Lesson of the Week

Life threatening symptoms due to morbid grief

STUART LIEBERMAN

Psychiatric illness is a known hazard after a bereavement. Though bereavement counselling is effective in preventing morbidity, patients with morbid grief reactions are more difficult to treat, and the doctor needs to be skilled in confrontative and cathartic techniques.[1]

I report on a patient who was both bereaved and became seriously ill as a result of that bereavement. To my knowledge this is the first report of a case of morbid grief in which the symptoms were life threatening.

Morbid grief may develop and become life threatening if bereavement is concealed from a patient and not discussed soon after the loss

Case report

A 19 year old woman sustained multiple compound fractures in a road traffic accident in which the driver, her fiancé, was killed. The news of his death was kept from her for a month while she recovered from her injuries. Finally, a student nurse was asked to tell her. She accepted the news without reaction initially, but the next day her need for pain relief was increased and she became highly emotional, required sleeping tablets, and stopped eating regularly. Her physical condition deteriorated rapidly. She developed unexpected abscesses, a sequestrum had to be removed, and pressure sores developed on her buttocks and heels. In view of her serious physical condition the liaison psychiatrist was asked to see her.

She had no psychiatric history, and a diagnosis of morbid grief was confirmed. She spoke as if her fiancé was alive but would not look at his photograph. She avoided all thought of him and believed her life was over. At the next interview she was given a general explanation of the effects of loss and its consequences. She tearfully explained, "It's all bottled up inside me." At subsequent sessions we explored her life with, and feelings about, her fiancé. A turning point came when she brought out pictures of her fiancé and sobbed for most of the session. Afterwards her appetite and sleep pattern improved rapidly, her pain tolerance increased, and within a week drainage from her wound slowed and then stopped. She made an uneventful recovery thereafter.

Comment

Bereavement which occurs at the same time as a physical illness must be recognised and handled with sensitivity. If the loss is ignored or the patient not soon told of the loss, as in this case, morbidity is more likely. Especially in fatal road traffic accidents hospital staff must recognise that the surviving victim loses someone important to them as well as physical integrity and mobility. Furthermore, grief reactions may become morbid and lead to serious physical symptoms. Loss of the will to live is always an ominous sign. The sleep disturbance, poor appetite, and low pain tolerance which curtailed essential physiotherapy were probably responsible for this patient's physical deterioration and were due to her morbid reaction to her loss.

There are techniques for dealing with morbid grief reactions, some of which fall within the expertise of all doctors.[2 3] For example, if the hospital staff as well as the relatives encourage the patient to discuss the loss and tolerate the resulting emotions, normal grieving can and will occur. Morbid grief may be prevented by psychotherapy in the form of guided mourning procedures.[4] A greater awareness of this problem and its treatment may sometimes save lives.

References

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4 Mawson D, Marks I, Ramm L, Stern R. Guided mourning for morbid grief. *Br J Psychiatry* 1981;**138**:185.

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Department of Psychiatry, St George's Hospital, London SW17 0RE
STUART LIEBERMAN, MD, MRCPSYCH, consultant and senior lecturer

What is the present status of the use of BCG vaccine in the diagnosis of tuberculosis? Is this test better than the Mantoux test in children and adults?

BCG vaccine is not usually regarded as useful in the diagnosis of tuberculosis. The Mantoux test is the most accurate and reliable test of tuberculin sensitivity and should usually be used to diagnose tuberculosis. It is, however, true that BCG has been used as an intradermal test of tuberculin sensitivity, probably equivalent to two tuberculin units of purified protein derivative (tuberculin) or even as much as five to 10 TU.[1] Udani *et al*[2] have recommended the use of BCG as a tuberculin test in vaccination programmes. This would enable a single injection to serve for diagnosis and prophylaxis in the case of non-infected individuals and would also show those for whom investigation might be appropriate to exclude active disease. The subject of tuberculin testing is fully discussed by Miller.[3]—JOHN MORRISON SMITH, honorary consultant physician, Birmingham.

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2 Udani PM, Parikh UC, Shah PM, Naik PA. BCG test in tuberculosis. *Indian Paediatr* 1971;**8**:143-50.
3 Miller FJW. *Tuberculosis in children*. Edinburgh: Churchill Livingstone, 1982. (Medicine in the tropics series.)