

# Differentiating Symptoms of Complicated Grief and Depression Among Psychiatric Outpatients

John S Ogrodniczuk, PhD<sup>1</sup>, William E Piper, PhD<sup>2</sup>, Anthony S Joyce, PhD<sup>3</sup>,  
Rene Weideman, PhD<sup>4</sup>, Mary McCallum, PhD<sup>5</sup>, Hassan F Azim, MD<sup>6</sup>, John S Rosie, MD<sup>7</sup>

**Objective:** This study examined whether dimensions of complicated grief (CG) could be distinguished from dimensions of depression and whether these dimensions were differentially affected by group psychotherapy for CG.

**Method:** A total of 398 psychiatric outpatients who had experienced one or more significant death losses provided ratings on standard measures of grief and depression. Factor analysis of the 56 items from these measures was used to explore the possibility that grief and depression symptoms would form separate dimensions of distress. Subsamples of the patients also participated in 1 of 2 forms of short-term group therapy for CG. Repeated-measures analysis of variance and calculation of effect sizes were performed to examine changes in the dimensions following treatment.

**Results:** The grief items formed 3 distinct clusters representing different dimensions of CG. None of the depression items loaded highly on these grief dimensions. The depression items formed 2 distinct clusters. Two of the grief dimensions demonstrated the most improvement following group therapy that addressed CG. There was also evidence for differential effectiveness of the 2 forms of group therapy.

**Conclusions:** When assessing psychiatric patients who have death losses, clinicians should consider different types of grief reactions. Different types of grief reactions may be responsive to different treatments. In the absence of depressive symptoms, clinicians should not assume the absence of CG.

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## Clinical Implications

Complicated grief is a multidimensional construct; thus, clinicians should attend to different areas of distress when assessing patients who have lost an important person through death.

Symptoms of complicated grief and depression should be considered separately.

Interpretive group therapy may be more effective than supportive group therapy for treating specific dimensions of complicated grief.

## Limitations

The cross-sectional design of the study did not allow us to determine the stability of the dimensions across time.

Because other available grief symptom measures were not included, it is possible that other aspects of complicated grief reactions were not assessed.

Principal components analysis is an exploratory factor analytic technique; thus, the results of the present study must be considered preliminary and require replication in a different sample using confirmatory factor analysis.

**Key Words:** *complicated grief, depression, symptom profile, response to treatment*

Acute distress is normal following the loss of a loved one. In some cases, grief reactions reach intensities and durations that are extreme, are associated with complications (for example, physical ailments), and interfere with daily func-

tioning. Such grief reactions are referred to as complicated grief (CG) (1). There is considerable interest in CG as a nosologic entity that is distinct from major depression, panic disorder, and posttraumatic stress disorder (2). However, there is

still much debate concerning the operationalization and validation of CG.

Clinicians frequently find that loss issues underlie and sustain patients' problems. Treatment interventions with these patients may need to focus on various aspects of CG (3). Robinson and Pickett recommended that measures of grief should cover multiple dimensions to elicit the most clinically useful material (4). They argued that complications may be restricted to specific symptoms rather than generalized distress. Unidimensional scales may fail to detect specific problems.

Several instruments have been developed to assess symptoms of CG (5). However, there have been no attempts to determine whether the different instruments measure unique aspects of grief or whether they address common features. Inability to clearly define the components of CG has contributed to its exclusion as a distinct diagnostic category from the major classification systems of mental disorders (1).

The debate over whether grief and depression are distinct constructs adds to the difficulty in clearly defining CG. Clayton defined CG as a "continued depressive symptom" (p 34, 6). Others have argued that CG is distinct from depression (7). Support for this argument comes from a study of older adults who had lost a spouse, which demonstrated that CG symptoms were empirically distinguishable from symptoms of depression and anxiety (8). This suggests that symptoms unique to CG may be overlooked if grief and depression are assumed to be part of the same condition.

