Indirect Self-Destructive Behavior and Overt Suicidality in Patients With Complicated Grief

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Background: Complicated grief is associated with increased suicidal ideation in samples of bereaved individuals; however, suicidal behavior has not been assessed in these patients. Additionally, there are no reports of suicidality among help-seeking individuals with complicated grief. Therefore, we examined suicidal behavior and its correlates in 149 patients who signed informed consent statements to participate in a National Institute of Mental Health–funded treatment study of complicated grief.

Method: All patients met criteria for complicated grief (Inventory of Complicated Grief score ≥ 25). Suicidality was assessed using a structured clinical interview administered prior to beginning treatment. Participants also completed self-report questionnaires and interview assessment measures rating the presence or absence of DSM-IV Axis I diagnosis and symptom severity. Data were gathered between April 2001 and April 2004.

Results: Thoughts of wanting to die following the death of a loved one were reported by 65% of participants. More than half of this group (38% of the study sample) engaged in self-destructive behavior, including 9% who made a suicide attempt and 29% who engaged in indirect suicidal behavior. In a multiple logistic regression model, only the severity of complicated grief symptoms (p < .0001) and history of a suicide attempt (p < .02) were significantly associated with postloss suicidal behavior.

Discussion: Consistent with reports of nonhelp-seeking bereaved people, a high rate of individuals seeking treatment for complicated grief endorsed a wish to die. Notably, 13% of this group made at least 1 suicide attempt, and 44% engaged in indirect self-destructive behavior. Given its frequency, this behavior should be included in assessment of bereaved people. (I Clin Prochiatry 2006:67:233-230)

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he risk of death from suicide is known to be increased during bereavement. Data indicate that such risk is highest in the first 2 years of bereavement, but remains elevated through the fifth year after the loss.¹ Among bereaved young white men, the suicide rate is increased 17-fold, and among young widowed African American men, there is a 9-fold increase, while there is a lesser increase among bereaved women.² Bereavement has been found to be a risk factor for all levels of suicidality, including completed suicide,¹⁻⁵ suicide attempt,^{6,7} and suicidal ideation.⁸⁻¹⁰ In a case-control study, 36% of the suicide victims versus 13% of the living controls lost a parent or a spouse within 5 years of the suicide or the interview.¹ However, all bereaved people are not at the same risk. Specifically, individuals suffering from complicated grief have significantly higher rates of suicidal ideation than bereaved people without this condition.^{8,11}

Complicated grief (also called traumatic grief) is diagnosed 6 months or more after the death of a loved one. This condition, analogous to posttraumatic stress disorder (PTSD), occurs in a subgroup of 10% to 20% of bereaved individuals.^{12,13} Complicated grief is characterized by intense and persistent yearning for the person who died, preoccupation with thoughts and images of the deceased, disbelief and inability to accept the death, bitterness or anger about the death, and avoidance of reminders of the lost loved one. Complicated grief can be reliably identified using a score of 25 or over on the Inventory of Complicated Grief (ICG).^{9,14} Two studies^{8,9} examined the impact of complicated grief on suicidal ideation in the elderly and in adolescents. In bereaved elderly spouses, 57% of those who met criteria for complicated grief compared with 24% of those who did not had suicidal ideation.⁸ In young friends of suicide victims, traumatic grief was associated with a 5 times greater likelihood of suicidal ideation even after controlling for depression.⁹ Given this risk, we devised a structured clinical interview for suicidality as part of an ongoing National Institute of Mental Health–funded study (MH060783) testing a newly devised complicated grief therapy.¹⁵ We included assessment of the wish to die, suicide attempts, indirect suicidal behaviors, and suicide deterrents. We administered this instrument to study participants at baseline.

