



Physical symptoms in prolonged grief disorder: a case report

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Background: Prolonged grief disorder (PGD) was added as a new disorder to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) in 2022. PGD is defined as an intense yearning or longing for the deceased and preoccupation with thoughts or memories of the deceased. The official diagnostic criteria for PGD do not include physical symptoms, but it is sometimes associated with somatic symptoms.

Case Description: We present the case of a patient suffering from facsimile illness who lost her husband due to the deterioration of a brain tumor. She suffers from similar physical symptoms (severe headache reminiscent of a brain tumor, and hypertension) as her deceased husband. We focused on the dual process model in which grief exposure and behavioral activation began, ensuring an oscillation between loss-oriented grief (e.g., crying, feeling a continuing bond) and restoration-oriented grief (e.g., attending to life changes, new roles/identities/relationships). Outpatient psychotherapy based on the dual-process model of grief improved her physical symptoms.

Conclusions: This case report highlights the physical symptoms experienced by those bereaved by a deceased loved one. Exposure therapy and behavioral activation approaches based on the dual-process model of grief response were effective in reducing the physical symptoms of facsimile illness. Physical symptoms in deceased family members triggered by bereavement are often overlooked and need to be recognized.

Keywords: Prolonged grief disorder (PGD); physical symptoms; facsimile illness; dual process model; case report

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Introduction

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) published in 2022 newly included prolonged grief disorder (PGD) as a disease entity (1). PGD is characterized by intense grief, including depression, emotional pain, emotional numbness, loneliness, identity disturbance, and difficulty managing

interpersonal relationships, which lasts longer than expected by social norms and causes impairment in daily functioning.

Recognition and appropriate management of PGD is clinically essential. First, PGD is associated with other health problems, such as sleep disturbances, substance abuse, suicidal ideation and behaviors, and immune dysfunction (2-5). Some studies have also shown it to be

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associated with increased risks of physical disease (e.g., cardiovascular disease, hypertension, diabetes, and chronic obstructive disease), as well as with a significantly higher rate of experiencing pain among bereaved families of suicide (6,7). Second, PGD is often overlooked in medical practice, and patients with physical symptoms (especially facsimile disease) of PGD are at particular risk of being treated only for their physical symptoms in general practice or being referred to psychosomatic medicine for medically unexplained physical symptoms (8).

Several psychiatric symptoms are listed as symptoms of PGD in the diagnostic criteria, such as a persistent and pervasive grief response characterized by longing for the deceased or persistent preoccupation with the deceased (1).

Highlight box

Key findings

- This case report highlights the physical symptoms experienced by a deceased loved one.
- Patients may complain of similar symptoms as the deceased, referred to as facsimile illness.
- Dual-process model-based exposure therapy/behavioral activation approaches to grief reactions were effective in reducing the physical symptoms of facsimile illness.

What is known and what is new?

- The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) published in 2022 newly included prolonged grief disorder (PGD) as a disease entity.
- The official diagnostic criteria for PGD do not include physical symptoms. However, grief reactions include a medical condition called “facsimile illness”, which causes physical symptoms similar to those of the deceased.
- Facsimile illness in PGD is not well documented in the literature.
- This manuscript presents a unique case of a woman experiencing the same physical symptoms as her deceased husband, and to our knowledge, this is the first case report detailing the treatment of Facsimile illness.

What is the implication, and what should change now?

- This case emphasizes the importance of physical symptoms in the deceased family members.
- PGD is associated with other health problems, such as sleep disturbances, substance abuse, suicidal ideation and behaviors, immune dysfunction, and increased risks of physical diseases.
- Physical symptoms in deceased family members triggered by bereavement are often overlooked and need to be recognized by both healthcare providers and patients.
- Further research is needed to better understand the meaning of physical symptoms in deceased families and to develop appropriate guidelines or policies.

