MORBID GRIEF—ITS CLINICAL MANIFESTATION AND PROPOSED CLASSIFICATION

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Grief as a reaction to the loss of a loved object is a common and clearly recognised phenomenon, and all cultures have evolved their own methods of coping with it. However, because of its specific causation, and its generally transient, self-limiting nature it seldom comes to the notice of the psychiatrist and is therefore often dismissed as a normal condition rather than a mental disorder. By analogy, a bruise or burn does not cease to be pathological simply because it is a normal reaction to injury and is generally treated at home (Engel, 1961). Further, just as a wound may become infected, so also some persons may manifest a morbid or pathological grief reaction.

Lindemann (1914) was the first to describe the symptomatology of normal grief, and he also described certain morbid grief reactions. A more detailed description of the symptoms of normal grief has been provided by Marris (1958, and Parkes (1965, 1972). Bowlby (1961, 1969) has described the process of grief and mourning in childhood as occurring in three stages; viz. protest, despair, and detachment-this sequence being common to all forms of mourning. Greenblatt (1978) suggests that in adults, the reaction to bereavement varies with the closeness of the relationship with the deceased, and apart from its specific content is characterised by (a) an initial period of shock, numbness or denial lasting from a few hours to a few days. Parkes (1965) estimates the upper limit for this as two weeks. (b) Thereafter, attacks of yearning and distress with a preoccupation with the image of the deceased person begins. Mood is sad with feelings of hopelessness and often anger directed either against others or the self. Somatic symptoms are often prominent. Although no clear limits can be placed, these symptoms generally tend to decline after approximately four to six weeks. (c) In the third phase, there is a progressive resolution and detachment from the image of the deceased and a finding of new outside interests and activities. This is generally completed by the sixth month, which is taken as an arbitrary upper limit for the normal grief reaction. (d) The emancipation from the loved one and readjustment to a new environment—the final goal of identity reconstruction may take several years.

Clayton et al. (1968, 1972) in a study of widows and widowers, reported that approximately a third of the bereaved subjects experience symptoms similar to those of a psychiatric depressed patient. Maddison and Walker (1967) also compared a group of twenty bad outcome with twenty good outcome widows in an effort to find out why most persons grieve “normally” and a few “abnormally”; and concluded that in general the bad outcome widows felt a lack of support from persons in their surroundings. The term “abnormal” or “morbid” grief reaction has since been used so loosely by different authors that Weisman (1975) suggests that a morbid grief reaction should be diagnosed only under the

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following conditions: (a) arrest of the normal process in which the patient has persistent symptoms without evidence of recovery, (b) an exaggeration of the normal symptoms, and (c) presence of deviant behaviour that violates conventional expectations. Parkes (1965) also observed that in cases of morbid grief, while none of the typical features of grief was permanently absent, these features might be prolonged or delayed, or particular aspects exaggerated.

Finally, if we consider bereavement as a non-specific stress, then apart from the general grief reaction, we would also expect to observe certain other responses—specific for each individual. In fact, a variety of reactions ranging from psycho-somatic disorders to neurotic and even psychotic breakdowns have been reported in the literature (Hollender and Goldin, 1978). Apparently, the total individual response is determined not only by the nature of the loss but also the personality of the bereaved and the cultural beliefs and practices of his community. It was therefore decided to study in detail the patterns and types of symptoms of subjects suffering from morbid grief after a bereavement in the Indian population.

MATERIAL AND METHODS

The study was carried out at the psychiatric unit of Rajwha Hospital, Patiala during 1977-78. All those subjects whose presenting complaints had started immediately after, and related to the death of some one close to the patient were taken up for the study. Patients with grief reaction to other forms of loss or the anticipation or threat of loss have not been included. A detailed psychiatric history and mental state examination was done on each patient, who were then clinically rated on the presence and severity of the symptoms listed in the “morbid grief scale” (Musaph, 1973). Only those patients rated as severely affected on one or more of these indicators and whose symptoms had persisted more than six months after the bereavement (which has been taken as the arbitrary upper limit for the normal grief reaction) were finally included in the study. Any other symptoms of behavioural manifestations obtained from the history or during clinical examination were noted, and where appropriate an additional diagnosis of a neurotic or psychotic illness was made.

