Traumatic Grief: A Case of Loss-Induced Trauma

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CASE PRESENTATION

History

A 59-year-old widow came for treatment of her depressive symptoms in response to a media announcement recruiting subjects for bereavement research. The patient described a series of difficulties and symptoms that had begun when her husband became terminally ill and that had persisted during the 8 years since his death.

Despite this patient's claim that "grieving is for other people, not for me," shortly after her husband's death she became depressed, with symptoms of low mood, anhedonia, poor sleep, poor appetite, 15-lb. weight loss, low energy, and poor concentration—symptoms for which a psychiatrist treated her with fluoxetine. After several months of taking fluoxetine, the patient's depressive symptoms remitted. She then discontinued the medication and moved across the country to begin a business venture that seemed promising to her at the time. She used nearly all of the money that her husband had left to her to open this franchise with the expectation that she would become financially successful on her own and would be able to assume the provider role that had formerly been her husband's. The patient described how the franchise was "taken from" her; she told convincingly of how she had been the victim of fraud. She provided a summation of the loss of her business by stating simply, "They robbed me of everything."

During this particularly stressful and upsetting period for the patient, her problems were compounded when her apartment was robbed. Many of her most valuable and cherished possessions were stolen, including a pearl necklace that her husband had given to her. Because she was having difficulty coping with these anxiety-provoking events, the patient sought help from a psychologist for symptoms of posttraumatic stress disorder (PTSD). The patient received sertraline and an unspecified psychotherapy. Although she experienced some improvement with this combination therapy, she still remained quite symptomatic.

With her finances decimated and a lawsuit pending, the patient decided to return to her hometown, where most of her family still resided. Despite a strong wish to be independent and to maintain the role of a competent and giving matriarch who provided for her family, she was forced to "live off their charity." The dependence and insecurity she felt as a result of her impoverishment both enraged and depressed her. She complained of feeling victimized, bitter, and helpless. Her confidence was shattered, and she felt unable to care for herself, much less provide for others.

Initial Assessment

At her first assessment, the patient reported persistently feeling angry and bitter over her husband's death, as well as incredulous and stunned. She said that she was not able to accept his death and that since his death she had often felt a mistrust of others. The patient indicated that frequent thoughts about her husband's death interfered with her daily functioning. Likewise, she reported often feeling upset by memories of her husband, longing for him, searching for him, and having frequent thoughts that life was empty in his absence. She indicated that she sometimes had felt detached from significant others since his death, avoided reminders of him, and had visual hallucinations of him (table 1).

The patient was anhedonic and saw herself as a "hermit" who was "hiding from creditors." She was frustrated with not being able to find a job commensurate with her abilities and felt degraded by the only work she was able to find. Her sleep and appetite were poor, although her weight was stable and her energy level was good. She said that she felt that her life was over but that she would not consider suicide because of her family. While she did have prominent depressive symptoms, these appeared to be clearly secondary to the grief-related symptoms. She denied feeling nervous but did report tension in her muscles. She reported no suicidal or homicidal ideation and had no history of manic symptoms or drug or alcohol abuse.

The patient was assessed with the Structured Clinical Interview for DSM-III-R—Non-Patient Edition (1) as part of the research protocol. This interview provides a systematic inquiry into symptoms of each DSM disorder. The diagnoses for this patient included PTSD and depressive disorder not otherwise specified with a history of major depressive disorder. She also completed the Inventory of Complicated Grief (2), a 19-item self-report measure used to evaluate symptoms of traumatic grief (appendix 1 lists the symptoms and scoring). (The symptoms of traumatic grief are derived from the Inventory of Complicated Grief. The name for these symptoms was changed from "complicated" to "traumatic" grief because we considered the latter to capture more precisely the two underlying dimensions of the syndrome, i.e., trauma and separation distress. We do consider traumatic grief to be one of several possible complications of bereavement, which also include major depression and anxiety disorders.) Her score of 49 on the Inventory of Complicated Grief placed her well above the cutoff score of 25—a threshold above which bereaved individuals have been shown to be at significantly greater risk for impairments in global functioning and at

