



The National Center for Post-Traumatic Stress Disorder PTSD RESEARCH QUARTERLY

VOLUME 13, NUMBER 1

ISSN 1050-1835

WINTER 2002

Published by:

The National Center for PTSD
VA Medical and Regional
Office Center (116D)
215 North Main Street
White River Junction
Vermont 05009-0001 USA

☎ (802) 296-5132
FAX (802) 296-5135

Email: ptsd@dartmouth.edu
<http://www.ncptsd.org>

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TRAUMATIC LOSS AND THE SYNDROME OF COMPLICATED GRIEF

M. Katherine Shear, M.D.
Krissa Smith-Caroff, B.S.
Department of Psychiatry
Western Psychiatric Institute and Clinic
University of Pittsburgh

Bereavement is a major life stressor, long known to be associated with onset or recurrence of psychiatric and/or medical illness. The death of a loved one can have a tremendous impact on the lives of those left behind. This is not surprising considering that close relationships play a central role in a person's life. One may orient his or her activities to make a loved one proud, bring them happiness, help them feel safe and secure, or to feel close to the person. We get a sense of pleasure when we are able to make the people we love happy or share things with them. Close relationships often afford a sense of personal security, social status, financial security, self-esteem, confidence, pride, or feelings of importance. These relationships may provide balance or a sense of completeness. The people to whom one is close may help regulate emotion, assist in confirming or revising our judgments and/or gaining confidence in our own opinions. A loved one will support us when others are critical and can bring solace in the form of comfort and/or humor. Grief is the price we pay for love.

Grief is the process by which we adjust to the death of someone close. What has been seen as "normal grief" is a transient state that may or may not be symptomatic. Many bereaved people experience a period of intense sadness and other dysphoric affects, social withdrawal, and difficulty concentrating—symptoms not unlike those seen in Major Depression. Also common are symptoms of separation distress, such as yearning or longing for the person who died, seeking proximity to reminders of the person, or a strong desire to think or talk about the deceased. Manifestations of grief vary in intensity and duration, depending upon the relationship with the deceased, the mode and timing of the death, characteristics of the bereaved, and other factors. For example, when a death is sudden and violent, there is often a sense of shock, disbelief, and numbness. Such a death can leave friends and relatives feeling lost, anxious, depressed, or physically unwell. Preoccupation with disturbing thoughts and images of the death are frequent and are often accompanied by intense, unfamiliar emo-

tionality. This highly dysphoric reaction may occur even when the death seems to be predictable and results from natural causes. In some individuals the grief reaction can become prolonged and debilitating. While there is wide agreement that grief can become a prolonged state of distress and impairment, there has been reluctance in the mental health field to define when and if grief should be considered pathological.

Recently, this reluctance has lessened and there is growing interest in better understanding grief-related disorders. *DSM-IV* includes a diagnosis of bereavement-related Major Depression two months following a loss. Also new in *DSM-IV* is the statement that learning about the death of a close relative or friend from any cause, including natural causes, qualifies as a stressor for PTSD, as long as the death was sudden and unexpected. However, there are no operationalized criteria for "sudden and unexpected," leaving this to subjective judgment. Inclusion of such losses in the PTSD category is questionable (Breslau & Kessler, 2001), though some authors have found that violent death of a loved one does cause a PTSD response similar to trauma exposure (Green et al., 2001). In her study, Green found that young women who lost a loved one had higher rates of acute stress disorder, intrusion symptoms, reexperiencing of the trauma, and impaired school performance than those who experienced no trauma and also more than women who experienced a single physical assault. Given the fact that the people we are close to inhabit our daily lives in thousands of ways, it makes sense that when they are gone their loss is omnipresent. This is very different from PTSD, where reminders are generally more circumscribed. A grieving person may experience a feeling of aching void—almost as though a part of themselves has been amputated—whereas someone with PTSD is more likely to feel fear.

Despite these differences, *DSM-IV* has yet to embrace the idea that there may be a pathological form of grief not subsumed under an existing illness category. This is somewhat surprising considering that reports of pathological grief abound in the psychiatric literature, and literally thousands of lay books have been written providing advice for those struggling with painful, persistent grief. Only in recent years has work been conducted to identify

Address for Dr. Shear and Ms. Smith-Caroff: Department of Psychiatry, Thomas Detre Hall of the Western Psychiatric Institute and Clinic, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213. Email: Shearmk@msx.upmc.edu; caroffkj@msx.upmc.edu.



criteria for this prolonged grief state. Two groups have proposed criteria for a condition called Complicated Grief. Others are working to understand the risk factors, consequences, and treatment of a putative grief disorder.