Our suicide assessment included indirect selfdestructive behaviors (ISDB) in addition to suicide attempts, as individuals who have religious or other deterrents to suicide may seek to hasten their death by hidden means such as not eating, not taking their medications, or refusing life-saving treatment.^{16,17} Kastenbaum and Mishara¹⁶ conceptualized ISDB as an attempt by the patient to regain control over a situation in which he or she feels hopeless or helpless. A number of authors have identified this behavior, variously defined as behavior, direct or indirect, that if uninterrupted will lead to the death of an individual or as "an act of omission or commission that causes self-harm leading indirectly, over time, to the patient's death."18(p153) A study¹⁹ found that this type of behavior, e.g., refusal to eat and/or take medications, predicted mortality in a nursing home sample. Studies of noncompliance as a manifestation of ISDB report that these patients feel more powerless and less valued and are more irritable than compliant patients,²⁰ personality traits similar to those of individuals who complete suicide.

We examined rates and correlates of suicide attempts and indirect suicidal behavior in a group of 149 help-seeking patients who met criteria for complicated grief and completed baseline suicidality assessments. Our aims were to (1) determine the frequency of reported desire to die among help-seeking complicated grief patients, (2) investigate the frequency of indirect selfdestructive behavior and overt suicidality after the loss, and (3) investigate demographic, loss-related, and clinical correlates of suicidal behavior in complicated grief patients, including the presence and types of deterrents.

METHOD

Sample

Patients were recruited for a treatment study of complicated grief through referrals, media announcement, and word-of-mouth. Three hundred thirty-seven individuals were screened. Of these, 174 individuals met screen criteria and signed written informed consent statements, under an institutional review board-approved protocol for Complicated Grief Treatment: A Randomized Controlled Study (MH60783), and underwent baseline assessment to confirm eligibility and establish baseline diagnosis and symptom severity. Data were gathered between April 2001 and April 2004. One hundred fifty-four individuals completed a Structured Clinical Interview for Suicidality (SCI-Suicide; available from the authors on request). We excluded from the current analysis 5 individuals whose loss was more than 30 years prior to entry of the study, since recollection of suicidality may not be reliable in that timeframe. Participants (N = 149) in the study reported here were 18 years or older, had baseline ICG^{21} scores ≥ 25 , had lost a loved one at least 6 months before, and did not have current or past bipolar disorder, current substance abuse or dependence, dementia, ongoing domestic violence, current or past psychosis, or any uncontrolled general medical illness. ICG scores of the 149 individuals reported here were not different from those of the 20 participants who did not complete the SCI-Suicide interview (mean [SD]: 46.5 [10.0] vs. 46.6 [11.0]; t = 0.23, df = 169, p = NS).

We assessed 114 women (77%) and 35 men with a mean age of 46.9 (± 12.1) years and with ICG scores ranging from 27 to 76. Forty participants (27%) lost a loved one by violent means (homicide/accident/suicide), including 11 (7% of the total) by suicide, and the remainder of the deaths were from natural causes. Twenty-eight percent lost a spouse, 35% a parent, 21% a child, and 16% a close friend or relative. The age of participants at the time of their loved one's death ranged from 6 to 80 years; mean = $42.0 (\pm 13.5)$ years. Median time since loss was 3 years, with a range of 6 months to 29 years. There was no difference in the mean ICG scores of those whose loss was within 3 years compared to those whose loss was more than 3 years ago $(47.0 \ [9.7] \text{ vs. } 45.7 \ [10.4]; t = 0.76,$ df = 147, p = NS). Fifty-two participants (35%) were on treatment with antidepressants at the time of the baseline assessment.