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TABLE 1. Resolution of Traumatic Grief Symptoms Over 5 Months of Treatment for a Widow With an Attachment Disturbance

Time	Score on Inventory of Complicated Grief	Frequency of Traumatic Grief Symptom				
		Always	Often	Sometimes	Rarely	Never
Intake (month 0)	49	Can't accept the death Angry about the death Disbelief over the death Stunned over the death Mistrust of others since the death Bitter over the death Lonely since the death	Functionally impairing intrusive thoughts Upset by memories of the deceased Longing for the deceased Drawn to or searching for the deceased Life empty without the deceased	Detached from significant others Avoid reminders of the deceased Visual hallucinations of the deceased		Have pain in same area or same symptoms of the deceased[a] Auditory hallucinations of the deceased[a] Unfair that I should live[a] Envious of others who have not lost someone close[a]
Month 5	11			Can't accept the death Angry about the death Disbelief over the death Mistrust of others since the death	Upset by memories of the deceased Bitter over the death Lonely since the death	Functionally impairing intrusive thoughts Longing for the deceased Drawn to or searching for the deceased Life empty without the deceased Stunned over the death Detached from significant others Avoid reminders of the deceased Visual hallucinations of the deceased

[a]Unchanged after 5 months.

risk for impairments in social, mental, and physical health (2).

The patient's Inventory of Complicated Grief symptoms appear to contain components of both separation distress and traumatic distress. Her yearning and searching for her deceased husband, her inability to accept his death, her feelings of mistrust and bitterness as a result of the loss, and her severe feelings of emptiness and loneliness occasioned by her husband's death might be considered symptoms of separation, or attachment-related, distress. The traumatic distress symptoms included the PTSD-like symptoms of reexperiencing, avoidance, and numbness (DSM-IV). For example, her disbelief of and being stunned by her husband's death, functionally impairing intrusive thoughts about him, avoidance of reminders of him, feeling upset by memories of the loss and of her deceased husband, emotional numbness since the death, and upsetting visual hallucinations about her husband could be viewed as symptoms of traumatic distress. It is noteworthy that these traumatic distress symptoms were associated with a death that was not particularly sudden, horrific, abnormal, or unnatural (i.e., not objectively traumatic).

Although pathological variants of bereavement have long been recognized in the psychiatric literature (3–8), there exists considerable confusion over the precise nature of symptoms that constitute a pathological grief reaction. Many formulations of complicated bereavement reactions, such as that found in DSM-IV, focus almost exclusively on symptoms of depression (e.g., sad mood, psychomotor retardation, poor appetite). In several reports (2, 9–11) we have shown that traumatic grief symptoms form a dimension of bereavement-related distress that is distinct from symptoms of depression and anxiety. These reports also indicate that the symptoms of traumatic and separation distress form a single, unified symptom cluster.

