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COMPLICATED GRIEF SYMPTOMS IN ANXIETY DISORDERS: PREVALENCE AND ASSOCIATED IMPAIRMENT

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Abstract

Background—Previous research has identified high rates of comorbid anxiety disorders among individuals presenting with primary CG. In the present study, we examined the prevalence of comorbid CG in bereaved primary anxiety disorder (AD) patients compared to bereaved healthy controls. We also examined the impairment associated with comorbid CG in AD.

Methods—Participants were 242 bereaved adults (mean (SD) age = 41.5 (13.1), 44.2% women) with a primary AD diagnosis, including generalized anxiety disorder (GAD; n = 57), panic disorder (PD; n = 49), posttraumatic stress disorder (PTSD; n = 29), and generalized social anxiety disorder (GSAD; n = 107), as well as 155 bereaved healthy controls with no current DSM-IV Axis I diagnosis (mean (SD) age = 43.0 (13.6), 51.0% women). CG symptoms were measured using the 19-item inventory of complicated grief (ICG), with threshold CG defined as an ICG score of ≥ 30. Quality of life and functional impairment were assessed with the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) and the Range of Impaired Functioning Tool (LIFE-RIFT), respectively.

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Results—Participants with primary ADs had significantly higher rates of threshold CG symptoms than bereaved controls (12.0% vs. 0.65%; Fisher's Exact $P < 0.001$). Rates of threshold CG were significantly elevated for each AD when compared to bereaved controls. After adjustment for age, sex, education, and comorbid major depressive disorder, threshold CG was associated with lower quality of life ($\beta = -0.140$, $P = 0.023$) and greater impairment ($\beta = 0.141$, $P = 0.035$) among individuals with AD.

Conclusions—Our findings suggest that threshold CG is of clinical relevance in bereaved individuals with a primary anxiety disorder. Screening for CG in patients with ADs may be warranted.

Keywords

Complicated grief; grief; bereavement; anxiety; comorbidity; quality of life

INTRODUCTION

Grief following the loss of a loved one is among the most painful and challenging experiences an individual will face in his or her life. For a subset of bereaved individuals, the psychological distress following loss is severe and enduring, resulting in the distressing and impairing syndrome of complicated grief (CG). Though variably defined, CG has been found to occur in approximately 6 to 18% of bereaved individuals.^[1–4] The syndrome is chiefly characterized by symptoms of separation distress, including frequent and intense yearning for the person who died, and loss-related traumatic distress that interfere with functioning.^[5] CG symptoms have been shown to be associated with lower quality of life,^[6] significant sleep disruption,^[7,8] negative health consequences,^[9] and suicidal ideation.^[10, 11]

As CG is a newly defined condition, with the precise diagnosis still under discussion for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM5),^[12] persistent loss-related difficulties are not formally assessed in clinical practice and therefore may not be consistently recognized. High rates of comorbid CG have been documented in individuals with a primary diagnosis of Major Depressive Disorder (MDD).^[13, 14] The prevalence of CG in individuals with a primary anxiety disorder, however, remains unknown. Furthermore, it is unclear whether comorbid CG results in additive impairment for patients with primary anxiety disorders.

CG is phenomenologically distinct from depression and anxiety, including that which is bereavement related.^[15–19] However CG and the anxiety disorders share some symptom overlap, particularly CG and posttraumatic stress disorder [PTSD;²⁰]. For example, CG and PTSD share symptoms of intrusive memories or ruminations, behavioral avoidance, emotional numbness, and anger.^[5, 21, 22] Individuals with CG also present with psychological characteristics often found in individuals with anxiety disorders, such as experiential avoidance^[23] and intolerance of uncertainty.^[24] Consistent with this overlap, individuals presenting for care with a primary diagnosis of CG exhibit elevated rates of comorbid anxiety disorders, especially PTSD (48% current, 52% lifetime) and PD (14% current, 22% lifetime).^[25] Given these data, although CG screening is not a routine part of

clinical care to date, it is possible that patients presenting with a primary anxiety disorder may suffer from elevated rates of comorbid CG.