Diagnostic criteria for complicated grief. Horowitz et al. (1997) developed a 7-item criteria set, including (a) unbidden memories or intrusive fantasies related to the lost relationship, (b) strong spells or pangs of severe emotion related to the lost relationship, (c) distressingly strong yearnings or wishes that the deceased were there, (d) feelings of being far too much alone or personally empty, (e) excessively staying away from people, places, or activities that remind the subject of the deceased, (f) unusual levels of sleep disturbance, and (g) loss of interest in work, social caretaking, or recreational activities to a maladaptive degree. In Horowitz et al.'s study of 70 bereaved individuals, these symptoms were prominent 6 months following the death and decreased by 14 months, but still 41% of bereaved individuals they interviewed met these criteria, with about 20% also endorsing symptoms of Major Depression. Their findings also indicated that a prior history of Major Depression appeared to be a risk factor for Complicated Grief.

Prigerson et al. (1995), in their development of the Inventory of Complicated Grief, identified a group of symptoms that were distinct from bereavement-related depression. These core symptoms included searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, feeling stunned by the death, and lack of acceptance of the death. Baseline complicated grief scores were found to be significantly associated with impairments in the areas of global functioning, mood, sleep, and self-esteem in the 56 spousally bereaved subjects who completed the 18-month assessment.

In 1999, Prigerson et al. proposed a criteria set for these symptoms, which at that time were designated "Traumatic Grief." These authors suggested that symptom clusters comprising separation distress and traumatic distress characterized individuals with this problematic grief reaction. Of note, this is the same condition previously and subsequently referred to by this group as "complicated" grief. Symptoms of separation distress included: (a) intrusive thoughts about the deceased, (b) yearning for the deceased, (c) searching for the deceased, (d) loneliness as a result of the death. Symptoms of traumatic distress included: (a) purposelessness or feelings of futility about the future, (b) Subjective sense of numbness, detachment, or absence of emotional responsiveness, (c) difficulty acknowledging the death, (d) feeling that life is empty or meaningless, (e) feeling that part of oneself has died, (f) shattered world view, (g) assuming symptoms or harmful behaviors of, or related to, the deceased, and (h) excessive irritability, bitterness, or anger related to the death. Empirical tests were conducted on data collected on 308 subjects who completed questionnaires 7 months after the loss of their spouses. This work suggests that endorsing 3 of the 4 symptoms of separation distress and 4 of the 8

traumatic distress symptoms as mostly true provides a diagnosis for TG that has a high degree of sensitivity and specificity.

The findings of both Horowitz et al. (1997) and Prigerson et al. (1995) suggest that there is a need for criteria for a syndrome of complicated grief. Since the symptoms they describe are similar, it makes sense to consolidate their criteria sets. Currently, there are no consensus criteria for deciding when to consider a prolonged grief state to be clinically significant, and no proven efficacious treatments. Nevertheless, there is clear recognition that such a state exists, and investigators are reporting risk factors, consequences, and empirically based treatment approaches.

Risk factors and consequences of complicated grief disorder. There have been many theories about how grief works. Theorists such as Parkes (1998) suggest that components of grief include an urge to look back, cry, and search for what is lost, and an urge to look forward, to explore the world that now emerges, as well as to discover what can be carried forward from the past. Typical in the course of grief are a period of numbness, intense feelings of pining for the lost person accompanied by intense anxiety, and feelings of disorganization and despair. This process eventually leads to intrapsychic reorganization. According to Parkes, there is no one pattern of grief, and the process can go awry.

In contrast, Wortman and Silver (1989) and Stroebe and Schut (1999) challenge the belief that one has to "work through" the loss. These authors believe that the "grief work hypothesis" has numerous shortcomings and argue that not everyone has to experience distress in order to move on from a loss.

Although there are various theories about the process of grief, there is emerging consensus regarding what makes someone susceptible to a pathologic grief reaction. Parkes (1998) identified risk factors for a problematic outcome that include traumatic circumstances of the death of a close relative (e.g., sudden, unexpected and untimely deaths, including suicide and murder), multiple deaths, and personal vulnerabilities. Among such vulnerabilities are low self-esteem, low trust in others, previous psychiatric disorder, previous suicidal threats or attempts, absent or unhelpful family, ambivalent attachment to the deceased person, dependent or inter-dependent attachment to the deceased person, and insecure attachment to parents in childhood. Many empirical studies have offered support to his theory.

One such finding which we wish to highlight is the observation by Piper, Ogrodniczuk, Azim et al. (2001) that psychiatric patients are at risk for problems with grief. This group interviewed 729 outpatients in a community mental health clinic about significant losses through death throughout their lifetime. More than half (403) of the patients reported experiencing one or more significant deaths, and one third of these met criteria for either moderate or severe complicated grief. The average time since the loss was 10 years. When patients who had severe

complicated grief were compared with patients who had not experienced the loss of another person, they were found to have significantly higher levels of depression, anxiety, and general symptomatic distress. Clearly, clinicians need to recognize such patients, and there is a pressing need for efficacious treatments.