CASE FIT WITH MODEL OF PATHWAYS TO TRAUMATIC GRIEF

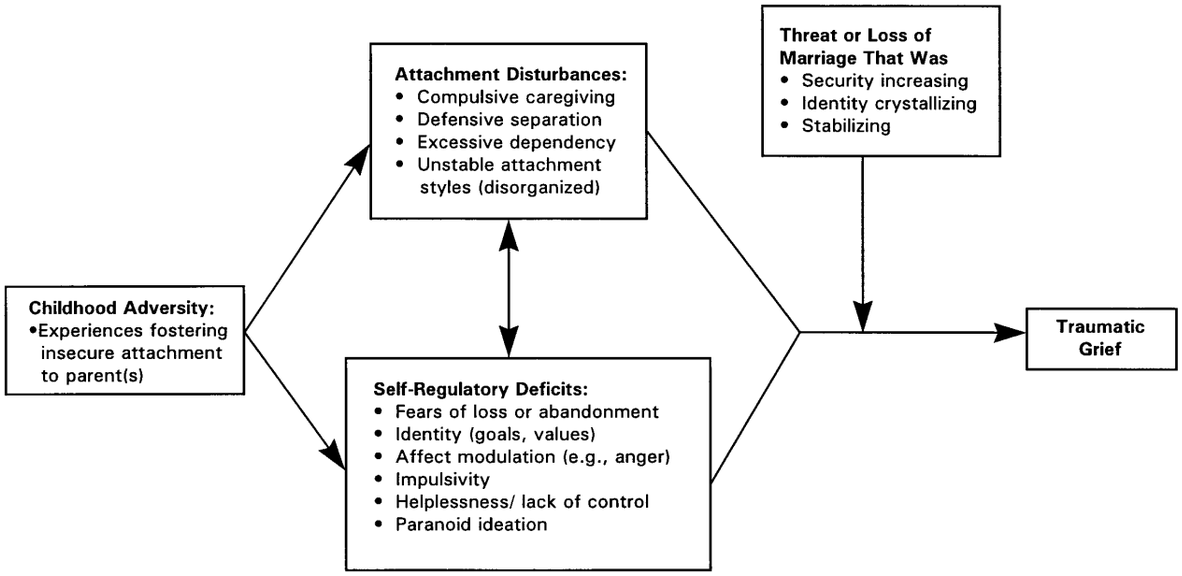
This case report is intended to illustrate the clinical features that we observe among approximately 20% of the bereaved subjects who participate in our research protocols, that is, the 20% who experience clinically significant levels of traumatic grief (2, 12). Aside from describing the distinctive symptom profile of traumatic grief, this report is intended to provide a prototypic case of a commonly observed pathway leading to traumatic grief. As will be discussed, this patient presents a set of vulnerabilities to traumatic grief, such as the experience of childhood adversity, lifelong patterns of insecure interpersonal attachments, and loss of a particularly important, self-defining relationship (figure 1). In addition, we will briefly describe a treatment approach that we have used for patients with this symptomatic presentation.

Early and Later Life Experiences With Adversity

In order to prepare this case report, the therapist (R.S.) administered a semistructured interview designed to assess experiences of early life adversity, the Childhood Experience of Care and Abuse interview (13). This instrument is a behaviorally based measure designed to evaluate childhood experiences from retrospective information obtained in adulthood. Core measures covered by the Childhood Experience of Care and Abuse interview include assessments of parental abuse, antipathy, and neglect.

The interview revealed three important experiences that left the patient with life-

FIGURE 1. Hypothesized Model of Pathway to Traumatic Grief for a Widow With an Attachment Disturbance



long worries about finances and an associated sense of underlying insecurity. First, the patient told of growing up in a situation in which her father had sired and was simultaneously supporting another family. Although she described having been shocked to learn in her mid-30s about her father's other family as a result of an inheritance settlement, she did recall long absences of her father and heated arguments between her father and mother during visits back to his hometown. She said that her parents were only "officially" married when she was 14 years old. Still, the patient believed that she had been unaware of this other family but had frequently sensed as a child that at times "something was drastically wrong." She said that when she tried to find out about the "deep dark secret that was being kept" from her and her sister, she was told by her parents to go to bed and not concern herself with their adult problems. The secrecy that surrounded her father's "other life" may have instilled in the patient a lack of trust in both her father and her mother (who knew of her husband's other family but withheld telling the patient about it specifically). The patient's feelings of persecution and distrust following her husband's death may well have had roots in her family's "conspiracy of silence" regarding her father's dual life, further compounded by the duplicity involved in her recent business dealings.

The second insult to the patient's sense of safety and worth occurred at the age of 9. As a result of inadequate financial resources, perhaps related to the burden of supporting two families, the patient's family moved from a "white collar" to a "blue collar" neighborhood. She remembered this move as humiliating and described feeling that she was disparaged by others because of it. The memory of this painful loss of status left the patient fearful of impoverishment and contributed to the sense of shame and embarrassment that followed her ruined business venture.