Stroebe and others (1) argued that, despite many recent advances in bereavement research, there remains a need for greater clarity in defining CG, finer delineation of the overlap and distinction between grief and other symptoms such as depression, and further validation of the concept of CG. The present study addressed each of these issues. The study used data from 2 recently completed investigations of the prevalence (9) and treatment of CG (10). The samples were unique for 2 reasons. First, the subjects were psychiatric outpatients who had significant death losses. Second, the losses occurred at least 3 months ago, most well over 1 year ago. Nearly all previous investigations of dimensions of grief have used nonpsychiatric samples with recent losses. Although CG has been found to be prevalent among psychiatric outpatients (9,11), few researchers have studied symptoms of CG in patient samples. In addition, Prigerson and others (12) recommended that future studies of the signs and symptoms of grief and depression be conducted using individuals whose most significant death loss occurred at least 18 months ago.

Specifically, the present study had 2 objectives. The first was to determine whether symptoms conceptualized as dimensions of CG could be identified and distinguished from symptoms conceptualized as dimensions of depression. The second

was to determine whether the dimensions of grief and depression would be differentially affected by group therapy for CG.

## Method

### *Data Collection for the Present Study*

To address the first objective of the present study, data from a large number of patients were required. Data from 398 patients were available from 2 previously conducted investigations (9,10) in which patients provided ratings on self-report measures of grief and depression. One of the previous investigations was a study of the prevalence of significant death losses and CG among psychiatric outpatients (9). The investigation involved collecting data from patients at 2 psychiatric outpatient clinics in Vancouver, British Columbia: the Assessment and Treatment Services, Department of Psychiatry, Lions Gate Hospital, and the Outpatient Psychiatry Program, Department of Psychiatry, Vancouver General Hospital. Data from 235 patients from the prevalence investigation were used in the present study to address the first objective. All these patients had at least 1 significant death loss. To determine whether they met criteria for CG, the patients completed 3 brief questionnaires. They included a set of Pathological Grief Items (PGI), adapted from work by Prigerson and others (13), the Impact of Events Scale (IES; 14), and the Social Adjustment Scale - Self Report (SAS-SR; 15). The PGI and IES were completed for the 1 or 2 most significant death losses in the patient's life.

To meet criteria for CG, the patient had to have a score of 10 or higher on the PGI, or on the Intrusion Subscale of the IES, or on the Avoidance Subscale of the IES for at least 1 loss and a score of 2.0 or higher on 1 of the 6 subscales of the SAS-SR. The loss must have occurred at least 3 months before. These criteria were selected, after a review of previous studies, to include patients with at least moderate grief symptomatology and social role dysfunction and to rule out immediate grief reactions. Sixty percent of the 235 patients met criteria for CG. Most patients who met the criteria considerably exceeded the cut-off scores on the questionnaires.

The second investigation that provided data for the present study was a randomized clinical trial of 2 forms of time-limited, short-term group therapy for CG (10). The trial was conducted at the Psychiatric Treatment Clinic of the Department of Psychiatry, University of Alberta Hospital Site in Edmonton, Alberta. Pretherapy data from 163 patients in the trial were used in the present study to address the first objective. All these patients had at least 1 significant death loss and all met criteria for CG as described above. Most patients considerably exceeded the cut-off scores.

To address the second objective of the present study, data from 119 of the 163 patients from the Edmonton trial were

available. These 119 patients completed group therapy for CG. The pretherapy and posttherapy data from these 119 patients were used to address the second objective.

### *Patients*

The diagnostic, demographic, and loss information presented in this section describe the combined sample ( $n = 398$ ) of patients from the 2 studies. Patients provided written informed consent before participating in the studies. The patients received DSM-IV diagnoses that were determined jointly by an intake interviewer and a psychiatrist. Almost all the patients (87%) received an Axis I diagnosis. The most frequent primary diagnoses were major depression (60%), dysthymia (15%), and substance abuse (9%). About one-half of the patients (48%) received one or more Axis II diagnoses. The most frequent of these diagnoses were obsessive-compulsive (29%), dependent (28%), avoidant (17%), and borderline (15%). Slightly more than one-third of the patients (39%) received both Axis I and Axis II diagnoses.