In another study by Piper, Ogrodniczuk, Joyce et al. (2001), ambivalence, affiliation, and dependence in the relationship and grief-specific symptoms and depression were examined in two samples ($n = 277$) of psychiatric outpatients, 84.7% of whom received an Axis I and 55.6% an Axis II diagnosis. Types of losses included parent, sibling, friend, child, grandparents, and other, and average time since a loss was 9.0 years. In the first sample, 56% of the patients met the criteria for complicated grief, as assessed by the Pathological Grief Items, Impact of Event Scale, and Social Adjustment Scale-SR, and 100% of the second sample met these criteria. Findings did not support the traditional belief that ambivalence has a negative impact on grief-specific symptoms. Rather, the more ambivalent, the less severe was the grief. The more positive the relationship with the deceased, the more severe was the grief. This important observation has been shared by many authors.

Not only are the risk factors for the development of pathologic grief important, but one must also consider the consequences that a condition like Complicated Grief has on the bereaved individual. Prigerson et al. (1997) interviewed 135 bereaved spouses 6 weeks, 6 months, 13 months, and 25 months after a hospital admission of the spouse. Scores on the Inventory of Complicated Grief declined from 57% at 2 months to 6% at 13 months and 7% at 25 months. The percentage with depression declined from 75% at 2 months to 36% at 13 months and 33% at 25 months. While fewer met criteria for anxiety at 2 months, the percentage hovered around 20% through the second year of bereavement. Four cases of cancer occurred in the group with complicated grief. Cancer was not noted in any other groups. Individuals with scores of 32 on the complicated grief scale at 6 months were 35.5 times more likely to develop high blood pressure at 13 months than someone whose score was 0. Complicated or Traumatic Grief at 6 months was significantly associated with the development of heart trouble at 25 months.

Silverman et al. (2000) examined the association between complicated grief and quality of life in 67 widowed subjects interviewed approximately 4 months after their loss. Twenty-five percent with complicated grief were also diagnosed with MDE and PTSD. A complicated grief reaction was associated with lower social functioning scores, lower mental health scores, and lower energy scores, though the majority (63%) with such grief problems did not meet criteria for PTSD, and half did not meet criteria for MDE. Overall, 37.5% would have received no *DSM-IV* diagnosis, though they were clearly impaired.

It is important to estimate the rate of complicated grief in the community. Raphael and Minkov (1999) reviewed the literature and concluded that approximately 9% of the

bereaved are likely to have persistent distressing grief reactions. Depression is more likely to be seen in those predisposed to depression and may also become chronic. Similar to Horowitz, this group noted that past depression appears to predispose individuals to syndromes of pathologic grief. Separation distress was common as a symptom of abnormal grief, independent of anxiety and depression. These authors argue that abnormal grief is neither depression nor PTSD and that bereavement-related depressions require treatment in their own right.

Treatment strategies for complicated grief. Considering the importance of the problem, the existing literature on grief interventions is remarkably small. Reported interventions include two main strategies. The first is preventative and based on observations that greater social support predicts better adjustment to spousal loss. Supportive psychotherapy, self-help groups, and widow-to-widow programs have been developed and documented to show moderate success (Marmar et al., 1988; Shuchter & Zisook, 1986; Windholz et al., 1985). This broad-based preventive strategy has some merit but is not relevant to treatment of individuals with established complicated grief conditions.

There are also reports in the literature that describe treatments targeting pathological grief (Gauthier & Marshall, 1977; Lieberman, 1978; Ramsey, 1977; Raphael, 1975; Volkan, 1971). Authors of these, with representation from each of the major therapeutic schools, consistently recommend a strategy that includes re-experiencing of the loss. However, there are very few controlled studies in this literature, none of which use proven reliable methods of identification of study subjects or grief measurement instruments proven psychometrically sound. Two studies of "guided mourning" (Mawson et al., 1981; Sireling et al., 1988) compared a brief exposure intervention with an anti-exposure treatment, where patients were encouraged to avoid thinking about the deceased and avoid doing anything upsetting. These showed a significant treatment effect on a few measures. A few studies compared psychodynamic psychotherapy with self-help support groups and found no difference (Horowitz et al., 1986; Marmar et al., 1988). It appears that no efficacious treatment has yet been identified.

Shear, Zukoff et al. (2001) have developed an intervention targeting individuals who score above 25 on the Inventory of Complicated Grief. They reported results of a pilot study of 21 subjects, of whom 13 completed the 4-month protocol (Shear, Frank et al., 2001). This treatment incorporates strategies from Interpersonal Psychotherapy for Depression (IPT) and prolonged exposure (PE), a cognitive behavior therapy for PTSD (Foa et al., 1999). The goals are to reduce grief intensity, facilitate ability to enjoy fond memories of the deceased, and support reengagement in daily activities and relationships with others. Results revealed significant improvement in both the completer and intent-to-treat groups, almost twice what has been seen using IPT alone. A randomized controlled study is currently underway with funding from NIMH.

Jacobs and Prigerson (2000) reviewed studies conducted in the area of complicated or traumatic grief. Because there is no DSM-IV diagnosis for such a condition, the authors looked for studies of separation anxiety, psychotherapy of pathologic grief, or high-risk bereaved persons. Findings include observations that both psychodynamically oriented treatments and behavioral/cognitive treatments hold some promise. The potential of two different therapies to help raises the possibility of different therapies for different people with different problems or symptoms.

