CMJ. 2024;46(3):217-221
DOI: 10.7197/cmj.1498748

Cumhuriyet Medical Journal

| cmj.cumhuriyet.edu.tr | Founded: 2004 Available online, ISSN:1305-0028 Publisher: Sivas Cumhuriyet Üniversitesi

Grief Accompanied by Suicidal Thoughts After Traumatic Loss in Adolescent: A Case Report

Özlem Şireli[1,a,*], İrem Naz Yazarlı[1,b], Elif Abanoz[1,c], Ayla Uzun Çiçek[1,d], Cansu Mercan Işık[1,e], Mehmet Çolak[2,f]

[1] *Sivas Cumhuriyet University, Faculty of Medicine, Department of Child and Adolescent Psychiatry, Sivas, Turkey*
[2] *Child and Adolescent Psychiatry, Freelance Physician, Izmir, Turkey*

**Corresponding author*

Case Report

History

Received: 10/06/2024
Accepted: 30/07/2024

ABSTRACT

Grief is a normal process that occurs following the irreversible loss of a loved one. This process, characterized by painful experiences, varies widely and is influenced by numerous factors, including the identity of the deceased, the circumstances of their death, the individual characteristics of the bereaved, and the availability of support systems. The suddenness and violence of a loss can disrupt the normal grieving process, leading to the manifestation of traumatic symptoms. This phenomenon, referred to as "traumatic grief" in the literature, is associated with an increased risk of various psychiatric disorders, including major depression, anxiety disorders, and post-traumatic stress disorder. The death of a parent represents a profound loss for an adolescent, complicating their coping mechanisms and significantly impacting their psychological well-being. Parental loss alone is a significant risk factor for suicidal behavior in adolescents. When a parent's death is traumatic, it can further exacerbate this risk, leading to suicidal thoughts and behaviors by disrupting the normal grief process, even in adolescents who were previously mentally healthy. This article presents the diagnosis and treatment of a 17-year-old female who exhibited active suicidal thoughts and behaviors after her father was killed with a firearm. The objective of this case report is to explore the atypical grief symptoms that can follow traumatic losses during adolescence and to assess the effectiveness of holistic approaches that combine supportive psychotherapy with pharmacotherapy in treating such cases.

Keywords: Adolescent, traumatic grief, suicide

Ergende Travmatik Kayıp Sonrası İntihar Düşüncelerinin Eşlik Ettiği Yas: Olgu Sunumu

Olgu Sunumu

Süreç

Geliş: 10/06/2024
Kabul: 30/07/2024

ÖZET

Yas, sevilen birinin geri dönüşümsüz kaybı sonrasında yaşanan normal bir süreçtir. Acı deneyimler içeren bu süreç, ölen kişinin kimliği, ölüm şekli, kayıp yaşayan kişinin bireysel özellikleri, destek sistemleri gibi birçok etmenle ilişkili olarak farklı biçimlerde yaşantılanabilir. Kayıp şeklinin ani ve şiddet içeren şekilde olması, olağan yas sürecini etkileyerek bireyin kayıp sürecinde travmatik belirti ve bulgular yaşamasına neden olabilir. Literatürde "travmatik yas" olarak tanımlanan bu süreç, major depresyon, anksiyete bozuklukları, posttravmatik stres bozukluğu başta olmak üzere birçok psikiyatrik hastalık açısından risk teşkil etmektedir. Ebeveynin ölümü ergen için benliğin baş etmesini zorlayan ağır bir kayıptır. Tek başına ebeveyn kaybı, ergenlerde intihar davranışı için önemli risk faktörüdür. Ebeveynin travmatik kaybı, ruhsal açıdan sağlıklı bir ergende dahi olağan yas sürecini bozarak ebeveyn ölümü sonrası intihar düşünce ve davranışlarına neden olabilir. Bu yazıda, babasının ateşli silahla öldürülmesi sonrasında aktif intihar düşünce ve davranışlar ile çocuk ve ergen psikiyatri polikliniğine başvuran 17 yaşında bir kadın hastanın tanı ve tedavi süreci anlatılacaktır. Bu olgu sunumunun amacı, ergenlik dönemindeki travmatik kayıplar sonrası olağan dışı yas bulgularının gözden geçirilmesi ve tedavide farmakoterapinin yanı sıra destekleyici psikoterapinin uygulandığı bütüncül yaklaşımların etkinliğinin değerlendirilmesidir.