The average age of the patients was 42.3 years. Sixty-six percent were women. Thirty-six percent were married or living with a partner, 29% were separated or divorced, 9% were widowed, and 26% had never been married. Seventy percent had at least a high school education, and 53% were employed. The types of losses reported by the patients and their prevalence were parent (46.3%), partner (7.8%), sibling (8.1%), friend (9.6%), child (7.6%), grandparents (5.5%), and other (13.4%). The average time since the loss(es) was 9.7 years (SD 10.2, range 0.25 to 47.0). For approximately one-half of the patients, the time since the loss exceeded 5 years.

### *Measures*

Three self-report questionnaires were used to assess CG symptoms. They included the PGI (13), the IES (14), and the 13-item Texas Revised Inventory of Grief (TRIG; 16). These measures were chosen because they purport to assess different aspects of an individual's grief response and have been used in many research studies of grief. The PGI addresses symptoms of traumatic distress and separation distress. The IES focuses on 2 major aspects: the intrusion of thoughts, images, and feelings about the death and attempts to avoid such feelings and cognitions. The TRIG was designed to assess symptoms associated with separation distress. Patients in both studies completed the 3 grief measures for their 1 or 2 most significant death losses, following their initial visit to the outpatient clinics. For the present study, scores on the 3 grief measures for the most troublesome loss were used. This was identified as the loss with the highest intrusion or avoidance score from the IES.

Depressive symptoms were assessed using the Beck Depression Inventory-II (BDI-II; 17). This self-report measure reflects the diagnostic criteria for major depressive disorders as

described in the DSM-IV. Patients in both studies completed the BDI-II upon their initial presentation to the outpatient clinics. Patients in the Edmonton outcome study also completed the 3 grief measures and the BDI-II a second time, following their completion of short-term group therapy for CG.

### *Therapies*

Patients in the Edmonton outcome study were randomly assigned to either interpretive or supportive group therapy for CG. The therapies were guided by treatment manuals and differed as intended according to assessments of therapist adherence to the manuals. Patients were scheduled for weekly 90-minute sessions for 12 weeks. In interpretive therapy, the primary objective was to enhance the patients' insight about repetitive conflicts (intrapsychic and interpersonal) and trauma that are associated with the losses and that were assumed to serve as impediments to experiencing a normal mourning process. In supportive therapy, the primary objective was to improve the patients' immediate adaptation to their life situations. It was assumed that improvements in symptomatology and social (role) functioning could be achieved through the provision of support and problem solving.

Management of medication was conducted by 1 of 2 project psychiatrists. Fifty-seven percent of the therapy completers were prescribed psychotropic medication prior to the start of the therapy groups and were maintained on a constant dosage for the duration of the study. In nearly all cases (92.3%), the medication was an antidepressant (tricyclic, selective serotonin reuptake inhibitor, or other). In the remaining cases (7.7%), an anxiolytic, antipsychotic, or hypnotic was prescribed. Statistical analyses revealed no significant differences between the 2 forms of therapy in initial use or pattern of use during therapy.

### *Data Analyses*

Data analyses proceeded in 2 parts. First, the 56 item scores from the 3 grief measures and the BDI-II that were provided by the 398 patients were subjected to a principal components analysis (PCA) with varimax rotation. The PCA was conducted to identify the dimensions underlying the grief and depression items. Dimensions had to have an eigenvalue of at least 1.0 to be retained, and Cattell's (18) scree test was used to ascertain the number of dimensions to extract. Items were assigned to factors based on their highest loading (minimum acceptable loading of 0.40). The subject to variable ratio was 7:1. After the dimensions were identified, dimension scores were calculated and the correlations among the dimensions were examined using Pearson correlations. Reliability of the dimensions was examined using Cronbach's alpha.

