Medicalizing Grief: A Response to Cheng and Shen

To the Editor: We believe the case report by Cheng and Shen[1] to be an example of how normal and understandably painful reactions to traumatic grief are cast into the likeness of illness. The subject is a middle-aged woman whose fiancé's death is described as a "terrible shock," obviously an unexpected and traumatic loss for her.

The article opens with some "stage-setting" that gives the impression of her reaction to his death as a disease. It refers to the *DSM*'s definition of *catatonia* as if there were some medical evidence that catatonia is a disease in the sense that diabetes is a disease, with identifiable bodily pathology that causes it. With catatonia, this is not the case. The term is merely a label used to define a particular kind of human behavior that expresses the person's inner experiences, not a pathological condition. The authors note that "…catatonia…is associated with many psychiatric and medical conditions," give percentages of the "causes" (without any evidence to support the cause), and go on to present a case of a person who, "…developed an emergent catatonia in a major depressive episode with psychotic features…." Such use of language further gives the impression that it is a pathological condition itself. It would be just as accurate to say, "In the face of extreme angst, people can shut down, becoming immobile and resistant to changes in movement and posture in an attempt to escape from the distress." This description would not make it sound like an illness; rather, it would sound like what it actually is. The coup de grâce is, "…catatonia was improved by injectable" valium and olanzapine. Incidentally, it strains credulity that the authors (and presumably the treating physicians) knew the olanzapine affected both the catatonia and psychotic depression, whereas valium affected only catatonia and mirtazapine affected only the psychotic depression. After all, the catatonia and psychotic depression are "in" the same person. Also incidentally, her so-called "psychosis" consisted of "guilty delusion." The literature is replete with evidence that such feelings are common, particularly in traumatic grief.[2,3] In addition, while the pharmacologic treatment is credited for its efficacy, in fact, this simply cannot be discerned in this case study. Merely the passage of time has been shown, in conjugal bereavement, to itself remedy psychiatric sequelae.

Finally, all biological laboratory tests verified no physiological pathology. Nonetheless, the authors refer to the "neurobiology of psychotic depression and that of catatonic syndromes," noting that pharmacology and electroconvulsive treatment may be used to "treat" catatonia.

This approach to "treating" traumatic grief violates the inviolable: a person's basic human right to experience extreme shock, angst, despair, and, yes, even catatonia in the face of such loss. This woman's reaction to the untimely death of her fiancé is likely to be influenced by many things, including her culture, social support, and the shockingly sudden circumstances under which her fiancé died, none of which are illumined in the article. How much more appropriate would it have been for her community to support her, give her space to fall silent to a world where such trauma can occur, and slowly regain her equilibrium? The most dangerous approach to bereavement seems to be one that medicalizes what it means to be human and to love deeply. This is reason for us all to be deeply concerned. We implore clinicians—and communities—to do better for the bereaved, particularly those bereaved under traumatic circumstances.

References

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Medicalizing Grief: Drs Cheng and Shen Reply

To the Editor: We appreciate Drs Cacciatore and Ruby's thoughtful rejoinder to our presented case, and we recognize that their disagreements with us are motivated by goals we all share—ensuring the well-being of those who seek our help and reducing the suffering and incapacity of seriously depressed patients associated with bereavement.

Ms A was a middle-aged woman whose fiancé's sudden death was a terrible shock to her. Afterward, she was sad and anhedonic, with guilty delusion and suicidal ideation. She presented with intense negativism about herself and severe psychomotor retardation. For days, she remained not eating or drinking and was urinating and defecating directly on the bed. Then she lost consciousness and was taken to the hospital. After regaining consciousness, she presented extreme loss of motor skill, held rigid poses for hours, and was not responding to any external stimuli. She required intensive nursing care and administration of intravenous fluids for nutrition and carried a urethral catheter for bladder distention. When taking into account her past experience of grief, we noted this time she had a particularly severe presentation that included some combination of unreasonable guilt, intense negativism about herself, alienation from others, and inability to be consoled, which suggested she wasn't grieving in the way she had in the past, ie, in her own way. Otherwise, when considering her cultural expressions of grief, the diagnosis of major depression was made because her grief was outside of cultural norms. Medicalizing her "complicated" grief resulted in gradual improvement of life-threatening catatonic and psychotic depression. Finally, she went home and appreciated our staffs' care.

In *DSM-IV*, there is an exclusion criterion for a major depressive episode that is applied to depressive symptoms lasting less than 2 months following the death of a loved one (ie, the bereavement exclusion). This exclusion is omitted in *DSM-5* for several reasons.[1] The first is to remove the implication that bereavement typically lasts for 2 months. Since there is no one right way to grieve, different cultures prescribe a wide variety of different lengths of time to bereave. Second, some individuals have severe, complicated grief that looks just like severe major depression and that does not get better spontaneously, as in the presented case. The longer that diagnosis and treatment are delayed, the greater an individual's suffering, impairment, and risks. Third, bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes. It shares similar patterns of comorbidity, personality characteristics, and risks of chronicity and recurrence as non–bereavement-related major depressive episodes and may be genetically influenced. Finally, the bereavement-related major depression responds to the same medication and psychosocial treatments as non–bereavement-related major depression.

We respectfully disagree with Drs Cacciatore and Ruby's statement that "treating traumatic grief violates the inviolable: a person's basic human right to experience extreme shock, angst, despair, and, yes, even catatonia in the face of such loss." As we report, "For days, she remained not eating or drinking and was urinating and defecating directly on the bed. Then she lost consciousness and was taken to the hospital." In such a critical case, should we still let her remain at home and grieve her own way?

If she is (mistakenly) given a diagnosis of catatonic or psychotic depression, the attendant "risks" are mainly those of entering the mental health system and receiving treatment—whether medication or psychotherapy. Both therapies may entail risk, and we are well aware of the unpleasant and sometimes harmful side effects that antidepressants or antipsychotics may produce in a minority of patients. Weighing the pluses and minuses, our call is to keep things as they are and not to normalize grief, especially those complicated ones.

Reference

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