The third incident occurred at the age of 15, when the patient's father suffered a severe heart attack, from which he never recovered fully. According to the patient, life in her home from that point onward ceased to be the same. From the time of her father's heart attack until she left home, the atmosphere was filled with the fear that her father could die at any moment and leave her and her family destitute. This precarious situation clearly contributed to the patient's sense of insecurity.

Two relevant events occurred when the patient was an adult. The first of these events took place when she was 21. While pregnant with her second child, she experienced a serious automobile accident that she barely survived. The accident left her extremely anxious about the well-being of her unborn fetus, and her face was permanently scarred. Although she admitted to feeling extremely self-conscious about her facial scars still and could readily and vividly recall her anxiety-filled pregnancy, she never discussed the fears and concerns that stemmed from this accident until they emerged during the therapy for traumatic grief, in the context of discussions about the traumatizing, disfiguring aspects of her husband's death.

A second highly stressful event occurred when she was 41, when her husband had a heart bypass operation. She identified this as a point of marked change in her sense of security. Frightened of the prospect of losing her husband, she decided to begin a career that could sustain her family in the event of his death.

Adult Attachment Style and Self-Regulatory Deficits

Bowlby (6) hypothesized that individuals with certain attachment disturbances would be prone to "disordered mourning." The patient's reported attitudes toward relationships were consistent with the "defensively separated" style characterized by Bowlby (6, p. 212). Defensively separated individuals consider independence from others to be a central concern, and they vigorously attempt to avoid situations in which they would have to be cared for by someone. The devastation for this patient in response to being forced to "live off [her family's] charity" is an example of this attitude.

However, in spite of the patient's strong need for independence, she had clearly become quite dependent on (or more precisely, interdependent with) her husband. Her husband's death appeared to challenge her sense of independence in two ways: first, she was confronted directly with her dependence on him, and second, she lost an important basis for her feelings of independence. Her husband had actually provided the emotional and financial security that had enabled her to function as an otherwise independent "matriarch." She experienced the loss of her partner as a loss of a part of herself, saying "my old self is gone and I want my old self back." Her inability to grieve his death seemed related to her

fear that acknowledging his death would entail acknowledging the fact that her "old" secure self was largely based on her husband's ability to foster feelings of well-being in her. Put another way, acknowledging her loss would confront her with a side of herself that was weak and dependent, a perception that was loathsome to her. By avoiding her grief, she avoided acknowledging her own dependency but paid the price of unresolved grief. The difficulty this patient experienced with integrating feelings of dependency into a positive sense of herself became a major focus of treatment. Without her husband, the patient became unsure of her identity, became enraged by her feelings of dependency and helplessness, and suffered from a lost sense of safety and purpose.

In sharp contrast to her clinical presentation, in the context of a stable, interdependent relationship with her husband this patient had functioned very well. She had been a competent accountant and an available and giving mother. She had participated actively in her community, taking a leadership role in the formation of a politically active coalition. After her husband's death she felt an urgent need to assume more financial responsibility for herself and her family. The patient's use of nearly all of her inheritance to undertake a business venture in a distant city removed from friends and family could be considered a somewhat impulsive response to her urgent need to convince herself that she was financially and emotionally strong and independent. Following the loss of her business, this crucial self-defining image collapsed and she suddenly saw herself as a disgraced, helpless, weak, and useless person. She believed herself unable to give anything of value to those whom she loved, although, in fact, she continued to give generously of herself. For example, she deprecated an album of family memories that she had painstakingly prepared for her family as a Christmas gift. Her family warmly and enthusiastically received this gift, but she described feeling ashamed by "how little" (i.e., monetarily) she was able to give them. She was enraged by her financial impoverishment and alternately blamed her widowhood, duplicitous business colleagues, and herself for her present condition. She stated that she was living in constant fear that she would reveal information that would be used against her in a pending lawsuit—fears that made her extremely suspicious and that had become central to her way of living and experiencing the world.