Second, to test the validity of the dimensions, we examined whether the dimension scores changed as a function of treatment for the 119 patients who completed therapy in the

**Table 1 Correlations among the grief and depression dimensions**

	Grief experiences and attitudes	Grief avoidance	Depression-cognitive	Depression-somatic
Grief symptoms	0.75	0.62	0.19	0.19
Grief experiences and attitudes	—	0.54	0.24	0.22
Grief avoidance	—	—	0.21	0.20
Depression-cognitive	—	—	—	0.69

All correlations are significant at  $P < 0.001$ .

**Table 2 Examination of change on each dimension following short-term group therapy using repeated-measures ANOVA**

Dimension	<i>F</i>	df	<i>P</i>
Grief symptoms	124.18	1, 105	< 0.001
Grief experiences and attitudes	52.48	1, 105	< 0.001
Grief avoidance	83.93	1, 104	< 0.001
Depression-cognitive	22.56	1, 104	< 0.001
Depression-somatic	32.85	1, 104	< 0.001

ANOVA = analysis of variance

Edmonton outcome study. Treatment (interpretive vs supportive) by time (pretherapy vs posttherapy) repeated-measures analyses of variance (ANOVAs) were used to examine whether scores on the dimensions changed across the treatment period and whether there were any differences in change between the 2 forms of therapy. We also calculated effect sizes to determine the magnitude of change on the dimensions. Comparisons of the effect sizes were performed using paired-samples *t*-tests to determine which dimensions changed the most and least following group therapy for CG. As well, because about one-half of our sample were on psychotropic medication, we examined the effect of medication on change in the 5 dimensions. Repeated-measures ANOVAs were used to examine this issue.

## Results

### *Defining Dimensions of Grief and Depression*

The PCA of the 56 items generated 6 dimensions. Because the sixth dimension had only one item, it was discarded. The 5-dimension solution accounted for 52.9% of the variance in the item ratings (a table of the item loadings is available from the authors upon request). The first dimension accounted for 14.8%. Five of the 6 PGI items, all of the items from the

Intrusion Subscale of the IES, and 1 item from the Avoidance Subscale of the IES loaded highly on this factor. The content of most items reflects intrusive grief symptoms such as distressful thoughts and feelings about the lost person, yearning, searching, and numbness or disbelief. These symptoms are most often associated with CG. Thus, we labelled this dimension grief symptoms. The second dimension accounted for 13% of the variance. Only the 13 items of the TRIG loaded highly on this dimension. Many of these items also reflect intrusive grief symptoms such as persistent emotional distress, rumination, and painful memories. In addition, several items reflect attitudes suggesting a lack of acceptance of the death. We labelled this dimension grief experiences and attitudes. The third dimension accounted for 11% of the variance and consisted of 12 of the 21 BDI-II items. Many items reflect self-blame and despair. We labelled this dimension depression-cognitive. The fourth dimension, accounting for 8.3% of the variance, consisted of 7 of the 8 items from the Avoidance Subscale of the IES. These items reflect an active quality of avoiding thoughts and feelings associated with the lost person. We labelled this dimension grief avoidance. The fifth dimension accounted for 6.8% of the variance. The remaining 9 items of the BDI-II loaded highly on this dimension. Many represent the somatic components of depression, notably fatigue and lack of energy. We labelled this dimension depression-somatic.

The reliability ( $\alpha$ ) coefficients for each dimension were high (ranging from 0.83 to 0.94), indicating that the dimensions of grief and depression are internally consistent. The correlations among the dimensions are presented in Table 1. The grief symptoms and grief experiences and attitudes dimensions shared much variance. This is not surprising considering the conceptual overlap between the 2. Similarly, the 2 depression dimensions shared much variance. In contrast, the correlations between the grief dimensions and the depression dimensions were low, thus providing evidence for their independence.