Anahtar Kelimeler: Ergen, travmatik yas, intihar

[a] *ozlemsireli@cumhuriyet.edu.tr* *0000-0002-5549-4154*
[b] *irem.yazarli16@gmail.com* *0009-0005-7784-9234*
[c] *elifabanoz_17@hotmail.com* *0000-0002-9214-4735*
[d] *aylauzun@cumhuriyet.edu.tr* *0000-0003-2274-3457*
[e] *dr.cansumercan@gmail.com* *0000-0001-9437-3024*
[f] *memocolak@gmail.com* *0000-0003-4880-3892*

How to Cite: Şireli Ö, Yazarlı İN, Abanoz E, Uzun Çiçek A, Mercan Işık C, Çolak M. Grief Accompanied by Suicidal Thoughts After Traumatic Loss in Adolescent: A Case Report, Cumhuriyet Medical Journal. 2024;46(3): 217-221

Introduction

Grief is the subjective reactions that an individual experience after irreversible loss(s). Freud (1917) defines grief as a reaction to the loss of a loved one or some abstract-ideal values such as country, freedom, ideal.[1] Although the reactions given after the loss include individual differences, most of the symptoms that occur in the normal mourning process show similar characteristics.[2-3]

Freud (1917) described the normal mourning process by drawing parallels to melancholia. After losing a loved one, individuals often experience a loss of interest in the external world, similar to melancholia, an inability to form new attachments as they feel nothing can replace the deceased, and a cessation of efforts related to the lost individual.[1] However, unlike melancholia, normal mourning does not involve a decline in self-esteem. Theorists posit that the normal mourning process involves several common phases, each marked by similar cognitive, emotional, and behavioral symptoms.[3-7] In the initial stages of grief, individuals typically experience shock and numbness, often accompanied by denial of the death.[3-5] While they recognize the loss, they may behave as if it did not occur. Anger is a prominent emotion during these early stages, often directed at the deceased or at others.[5]As grief progresses, individuals actively experience and process their emotions, leading to periods dominated by feelings of hopelessness and pessimism. These stages, known as the acceptance phase, involve reflecting on the relationship with the deceased and attempting to keep memories alive. In a healthy mourning process, these phases eventually lead to a reduction in preoccupation with the deceased, acceptance of the loss, increased interest in the external world, and adaptation.[6-7] The grief process can become complicated if an individual remains stuck in any stage, exhibits exaggerated grief reactions, or fails to complete the expected phases of mourning. [2,8-10]

Normal grief reactions do not necessitate treatment, as they are part of a natural and essential process. However, complicated grief is a clinical condition that requires both diagnosis and intervention. Pathological grief, encompassing abnormal grief reactions, is referred to by various terms in the literature, including “complicated grief,” “unresolved grief,” and “chronic grief,” due to its manifestation through diverse symptoms and presentations. In the DSM-5-TR, it is classified as "Prolonged Grief Disorder." According to the diagnostic criteria, the individual's exaggerated grief reactions, relative to cultural, religious norms, and age, must significantly impair work and social functioning, with symptoms persisting for at least one year in adults and six months in children after the loss.[11] Although not specifically defined in the DSM-5, the term “traumatic grief” is also used in the literature to describe pathological grief reactions.[12]