In summary, bereavement is a major stressor that can result in physical and mental health problems. When a loss is sudden and unexpected, or is experienced as such, and when a death is violent, the loss may be traumatic for the bereaved person and a painful and debilitating complicated grief reaction may ensue. We urge clinicians and researchers to attend to the recognition and treatment of such individuals.

SELECTED ABSTRACTS

GREEN, B.L., KRUPNICK, J.L., STOCKTON, P., GOODMAN, L., CORCORAN, C., & PETTY, R. (2001). **Psychological outcomes associated with traumatic loss in a sample of young women.** *American Behavioral Scientist*, 44, 817-837. Traumatic loss has recently emerged as an important subcategory of bereavement. This study compared structured clinical interviews and self-report measures among female undergraduates with no reported history of trauma ($n = 58$), a single physical assault as their only trauma ($n = 34$), and a single violent loss as their only trauma ($n = 32$). The traumatic loss group had higher rates of acute stress disorder, intrusion symptoms, reexperiencing of the trauma, and impaired school performance compared to the no trauma and physical assault groups. Their levels of dissociation and overall adjustment were similar to those for the physical assault group.

HOROWITZ, M.J., SIEGEL, B., HOLSEN, A., BONANNO, G.A., MILBRATH, C., & STINSON, C.H. (1997). **Diagnostic criteria for complicated grief disorder.** *American Journal of Psychiatry*, 154, 904-910. *Objective:* Some prolonged and turbulent grief reactions include symptoms that differ from the DSM-IV criteria for major depressive disorder. The authors investigated a new diagnosis that would include these symptoms. *Method:* They developed observer-based definitions of 30 symptoms noted clinically in previous longitudinal interviews of bereaved persons and then designed a plan to investigate whether any combination of these would serve as criteria for a possible new diagnosis of complicated grief disorder. Using a structured diagnostic interview, they assessed 70 subjects whose spouses had died. Latent class model analyses and signal detection procedures were used to calibrate the data against global clinical ratings and self-report measures of grief-specific distress. *Results:* Complicated grief disorder was found to be characterized by a smaller set of the assessed symptoms. Subjects selected by an algorithm for these symptom patterns did not significantly overlap with subjects who received a diagnosis of major depressive disorder. *Conclusions:* A new diagnosis of complicated grief disorder may be indicated. Its criteria would include the current experience (more than a year after a loss) of intense intrusive thoughts, pangs

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FOA, E.B., DANCU, C.V., HEMBREE, E.A., JAYCOX, L.H., MEADOWS, E.A., & STREET, G.P. (1999). **A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims.** *Journal of Consulting and Clinical Psychology*, 67, 194-200.

of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities.

JACOBS, S., & PRIGERSON, H. (2000). **Psychotherapy of traumatic grief: A review of evidence for psychotherapeutic treatments.** *Death Studies*, 24, 479-495. The authors present the concept of Traumatic Grief and then review controlled studies that pertain to its psychotherapeutic treatment. They conclude that it will most likely be a specific therapy for Traumatic Grief that will be proven most effective in systematic studies completed in the future.

LIEBERMAN, S. (1978). **Nineteen cases of morbid grief.** *British Journal of Psychiatry*, 132, 159-163. Three different patterns of morbid grief are noted. The effect of forced mourning procedures on morbidly grieving patients is discussed with some indication of beneficial and harmful effects of psychotherapeutic intervention.

PARKES, C.M. (1998). **Coping with loss: Bereavement in adult life.** *British Medical Journal*, 316, 856-859. This is the first in a series of 10 articles dealing with the different types of loss that doctors will meet in their practice. Three main components affect the process of grieving. They include the urge to look back, cry, and search for what is lost, and the conflicting urge to look forward, explore the world that now emerges, and discover what can be carried forward from the past. As time passes the intensity and frequency of the pangs of grief tend to diminish, although they often return with renewed intensity at anniversaries and other occasions which bring the dead person strongly to mind. Bereavement has physiological as well as emotional effects. It also affects physical health and there are endocrine changes as in other situations that evoke depression and stress. Doctors are in a unique position to help people through the turning points in their lives which arise at times of loss. In order to fulfill this role we need information and skills. [Adapted from Text]

PIPER, W.E., OGRODNICZUK, J.S., AZIM, H.F., & WEIDEMAN, R. (2001). **Prevalence of loss and complicated grief among psychiatric outpatients.** *Psychiatric Services, 52*, 1069-1074. *Objective:* This study examined the prevalence of significant loss through the death of another person as well as complicated grief among patients at two psychiatric outpatient clinics for one year. *Methods:* A total of 729 patients were interviewed about their lives. Standard questionnaires were used to classify 235 patients who had experienced such losses into 3 groups: those who had minimal disturbance, those who had moderate complicated grief, and those who had severe complicated grief. Multivariate and univariate analyses of variance were used to test for differences in loss-specific variables (for example, pathological grief) and variables that were not specific to loss (for example, depression) among the three groups. *Results:* More than half of the 729 patients reported that they had experienced one or more significant losses through death. About a third of all patients who came to the clinics met the criteria for either moderate or severe complicated grief. The average time since the loss was about ten years, indicating that these patients had long-term complicated grief. Significant differences in loss-specific variables and variables that were not specific to loss were detected among the three groups. Patients who had severe complicated grief scored higher than patients in the other two groups on both types of variables. Patients with moderate complicated grief had higher scores than those with minimal disturbance. *Conclusions:* Clinicians should routinely assess outpatients for loss and complicated grief and should consider addressing loss and complicated grief in treatment. Rather than a single classification of complicated grief, different levels should be considered.