OBSERVATIONS AND RESULTS

Out of a total of fifty-two consecutive patients suffering from grief reactions, only 44 patients—14 males and 30 females—fulfilled the inclusion criteria for diagnosis of morbid grief. Their age and sex distribution are shown in Table I. It is evident that there are more than twice the number of women as men in the sample, and a majority of the subjects (70.5%) were in the age range of 21-40 years. Whereas, there are more females in the 31 to 40 age group (46.6%), more males were in the earlier age group of 21 to 30 years (42.8%). The slightly higher average age of women is probably due to the fact that many of these grief reactions were related to the death of the husband in his fifth or sixth decade, whereas in men it was more often related to the loss of a parent.

In all cases without exception, it was reported that the bereaved person had been...

| Age in years | Males (N=14) | Females (N=30) | Total (N=44) |
|--------------|--------------|----------------|--------------|
|              | N %          | N %            | N %          |
| 11-20        | 2 14.3       | 1 3.3          | 3 6.8        |
| 21-30        | 6 42.8       | 8 26.6         | 14 31.8      |
| 31-40        | 3 21.4       | 14 46.6        | 17 38.7      |
| 41-50        | 3 21.4       | 3 10.0         | 6 13.6       |
| 51-60        | 0 0          | 4 13.3         | 4 9.1        |
very closely associated with and strongly attached to the deceased person. The exact nature of the relationship is given in Table II. It will be observed that morbid grief reactions were most common after the loss of a parent—in over a third of all cases (34.1%), and more after loss of father (11 cases) as compared to loss of the mother (4 cases). The second commonest cause was the death of a child in 10 cases (22.7%)—here again loss of a son was more frequent than loss of a daughter. In both these relationships women are twice as prone to develop morbid grief reactions as men. Contrary to expectations from the western literature, the death of a spouse comes third in order of frequency (20.5%) as a cause of morbid grief in the present series. Furthermore, it seems to occur almost entirely among women only (8 cases) as against only one male who developed a morbid grief reaction to the loss of his wife. There were 3 cases (6.8%) where a morbid grief reaction occurred following the death of a paternal uncle—in two cases the patient was living in a joint family and had been very much attached to his uncle, while in the third case the child had been brought up by this uncle as his own child; thus in all three cases the uncle was in reality a father figure to the patient. The loss of a sibling was present in 7 cases (15.9%) and its incidence is equal among the two sexes.

Thus the loss of a parent or parent substitute as a cause of morbid grief is found to be nearly twice as common as the loss of a spouse or a child. The loss a wife does not seem to cause much distress as to lead to morbid grief, probably because of the accepted practice of early remarriage by the widower, unlike in the case of a woman who is not normally permitted to remarry.

**CLINICAL PRESENTATION**

Of the total of 44 cases, the largest number (19) present with symptoms—both somatic and psychic, of a persistent, severe grief reaction clinically indistinguishable from a depressive neurosis (Table III).

**TABLE II—Showing nature of relationship with deceased**

| Relationship   | Males (N=14) | Females (N=30) | Total (N=44) |
|----------------|--------------|----------------|--------------|
| Parents        |              |                |              |
| Father         | 5            | 6              | 11 (34.1%)   |
| Mother         | 0            | 4              | 4 (15.9%)    |
| Siblings       |              |                |              |
| Brother        | 3            | 3              | 6 (15.9%)    |
| Sister         | 3            | 1              | 4 (15.9%)    |
| Children       |              |                |              |
| Son            | 3            | 3              | 6 (15.9%)    |
| Daughter       | 1            | 8              | 9 (20.5%)    |
| Spouse         | 1            | 2              | 3 (6.8%)     |

Fifteen of these 19 cases were females and 4 males, suggesting a greater tendency for prolonged grief reactions among females. Disturbed sleep was a very common complaint, but a clear history of nightmares or waking up with recurrent bad dreams was available in only three subjects. Attacks

**TABLE III—Clinical manifestations of morbid grief**

| Symptom                  | Males (N=14) | Female (N=30) | Total (N=44) |
|--------------------------|--------------|---------------|--------------|
| Chronic grief            | 4            | 15            | 19           |
| Delayed onset of grief   | 1            | 1             | 2            |
| Excessive anxiety         |              |               |              |
| a) Nightmares            | 2            | 3             | 5            |
| b) Panic attacks         | 1            | 1             | 2            |
| Excessive guilt           | 0            | 2             | 2            |
| Excessive anger           | 2            | 2             | 4            |
| Identification with the deceased | 1 | 3 | 4 |
| Overidealization         | 1            | 1             | 2            |
| Anniversary reactions     | 0            | 1             | 1            |
| Excessive religious pre-occupation | 1 | 2 | 3 |
| Denial of death          | 2            | 0             | 2            |
of acute anxiety with feelings of suffocation and palpitation were present in two cases. Both these symptoms are apparently different manifestations of anxiety, and hence have been clubbed together as expressions of "excessive" anxiety.

