World ▮ Cultural ▮ Psychiatry ▮ Research ▮ Review
OFFICIAL JOURNAL OF
WORLD ASSOCIATION OF CULTURAL PSYCHIATRY

Case Report

Culture and complicated grief

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Abstract. *Grief is a universal phenomenon with cultural variations in mourning practices. Grief can occasionally be prolonged or intense and is referred to as complicated grief. This can result in increased morbidity and mortality and may persist if untreated. Complicated grief is distinct from other disorders including Depressive Disorders or Post Traumatic Stress Disorder with respect to its risk factors, clinical correlates, course and outcome. We report a patient who presented with a culture specific dissociative symptom as a manifestation of complicated grief process. Our report, therefore, highlights the role of culture in complicated grief.*

Keywords: Culture, Grief, Complicated, Dissociation, Possession.

WCPRR December 2010: 99-101. **© 2010 WACP**
ISSN: 1932-6270

INTRODUCTION The patient described in this case was a 22 year old single female, an engineering student from a semi-urban background. She was depicted as a sensitive individual premorbidly with dependent personality traits. She did not have any past psychiatric or medical history. Her elder sister was receiving psychological treatment from our team for unconsummated marriage. There was no other significant family history.

She was brought to us with a four month history of episodes of unresponsiveness. The first episode had occurred when the patient was attending classes. She fell forward on the desk and did not respond for the next five minutes. She did not have any loss of consciousness, tonic clonic movements of the limbs, tongue bite or urinary incontinence. She was taken to a doctor who prescribed hematinics after ruling out organic causes for her symptoms. She did not have symptoms for the next three months, following which she developed three similar episodes on the same day. She was admitted in a local hospital for ten days during which she continued to be symptomatic and hence was brought to our team.

Interview with the patient revealed a two year history of sadness of mood following the death of her elder brother in a road traffic accident two years before. Patient had had a very close relationship with her brother, whom she considered her role model. She would ask his advice before making even minor decisions. After his death, the patient has felt guilty for not having done enough to prevent the accident. She also gave history of intrusive thoughts about her brother's death and yearning for him.

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Received July 23rd, 2010. Accepted August 11th, 2010.

She began to distance herself from other family members, even though she felt lonely. She would accuse them of not caring for her the way her brother had. She was attending college regularly but could not concentrate on her studies. Her biological functions were disturbed. The dissociative symptoms had started soon after the completion of religious rituals that the family had performed for the deceased on the second death anniversary.

On mental status examination, patient had intact higher mental functions. On suggestion by the examiner patient fell backward in the chair. She recovered on her own after five minutes and started interacting normally. She did not have any suicidal ideas or psychotic symptoms. Diagnoses of Prolonged Grief and Dissociative Disorder were made. She was allowed to ventilate her distress regarding her brother's death, and advised to follow up after one week.

During the next visit relatives reported that patient subsequently had had a possession attack where she had taken on her dead brother's identity. She was noticed to be staring intently at her brother's photograph following which she had taken on her dead brother's identity and spoken as though she were her dead brother. During the possession attack, she had advised her eldest sister to engage in sexual relationship with her husband. She had also given advice to her cousins regarding their interpersonal problems. This lasted five minutes following which the patient ran towards her brother's grave saying that she was going to die and had to be forcefully brought home. During the interview patient claimed amnesia for the episode. Symptoms of prolonged grief persisted. Patient and family were educated about the nature of illness and advised regular psychotherapy.

DISCUSSION The term *grief* describes the emotional, cognitive, functional and behavioral responses to death (Zisook *et al*, 2009). It is a universal experience which leads to increased morbidity and mortality. There are variations in people's response to death, process of mourning and internalization of the lost object (Hagman, 1995). Cultural factors play an important role in the grief process. Mourning is typically more elaborate in Eastern cultures than in Western cultures (Mitchell & House, 2000).

The term *complicated grief* refers to a unique pattern of symptoms that are slow to resolve and can persist for years (Lichtenthal *et al*, 2004). It encompasses chronic or prolonged grief, inhibited or absent grief, delayed grief and hypertrophic grief. Complicated grief is found to have serious consequences on the survivor's emotional and physical health (Brown & Stoudemire, 1983). Criteria proposed for chronic grief include the experience of yearning and five of nine other disabling symptoms such as feeling emotionally numb, stunned or that life is meaningless; experiencing mistrust; bitterness over the loss; difficulty accepting the loss; identity confusion; avoidance of the reality of the loss; or difficulty moving on with life at least six months from the death (Prigerson *et al*, 2009). The nature of the relationship with the deceased is an important predisposing factor for complicated grief. An especially close, identity defining relationship is always seen in complicated grief (Zisook, 2009). Other crucial factors include insufficient integration of the loss into the autobiographical knowledge base, negative global beliefs and anxious and depressive avoidance strategies (Boelen *et al*, 2006). It is found to be distinct from usual grief, major depression and other DSM-IV diagnostic entities (Shear & Shair, 2005). Therefore it has been proposed that complicated grief deserves a place in future diagnostic systems.

Grief is a known precipitant of dissociative states. Dissociative possession attack is a common dissociative disorder seen in the Indian population with a female preponderance whereas dissociative identity is rarely diagnosed (Chaturvedi *et al*, 2009). This has been attributed to the greater socio-centric organization of culture in the East as opposed to the West, whereby the problem takes the form of an intruding outside entity and not an internal identity as in the West (Spiegel & Maldonado, 1999). Psychiatric consultation is more likely to be sought in South Asian cultures if the possessing entity is

not a supernatural being but rather a human. Spirit possession in India and dissociative identity disorder in North America are both considered as *Trance-related disorders* (Castillo, 1994).

Our patient presented with dissociative stupor followed by dissociative possession attacks. History and mental status revealed prolonged grief symptoms persisting for two years after the death of her brother with whom she had had an especially close relationship. Clinical attention was sought only after the onset of dissociative symptoms. Culture plays an important role in almost all mental disorders. Though grief is a universal phenomenon, cultural variations are seen in the normal grieving process. Our patient presented with a culture-specific dissociative symptom as part of complicated grief. Our case report highlights the role of culture in complicated grief.

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