### *Statistically Significant Change in the Dimensions*

The repeated-measures ANOVAs indicated statistically significant change for each of the 5 dimensions over the course of short-term group therapy for CG (Table 2). They also revealed a significant time by treatment effect for the grief symptoms dimension ( $F = 5.48$ ,  $df 1, 105$ ,  $P = 0.021$ ). Improvement in grief symptoms was significantly greater in interpretive therapy than in supportive therapy. Medication was not significantly related to change on any of the 5 dimensions.

### *Magnitude of Change in the Dimensions*

Table 3 presents the effect sizes for each of the 5 dimensions. Effect size was defined as the pretherapy mean minus the posttherapy mean divided by the pretherapy standard

**Table 3 Effect sizes for the grief and depression dimensions following short-term group therapy**

Dimension	All cases	Interpretive cases	Supportive cases
Grief symptoms	0.99	1.42	0.71
Grief experiences and attitudes	0.60	0.67	0.53
Grief avoidance	1.02	1.14	0.92
Depression-cognitive	0.42	0.53	0.31
Depression-somatic	0.60	0.58	0.65

**Table 4 Significant differences in effect sizes among the dimensions for all therapy completers**

Dimension	Compared with	<i>t</i>	df	<i>P</i>
Grief symptoms	Grief experiences and attitudes	4.54	106	< 0.001
	Depression-cognitive	5.54	105	< 0.001
	Depression-somatic	3.49	105	0.001
Grief avoidance	Grief experiences and attitudes	3.43	105	0.001
	Depression-cognitive	5.15	104	< 0.001
	Depression-somatic	3.23	104	0.002

deviation. For all cases combined, larger effect sizes were for grief symptoms and grief avoidance, and smaller effect sizes were for the depression dimensions. Also apparent is the sizeable difference in effect sizes between the 2 forms of therapy for grief symptoms. The effect size for interpretive therapy was twice as large.

Comparisons among the effect sizes for the 5 dimensions for all therapy completer cases required 10 *t*-tests. To control for type I error, we used a Bonferroni-adjusted criterion value of 0.005 (0.05/10). The grief symptoms and grief avoidance dimensions did not differ from each other. However, as seen in Table 4, each differed significantly from the grief experiences and attitudes dimension. In addition, the grief symptoms and grief avoidance dimensions differed significantly from each of the depression dimensions. This provides further evidence for the distinction between grief and depression symptoms. Conversely, the grief experiences and attitudes dimension did not differ significantly from either of the depression dimensions. In addition, the 2 depression dimensions did not differ significantly.

## Discussion

This study found that, among a sample of psychiatric outpatients, CG symptoms emerged as a distinct set of dimensions that were relatively independent of depressive symptoms. The results support findings of previous studies that used nonpatient samples (8,12,13). The present study further

differentiated different aspects of CG, highlighting its complex multidimensional nature.

The grief-related dimension that accounted for the most variance reflected many of the symptoms that are most often associated with CG. These include intrusive thoughts and feelings about the lost person, yearning and searching for the lost person, and numbness about the death. We termed these grief symptoms to reflect the prominence of this set of symptoms in CG. The second grief-related dimension, grief experiences and attitudes, consisted of a set of symptoms that conveyed a notion of persistent emotional distress related to the death. The items reflected a propensity to ruminate about the lost person and painful feelings associated with the death. In addition, several items reflected negative attitudes, indicating a lack of willingness to accept the death. Adhering to such attitudes would likely perpetuate the emotional turmoil associated with losing a loved one. The third grief dimension, grief avoidance, reflected an active avoidance of thoughts and feelings associated with the lost person.