Identification with the deceased was the next most frequent manifestation—in 4 cases, 1 male and 3 females. Under this head we have included both (a) those showing identification with the symptoms present during the last illness of the deceased (3 cases), as well as (b) one person who showed a clear identification with the personality characteristics or traits of the deceased. Marked hostility and anger directed at doctors and/or relatives was seen in four cases. Feelings of excessive guilt and self-blame were evident in 2 persons, and a marked tendency to overidealisation e.g., describing the dead person as a "saint" was seen in a further 2 cases. There was one case of a typical anniversary reaction in our series.

There were two additional symptoms manifested in our series which have not been previously reported in the literature. The first is a tendency to become excessively religious, with constant praying and frequent visits to the temple or gurudwara—2 cases, and in one case accompanied by constant rationalisations concerning the death of the beloved person; such as, "it was the will of God," or "He wanted to have his loved child back with him" and discussing the inevitability of death etc. This occurring in a person who was not previously reported to be overtly religious. This we have referred to as excessive religiosity (total of 3 cases). The second was a dramatic and gross use of denial as a defence mechanism in two subjects—both males. In these cases even when confronted with last illness and death of the loved person, the patient continued to insist that the evidence concerning the deceased was still alive and well and would return shortly. This we have labelled as denial of death.

Although most patients presented with more than one symptom, they have been categorised according to the most prominent symptom displayed.

Apart from manifesting one or more of the symptoms of a grief reaction as described above, there were fifteen patients who showed in addition, certain neurotic or psychotic symptoms. The commonest clinical manifestation in this group was the occurrence of hysterical "fits" in 7 cases—all females. This was followed by three patients showing features of an obsessive-compulsive neurosis. Two of these developed marked hand washing or other ritualistic behaviours, and in one case there was a constant obsessive rumination of death, about the illness of the deceased person and a fear of contamination. There were three cases (two males and one female) who showed marked joviality, cheerfulness, overtalkativeness and overactivity following the death of the beloved person clinically diagnosed as a manic episode. There was one patient who developed typical phobic symptoms, including fear of being alone, a fear of darkness, as well as a phobic avoidance of crowds and especially funeral processions and cremation grounds. Finally, there was one patient who manifested grossly disturbed psychotic behaviour, such as inappropriate laughing and crying, shouting, expressing persecutory ideas and auditory and visual hallucinations along with a neglect of personal hygiene or normal

| Symptoms       | Males (N=4) | Females (N=11) | Total (N=15) |
|----------------|-------------|----------------|--------------|
| Hysterical     | 0           | 7              | 7            |
| Obsessive compu-| 1           | 2              | 3            |
| sive           |             |                |              |
| Phobic         | 1           | 0              | 1            |
| Manic          | 2           | 1              | 3            |
| Acute psychosis| 0           | 1              | 1            |
eating. She was clinically labelled as suffering from an acute psychotic episode. Such non-specific psychoses have previously been reported by Parkes (1955) in two of his series of thirty-five cases. These various neurotic and psychotic pictures are seen as manifestations of "complicated" grief reactions (See Table IV).

DISCUSSION

Early in the course of the study it became evident that a majority of subjects coming to the psychiatric clinic following a bereavement were suffering from a morbid grief reaction (44 out of 52), while only eight subjects were thought to be suffering from a normal grief reaction. The differentiating feature being the presence of certain of the manifestations of normal grief in an extremely exaggerated form, or a prolongation of the reaction beyond a period of six months. A look at the presenting picture of these 44 cases suggested a clear subdivision into two further categories of "morbid" grief reactions.

A. Those who presented primarily with one or more of the normal symptoms of grief, though in a highly exaggerated form. These we will refer to as "pathological" grief reactions, as listed in Table III.