Examining the presence of CG symptoms among patients with a primary anxiety disorder diagnosis is important for a number of reasons. First, identifying comorbid CG in patients with primary anxiety disorders has considerable clinical utility as treatments focused on the reduction of anxiety or depressive symptoms may not be effective at reducing symptoms of CG.^[26, 27] Second some evidence suggests that a comorbid diagnosis of CG may be associated with greater psychosocial distress and impairment.^[28, 29] Although comorbid CG has been associated with more severe depression, elevated rates of alcohol dependence, and lower levels of perceived social support among patients with primary MDD,^[13, 14] to date, no studies have examined whether a comorbid diagnosis of CG is associated with additional impairment in those with primary anxiety disorders. Finally, in addition to being a potential severity factor, preexisting anxiety disorders may also increase the risk for CG after a significant loss by complicating the natural healing process.^[30] Support for this hypothesis comes from a study that demonstrated that among individuals with CG and a comorbid anxiety disorder, the majority experienced the onset of the anxiety disorder prior to bereavement.^[25]

In the present study, we examined the rates of CG in patients with a primary diagnosis of one of four anxiety disorders: GAD, PD, PTSD, or GSAD. We hypothesized that bereaved primary anxiety disorder patients would exhibit higher rates of comorbid CG compared to bereaved healthy controls. We further hypothesized that among those with an anxiety disorder, the presence of comorbid CG would be independently associated with lower quality of life and increased psychosocial impairment.

METHODS

PARTICIPANTS

Participants were 155 bereaved controls with no current DSMIV Axis I disorder diagnosis and 242 bereaved individuals with at least one primary anxiety disorder diagnosis (GAD, PD with or with agoraphobia, PTSD, and GSAD) who completed an ancillary questionnaire-based protocol prior to participation in research at the Center for Anxiety and Traumatic Stress Disorders (CATSD) at the Massachusetts General Hospital (MGH). All participants were bereaved, i.e. all participants reported the loss of a close relative or significant other. Participants were age 18 and older and were recruited through advertisement or clinical referral. Individuals with a lifetime history of bipolar disorder or psychosis or past 6-month alcohol or substance abuse or dependence were excluded from participation in primary research studies at the CATSD. As such, these individuals were effectively excluded from participation in the present study.

PROCEDURE

After informed consent, psychiatric diagnoses were assessed with a structured clinical interview (either the Structured Clinical Interview for DSM-IV [SCID;³¹] or the Mini-International Neuropsychiatric Interview [MINI;³²]. The primary diagnosis was defined as

the patient's most significant current psychiatric problem and was confirmed by a trained clinical assessor. Participants were then assessed for functional disability and quality of life. Those answering affirmatively to "Have you ever had a close relative or significant other pass away?" completed the Inventory of Complicated Grief [ICG;³³]. However due to an oversight in questionnaire administration, data on time since the loss were not collected. The present study sample included individuals with complete diagnostic and demographic information who reported the loss of a loved one and completed the ICG. All study procedures were approved by the institutional review board of the MGH.

MEASURES

The 19-item, self-report Inventory of Complicated Grief^[33] was used to identify individuals with threshold CG. This scale assesses maladaptive grief symptoms, such as intrusive thoughts about the person who died, avoidance of reminders of the death, and inability to accept the death. Participants rate the frequency of each symptom on a 5-point Likert scale, total scores ranging from 0 to 76. Consistent with prior research,^[34] we defined individuals with scores of ≥ 30 as having threshold CG symptoms.

The clinician rated Life Range of Impaired Functioning Tool [LIFE-RIFT;³⁵] assesses functional impairment across four domains: work, interpersonal relations, satisfaction, and recreation. Total scores range from 0 to 24, with higher scores indicating more impairment.

The 16-item self-report Quality of Life Satisfaction and Enjoyment Questionnaire–Short Form [Q-LES-Q;³⁶] assesses various aspects of quality of life, including mood, physical health, work and economic status, and social and family relationships. Participants rate their satisfaction on a scale from 1 ("very poor") to 5 ("very good"). Scaled scores range from 0 to 100, with higher scores representing higher subjective quality of life.

ANALYTICAL APPROACH

We compared rates of threshold CG between diagnostic groups using Fisher's Exact test (FET) and we compared CG symptom severity between diagnostic groups with analysis of variance. We conducted two multivariate linear regression analyses to assess the independent association of threshold CG symptoms with Q-LES-Q and LIFE-RIFT among bereaved anxiety disorder participants. Among bereaved anxiety disorder participants, CG was associated with female sex, lower education, and comorbid MDD. CG was not associated with age, race, or marital status. We therefore controlled for sex, education, and comorbid MDD in the regression analyses predicting Q-LES-Q and LIFE-RIFT by threshold CG symptoms. We also controlled for age because older age is known to be associated with lower health-related quality of life in the general population.^[37] All data analyses were performed using STATA version 11.1 (College Station, Texas). The alpha level of significance was set to 0.05 (two sided).