Measures

Complicated grief was assessed using the ICG.^{9,21} The ICG has been shown to have good psychometric properties, with an internal consistency of Cronbach $\alpha = 0.92$ and test-retest reliability of 0.80. Psychiatric diagnosis was established using the Structured Clinical Interview for DSM-IV²² administered by trained raters. Eighty-two participants (55%) met criteria for current major depressive disorder (MDD). Twenty-nine more met criteria for past MDD. Among the 111 individuals (74%) with a lifetime history of MDD, age at onset was available for 109. Eighty-seven (80%) of these individuals had their first episode of depression postloss. Severity of depressive symptoms was assessed at baseline using the rater-administered 25-item Hamilton Rating Scale for Depressive for the seven the seven term of the seven term of the seven term. sion (HAM-D),²³ and anxiety was assessed using a structured interview guide for the Hamilton Rating Scale for Anxiety.²⁴ Perceived social support was measured using the Interpersonal Support Evaluation List (ISEL).²⁵

Information about suicidality was obtained using the SCI-Suicide, a semistructured interview guide developed for our treatment study in order to systematically collect information about suicidality before starting treatment and to monitor participants during an emotionally evocative psychotherapy. The baseline SCI-Suicide, used in this report, provides retrospectively assessed information related to suicidality since the death of the participant's loved one, as well as prior to the death, assessed separately. Participants were asked if they had a wish to die and, if so, about suicidal behavior. Suicidal behavior included both direct attempts and indirect self-destructive behavior. We also asked about desire to live and about suicide deterrents. Interrater reliability for SCI-Suicide items used in this report was assessed for 12 subjects using coratings of taped interviews. Agreement was 100% on all ratings.

Using information from the SCI-Suicide, we grouped patients hierarchically into 1 of 4 suicidality levels as follows: (1) Suicide attempt: affirmative response to the questions "Have you had thoughts of wanting to die? Were the thoughts so strong that you actually tried to hurt yourself?" (2) Indirect self-destructive behaviors (ISBD): in the absence of a suicide attempt, affirmative response to the question "Have you deliberately ignored taking care of your health and/or safety (e.g., eating too little, not taking medications) because you did not care if you lived or died?" (3) Thoughts of wanting to die: affirmative response to the questions "Have you had thoughts of wanting to die?" and/or "Have you thought it might be good to leave life or death to chance (e.g., carelessly crossing a busy street, driving recklessly, or walking alone at night in a rough part of town)?" with negative responses to questions about direct or indirect suicidal behavior. (4) Nonsuicidal: negative response to questions about suicidal ideation and behavior.

Data Analyses

Demographic and clinical measures were compared across the suicidal groups with a 1-way analysis of variance (ANOVA) on continuous measures and χ^2 test for contingency tables on categorical variables. Highly skewed variables (such as years since loss) were tested with a Kruskal-Wallis nonparametric test. Tukey post hoc comparisons were done on significant measures to determine which groups differed. A multiple logistic model was used to assess correlates of suicidal behavior after the loss. Data were available for all measures with no more than 12% missing on any given variable. In 4 cases with ≤ 2 items missing, we imputed ICG item score from the total score.

RESULTS

Rates of Suicidal Ideation and Behavior

Ninety-seven participants (65%) reported a wish to die following the loss of their loved one. A subset of these reported suicidal behavior, including 13 people (9% of the total group) who reported a total of 27 suicide attempts after the loss; an additional 43 (29%) reported ISDB. Thus, 28% reported that they wished to die without associated behavior. When asked about the period prior to the loss, only 57 participants (38%) reported ever having had thoughts of wanting to die, and 21 (14%) reported at least 1 suicide attempt. These 21 individuals made a total of 37 attempts prior to the loss.

Although only 19% (4/21) of those who reported a suicide attempt before the loss made an attempt after the death, twice this number engaged in ISDB. Thus, 57% (12/21) of those who attempted suicide before their loss engaged in suicidal behavior postloss. Participants who said they had a wish to die following the death of their loved one, with or without suicidal behaviors, were more likely to have attempted suicide prior to the loss than those with no such wish ($\chi^2 = 14.33$, df = 3, p < .01). However, most of those who engaged in suicidal behaviors postloss (69% of those who had attempted suicide and 81% of those with ISDB) had not made a suicide attempt prior to the loss.