Qualities of Lost Relationship

This raises a related area of interest, the nature of the antecedent relationship to the deceased. Characteristics of this relationship appear to be critical to understanding the traumatizing nature of the loss (3, 6, 7). According to Freud (3), pathological responses to bereavement could be attributed to the presence of an ambivalent, narcissistic relationship to the deceased. While the patient's antecedent relationship to her husband might be conceptualized as a narcissistic self-object attachment (see following discussion), preliminary evidence does not support Freud's contention that ambivalent or conflictual marriages result in traumatic grief reactions. Our repeated observation with traumatic grief patients suggests an alternative pattern. This patient, along with the other traumatic grief patients who have participated in our research protocols, described her marriage as having been loving and nonconflictual with a high degree of mutual positive regard, although sometimes suggestive of a symbiotic connection between the two partners.

More specifically, the patient described to the therapist a relationship with her husband that could be characterized as identity-crystalizing and security-increasing. She depicted her relationship with her husband as having been one of extreme interdependence. She remarked that she had met him when they both were 14 years old and that they had "grown up together like vines that were intertwined." The husband appeared to foster in the patient a sense of safety, stability, and security, as well as a sense of her own identity and purpose. Perhaps, having failed to internalize a stable sense of self early in life, this patient had compensated by incorporating into herself aspects of an external relationship. As long as this relationship was in place, her inner vulnerability was protected. However, in this situation, the loss of her spouse left her feeling stunned and incomplete, lacking a clear sense of her own identity, what she could accomplish, whom she could trust, and essentially, how she could survive.

We have observed that symptoms of traumatic grief are frequent in individuals like this patient, who have lost someone who played a crucially identity-defining role in their lives. Her husband's death appeared to have removed a part of herself, leaving her with a sense of painful insecurity, hopelessness, and self-doubt. The experience of this death as a catastrophic loss or abandonment shook the patient's faith in the constancy of relationships and was experienced as a personal disaster. Thus, as a result of her husband's death, in a manner similar to posttraumatic stress reactions, the patient's fundamentally benign view of the world was shattered, her sense of self and feelings of safety were lost, and her hopes for a rewarding and meaningful future were dashed.

Psychoanalysts have described similar patterns of object relations in such patients. Applying this perspective to bereavement, Horowitz et al. (7) proposed that the loss of a compensatory spouse might re-evoke early attachment conflicts and deprive widowed individuals of the person who made them feel worthy, capable, and lovable. He and his colleagues concluded that among their patients with pathological grief the deceased was a "supplier and stabilizer of the strength of the self. With recognition of the death, the patient's self-image shifted back, from that of a strong person well sustained by the relationship with a strong other to the preexisting structure of a weak, helpless waif supplicating in vain for rescue by a lost or abandoning person" (7, p. 1160). In this way, the loss appears to re-evoke the early conflicted self-object constellations and to create a need to find a substitute source for feelings of self-worth. The patient's impulsive purchase of a business franchise was an unsuccessful attempt to meet this need. As we will describe, a better solution may have been the establishment of a secure relationship with the therapist—as always, a critical dimension of treatment. However, attachment to her therapist may ultimately presage problems once termination looms near.

Summary

This patient described several childhood and adult experiences that appear to have instilled in her a predisposition for anxious, insecure attachments to others. More specifically, the patient's insecure attachment style could be characterized as defensively separated. This attachment style may have been quite adaptive in the context of a longstanding interdependent, or symbiotic, marital relationship. Upon the loss of

this relationship, however, she was confronted with frightening feelings of dependency. She was unable to grieve and instead tried to recreate the lost sense of stability through an ambitious financial venture. When her business dealings soured, this exacerbated her feelings of vulnerability and victimization, and her sense of self was deeply eroded. Self-regulatory deficits emerged, such as fear of loss, unstable goals and identity, rage, feelings of helplessness and persecution, and suspiciousness, leaving her highly symptomatic and significantly disabled.