Traumatic grief is characterized by the symptoms and findings that emerge in individuals following the sudden, unexpected, and often horrifying or violent death of a loved one.[13] A key feature distinguishing traumatic grief from pathological or complicated grief is the traumatizing nature of the separation experience.[12] The simultaneous occurrence of trauma and loss significantly alters an individual's worldview and coping mechanisms, impeding the normal grief resolution process. This condition often involves an excessive preoccupation with the deceased and separation anxiety that severely affects daily functioning.[14]According to Parkers (2001), a diagnosis of traumatic grief requires symptoms affecting psychosocial functionality to persist for at least two months. Prigerson et al. (1997) further identify traumatic grief as a risk factor for both physical and mental disorders.[15] Research indicates that traumatic grief may precede major depression (MD) and post-traumatic stress disorder (PTSD) and is associated with a heightened risk of suicide.[16-17]

While normal grief typically does not necessitate treatment, complicated and/or traumatic grief is a clinical condition requiring therapeutic intervention. Identifying the clinical features of grief is crucial for both completing the grief resolution process and preventing the development of subsequent mental disorders. This article explores the diagnosis and treatment of a case involving traumatic loss, where the patient exhibited active suicidal thoughts and sought help at a child and adolescent psychiatry outpatient clinic following the loss. The objective of this case report is to examine the atypical grief symptoms following traumatic losses in adolescence and to evaluate the effectiveness of holistic approaches combining supportive psychotherapy with pharmacotherapy. Informed consent was obtained from the patient and her parents for the study.

Case Report

A 17-year-old female patient, referred to as Z, accompanied by her mother, presented to the child and adolescent psychiatry outpatient clinic with complaints of temper tantrums and suicidal ideation.

According to the history provided by the mother, Z's father and grandfather had been murdered two and a half months before. It was revealed that Z's father was killed by his brother with a firearm over a property dispute while working in the field. Upon learning of her father's death via phone, Z exhibited extreme distress, including screaming, throwing herself on the ground, and stomping. She was inconsolable for an extended period, marked by persistent crying and shouting. At the funeral the following day, Z fainted twice consecutively and was removed from the ceremony. Upon regaining consciousness, she screamed and cried, exclaiming, "No, my father cannot die," and lashed out at individuals offering condolences.

Z's mother reported that her daughter's intense anger persisted for days. From the onset, she reacted violently when her father's death was mentioned, shouting,

swearing, and crying at home. She blamed her grandmother and aunts for her father's death, frequently sending them abusive messages. Efforts by relatives, including her mother, to console her were met with denials and accusations, such as "My father is not dead" and "You are lying." Normally attentive to her diet and exercise, Z began binge eating, expressing fatalistic thoughts like, "I'm going to die anyway, leave me alone, I'll eat whatever I want." She frequently talked about death and left notes indicating her intent to commit suicide. Her sleep was significantly disturbed, with difficulty falling asleep and a preference for sleeping with her mother. Despite previously enjoying school, she now avoided it, could not attend classes, and spent hours crying in the counselor's office.

Continued temper tantrums and suicidal ideation led Z's mother to insist on psychological intervention. After two sessions, Z refused further therapy, claiming, "This is not helping me at all." Repeated mentions of her father resulted in emergency hospital visits due to trembling, shortness of breath, and fainting. A child and adolescent psychiatrist at an external center prescribed medication (dideral tb) for as-needed use, but Z refused to take it, citing its ineffectiveness.

Z's psychosocial, developmental, and family history revealed that she was born at term via normal delivery without complications during pregnancy and delivery. Her language, cognitive, motor, and communication development were age-appropriate. She began kindergarten at age 4 and maintained good relationships with teachers and peers throughout her schooling, consistently performing well academically. As a young child, Z was affectionate, outgoing, responsible, and exhibited normal premorbid characteristics. The mother, a 47-year-old anesthesia technician, voluntarily stopped working after Z's birth. She had a history of breast cancer diagnosed when Z was 7, which was successfully treated over two years, and currently had no medical illnesses. The father, who was 52 years old at the time of his death, was a science teacher with no medical illnesses. Z was an only child, and her mother had been her primary caregiver since birth. Both parents had a very close relationship with Z, with the father being particularly affectionate and attentive. There was no history of psychiatric illness in the family.

