complicated grief inventory

please tick the boxes that best describe how you feel, where ***never*** is taken to mean less than once monthly, ***rarely*** means more than once monthly but less than once weekly, ***sometimes*** more than weekly but less than daily, ***often*** about daily, & ***always*** means more than once daily:

		0: never	***1: rarely***	***2: some times***	***3: often***	***4: always***
1	I think about this person so much that it's hard for me to do the things I normally do					
2	memories of the person who died upset me					
3	I cannot accept the death of the person who died					
4	I feel myself longing for the person who died					
5	I feel drawn to places and things associated with the person who died					
6	I can't help feeling angry about his/her death					
7	I feel disbelief over what happened					
8	I feel stunned or dazed over what happened					
9	ever since s/he died it is hard for me to trust people					
10	*e*ver since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about					
11	I have pain in the same area of my body or I have some of the same symptoms as the person who died					
12	I go out of my way to avoid reminders of the person who died					
13	I feel that life is empty without the person who died					
14	I hear the voice of the person who died speak to me					
15	I see the person who died stand before me					
16	I feel that it is unfair that I should live when this person died					
17	I feel bitter over this person's death					
18	I feel envious of others who have not lost someone close					
19	I feel lonely a great deal of the time ever since s/he died					
	scoring:					

total score =

background to complicated grief inventory

People react in many different ways to bereavement and loss. Depression and anxiety symptoms are quite common. So too is traumatic grief which involves a cluster of symptoms, such as emotional numbing, re-experiencing and avoidance, which are similar too but not the same as the symptoms of post-traumatic stress disorder – PTSD (Prigerson, Shear et al. 1999). Why some people become depressed, some develop PTSD, and some suffer from traumatic grief seems to be influenced by earlier life experiences (Silverman, Johnson et al. 2001). Childhood traumas such as death of a parent or abuse produce more vulnerability to traumatic grief, whereas death of a child or other adult trauma seems more associated with later post-bereavement PTSD. Traumatic grief, which has only recently been recognized as a separate disorder, seems often to be associated with worse long term outcome than either post-bereavement depression or PTSD (Silverman, Jacobs et al. 2000).

150 people who had recently lost their spouse were followed up for over two years (Prigerson, Bierhals et al. 1997). Most of them were aged between 55 and 70 years old. On average they had been married for about 35 years. They were assessed for anxiety, depression, physical health and they also completed the *Traumatic grief inventory (TGI)*. A score of 32 or more on the *TGI* was considered high. 57% scored at this level 2 months after their bereavement. This had dropped to 20-25% at 6 months, 6% at 13 months, and 7% at 25 months. Scores for probable depressive disorder also decreased from 75% in the immediate weeks after bereavement, to 36% at 13 months, and 33% at 25 months. Scores for a probable anxiety disorder started at about 20%, and declined only very slowly over subsequent months.

TGI scores in the first few weeks after bereavement were not related to how the bereaved person did over the next two years. However a high *TGI* score 6 months or more after bereavement, even after allowing for high depression scores, was associated with a greater risk of poor diet, increased smoking, and of developing heart disease or cancer over the next 2 years.

It does seem that it is well worthwhile considering seeing a therapist if you are scoring above 24 on the *TGI* (or are still significantly depressed), 6 months or more after bereavement (Harkness, Shear et al. 2002). Sometimes loss of one's partner may leave one feeling very insecure, and possibly the loss may also leave one unclear about one's own identity and value as a person. Of course the bereavement is the major trauma, but one's early life experiences of loss and personal self-worth may also contribute to how hard it is to come to terms with what has happened. Therapy is likely to consist of under-standing, expressing feelings, and going over what has happened (in much the same way as found useful in post-traumatic stress disorder), as well as exploring how to become more active and involved again with life.

Harkness, K. L., M. K. Shear, et al. (2002). "Traumatic grief treatment: case histories of 4 patients." J Clin Psychiatry **63**(12): 1113-20.

BACKGROUND: Traumatic grief treatment is a newly developed intervention for a debilitating bereavement-related condition. Traumatic grief treatment uses imaginal and in vivo exposure techniques to target emotional distress and behavioral avoidance hypothesized to be core features of the syndrome, along with interpersonal psychotherapy techniques to engage patients and maintain rapport. The present report describes 4 case histories of patients treated in this way. METHOD: Each patient met our criterion for traumatic grief, defined as a score of at least 25 on the Inventory of Complicated Grief. Additionally, all 4 patients met DSM-IV criteria for a current episode of major depression and 1 patient for bipolar II disorder. The treatment course followed a direct replication design and ranged from 14 to 18 weekly 60- to 90-minute sessions. RESULTS: These 4 cases illustrate reduction in distress during exposure to painful emotional memories and avoided situations that was associated with decreased scores on measures of traumatic grief, depression, and anxiety and increased participation in and enjoyment of daily-life activities. CONCLUSION: Case histories of traumatic grief treatment suggest it is a promising treatment for individuals suffering from traumatic grief. It appears that imaginal relieving and in vivo exposure are effective in reducing grief intensity and lead to reduction in symptoms.

Prigerson, H. G., A. J. Bierhals, et al. (1997). "Traumatic grief as a risk factor for mental and physical morbidity." Am J Psychiatry **154**(5): 616-23.

OBJECTIVE: The aim of this study was to confirm and extend the authors' 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., M. K. Shear, et al. (1999). "Consensus criteria for traumatic grief. A preliminary empirical test." Br J Psychiatry **174**: 67-73.

Silverman, G. K., S. C. Jacobs, et al. (2000). "Quality of life impairments associated with diagnostic criteria for traumatic grief." Psychol Med **30**(4): 857-62.

BACKGROUND: This study examined the association between a diagnosis of traumatic grief and quality of life outcomes. METHOD. Sixty-seven widowed persons were interviewed at a median of 4 months after their loss. The multiple regression procedure was used to estimate 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 post-traumatic stress disorder. 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.

Silverman, G. K., J. G. Johnson, et al. (2001). "Preliminary explorations of the effects of prior trauma and loss on risk for psychiatric disorders in recently widowed people." Isr J Psychiatry Relat Sci **38**(3-4): 202-15.

BACKGROUND: This study compared the relative influence of childhood and adulthood adversities on current diagnoses of Major Depressive Episode (MDE), Post-Traumatic Stress Disorder (PTSD) and Traumatic Grief (TG) among recently widowed older adults. METHOD: Eighty-five widowed persons were interviewed at a median of 4 months after their loss. The logistic regression procedure was used to estimate the effects of three childhood adversities (parental death, abuse, death of a sibling) and three prior adulthood adversities (death of a child, non-bereavement traumatic event, death of a sibling) on current diagnoses of MDE, PTSD and TG. RESULTS: Adversities occurring in childhood (abuse and death of a parent) were significantly associated with TG and, secondarily, MDE, while adversities occurring in adulthood (non-bereavement traumatic event and death of a child) were only significantly associated with PTSD. The tendency of childhood adversities to predict TG and adult adversities to predict PTSD remained significant even after the clustering of adversities and comorbidity among psychiatric disorders were taken into account. CONCLUSIONS: The results suggest that there is a vulnerability to TG rooted in childhood experiences explicitly, with more recent traumas having a stronger influence on PTSD secondary to widowhood. The distinctive etiological risks for bereavement-related PTSD, MDE, and TG suggest that therapeutic approaches should be tailored to the particular syndrome(s) present.