RESULTS

SAMPLE CHARACTERISTICS

Sample demographics and clinical characteristics are presented in Table 1. The bereaved anxiety disorder sample comprised 57 participants with primary GAD, 49 with primary PD, 29 with primary PTSD, and 107 with primary GSAD. Participants ranged in age from 18 to 76 years (bereaved controls 19–70 years, bereaved anxiety disorder participants 18–76 years). Anxiety disorder participants did not differ from controls in terms of age, sex, ethnicity, marital status, or education. A larger proportion of the anxiety disorder sample was white compared to the control sample (85.5% vs. 69.7%; FET $P < 0.001$). Secondary anxiety and mood disorder comorbidity was high in the bereaved anxiety disorder sample (see Table 1). Compared to controls, participants in the bereaved anxiety disorder sample reported significantly lower quality of life (Q-LES-Q $M = 0.537$, $SD = 0.171$ vs. $M = 0.774$, $SD = 0.149$), $t(395) = 14.639$, $P < 0.001$, and greater psychosocial impairment (LIFERIFT $M = 11.34$, $SD = 2.82$ vs. $M = 6.21$, $SD = 1.83$), $t(324) = 19.789$, $P < 0.001$.

COMPLICATED GRIEF

Bereaved anxiety participants had significantly higher rates of threshold CG symptoms than bereaved control participants (11.98% vs. 0.65%; FET $P < 0.001$). Threshold CG symptoms were higher for each individual anxiety disorder group when compared to the bereaved control group separately, including GAD (8.77%; FET $P = 0.006$), PD (18.37%; FET $P < 0.001$), PTSD (27.59%; FET $P < 0.001$), and GSAD (6.54%; FET $P = 0.009$). A one-way analysis of variance with Bonferroni correction demonstrated that individuals in each anxiety disorder group reported greater CG symptoms than bereaved controls ($F(4, 392) = 24.7$, all P 's < 0.001).

IMPAIRMENT ASSOCIATED WITH CG SYMPTOMS

A regression model predicting impairment in quality of life among bereaved anxiety disorder participants ($F(5, 236) = 11.57$, $P < 0.001$, $R^2 = 0.197$) revealed that after adjustment for age, sex, level of education, and comorbid MDD, the presence of threshold CG symptoms was independently associated with lower quality of life ($\beta = -0.140$, $P = 0.023$). Comorbid MDD was also independently associated with lower quality of life ($\beta = -0.359$, $P < 0.001$). A regression model predicting functional disability among bereaved anxiety disorder participants ($F(5, 210) = 8.02$, $P < 0.001$, $R^2 = 0.160$) revealed that after adjustment for age, sex, level of education, and comorbid MDD, the presence of threshold CG symptoms was independently associated with greater functional disability ($\beta = 0.141$, $P = 0.035$). Higher education ($\beta = 0.131$, $P = 0.048$) and comorbid MDD ($\beta = 0.291$, $P < 0.001$) were also independently associated with greater functional disability.

DISCUSSION

As predicted, rates of threshold CG appear to be elevated for bereaved individuals with a primary diagnosis of GAD, PD, PTSD, and GSAD relative to bereaved controls. The presence of comorbid CG was associated with lower quality of life and increased impairment among bereaved individuals with an anxiety disorder.

Rates of threshold CG symptoms were particularly elevated in bereaved PTSD and PD patients. This pattern may be explained by a shared risk factor for these disorders (e.g., anxiety sensitivity). We have recently identified elevated rates of lifetime panic-spectrum symptoms in CG patients,^[38] supporting the hypothesis that a shared diathesis contributes to the development of both PD and CG. Additional research is needed to understand the cause(s) of the high comorbidity between PTSD, PD, and CG.

The present results are relevant for the evaluation and treatment of patients with primary anxiety disorders, as many patients reported elevated CG symptoms when directly assessed. Some evidence suggests that treatments focusing on the reduction of anxiety and depressive symptoms may be less effective for grief symptoms^[25–27] suggesting that although effective treatments for CG are available,^[34] failing to recognize it in this population may result in poorer treatment response. Moreover, data suggest that most individuals with undiagnosed CG would be relieved to know that their symptoms are indicative of an identifiable syndrome and interested in receiving treatment for grief.^[39] Therefore, effective screening and diagnosis of CG is a missing step that is needed to ensure that individuals with primary and comorbid CG have access to appropriate and effective treatment options.