During the psychiatric examination, the patient, Z, displayed physical characteristics appropriate for her age but showed a decline in self-care. Her mood was depressed, and her affect was consistent with her mood. When discussing the "loss of her father," she became agitated, repeatedly stating, "no, he is not dead," accompanied by shortness of breath and tremors. She demonstrated normal intelligence and full orientation but was easily distractible. Her thought content was marked by excessive preoccupation with her father, thoughts about the meaninglessness of life, denial, persistent ruminations about her father's death, and pervasive suicidal ideation. The Beier Sentence Completion Test revealed expressions of longing and love for her father, as well as feelings of despair and pessimism about death being a form of salvation and life being meaningless. The Child Depression Inventory (CDI) score was 39, and the Beck Anxiety Inventory (BAI) score was 38.

The psychiatric evaluation concluded that Z experienced her father's sudden and violent death as a traumatic loss, leading to denial and complicating her grief process. Psychiatric interviews were planned to control the patient's active suicidal thoughts, to reduce depressive symptoms, to support the grief process regarding the loss of the father, and to strengthen the mother's attitude and behavioral skills, initially twice a week and then once a week. In order to control the patient's agitation and tantrums, medication was started as risperidone 1 mg/day and alprazolam 0.5 mg/day.

In the second evaluation, it was noted that Z's sleep patterns had normalized, and her temper tantrums had decreased. However, her active suicidal thoughts persisted, and she continued to make plans for suicide. She reported feeling temporarily better while at school with friends and when talking to her counselor. Z expressed anger towards her mother, perceiving her sadness and tears as if "something bad had happened," which intensified Z's distress. The mother, experiencing helplessness, burnout, and difficulty sleeping, was referred to a psychiatrist to support her grief process. The school counselor was informed of Z's clinical status and given recommendations for supportive strategies. An agreement was made with Z to ensure her safety, and sertraline 50 mg/day was added to her treatment regimen.

By the third and fourth interviews, Z's depressive symptoms had decreased, her attendance and participation in school had improved, and she began preparing for exams and spending time with a newly adopted cat. Z was more engaged in the interviews but avoided discussing her father. Her anxiety spiked in situations that reminded her of her father, causing tearfulness. She reported intrusive thoughts about her father's death, hypervigilance to loud noises, and episodes of palpitations and shortness of breath. Risperidone was replaced with aripiprazole 5 mg/day due to weight gain and increased appetite, and alprazolam was discontinued by the fourth week. Her medication was adjusted to sertraline 100 mg/day and aripiprazole 5 mg/day. The mother's condition improved, and she received further recommendations to support Z's grief process.

During psychiatric, interviews Z was encouraged to express her anger towards those she blamed for her father's death. Emotional catharsis techniques were employed to help her acknowledge her feelings of sadness and helplessness. Approximately three months into treatment (at the end of 10 treatment sessions), Z began to accept her father's death, marking the end of her denial phase. Supportive interventions were intensified during periods of acute sadness in the acceptance process. The relationship with her father was explored, and a memory formulation was developed. As Z's external support systems were strengthened, her father-related activities diminished. She started spending more time with friends

and engaging in sports activities, indicating a positive trajectory in her grief resolution.

Currently, Z's psychiatric follow-up and treatment has been ongoing for 10 months (20 treatment sessions) and psychiatric interviews are conducted every 4 weeks. Her anxiety symptoms have improved (BAI score: 6), suicidal thoughts have ended, and depressive symptoms have decreased considerably (CDI score: 17). Drug treatment continues as sertraline 50 mg/day and aripipirazole 2.5 mg/day with decreasing doses. During the interviews, Z has shown increased comfort in discussing the loss of her father and expressing her related emotions and thoughts, indicating a resolution of her conflict regarding the loss. Her social and academic functioning has greatly improved. She receives support in coping with her father's absence and in formulating future plans. Z has decided to pursue a career as a veterinarian and is actively preparing for university entrance exams.