Social-Demographic, Loss-Related, and Clinical Correlates of Suicidality

There were no statistically significant demographic differences among the suicide groups, though almost twice as many men as women endorsed direct or indirect suicidal behavior (Table 1). There was no relationship between suicidality and loss through violent death, and there was no difference in rates of deterrents according to level of suicidality. All other loss-related and clinical variables (except ISEL appraisal) differed among the groups.

A longer time had elapsed since the loss for those who had attempted suicide (median = 7 years) than for those with ISDB (2 years), those who wished to die (3 years), or those without such a wish (2 years) ($\chi^2 = 8.30$, df = 3, p < .05 for the omnibus test). Patients with ISDB showed higher grief, depression, and anxiety symptom severity than those who made attempts; however, these differences did not reach statistical significance, possibly because of insufficient power, as the suicide attempt group was very small. The only difference between those who expressed a wish to die and those who did not was a history of suicide attempt. By contrast, participants who endorsed ISDB showed greater clinical severity on all measures, and reported less perceived social support, than those who did not engage in suicidal behavior, with or without a wish to die (ICG: F = 11.27, df = 3,145; p < .001; HAM-D minus the suicide item: F = 8.18, df = 3,132; p < .001; HAM-A:

Table 1.	Clinical	Characteris	tics of F	Patients V	Nith Suicid	e Attempt,	Patients	With Indire	t Self-Dest	tructive E	Behavior, I	Patients
With Th	noughts o	of Wanting t	o Die, a	nd Nons	uicidal Pati	ents						

	А	В	С	D			
	Suicide	Indirect Self-	Thoughts of				
	Attempt	Destructive Behavior	Wanting to Die	Nonsuicidal			Post Hoc
Characteristic	(N = 13)	(N = 43)	(N = 41)	(N = 52)	Test Result	df	Comparisons
Age, mean (SD), y	45.3 (11.1)	45.3 (10.7)	46.9 (11.3)	48.7 (13.9)	F = 0.69	3,145	NA
Men, N (%)	4 (31)	16 (37)	7 (17)	8 (15)	$\chi^2 = 7.73$	3	NA
White, N (%)	8 (62)	24 (56)	30 (75)	36 (69)	$\chi^2 = 3.80$	3	NA
Loss, N (%) ^a					$\chi^2 = 5.69$	9	NA
Spouse/partner	4 (31)	14 (33)	13 (32)	11 (21)			
Parent	3 (23)	13 (30)	12 (29)	24 (46)			
Child	4 (31)	8 (19)	9 (22)	10 (19)			
Other	2 (15)	8 (18)	7 (17)	7 (14)			
Violent loss, N (%)	5 (38)	14 (33)	10 (24)	11 (21)	$\chi^2 = 2.59$	3	NA
Years since loss, median (range) ^b	7.0 (1, 29)	2.0 (1, 23)	3.0 (0, 20)	2.0 (1, 20)	$\chi^2 = 8.30^*$	3	AB, AC, AD
Current MDD, N (%) ^c	10(77)	30 (75)	22 (54)	20 (38)	$\chi^2 = 14.76^{**}$	3	AD, BC ,BD
Lifetime MDD, N (%) ^c	13 (100)	33 (83)	31 (76)	34 (65)	$\chi^2 = 8.25^*$	3	AC, AD
Current PTSD, N (%) ^d	4 (36)	21 (57)	18 (47)	14 (27)	$\chi^2 = 8.35^*$	3	BD
Lifetime PTSD, N (%) ^d	5 (45)	24 (65)	19 (50)	20 (39)	$\chi^2 = 5.73$	3	NA
History of suicide attempt, N (%)	4 (31)	8 (19)	9 (22)	0 (0)	$\chi^2 = 14.33^{**}$	3	AD, BD, CD
No. of deterrents, mean (SD)	1.3 (0.6)	1.6 (0.9)	1.6 (0.7)	1.5 (0.6)	F = 0.66	3,144	NA
ICG total score, mean (SD)	46.1 (8.0)	53.1 (10.1)	43.8 (9.3)	43.1 (8.3)	F = 11.27***	3,145	BC, BD
HAM-D score, mean (SD) ^e	27.0 (7.3)	30.1 (9.7)	23.6 (8.0)	21.1 (8.4)	F = 8.18 * * *	3,132	BC, BD
HAM-A score, mean (SD)	19.4 (8.1)	24.9 (8.5)	20.1 (6.7)	18.3 (8.1)	F = 5.11 * *	3,128	BC, BD
ISEL total score, mean (SD)	62.8 (28.6)	60.9 (20.8)	75.0 (20.6)	79.3 (20.5)	$F = 6.05^{***}$	3,128	BC, BD
Self-esteem ^f	15.2 (5.6)	13.8 (5.3)	17.5 (5.1)	17.7 (5.0)	F = 4.86 * *	3,128	BC, BD
Appraisal ^g	16.3 (8.4)	15.8 (5.4)	18.0 (4.7)	19.0 (5.9)	F = 2.50	3,128	NA
Tangible ^h	16.0 (8.6)	17.3 (7.1)	20.7 (7.0)	22.6 (7.1)	F = 5.04 **	3,128	BC, BD
Belonging ⁱ	15.3 (8.4)	14.1 (5.9)	18.7 (6.7)	20.0 (6.3)	F = 6.59***	3.128	BC, BD