However, the official diagnostic criteria for PGD do not include physical symptoms. In contrast, one report found that over than 30% of soldiers bereaved by the death of a close friend experienced pain, including headaches, as a physical symptom of grief (9). This report concluded that this should be more widely recognized. Accordingly, grief can cause physical sensations such as tightness or heaviness in the chest or throat, nausea or upset stomach, dizziness, headache, numbness, muscle weakness, upset stomach, tension, or fatigue (10). However, to date, few reports on grief in patients who have lost a spouse to cancer, especially those who have the same symptoms as the deceased, have described physical symptoms and their treatment. Worden *et al.* [2018] (11) described masked grief as follows “*occurring when a bereaved person experiences symptoms or behaviors that lead to difficulties in functioning but does not recognize these symptoms as being related to the loss (12)*”. The etiology of masked grief is an arrest of the grief response, and psychopathology is a manifestation of the symptoms and behaviors (facsimile illness) that characterize the deceased’s illness at the end of life (11).

In our report, we present a case of a patient who was suffering from physical symptoms (severe headaches reminiscent of a brain tumor and hypertension), which her deceased husband had long experienced, alongside psychiatric symptoms of PGD. We focused on the dual process model (*Figure 1*) (13), in which we started exposure to grief and behavioral activation, ensuring there was an oscillation between loss-oriented grief (crying, feeling a continuing bond, grief work, intrusion of grief) and restoration-oriented grief (attending to life changes, doing new things, distraction from grief, denial/avoidance of grief, new roles/identities/relationships). Outpatient psychotherapy based on the dual process model of grief improved her physical symptoms. We present this article in accordance with the CARE reporting checklist (available at <https://apm.amegroups.com/article/view/10.21037/apm-24-53/rc>).

Case presentation

A 57-year-old Japanese female with no relevant medical, family, and psycho-social history whose husband had died 3 months earlier due to the deterioration of his brain tumor visited National Cancer Center Hospital outpatient bereavement clinic with the main complaints of a lack of sense of reality about her deceased husband’s death, remorse over her husband’s death and regret about

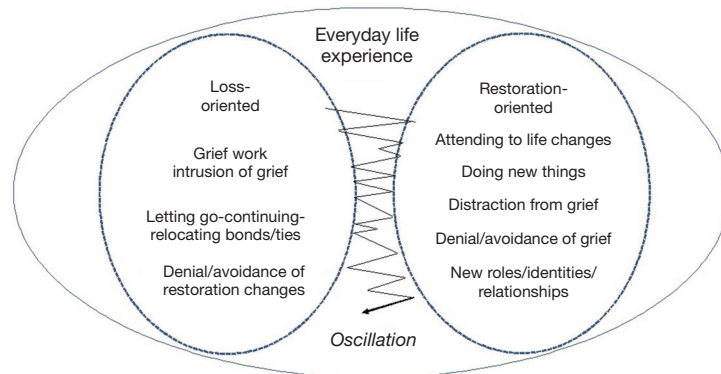


Figure 1 The dual process model. Published with permission from SAGE Publications (13).

his treatment (the dose of oral medication was halved by medical staff). Before her visit to our clinic, she had seen her general practitioner complaining of headaches and had subsequently been examined closely including magnetic resonance imaging but found nothing abnormal. Painkillers and antidepressants were prescribed but proved ineffective. Her husband had brain cancer for several years before he died. At the first visit, she reported that her husband's health had deteriorated suddenly and after his unexpected death, she was too busy preparing for the wake and funeral to cry. She was ruminating on anger and guilt-related resentment about the circumstances of his death, feeling an urge to avoid situations that reminded her of the loss, and clinging to the deceased by constantly remembering him or seeing, touching, or smelling his belongings. She reported severe left frontal headaches (as her husband had experienced) and elevated blood pressure, sometimes exceeding 200 mmHg systolic. On the other hand, she also complained that she still did not have a sense of reality. The patient did not meet diagnostic criteria for depression or post-traumatic stress disorder (PTSD), was in a state of acute grief reaction, did not seek medical attention for several months due to coronavirus 2019 (COVID-19), and was seen again 12 months later. Upon examination, she did not meet the diagnostic criteria for depression or PTSD, and she was diagnosed with PGD. She began a course of psychotherapy consisting of 40-minute sessions every month or two at our outpatient clinic, run by a specialized psycho-oncologist, for a total of 12 sessions.