PIPER, W.E., OGRODNICZUK, J.S., JOYCE, A.S., MCCALLUM, M., WEIDEMAN, R., & AZIM, H.F. (2001). **Ambivalence and other relationship predictors of grief in psychiatric outpatients.** *Journal of Nervous and Mental Disease, 189*, 781-787. Ambivalence has been viewed as an important causal agent in the development of complicated grief. However, examination of studies commonly cited as supporting this belief reveals basic limitations in their methodology and conclusions. The current study examined associations between several relationship predictors (ambivalence, affiliation, and dependence) and both grief-specific symptoms and depression in two samples of psychiatric outpatients who had experienced loss of significant others. Findings from the first sample ($n = 138$) were used to test for evidence of cross-validation in the second sample ($n = 139$). Contrary to traditional belief, ambivalence was inversely related to severity of grief symptoms. In contrast, affiliation and dependence were directly related to severity of grief symptoms. None of the predictors provided evidence of cross-validation in the case of depression. Explanations for the findings and clinical implications are considered.

PRIGERSON, H.G., SHEAR, M.K., JACOBS, S.C., REYNOLDS, C.F., MACIEJEWSKI, P.K., DAVIDSON, J.R., ROSENHECK, R., PILKONIS, P.A., WORTMAN, C.B., WILLIAMS, J.B., WIDIGER, T.A., FRANK, E., KUPFER, D., & ZISOOK, S. (1999). **Consensus criteria for traumatic grief: A preliminary empirical test.** *The British Journal of Psychiatry, 174*, 67-73. *Background:* Studies suggest that symptoms of traumatic grief constitute a distinct syndrome worthy of diagnosis. *Aims:* A consensus conference aimed to develop and test a criteria set for traumatic grief. *Method:* The expert panel proposed consensus criteria for traumatic grief. Receiver operator characteristic (ROC) analyses tested the performance of the proposed criteria on 306 widowed respondents at

seven months post loss. *Results:* ROC analyses indicated that 3 of 4 separation distress symptoms (e.g. yearning, searching, loneliness) had to be endorsed as at least "sometimes true" and 4 of the final 8 traumatic distress symptoms (e.g. numbness, disbelief, distrust, anger, sense of futility about the future) had to be endorsed as at least "mostly true" to yield a sensitivity of 0.93 and a specificity of 0.93 for a diagnosis of traumatic grief. *Conclusions:* Preliminary analyses suggest the consensus criteria for traumatic grief have satisfactory operating characteristics, and point to directions for further refinement of the criteria set.

PRIGERSON, H.G., BIERHALS, A., KASL, S.V., REYNOLDS, C.F., SHEAR, M.K., DAY, N., BEERY, L.C., NEWSON, J.T., & JACOBS, S. (1997). **Traumatic grief as a risk factor for mental and physical morbidity.** *American Journal of Psychiatry, 154*, 616-623. *Objective:* The aim of this study was to confirm and extend the author's previous work indicating that symptoms of traumatic grief are predictors of future physical and mental health outcomes. *Method:* The study group consisted of 150 future widows and widowers interviewed at the time of their spouse's hospital admission and at 6-week and 6-, 13-, and 25-month follow-ups. Traumatic grief was measured with a modified version of the Grief Measurement Scale. Mental and physical health outcomes were assessed by self-report and interviewer evaluation. Survival analysis and linear and logistic regressions were used to determine the risk for adverse mental and physical health outcomes posed by traumatic grief. *Results:* Survival and regression analyses indicated that the presence of traumatic grief symptoms approximately 6 months after the death of the spouse predicted such negative health outcomes as cancer, heart trouble, high blood pressure, suicidal ideation, and changes in eating habits at 13- or 25-month follow up. *Conclusions:* The results suggest that it may not be the stress of bereavement, per se, that puts individuals at risk for long-term mental and physical health impairments and adverse health behaviors. Rather, it appears that psychiatric sequelae such as traumatic grief are of critical importance in determining which bereaved individuals will be at risk for long-term dysfunction.