^aSibling, other relative, and friend were combined before statistical comparison.

^bMedian (minimum, maximum) reported, nonparametric Kruskal-Wallis test.

^cMDD data were available for 146 subjects.

^dPTSD data were available for 136 subjects.

eItem assessing suicidal ideation (item 3) in HAM-D was omitted from the summary score.

^fPositive comparison when comparing oneself to others.

^gPerceived availability of someone to talk to about problems.

^hPerceived availability of material aids.

Perceived availability of people one can do things with.

*p < .05.

**p < .01.

****p < .001.

Abbreviations: HAM-A = Hamilton Rating Scale for Anxiety, HAM-D = Hamilton Rating Scale for Depression (25-item), ICG = Inventory of Complicated Grief, ISEL = Interpersonal Support Evaluation List, MDD = major depressive disorder, NA = nonapplicable, PTSD = posttraumatic stress disorder.

F = 5.11, df = 3,128; p < .01; ISEL: F = 6.05, df = 3,128; p < .001).

Relative Importance of Variables Associated With Suicidality

We found a significant correlation between scores on measures of complicated grief and depression (r = 0.48, N = 136, p < .001). Therefore, we examined the unique contribution of grief to suicidality using ANOVA and controlling for the level of depression. Given that there were relatively few participants who had attempted suicide, and that these individuals resemble those with ISDB, we combined these 2 groups to form a "suicidal behavior" group for the purposes of this analysis. Patients with suicidal behavior had significantly higher ICG scores even after covarying for the depression scores (HAM-D score minus suicide item) (F = 5.40, df = 3,131; p < .001) than those without such behavior.

We next performed a multiple logistic regression to further examine correlates of suicidal behavior after the loss, including severity of grief (ICG score), anxiety (HAM-A), depression (HAM-D minus the suicide item), presence of lifetime MDD, and preloss suicide attempt. Due to missing data, 131 participants were available for the logistic regression. Results showed that only ICG score and preloss suicidality (ICG: $\chi^2 = 19.73$, df = 1, p < .0001; preloss suicidality: $\chi^2 = 6.09$, df = 1, p < .02) were significantly associated with suicidal behavior.