Discussion

In this study, the traumatic grief process of an adolescent female who lost her father as a result of his murder with a firearm was examined.

The diagnosis of traumatic grief remains a contentious issue. It is crucial to accurately diagnose and treat traumatic grief as it often co-occurs with other mental disorders such as major depression (MD), anxiety disorders, and post-traumatic stress disorder (PTSD). This condition significantly impacts functionality and increases the risk of suicide.[15-17] According to Parkers' (2001) diagnostic criteria for traumatic grief, the diagnosis requires a “sudden, violent death of a relative and excessive preoccupation (longing, searching, yearning) with the deceased”.[14] Additionally, there must be at least four specific symptoms of traumatization, including a sense of meaninglessness about the future, emotional numbness, shock, difficulty accepting the death, feelings that life is empty, a sense that a part of oneself is missing, an inability to envision a meaningful life without the deceased, feelings that the world is falling apart, insecurity, beliefs of harming the deceased, and extreme pain and anger related to the death. Symptoms must persist for at least two months to affect psychosocial functioning. In this case, the patient experienced the sudden and violent death of her father by gunshot, exhibited excessive preoccupations such as longing and searching for her father, had difficulty accepting the death, experienced extreme anger and pain, believed she could not continue life without her father, made suicide plans, felt life had lost its meaning, and these symptoms persisted for 2.5 months following the loss.

Differentiating traumatic grief from MD and PTSD is challenging due to overlapping symptoms. Research indicates that the unexpected death of a close person is a significant risk factor for anxiety disorders, MD, and PTSD.[18] However, researchers emphasize that traumatic and/or complicated grief has distinct clinical features.[19] According to Prigerson and colleagues (2009), a key feature of traumatic grief not present in MD and PTSD is the feeling of longing.[20] While PTSD centers on overlearned fear, the primary reaction to loss in traumatic grief is longing. In traumatic and/or complicated grief, the negative mood is associated with longing for the deceased and memories, whereas in MD, there is a pervasive dysphoria with an inability to experience positive emotions, and no avoidance behaviors related to reminders of the loss are present.[21]In this case, the primary emotion was longing, and avoidance behaviors were related to situations and thoughts about the loss. The depressive mood was triggered by memories and thoughts about the father and fluctuated, with no anhedonia when distanced from reminders about the father, which allowed the exclusion of PTSD and MD diagnoses.

While normal grief does not require treatment, traumatic grief necessitates intervention as it is a precursor to other mental disorders, affects psychosocial functioning, and increases the risk of suicide.[22] In this case, the initial psychiatric evaluation revealed a high risk of suicide, significant anxiety, and depressive symptoms. With medication and grief-oriented, supportive psychotherapy, the patient's clinical symptoms improved, and her social and academic functioning enhanced. The therapy aimed to help the patient confront the loss, cope with the pain, accept the death while preserving positive memories, and make future plans. For children and adolescents to complete the grief process, it is essential to include their parents in the grief process through psychoeducation.[23] Z's mother was directed to receive specialized support to complete her grief process and was included in Z's treatment through psychoeducation.

Conclusion

This article examines the diagnosis and treatment of traumatic grief. While normal grief does not necessitate treatment, traumatic grief is a condition requiring both diagnosis and intervention. Traumatic grief is not currently included in diagnostic systems, and its diagnostic criteria remain unclear. Despite concerns that the medicalization of normal grief reactions might lead to stigmatization and unnecessary interventions, substantial evidence supports the benefits of clarifying diagnoses and implementing early interventions. In clinical evaluations of traumatic grief, identifying risk groups and adopting appropriate treatment approaches can prevent complications such as suicide. Early and targeted interventions enable patients to complete the grieving process and enhance their psychosocial functioning.

References

1. Freud S. *Mourning and melancholia*. The standard edition of the complete psychological works of Sigmund Freud,1917, 237-258.
2. Lindemann E. Symptomatology and management of acute grief. *Am J Psychiatry*. 1944; 101: 141-148.
3. Engel GL. Is grief a disease? A challenge for medical research. *Psychosom. Med*. 1960; 22:18-25.