PRIGERSON, H.G., FRANK, E., KASL, S.V., REYNOLDS, C.F., ANDERSON, B., ZUBENKO, G.S., HOUCK, P.R., GEORGE, C.J., & KUPFER, D.J. (1995). **Complicated grief and bereavement related depression as distinct disorders: Preliminary empirical validation in elderly bereaved spouses.** *American Journal of Psychiatry, 152*, 22-30. *Objective:* This study sought to determine whether a set of symptoms interpreted as complicated grief could be identified and distinguished from bereavement-related depression and whether the presence of complicated grief would predict enduring functional impairments. *Method:* Data were derived from a study group of 82 recently widowed elderly individuals recruited for an investigation of physiological changes in bereaved persons. Baseline data were collected 3-6 months after the deaths of the subjects' spouses, and follow-up data were collected from 56 of the subjects 18 months after the baseline assessments. Candidate items for assessing complicated grief came from a variety of scales used to evaluate emotional functioning (e.g., the Hamilton Depression Rating Scale, the Brief Symptom Inventory). The outcome variables measured were global functioning, medical illness burden, sleep, mood, self-esteem, and anxiety. *Results:* A principal-components analysis conducted on intake data ($n = 82$) revealed a complicated grief factor and a bereavement-depression factor. Seven symptoms constituted complicated grief: searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, feeling

stunned by the death, and lack of acceptance of the death. Baseline complicated grief scores were significantly associated with impairments in global functioning, mood, sleep, and self-esteem in the 56 subjects available for follow-up. *Conclusions:* The symptoms of complicated grief may be distinct from depressive symptoms and appear to be associated with enduring functional impairments. The symptoms of complicated grief, therefore, appear to define a unique disorder deserving of specialized treatment.

RAPHAEL, B., & MINKOV, C. (1999). **Abnormal grief.** *Current Opinion in Psychiatry, 12*, 99-102. Various models and concepts of abnormal grief are reviewed and empirical data to support these is critically appraised. It is concluded that the majority of findings support a concept of abnormal grief reflecting prolonged intense separation distress, preoccupation with images of the deceased and distress or avoidance at reminders. Although depressive phenomena and disorders, and anxiety disorders may occur after bereavement, with some populations being at greater risk, these are distinct from abnormal grief. Management of abnormal grief needs to take into account such issues.

SHEAR, M.K., ZUCKOFF, A., & FRANK, E. (2001). **The syndrome of traumatic grief.** *CNS Spectrums, 6*, 339-346. Traumatic grief is a common and debilitating syndrome whose clinical presentation is well recognized but whose diagnostic criteria have only recently been delineated. Though it shares features with major depressive disorder, none of these subsume the criteria set for traumatic grief, and the diagnostic overlap is limited in community samples. Furthermore, diagnosis of traumatic grief appears to have prognostic value for clinical course and treatment response among bereaved individuals. In the absence of empirically supported treatments of pathological grief, a new, manualized treatment for traumatic grief symptoms has been developed and is currently undergoing testing in a randomized controlled trial. The conceptual basis for Traumatic Grief Treatment (TGT) is presented, the structure of the treatment is outlined, and the primary clinical strategies employed are described.

SHEAR, M.K., FRANK, E., FOA, E., CHERRY, C., REYNOLDS, C.F., VANDERBILT, J., & MASTERS, S. (2001). **Traumatic grief treatment: A pilot study.** *American Journal of Psychiatry, 158*, 1506-1508. *Objective:* The effects of a treatment program targeting debilitating grief symptoms were tested in a pilot study. *Method:* 21 individuals experiencing traumatic grief were recruited for participation, and 13 completed the full 4-month protocol. The treatment protocol used imaginal re-living of the death, in vivo exposure to avoided activities and situations, and interpersonal therapy. *Results:* Significant improvement in grief symptoms and associated anxiety and depression was observed for both completer and intent-to-treat groups. *Conclusions:* The traumatic grief treatment protocol appears to be a promising intervention for debilitating grief.

SILVERMAN, G.K., JACOBS, S.C., KASL, S.V., SHEAR, M.K., MACIEJEWSKI, P.K., NOAGHIUL, F.S., & PRIGERSON, H.G. (2000). **Quality of life impairments associated with diagnostic criteria for traumatic grief.** *Psychological Medicine, 30*, 857-862. *Background:* This study examined the association between a diagnosis of traumatic grief and quality of life outcomes. *Method:* 67 widowed persons were interviewed at a median of 4 months after their loss. The multiple regression procedure was used to esti-

mate the effects of a traumatic grief diagnosis on eight quality of life domains, controlling for age, sex, time from loss, and diagnoses of major depressive episode and post-traumatic stress disorder. *Results:* A positive traumatic grief diagnosis was significantly associated with lower social functioning scores, worse mental health scores, and lower energy levels than a negative traumatic grief diagnosis. In each of these domains, traumatic grief was found to be a better predictor of lower scores than either major depressive episode or PTSD. *Conclusions:* The results suggest that a traumatic grief diagnosis is significantly associated with quality of life impairments. These findings provide evidence supporting the criterion validity of the proposed consensus criteria and the newly developed diagnostic interview for traumatic grief — the Traumatic Grief Evaluation of Response to Loss (TRGR2L).