COURSE OF TREATMENT

Tricyclic antidepressants have proven relatively ineffective for reducing some PTSD symptoms (14–16), such as those of avoidance, and symptoms of grief (17, 18). By contrast, preliminary evidence has shown selective serotonin reuptake inhibitors (SSRIs) to effectively reduce symptoms of PTSD, namely, intrusion and avoidance (19–21). For this reason, we considered an SSRI (paroxetine) to offer promise for the resolution of traumatic grief symptoms.

The patient began treatment with a 10-mg daily dose of paroxetine. On day 8 her dose was increased to 20 mg/day, and it was maintained at that level for the next 4 weeks. The patient's dose was increased to 30 mg/day at the start of week 6 and was maintained at that level for the next 4 weeks. The patient received 40 mg/day of paroxetine for the remaining 9 weeks of treatment.

In addition to paroxetine, the patient participated in weekly psychotherapy sessions as part of a treatment development project targeting symptoms of traumatic grief. The treatment began with a psychoeducational component in which symptoms on the Inventory of Complicated Grief (2) were reviewed with the patient and explained to her. As part of traumatic grief therapy, the patient was told that these symptoms, like those of depression, can be very debilitating and cause substantial suffering. She was told that we consider the symptoms of traumatic grief to be similar to those of posttraumatic stress experienced by some people following a life-threatening trauma. For example, the patient's intrusive thoughts and images of her deceased husband, her tendency to avoid people and things that reminded her of him, a general mistrust and sense of emotional detachment from others since his death, feelings of helplessness, anger, and disbelief over his death—all are symptoms that traumatic grief and PTSD have in common.

We consider a traumatic loss to be one that disrupts a person's sense of safety and control and causes the loss of a sense of identity and purpose. Treatment focused initially on the clear identification of the patient's traumatic grief symptoms and the labeling of them as "illness" in order to provide the patient with some relief of a sense of guilt and self-blame for difficulties in functioning. The therapist then helped the patient to confront her loss and experience her grief. This entailed identifying and processing a range of emotional reactions, including why the patient felt like the death of her husband felt like a personal disaster for her. Principles of experiential and psychodynamic therapy were used to facilitate the emotional processing component of the therapy.

More specifically, unrecognized and/or unmanageable painful emotions—such as the patient's anger at her deceased husband for leaving her and at herself for not having been able to prevent his death, feelings of being devalued in the job market by her age and gender, feelings of distrust and persecution triggered by an unsuccessful business venture, guilt about her inability to be self-sufficient, shame about her current circumstances—were identified. Each of these reactions was considered to have underpinnings in the patient's preexisting patterns of thinking and functioning and to be related in an important way to her shame and contempt for dependency. An attempt was then made to relate the patient's emotional reactions to the meaning of the loss in the overall context of her life, and possible reasons for the death's traumatic impact were explored with her—for example, reactivation of an earlier fear of losing her father; feelings of distrust that may have emerged from her relationship with her parents and have been compounded by her recent business experiences and the current job market; feelings of being damaged or ashamed of her situation, much like the sense of being stigmatized as a child when her family moved to a lower-status neighborhood, and of the facial scars left by her earlier automobile accident.

The therapist's work then targeted maladaptive thinking patterns that underlay her fear of loss and feelings of rage, shame, worthlessness, and guilt. Attention was paid to her current life functioning and to the correction of behaviors that impaired her functioning. For example, the therapist worked with the patient to cognitively restructure her self-defeating view of herself as a victim who had been robbed of her husband, business, livelihood, and, more generally, her sense of safety, dignity, and trust. Several identity issues were discussed. Together, the patient and therapist explored her personal stake in being the all-providing matriarch of her family, in order to lessen the degree to which her identity was invested in success at that role. The patient was encouraged to accept the reality that she would not be able to return to a time before her recent misfortunes had befallen her. At the same time, the therapist worked to rebuild the patient's self-confidence and sense of self-control, focusing on the very real value of her strengths and accomplishments beyond her monetary assets. The discussion also covered behavioral changes that would support an improved sense of self-efficacy and more satisfying interpersonal relationships (e.g., increased involvement with her family within the means available to her).