B. Those who presented with idiosyncratic symptoms of a neurotic or psychotic illness in addition to the other manifestations of grief. These we will refer to as "complicated" grief reactions, as listed in Table IV.

There are interesting sex differences in the frequency of occurrence of certain manifestations both in the pathological grief and complicated grief reactions. Females predominate over males in the total sample of morbid grief reactions (30:14). Parkes (1965) also reported an excess of females over males. This difference holds true for the group of pathological grief reactions (30 females to 14 males) as well as to the complicated grief reactions (11 females to 4 males). As regards the frequency of specific symptoms in the two sexes, it is seen that chronic grief if extremely common among females (15 out of 30) as compared to only 4 out of 14 males. This is consistent with the findings of Parkes (1965) who reported this symptom in 17 females as compared to only 4 males. The only other symptom that is seen more frequently in females is the tendency for identification with the deceased (3 females and one male). In the present series the symptom of excessive guilt and self blame (two patients), and the anniversary reaction (one patient) were seen only among females. The symptom of increased religiosity and preoccupation with religious observances and rituals was seen in two cases—both women, whereas the tendency for indulging in philosophical and religious rationalisation was seen in one case (male). These differences can be readily understood on the basis of the generally passive and dependent role of women in the Indian society, and their greater involvement in the day to day religious practices. On the other hand, the only symptom that was seen more frequently in men as compared to women was the total denial of death of the deceased relative (both males).

In the group of complicated grief reactions also we find a sex difference for specific manifestations e.g. hysterical symptoms were seen only among women, whereas the hypomanic behaviour was seen more often in males as compared to females.

The morbid grief scale (Musaph, 1973; Lieberman, 1978) based as it is on the list of symptoms reported by previous workers including Lindemann, Bowlby, Parkes and others from western countries was not found very useful except as a screening device. There is a degree of overlap in some of the items, and is obviously incomplete—two more items having been added by the present study, and further items may be added by future workers. Furthermore,
it includes phobic and other neurotic or psychotic manifestations along with the symptoms of normal grief. We have suggested that these be kept separately as an idiosyncratic response of the individual to the stress of bereavement. We therefore suggest the following classification of grief reactions.

PROPOSED CLASSIFICATION OF GRIEF REACTIONS

I. **Normal Grief Reaction**
   A self-limiting disorder with a typical symptomatology, and spontaneous recovery within six months.

II. **Morbid or Pathological Grief Reactions**
   Manifested by an exaggeration of one or more of the symptoms of the normal grief reaction, or prolonged duration of the symptoms beyond six months with no evidence of spontaneous recovery. These can be further subdivided according to the most prominent manifestation as follows:
   1. **Chronic grief.** Depressive symptoms persisting beyond six months.
   2. **Delayed Grief.** The initial period of numbness is prolonged so that the onset of the typical grief reaction is delayed beyond the normal two weeks.
   3. **Inhibited grief.** A gross denial of the loss with superficial cheerfulness and normal social activity.
   4. **Excessive Anxiety.** Manifesting as persistent anxiety and nervousness, or acute panic attacks, and/or sleep disturbance with nightmares.
   5. **Excessive Guilt.** A marked tendency for self-blame and guilt in relation to the behavior of the subject to the deceased during his life or in his terminal illness and death.
   6. **Excessive Anger.** Extreme and often inappropriate anger is expressed either towards others or the self.
   7. **Excessive religiosity.** A preoccupation with religious rituals and prayers, or the use of religious-philosophical concepts for rationalization of the loss.
   8. **Identification with the deceased.** An attempt at revival of the image of the deceased either by identification with his personal characteristics, or the symptoms of the deceased during his last illness.
   9. **Over-idealization.** There is excessive tendency to idealize and attribute certain qualities to the deceased.
   10. **Anniversary Reactions.** A grief reaction that occurs subsequently at the time of the death anniversary.

III. **Complicated Grief Reactions**
   Those subjects showing a specific neurotic or psychotic illness in addition to symptoms of the grief reaction (whether normal or pathological). It is further sub-divided according to the clinical picture:
   1. **Hysterical**
   2. **Phobic**
   3. **Obsessive-compulsive**
   4. **Manic**
   5. **Acute psychotic episode.**

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