STROEBE, M. & SCHUT, H. (1999). **The dual process model of coping with bereavement: A rationale and description.** *Death Studies, 23*, 197-224. There are shortcomings in traditional theorizing about effective ways of coping with bereavement, most notably, with respect to the so-called "grief work hypothesis." Criticisms include imprecise definition, failure to represent dynamic processing that is characteristic of grieving, lack of empirical evidence and validation across cultures and historical periods, and a limited focus of intrapersonal processes and on health outcomes.

WORTMAN, C.B. & SILVER, R.C. (1989). **The myths of coping with loss.** *Journal of Consulting and Clinical Psychology, 57*, 349-357. Drawing from theory and clinical lore, we consider how individuals are assumed to cope following irrevocable loss. Several assumptions are reviewed reflecting beliefs concerning the grieving process. Specifically, we examine the expectation that depression is inevitable following loss; that distress is necessary, and failure to experience it is indicative of pathology; that it is necessary to "work through" or process a loss; and that recovery and resolution are to be expected following loss. Although limited research has examined these assumptions systematically, available empirical work fails to support and in some cases contradicts them. Implications of our analysis for theoretical development and research are explored. Finally, we maintain that mistaken assumptions held about the process of coping with loss fail to acknowledge the variability that exists in response to loss, and may lead others to respond to those who have endured loss in ways that are unhelpful.

ADDITIONAL CITATIONS

Annotated by the Editor

GAUTHIER, J. & MARSHALL, W.L. (1977). **Grief: A cognitive-behavioral analysis.** *Cognitive Therapy and Research, 1*, 39-44.

Offers a cognitive-behavioral analysis of grief in which the role of social reinforcement and the "conspiracy of silence" about loss are emphasized. Prolonged grief reactions are compared with the Napalkov phenomenon and the incubation of distress hypothesis. Four cases are presented.

HOROWITZ, M.J., MARMAR, C.R., WEISS, D.S., KALTREIDER, N.B., & WILNER, N.R. (1986). **Comprehensive analysis of change after brief dynamic psychotherapy.** *American Journal of Psychiatry, 143*, 582-589.

Assessed 33 patients who sought psychotherapy following bereavement. Assessments performed at 5-months and 1-year post-treatment showed large improvements, with pre-post effect sizes ranging from $d = 0.9-2.0$. Results were consistent across reports from patients, treating clinicians, evaluating clinicians, and independent judges.

MARMAR, C.R., HOROWITZ, M.J., WEISS, D.S., WILNER, N.R., & KALTREIDER, N.B. (1988). **A controlled trial of brief psychotherapy and mutual-help group treatment of conjugal bereavement.** *American Journal of Psychiatry, 145*, 203-209.

Randomly assigned 61 bereaved women with unresolved grief to receive brief dynamic psychotherapy or self-help group treatment. Although both groups of women showed improvement, women who received psychotherapy showed greater decline in a general symptom measure and were more likely to stay in treatment, relative to women who received self-help.

MAWSON, D., MARKS, I.M., RAMM, L., & STERN, R.S. (1981). **Guided mourning for morbid grief: A controlled study.** *British Journal of Psychiatry, 138*, 185-193.

Randomly assigned 12 bereaved patients (who had not improved during a 2-week waiting period) to receive either guided mourning treatment that encouraged exposure to bereavement cues or to control treatment that discouraged such exposure. By four weeks after beginning treatment, patients who received guided mourning showed greater improvement than control patients.

RAMSAY, R.W. (1977). **Behavioural approaches to bereavement.** *Behaviour Research & Therapy, 15*, 131-135.

Applies Eysenck's therapy on the development and maintenance of phobias to the understanding of unresolved grief. The author describes a modified flooding technique for treating unresolved grief, and presents descriptive information about the efficacy of the technique.

RAPHAEL, B. (1975). **The management of pathological grief.** *Australian & New Zealand Journal of Psychiatry, 9*, 173-180.

Describes methods for the treatment of pathological grief, including the encouragement of the expression of suppressed affects (anger, sadness, and guilt in particular) and the review of memories and feeling associated with the loss. The author discusses other topics, including resistance, assessment of progress, termination, and transference and counter-transference.

REYNOLDS, C.F., MILLER, M.D., PASTERNAK, R.E., FRANK, E., PEREL, J.M., CORNES, C., HOUCK, P.R., MAZUMDAR, S., DEW, M.A., & KUPFER, D.J. (1999). **Treatment of bereavement-related major depressive episodes in later life: A controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy.** *American Journal of Psychiatry, 156*, 202-208.

Randomly assigned 80 bereaved patients with depression to one of four treatment conditions: nortriptyline alone, interpersonal psychotherapy alone, both nortriptyline and interpersonal psychotherapy, or placebo medication. Nortriptyline, either alone or in combination with interpersonal therapy, was better than placebo for achieving remission, but there was no effect of interpersonal therapy alone or the interaction of medication and psychotherapy.