Suicide deterrents. All but 2 of the participants endorsed at least 1 deterrent against suicide. Fifty-five mentioned children; 13, parents; 12, spouse or partner; 6, friends; and 58 reported that family, as a whole, was a deterrent against suicide. One patient said that finding justice for the death of the loved one was a deterrent; 2, self-respect; 10, love of life; 10, pets; 34, religion; and 3, fear of injury. There were no significant differences in

the number of deterrents across the 4 groups (F = 0.66, df = 3,144; NS). However, 3 times as many patients in the ISDB group reported that religion was a deterrent to suicide as in the suicide attempt group (33% vs. 8%, $\chi^2 = 3.14$, p = .08).

Case Report

We provide the following case vignette to illustrate the relationship between complicated grief and suicidality. We based this vignette upon information provided by a study participant. However, details have been modified to protect confidentiality.

Ms. A was a single woman in her mid fifties who sought treatment for persistent, debilitating grief following the death of her father, which had occurred approximately 10 years earlier, within a year after her mother died. The patient reported that, prior to her parents' deaths, she had been a happy, productive person, with no psychiatric history. She came from a large family, and she described her childhood as happy. She recalled that she had been popular as a child, very involved in student activities. After high school, she went on to pursue higher education and began working in the medical field.

Both of Ms. A's parents developed a serious illness around the same time, and she became the primary caregiver. She never married and was living by herself when her parents became ill. Her mother died a short time after she began caring for her, and her father died not long thereafter. Ms. A was devastated by these deaths. She felt despondent to the point where she could no longer function and stopped working. She sought outpatient therapy, but her symptoms worsened, and she was hospitalized. Shortly after being discharged, she made her first suicide attempt, by taking an overdose of her prescribed medications. As a result, the patient was hospitalized again and while on the inpatient unit attempted to suffocate herself. She was then moved to a psychiatric facility, which provided longer-term care.

For several years prior to presenting to our treatment program, Ms. A had been seeing a psychiatrist who prescribed a variety of antidepressant medications, with little effect on her symptoms. She was maintaining her own home; however, she had been unable to return to work. At the time of her interview, she said that she still felt intense yearning and longing for both parents and experienced frequent intense pangs of grief. She had intrusive thoughts and images of her father's body decaying. She felt guilty about the deaths of her parents, especially her father. She felt that she should have been able to prevent his death. Ms. A avoided people and places that reminded her of her father and felt as if her life had no purpose or meaning since his death. She said it was difficult to care about others and felt she had estranged herself from family members. She felt sad, tended to overeat, and had difficulty falling asleep. She was often fidgety, as well as lethargic, with low energy, and she reported a passive death wish.

DISCUSSION

Complicated grief is a recently described condition that occurs in a subset of individuals who have lost a close attachment. Prior reports indicate that it is associated with suicidal ideation. Our results provide further support for the association of complicated grief with endorsement of a wish to die and suggest that there is an associated risk for suicidal behavior, especially indirect self-destructive behavior, in these individuals. Our results are limited by the fact that we evaluated individuals seeking help for their grief, rather than a community sample of bereaved people; by the lack of a control group; by the relatively small number of participants who had attempted suicide; and by the fact that our data were collected using only retrospective patient report. There was a wide range of time since the death of the loved one; thus, recall may be variable. However, knowing the rate of suicidality among treatment-seeking patients is useful for clinicians. Given that recall problems are more likely to lead to underestimation of suicide attempt rates, and probably of rates of ISDB as well, we believe our findings are unlikely to overestimate rates of clinically significant suicidality among help-seeking bereaved populations.

It is notable that 9% of our sample reported that they had made a suicide attempt in the period (mean of 5 years) since the death of their loved one. This is a very high rate of suicide attempts. In comparison, according to data from the National Comorbidity Survey Replication, in a randomly selected sample aged 15 to 54 years, 0.6% ac-knowledged making a suicide attempt and 0.2% acknowledged making a suicide gesture in the previous year.²⁶ Even taking into consideration that in most samples the female suicide attempt rate is approximately 1.5 times higher than the male rate, and 77% of our sample was female, the 9% attempt rate in 5 years is much higher than would have been expected.