The present study has several limitations. First, participants were not formally diagnosed with CG by clinical interviewers, but instead the presence of threshold CG symptoms was determined by using a cut-off score of 30 or higher on the self-report ICG. Additionally, because information on time since the loss was not available, it is possible that some participants in the CG group were suffering from more acute reactions to loss, rather than meeting proposed CG time criterion of at least 6 months postloss. Another limitation is that individuals with CG may have been excluded from the healthy control group if their CG symptoms were misdiagnosed as indicative of a mood or anxiety disorder. Therefore, the present study may actually underestimate the presence of CG among individuals without another DSM-IV disorder. Diagnostic comorbidity in the bereaved anxiety disorder sample was also limited by the inclusion/exclusion criteria of the parent studies from which this sample was drawn, limiting the generalizability of these findings to clinical anxiety populations. Finally, the results of the present study are cross-sectional, precluding conclusions regarding causality.

Notwithstanding these limitations, these findings suggest a need for routine screening of CG in anxiety patient populations, with particular attention in future work to the greater prevalence of comorbid CG with PTSD and panic. Future studies should examine the longitudinal development of CG in order to determine whether a current and/or lifetime anxiety disorder diagnosis constitutes a risk factor for the development of CG after a loss, or whether some underlying vulnerability such as anxiety sensitivity is predictive of the development of both disorders. The present findings also suggest a need for research that examines the optimal treatment approach for individuals suffering from comorbid anxiety disorders and CG.

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TABLE 1

Sample demographic and clinical characteristics

	Control (n = 155)	Any anxiety disorder (n = 242)	GAD (n = 57)	PD (n = 49)	PTSD (n = 29)	GSAD (n = 107)
Demographics						
Age; mean (SD)	43.0 (13.6)	41.5 (13.1)	43.6 (12.5)	41.4 (13.9)	45.0 (10.0)	39.4 (3.5)
Sex;% female (n)	51.0% (79)	44.2% (107)	45.6% (26)	53.1% (26)	82.8% (24)	29.0% (31)
Race;% White (n)	69.7% (108)	85.5% (207)	91.2% (52)	89.8% (44)	69.0% (20)	85.0% (91)
Ethnicity;% Non-Hispanic/Latino (n)	93.5% (145)	94.6% (229)	94.7% (54)	95.9% (47)	93.1% (27)	94.4% (101)
Marital status;% married/cohabitating (n)	37.4% (58)	46.7% (113)	64.9% (37)	49.0% (24)	24.1% (7)	42.1% (45)
Education;% part college or above (n)	90.3% (140)	87.6% (212)	93.0% (53)	77.6% (38)	82.8% (24)	90.7% (97)
Current DSM-IV diagnoses						
Major depressive disorder;% (n)	0% (0)	20.7% (50)	14.0% (8)	18.4% (9)	51.7% (15)	16.8% (18)
Dysthymic disorder;% (n)	0% (0)	4.5% (11)	10.5% (6)	6.1% (3)	3.4% (1)	0.9% (1)
Generalized anxiety disorder;% (n)	0% (0)	37.6% (91)	100% (57)	24.5% (12)	10.3% (3)	17.8% (19)
Panic disorder;% (n)	0% (0)	29.3% (71)	14.0% (8)	100% (49)	17.2% (5)	8.4% (9)
Posttraumatic stress disorder;% (n)	0% (0)	13.6% (33)	0% (0)	2.0% (1)	100% (29)	2.8% (3)
Social anxiety disorder% (n)	0% (0)	52.5% (127)	19.3% (11)	10.2% (5)	13.8% (4)	100% (107)
Agoraphobia;% (n)	0% (0)	20.7% (50)	10.5% (6)	65.3% (32)	13.8% (4)	7.5% (8)
Obsessive compulsive disorder;% (n)	0% (0)	0.8% (2)	0% (0)	2.0% (1)	3.4% (1)	0% (0)
Threshold complicated grief;% (n)	0.65% (1)	11.98% (29)	8.77% (5)	18.37% (9)	27.59% (8)	6.54% (7)
Clinical characteristics						
Inventory of complicated grief; m (SD)	7.18 (7.29)	15.21 (11.39)	14.07 (10.19)	15.80 (12.17)	24.17 (13.69)	13.11 (9.80)
Q-LES-Q; m (SD)	77.5 (14.9)	53.7 (17.1)	54.5 (16.0)	54.2 (19.3)	43.0 (16.3)	55.9 (15.8)
LIFE-RIFT; m (SD)	6.2 (1.8)	11.3 (2.8)	11.2 (2.4)	10.8 (2.9)	13.5 (2.7)	11.1 (2.9)