SHUCHTER, S.R., & ZISOOK, S. (1986). **Treatment of spousal bereavement: A multidimensional approach.** *Psychiatric Annals, 16*, 295-305.

Describes the outcomes associated with spousal bereavement and suggests several considerations for treatment: examining mental and emotional disruptions, facilitating the adaptive modulation of affects, helping the patient integrate the continuing relationship with the dead spouse, and encouraging maintenance of health and functioning.

SIRELING, L., COHEN, D., & MARKS, I. (1988). **Guided mourning for morbid grief: A controlled replication.** *Behavior Therapy, 19*, 121-132.

Randomly assigned 26 patients with morbid grief to 6 sessions of either guided mourning or anti-exposure treatment; all patients had not improved during a 2-week waiting list period. Both groups showed improvement at 9 months, but avoidance and distress to bereavement cues improved more in guided mourning than in anti-exposure treatment.

VOLKAN, V. (1971). **A study of a patient's "re-grief work" through dreams, psychological tests and psychoanalysis.** *Psychiatric Quarterly, 45*, 255-273.

Describes the method of "re-grief work" as a treatment for bereaved individuals who have a more extreme reaction than normal grief and a less extreme reaction than depression or other major psychiatric problems. The method involved demarcation, externalization, and organization. The results of treatment for 5 cases are presented.

WINDHOLZ, M.J., MARMAR, C.R., & HOROWITZ, M.J. (1985). **A review of the research on conjugal bereavement: impact on health and efficacy of intervention.** *Comprehensive Psychiatry, 26*, 433-447.

Reviews findings on conjugal bereavement. Topics covered include psychological responses, mortality and morbidity, the duration of psychological and physical effects, predictors of outcome, and efficacy of intervention methods.

PILOTS UPDATE

Most bibliographic databases index the contents of a predefined set of sources. There are 9,613 publications listed in the National Library of Medicine's *List of Serials Indexed for Online Users*, of which 4,514 are currently indexed. Articles from journals not on that list will not be found in MEDLINE. PsycINFO indexes books, book chapters, and doctoral dissertations as well as journal articles, but its coverage of journals is restricted to those on a defined list.

Such a list can be designed to include the most significant journals in a particular field, and to provide a balance of coverage among languages, methodological approaches, and subdisciplines. But it cannot ensure that valuable literature will not be overlooked by the indexer and the user. Our goal has always been to include in the PILOTS database citations to all literature relevant to PTSD and related sequelae to traumatic experiences. We do not restrict our coverage to a predefined list of journals, but rather attempt to find everything relevant to our defined subject-matter. This is easier said than done.

For all the magnitude of the task they have set themselves, at least the compilers of MEDLINE know where they stand. They have undertaken to index the contents of 4,514 journals. An article either is published in one of those journals, or it is not. If they have indexed all the articles in all of the journals they cover, their task is complete — at least until the appearance of the next issue of one of the journals on their list.

We haven't got that advantage. We examine closely all of the journals devoted to PTSD as well as the leading general journals in psychiatry and psychology. But there is no way that we can examine every issue of every journal that might contain an article that falls within the scope of our indexing.

So how do we do it?

First, we do indeed receive and examine every issue of several specialist journals. We also look through the *American Journal of Psychiatry*, *Journal of Abnormal Psychology*, and other high-impact mental health publications. Second, we subscribe to alerting services such as Journal Tracker and Ingenta Reveal. Journal Tracker provides us with tables of

contents for over 125 important mental health journals. Ingenta Reveal runs our search profile against new issues of thousands of journals, and sends us citations for articles relevant to our interests. Third, we routinely search other databases—not only MEDLINE and PsycINFO, but also a wide range of highly specialized indexing services—to find articles published in journals that our subscriptions and alerting services don't cover. We use these other indexes to identify likely articles for inclusion in the PILOTS database, but PILOTS records are always based on our own examination of each publication.

Our searches of alerting services and databases rely upon the occurrence of specified terms within the title or abstract of an article, or among the indexing terms applied by indexers. Sometimes it happens that the author of an article relevant to our concerns conceals that fact so effectively that our search criteria don't find it. Even then there is a good chance that we will locate, collect, and index that publication—eventually. Perhaps it will be listed in the bibliography of an important literature review, or perhaps a colleague, coming across it in some other context, will call it to our attention.

Or perhaps the author of the article, desiring to increase the impact of his work on the traumatic stress field, will send us a copy. Many of the publications that we have indexed have come to our attention in this way. We have been especially happy to receive material published in sources far removed from the mainstream of traumatic stress studies. How else would we ever find out about articles in PTSD from the viewpoint of Armenian studies, or canon law, or general semantics?

We encourage our readers to send us copies of any of their publications that are not indexed in the PILOTS database but should be. It's easy: just go to our website at <www.ncptsd.org>, click on **search PILOTS**, and enter your name next to the "Author" box. Look through the search results, and if one or more of your papers comes up missing—just send it along to us. We've got more than 21,000 records in the PILOTS database, but there's always room for a few more.

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