Symptoms reflecting avoidance have received mixed support in the literature as indicators of CG. However, Horowitz and others (19) view intense avoidance as a key symptom of CG and have suggested that it be one of the criteria for diagnosing CG.

Depressive symptoms loaded on 2 dimensions, independently from any of the grief-related symptoms. The item content of these 2 depression dimensions is remarkably similar to the item content of 2 factors found by Steer and others (20) in their work with the BDI-II. One dimension reflected self-blame and dislike and despair. Steer and colleagues termed this dimension depression-cognitive, which we adopted. The second dimension reflected somatic fatigue and lack of energy. Again, to be consistent with Steer and colleagues, we termed this dimension depression-somatic.

For the most part, the content of each of the 5 dimensions was conceptually meaningful. The dimensions were also internally consistent, as indicated by the high alpha coefficients for each. A high correlation was observed between the grief symptoms and grief experiences and attitudes dimensions. This may be attributed to overlap in the content that many items from each factor address. One possibility as to why the items from the TRIG loaded on a separate factor is that the questionnaire format of the TRIG differed from that used for the 2 other grief measures. The TRIG asked respondents to rate how they presently felt about a person's death on a 5-point scale. The PGI and IES each asked respondents to rate the extent to which the items were true for them during the past week

on a 4-point scale. Further research is required to determine whether these 2 factors truly represent different aspects of CG.

The correlations between each of the 3 grief-related dimensions and each of the 2 depression-related dimensions were fairly low, reflecting considerable independence. This supports previous findings of Prigerson and colleagues (13). Such findings do not imply that the grief and depression dimensions cannot cooccur, rather that each dimension represents a distinct form of emotional dysfunction.

To test the validity of the 5 dimensions, we examined whether the grief and depression dimensions were differentially affected by short-term group therapy for CG. We found that, although all dimensions demonstrated significant change, the greatest change occurred for the grief symptoms and grief avoidance dimensions. There was significantly less change on the grief experiences and attitudes dimension relative to the other 2 grief-related dimensions. The 2 depression dimensions also evidenced significantly smaller amounts of change compared with the grief symptoms and grief avoidance dimensions. The depression dimensions likely demonstrated less change because the therapies provided were focused on helping patients resolve issues related to their losses, not issues related to their depressive symptoms.

It is interesting to note the dissimilarity of the effect size for the grief experiences and attitudes dimension, compared with the other 2 grief dimensions. The effect size for this dimension was more similar to that of the depression dimensions. One possible explanation for why this dimension demonstrated less change is that patients' attitudes toward their death losses may be a stable characteristic and more difficult to change than grief symptoms and avoidance behaviours. Longer treatment may be required to demonstrate greater change on this dimension. In addition, the forms of group therapy that were provided in this study devoted relatively little attention to modifying negative attitudes toward death losses. Modifying negative attitudes is more consistent with cognitive-behavioural therapy.

We also found that patients who participated in interpretive group therapy had significantly greater improvement on the grief symptoms dimension, compared with patients who participated in supportive group therapy. This suggests that interpretive therapy may be more appropriate to address certain aspects of CG. The greater effectiveness of interpretive group therapy for treating grief symptoms may have been due to its primary objective of helping patients understand and resolve unconscious conflicts that underlie grief symptoms. These unconscious conflicts were assumed to serve as impediments to the patients' mourning process. Conversely, the primary objective of supportive group therapy was to improve the

patients' immediate adaptation to their life situation through teaching problem-solving skills and guidance. The assumption was that a normal mourning process would occur once an adaptive level of functioning was restored. Thus, in supportive therapy, the conflicts underlying and sustaining grief symptoms were not explored.