4. Bowlby J, Parkes C. *Separation and Loss within the Family*. In Anthony EJ (ed.) *The Child in His Family*. New York: Whiley, 1970.
5. Volkan V. Normal and pathological grief reactions—a guide for the family physician. *Virginia Med*. 1966;93: 651–656.
6. Kübler-Ross E. *On Death and Dying*. Collier Books Macmillan Publishing, 1969.
7. Worden W. *Grief counselling and grief therapy: A handbook for the mental health practitioner.* New York, Brunner-Routlege, 2001.
8. Çevik A, Öncü B. Normal ve patolojik yas kliniğinin çok boyutlu incelenmesi ve tedavi ilkeleri. *Psikiyatri Bülteni*.1995;3(3):109-14. *(Turkish article).*
9. Lindemann E. Symptomatology and management of acute grief. *Pastoral Psychology*. 1963; 14(6): 8-18.
10. Horowitz MJ, Siegel B, Holen A, Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry*. 1997; 154: 904-910.
11. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, fifth edition, text revision*. Washington: American Psychiatric Association, 2022.
12. Prigerson HG, Shear MK, Jacobs SC, et al. Consensus criteria for Traumatic Grief: A preliminary empirical test. *Br J Psychiatry*. 1999;174: 67–73. https://doi.org/ 10.1192/bjp.174.1.67.
13. Jacobs S, Mazure C, Prigerson H. Diagnostic criteria for traumatic grief. *Death Stud*.2000; 24(3): 185–199. https://doi.org/10.1080/074811800200531.
14. Parkes CM. *A historical overview of the scientific study of bereavement*. In: Stroebe MS, Hansson RO, Stroebe W, Schut H (eds.). *Handbook for bereavement research: Consequences, coping, and care.* Washington, DC. APA, 2001.
15. Prigerson HG, Bierhals AJ, Kasl SV et al. Traumatic grief as a risk factor for mental and physical morbidity. *Am J Psychiatry*. 1997; 154: 616-623.
16. Hensley PL (2006). Treatment of bereavement-related depression and traumatic grief. *J Affect Disord*. 2006; 92(1): 117-124. https://doi.org/10.1016/j.jad.2005.12.041.
17. Melhem NM, Day N, Shear MK, Day R, Reynolds III CF, Brent D. Traumatic grief among adolescents exposed to a peer's suicide. *Am J Psychiatry*. 2004; 161(8): 1411-1416. https://doi.org/10.1176/appi.ajp.161.8.1411.
18. Keyes KM, Pratt C, Galea S, McLaughlin KA, Koenen KC, Shear MK. The burden of loss: Unexpected death of a loved one and psychiatric disorders across the life course in a national study. *Am J Psychiatry*. 2014;171(8); 864–871. https://doi.org/10.1176/appi.ajp.2014.13081132.
19. Simon NM, Shear MK, Reynolds CF et al. Commentary on evidence in support of a grief-related condition as a DSM diagnosis. *Depression and Anxiety*. 2020;37(1):9-16. https://doi.org/10.1002/da.22985.
20. Prigerson HG, Horowitz MJ, Jacobs SC et al. Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Med*. 2009;6(8): e1000121. https://doi.org/10.1371/journal.pmed.1000121.
21. Baker AW, Keshaviah A, Horenstein A et al. The role of avoidance in complicated grief: A detailed examination of the grief-related avoidance questionnaire (GRAQ) in a large sample of individuals with complicated grief. *J Loss Trauma*. 2016; 21(6): 533–547. https://doi.org/10.1080/15325024. 2016.1157412.
22. Jacobs S. *Traumatic grief: Diagnosis, treatment, and prevention*. Routledge, 2016.
23. Mannarino AP, Cohen JA. Traumatic loss in children and adolescents. *J Child Adolesc Trauma*. 2011; *4*:22-33. https://doi.org/10.1080/19361521.2011.545048.