Although our assessment provides only a rough estimate of preloss rates in the same individuals, it appears that over a mean of 42 total preloss years, there were 21 patients who attempted suicide, while over a mean of 5 total postloss years in the same population there were 13 patients who made such attempts. Although it is possible that the preloss reports are underestimates, and that preloss rates should be corrected for the fact that suicide attempt rates are lower in childhood, the 5-fold difference in attempts per person-year in the postloss period is striking.

The 29% rate of indirect self-destructive behavior is also important, in part because this kind of behavior is often neglected as a focus of clinical attention. Since these behaviors are dangerous and associated with increased risk for morbidity and mortality, it is important to document their occurrence. We found that individuals with ISDB had similar clinical characteristics to those who attempted suicide after the loss, including lifetime and current depressive episodes, severity of depression, and perceived social support. Also consistent with the seriousness of ISDB, 19% of those who reported this behavior had made a suicide attempt prior to the loss, a rate even higher than for those who made an attempt postloss. Grief severity was also higher among those with ISDB than among those who had attempted suicide, as was anxiety severity. On each of these measures, the ISDB group was significantly different from participants with a wish to die but without such behaviors. Patients who had attempted suicide and patients with ISDB were similar on clinical measures. By contrast, those who endorsed a wish to die without suicidal behavior did not differ from those who did not wish to die. The association of severity of psychopathology with severity of suicidality supports the validity of the newly developed SCI-Suicide.

We found that participants who made suicide attempts or engaged in indirect self-destructive behaviors reported lower levels of social support than study participants with or without a wish to die, in the absence of such behavior. Bunch¹ reported that bereaved individuals who had committed suicide and bereaved controls did not differ in the number or geographical distribution of first-degree relatives, but those who had committed suicide had less contact with their relatives and were less likely to set up alternative living arrangements with friends and relatives than controls. Patients with complicated grief often feel estranged from friends and family members. Consistent with a sense of estrangement, only a third of respondents in our study living with a spouse or partner reported that this person was a deterrent against suicide. Religion has been reported to be a deterrent to suicide. However, this may be true for suicide attempts, but not for ISDB. In our study, similar to observations of ISDB in nursing homes,¹⁷ patients with ISDB were more likely to report religion as a deterrent for suicide than those who made a suicide attempt after the loss of a loved one.

Our sample had a high rate of MDD, also associated with suicidality. However, in a logistic regression model, we found that only high levels of complicated grief and preloss suicidality were significantly associated with suicidal behavior postloss, while anxiety, depression, and lifetime MDD were not. While we consider the effect of preloss suicidality to be preliminary given the small number of patients who attempted suicide both preloss and postloss, our finding that patients with suicidal behavior showed higher levels of grief even after controlling for the severity of depression was strong. Latham and Prigerson²⁷ reported that complicated grief heightened the risk of suicidal ideation even after controlling for major depression and PTSD in a community sample

of bereaved individuals. Although complicated grief is not yet included in the diagnostic nomenclature, we believe our results provide further support that this is a distinct syndrome. In most clinical samples, complicated grief had high comorbidity with mood and anxiety disorders,²⁸ so our findings are not unique in this respect. Moreover, there are no instructions in DSM-IV to take into consideration when symptoms of MDD or PTSD might be better explained by complicated grief, so we did not make such a distinction in this study. It is likely that rates of the former conditions might be somewhat lower if we had omitted symptoms better explained by complicated grief.

We report a high rate (65%) of endorsement of the wish to die among help-seeking patients with complicated grief, and more than half of this group also engaged in suicidal behavior. Given these results, we urge clinicians and researchers to become familiar with the clinical problem of indirect self-destructive behavior and to attend to the possibility of its occurrence, especially among bereaved individuals with complicated grief who express a wish to die. We note that suicidality persisted in our sample, even many years after the loss of a loved one.

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