There are both limitations and strengths associated with the present study. With regard to limitations, the cross-sectional design of the study does not allow us to determine the stability of the factor structure across time. Future studies with large samples and repeated-measures designs are necessary to determine whether our 5-factor structure is stable. Second, because we chose a select set of grief measures for our study, it is possible that some aspects of complicated grief reactions were not assessed. As a result, our factor structure may not reflect the full spectrum of complicated grief reactions. Similarly, because we used only 1 measure of depression (the BDI), we do not know whether grief and depression symptoms would overlap more if a different measure of depression were used. Third, because PCA is an exploratory factor analytic technique, the results of the present study must be considered preliminary and require replication in a different sample using confirmatory factor analysis. Finally, although we found a significant difference in outcome between the 2 forms of group therapy, it was for only 1 of the 5 outcome dimensions.

With regard to strengths, the present study used a large sample. This provided a favorable subject-to-item ratio of 7:1 for our PCA. The sample also included subjects with mixed ages and types of losses. Thus, our study used a more representative sample than several previous studies that used elderly subjects with spousal losses. Further, the sample consisted of psychiatric outpatients, not community volunteers as in many other studies, thus making our findings more applicable to patient populations. Finally, the present study attempted to validate the dimensions that were identified by examining their responsiveness to group therapy for CG.

## Conclusion

The present study illustrated the multidimensional nature of CG and defined some of its components. Clinicians should attend to these different areas of distress when assessing patients who have lost an important person through death. In addition, this study demonstrated the independence of CG and depression symptoms. The independence of CG and depression symptoms was further validated by the finding that they responded differently to short-term group therapy for CG. Clinicians should not assume the absence of CG if depressive symptoms are not present.

The findings of this study also have implications for treatment. Given that an accurate understanding of a patient's difficulties is a precursor to efficacious treatment, the assessment

of the different dimensions of CG and depression is important. Treatments can be tailored to address particular areas of disturbance. The present study suggests that interpretive group therapy may be more effective than supportive group therapy for treating the classic grief symptoms associated with CG.

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#### References

1. Stroebe M, von Son M, Stroebe W, Kleber R, Schut H, van den Bout J. On the classification and diagnosis of pathological grief. *Clin Psychol Rev* 2000;20:57-75.
2. Jacobs S, Mazure C, Prigerson H. Diagnostic criteria for traumatic grief. *Death Stud* 2000;24:185-99.
3. Rando TA. Treatment of complicated mourning. Champaign (IL): Research Press; 1993.
4. Robinson L, Pickett M. Assessment of adult sibling grief: a review of measurement issues. *Hospice J* 1996;11:1-18.
5. Hansson RO, Carpenter BN, Fairchild SK. Measurement issues in bereavement. In: Stroebe M, Stroebe W, Hansson RO, editors. *Handbook of bereavement*. Cambridge (UK): Cambridge University Press; 1993. p 62-74.
6. Clayton PJ. Bereavement and depression. *J Clin Psychiatry* 1990;51:34-40.
7. Robinson PJ, Fleming S. Differentiating grief and depression. *Hospice J* 1989;5:77-88.
8. Prigerson H, Bierhals A, Kasl S, Reynolds CF, Shear MK, Newsom JT, and others. Complicated grief as a disorder distinct from bereavement-related depression and anxiety: a replication study. *Am J Psychiatry* 1996;153:1484-6.
9. Piper WE, Ogrodniczuk JS, Azim HF, Weideman R. Prevalence of losses and levels of complicated grief in psychiatric outpatient clinics. *Psychiatr Serv* 2001;52:1069-74.
10. Piper WE, McCallum M, Joyce AS, Rosie JS, Ogrodniczuk JS. Patient personality and time-limited group psychotherapy for complicated grief. *Int J Group Psychother* 2001;51:525-52.
11. Zisook S, Lyons L. Bereavement and unresolved grief in psychiatric outpatients. *Omega* 1989-1990;20:307-22.
12. Prigerson H, Shear K, Newsom J, Frank E, Reynolds CF, Maciejewski PK, and others. Anxiety among widowed elders: is it distinct from depression and grief? *Anxiety* 1996;2:1-12.
13. Prigerson H, Frank E, Kasl S, Reynolds CF, Anderson B, Zubenko GS, and others. Complicated grief and bereavement-related depression as distinct disorders: preliminary empirical validation in elderly bereaved spouses. *Am J Psychiatry* 1995;152:22-30.
14. Horowitz MJ, Wilner N, Alvarez W. Impact of Event Scale: a measure of subjective stress. *Psychosom Med* 1979;41:209-18.
15. Weissman MM, Bothwell S. Assessment of social adjustment by patient self-report. *Arch Gen Psychiatry* 1976;33:1111-5.
16. Faschingbauer TR, Zisook S, DeVaul RA. The Texas Revised Inventory of Grief. In: Zisook S, editor. *Biopsychosocial aspects of bereavement*. Washington (DC): American Psychiatric Press; 1987. p 111-24.
17. Beck AT, Steer RA, Brown GK. *Manual for Beck Depression Inventory-II*. San Antonio (TX): Psychological Corporation; 1996.
18. Cattell RB. The scree test for the number of factors. *Multivariate Behav Res* 1966;1:245-76.
19. Horowitz MJ, Siegal B, Hohen A, Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry* 1997;154:904-10.
20. Steer RA, Ball R, Ranieri WF. Dimensions of the Beck Depression Inventory-II in clinically depressed outpatients. *J Clin Psychol* 1999;55:117-28.

