16.2 years (range, 21–71 years). The group included 21 white and 2 African American patients. The mean number of years of education was 13.4 ± 2.3. The mean time since the loss was 4.4 ± 5.7 years. Six patients had suffered the loss of a child; 8, the loss of a spouse; 7, the loss of a parent; and 2, the loss of a sibling.

Table 1. Distribution of Psychiatric Diagnoses in a Traumatic Grief Treatment Sample (N = 23)

Axis I Diagnosis	Patients With Current Diagnoses		Patients With Lifetime Diagnoses	
	N	%	N	%
Major depressive disorder	12	52.2	16	69.7
Depression not otherwise specified	2	8.7	2	8.7
Bipolar disorder	2	8.7	3	13.0
Posttraumatic stress disorder	7	30.4	8	34.8
Other anxiety disorders				
Social phobia	0	0.0	1	4.3
Specific phobia	2	8.7	3	13.0
Panic disorder	6	26.1	7	30.4
Generalized anxiety	5	21.7	5	21.7
Obsessive-compulsive disorder	1	4.3	3	13.0
No Axis I disorder	2	8.7	2	8.7

During the intake interview, the Structured Clinical Interview for DSM-IV[13] was administered by a trained rater to assess lifetime and current psychiatric disorders other than traumatic grief. Patients completed self-report measures of anxiety (Beck Anxiety Inventory [BAI][14]) and depression (Beck Depression Inventory [BDI][15]) along with the Posttraumatic Diagnostic Scale (PDS)[16,17] and the Work and Social Adjustment Scale (WSAS),[18] a reliable measure of functional impairment.

We examined the prevalence of current and lifetime psychiatric diagnoses and the temporal sequence of the coexisting disorders. We used analysis of variance to examine the relationship between the number of DSM-IV diagnoses, severity of traumatic grief (ICG scores), and functional impairment (WSAS scores). Pearson correlation coefficients were used to assess the relationship of severity of traumatic grief to functional impairment and severity of self-reported symptoms of anxiety (BAI) and depression (BDI). The alpha level for statistical significance of the Pearson correlation coefficients was set at .05.

RESULTS

The distribution of current and lifetime psychiatric disorders based on DSM-IV criteria in our traumatic grief sample is shown in Table 1. Major depressive disorder (MDD) was the most prevalent comorbid illness: 52% of patients (N = 12) had a current diagnosis of MDD, and 70% (N = 16) met criteria for a lifetime diagnosis. Seven (30%) of 23 patients had current PTSD, and 8 (35%) had a lifetime diagnosis. Nearly as many met criteria for current (26% [N = 6]) or lifetime (30% [N = 7]) panic disorder. One patient had a history of alcohol abuse and binge eating, and another had a history of substance abuse. Only 2 patients (9%) had no lifetime or current DSM-IV Axis I diagnosis.

Approximately 44% (N = 10) had only 1 concurrent diagnosis, and 48% (N = 11) had 2 or more additional psychiatric disorders. Twelve (57%) of the 21 diagnosed

patients had a previous psychiatric history, and the remaining 9 (43%) developed a mental illness only after the loss. Of the patients with a previous psychiatric history, most (10/12 [83%]) were ill at the time of the loss.

ICG scores were higher in those with a greater number of current Axis I diagnoses (F = 3.48, df = 3,17; p = .039). The mean ICG scores for patients with 2 diagnoses and for those with 3 or more diagnoses were 42.3 ± 8.3 (N = 6) and 52.7 ± 8.1 (N = 3), respectively, compared with 39.0 ± 5.7 (N = 2) and 35.9 ± 8.2 (N = 10) for those with no and only 1 additional diagnosis. ICG scores were higher among patients with more than one concurrent Axis I diagnosis. We found a significant association between the severity of traumatic grief (ICG scores) and functional impairment (WSAS scores; r = .64, N = 13, p = .019). ICG scores were also significantly correlated with self-reported anxiety (BAI; r = .55, N = 16, p = .028), self-reported depression (BDI; r = .53, N = 16, p = .035), and PDS scores (r = .65, N = 14, p = .011).

DISCUSSION

We observed a high rate of comorbidity of DSM-IV Axis I disorders with traumatic grief, especially major depressive disorder and PTSD. Because our sample consisted of referred and help-seeking patients, the level of psychiatric comorbidity observed is likely to be higher than in a community sample. The severity of traumatic grief symptoms may be higher as well among this help-seeking sample. Comparison between referred and self-referred patients could not be conducted because of the very small number of patients who were self-referred (N = 2). Despite these limitations, our results suggest that clinicians and researchers should be alert to the co-occurrence of traumatic grief and other DSM-IV Axis I conditions. Prior psychiatric history was found in about half (52%) of our patients, and most of these patients (83%) were still suffering from these disorders at the time of the loss. An almost equal percentage (48%) developed traumatic grief without any previous history of mental illness. Interestingly, almost all of these patients with no previous psychiatric history developed subsequent Axis I disorders. Factors such as the circumstances of the death, the nature of the relationship with the deceased, and the psychological characteristics of the bereaved may predispose to traumatic grief in these patients.

We found that severity of traumatic grief was correlated with scores on our measure of functional impairment, a result in accord with prior studies that showed that complicated grief predicted lower levels of global functioning.[6]

This study has several limitations. The sample size is small, all patients presented for treatment of grief symptoms, and rates of preexisting or coexisting psychiatric disorders are likely to be higher than in an unselected group. Examination of differences between different groups, including type of death, kinship relationship, and demographics, was not possible in our sample. In a study conducted by Breslau et al.,[19] sudden unexpected death of a loved one was the most important trauma as a cause of PTSD among a representative sample of 2182 subjects 18 to 45 years of age in Detroit, Mich. However, previous psychiatric history among this sample was not addressed. The distinctiveness of traumatic grief from PTSD needs to be systematically addressed in future studies.

The lack of a comparative group of bereaved individuals with low ICG scores is another limitation. Nevertheless, we provide the first report of systematic assessment of co-occurring psychiatric illness in a group of individuals with traumatic grief. Based on these results, we hypothesize that prior psychiatric illness may be a risk factor for traumatic grief, and this may be especially true when the death of a loved one occurs in the midst of an episode of illness. Similarly, onset of a psychiatric disorder may be a consequence of untreated traumatic grief. These hypotheses need to be tested in future studies; however, in either situation such illness will require attention. We present these results to alert clinicians and researchers to the frequency of co-occurrence of DSM-IV Axis I disorders among individuals who present for treatment of traumatic grief symptoms. We further wish to raise awareness of the need to treat both traumatic grief symptoms and comorbid disorders, since previous studies have shown that treating only depression with the antidepressant nortriptyline did not affect traumatic grief symptoms.[9] Further work is needed to elucidate the nature of the relationship between traumatic grief and DSM-IV Axis I conditions and to map out pathways for development of traumatic grief in a community-based sample of bereaved subjects.

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