Last, treatment also included an exposure strategy similar to that described by Foa et al. (22) for patients suffering from PTSD. The details of the experience of the death and dying of her husband were reviewed repeatedly during several sessions. The emotionally difficult elements of the death were discussed, as the patient reviewed with the therapist the various reasons why his death was especially painful and devastating for her. The meaning of this death in the context of earlier losses and traumas was again discussed. Being able to talk about her husband's illness and death and drawing connections between past experiences and her reactions to her husband's death and her current symptoms provided her with an increased sense of control.

After 5 months of combination treatment with medication and psychotherapy, the patient had experienced a 78% reduction in symptoms of traumatic grief (i.e., her score on the Inventory of Complicated Grief decreased from 49 at intake to 11 almost 5 months later) (table 1) and a 47% reduction in symptoms of depression (her score on the Hamilton Depression Rating Scale score decreased from 17 at intake to 9 almost 5 months later).

Many of the patient's symptoms diminished (table 1). It is interesting that the inability to accept her husband's death, anger and disbelief about his death, and mistrust of others since his death seemed to be the most resistant to treatment, although these symptoms declined from being experienced "always" to "sometimes." It is noteworthy that the patient had received a prior course of an SSRI medication (sertraline) and an unspecified psychotherapy. However, after this prior treatment she had remained symptomatic. We believe that the specific focus of the psychotherapy on the experience of the traumatic loss may be a necessary component of efficacious treatment for this syndrome.

We also wish to acknowledge that the patient's improvement may have been related to the nature of the relationship that she formed with her therapist. In other words, the patient's corrective attachment to the therapist may have fulfilled many of the functions that the relationship with her husband had previously. At the time of this writing, the patient is still receiving treatment because of unresolved legal matters that often trigger fears of victimization and dependency. Because

the patient-therapist relationship in and of itself may be therapeutic, especially in light of the patient's dire need for a security-increasing relationship, the patient may experience an inordinate amount of difficulty upon the termination of treatment.

CONCLUSIONS

We have presented the case of a woman whose reaction to the loss of her husband involved symptoms of trauma, as well as grief. In addition to the case material that describes clinical features associated with traumatic grief, we have also illustrated how the administration of a brief questionnaire can provide a useful way of understanding the nature of the patient's illness and documenting improvements in symptoms. The combined therapy did appear efficacious for resolving the patient's symptoms of traumatic grief. Nevertheless, in the absence of a controlled clinical trial, we cannot be certain which parts of this intervention were most helpful in reducing her distress. Nor can we be certain how long-lasting or generalizable the effects of this treatment will be.

The patient's case was shown to fit well with a model hypothesizing that the loss of a security-increasing partner for an individual with insecure, anxious attachments and self-regulatory deficits could result in symptoms of traumatic grief. Future research is planned to examine systematically the ways in which insecure attachments and the loss of a compensatory spouse together create a situation that puts bereaved individuals at heightened risk for the experience of traumatic grief. We believe that inclusion of a role for attachment disturbance in the experience of psychic trauma advances our understanding of traumatic grief and points to an important focus for future intervention.

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APPENDIX 1. Inventory of Complicated Grief[a,b]

PLEASE fill in the circle next to the answer which best describes how you feel right now:

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

[a]Scoring is as follows: never (less than once a month) = 0; rarely (once a month or more, less than once a week) = 1; sometimes (once a week or more, less than once a day) = 2; often (once every day) = 3; always (more than once a day) = 4.
[b]Reprinted with permission from *Psychiatry Research* (2, p. 79).