<sup>1</sup>Assistant Professor, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia.

<sup>2</sup>Professor, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia.

<sup>3</sup>Associate Professor, Department of Psychiatry, University of Alberta, Edmonton, Alberta

<sup>4</sup>Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia.

<sup>5</sup>Clinical Professor, Department of Psychiatry, University of Alberta, Edmonton, Alberta.

<sup>6</sup>Clinical Professor, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia.

<sup>7</sup>Clinical Professor, Department of Psychiatry, University of Alberta, Edmonton, Alberta.

*Address for correspondence:* Dr J Ogrodniczuk, 2250 Wesbrook Mall, University of British Columbia, Vancouver, BC V6T 1W6  
e-mail: ogrodnic@interchange.ubc.ca

#### Résumé : Différencier les symptômes du deuil complexe et de la dépression chez les patients psychiatriques externes

**Objectif :** Cette étude examine si les dimensions du deuil complexe peuvent être distinguées des dimensions de la dépression, et si ces dimensions sont affectées différemment par la psychothérapie de groupe pour le deuil complexe.

**Méthode :** Un total de 398 patients psychiatriques externes qui avaient subi un ou plusieurs deuils importants ont fourni des cotes à des mesures régulières du deuil et de la dépression. L'analyse factorielle des 56 items de ces mesures a servi à explorer la possibilité que les symptômes du deuil et de la dépression forment des dimensions de détresse distinctes. Des sous-échantillons des patients ont aussi participé à l'une de deux formes de thérapie de groupe à court terme pour le deuil complexe. L'analyse de variance des mesures répétées (ANOVA) et le calcul des valeurs de l'effet ont été effectués pour examiner les changements des dimensions par suite du traitement.

**Résultats :** Les items portant sur le deuil formaient trois grappes distinctes représentant différentes dimensions du deuil complexe. Aucun item de la dépression ne chargeait lourdement ces dimensions du deuil. Les items de la dépression formaient deux grappes distinctes. Deux des dimensions du deuil démontraient le plus d'amélioration par suite de la thérapie de groupe qui abordait le deuil complexe. Il y avait aussi des preuves d'une efficacité différentielle des deux formes de thérapie de groupe.

**Conclusions :** Quand les cliniciens évaluent des patients psychiatriques qui vivent un deuil, ils devraient envisager différents types de réactions au deuil. Les différents types de réactions au deuil peuvent répondre à différents traitements. En l'absence de symptômes dépressifs, les cliniciens ne devraient pas supposer l'absence de deuil complexe.