We focused on explaining the dual process model of grief (12) and started exposure to grief and behavioral activation, ensuring there was a balance between loss-oriented grief (crying, feeling a continuing bond, grief work, intrusion of grief) and restoration-oriented grief (attending

to life changes, new roles/identities/relationships). Our intervention also included exposure therapy involving situational revisiting of memories up to the time of her late husband's death and encouraging imagined conversations with him (8). Specifically, we reviewed the details of her husband's illness in the months before his death (revisiting), spoke to her husband's image on the altar (imaginary conversation in the present tense), and asked her to bring a photo album of her memories and reflect on episodes with her husband together.

Intervention adherence was good, it could be implemented as scheduled, and she did not complain of adverse events.

A year later, after nine visits, she expressed conflict with the hospital where her husband had died and wondered if she should return. She had no desire to return to the hospital, but she realized that her symptoms would not improve until she resolved her distrust of her late husband's doctor. She interpreted her headaches as a transference of her husband's illness, and she was also aware of feelings of loneliness, regret, anger at the hospital, and apology to her late husband. She recognized the need to return to the hospital, which we encouraged.

She visited the doctor with her daughter to seek an explanation for his death. The doctor and a nurse spent 90 min explaining the medical procedure performed, telling her they were worried about her for a long time and being openly emotional with her. Subsequently, her headaches were less severe and almost disappeared, and her blood pressure improved to normal hypertension (systolic around 140 mmHg). Her scores on the Inventory of Complicated Grief (ICG) and Patient Health Questionnaire-9 (PHQ-9) decreased slightly compared with those before treatment, although her ICG remained above the cut-off score (>25) (Figure 2) (15,16). She continues to receive psychotherapy

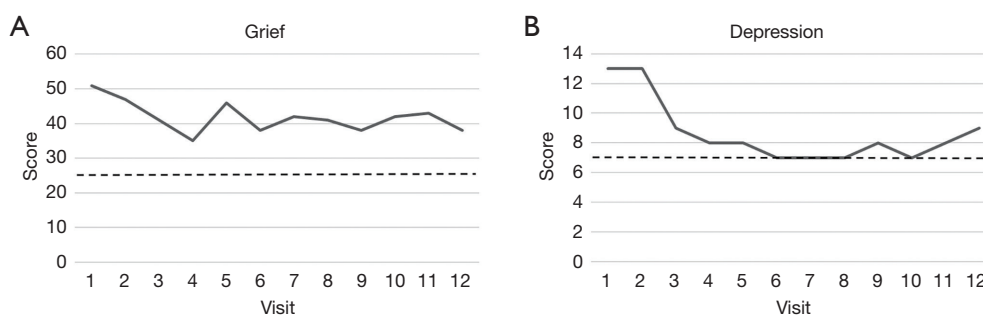


Figure 2 Transition of self-reported outcomes throughout the counseling. (A) Grief is measured by the Inventory of Complicated Grief Inventory (14). (B) Depression was measured by Patient Health Questionnaire-9 (15). The straight lines indicate the cut off score.

during periodic follow-up visits.

All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committees and with the Helsinki Declaration (as revised in 2013). Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the editorial office of this journal.

Discussion

Although somatic symptoms are not included in the diagnostic criteria for PGD, it is known that somatic symptoms may be present. In this case, a patient suffering from similar physical symptoms as her deceased husband showed improvement after outpatient psychotherapy based on the dual-process model.

This case highlights two critical points related to the clinical practice of PGD. First, some patients with PGD can have prominent physical symptoms and the predominance of somatic symptoms means they may seek non-psychiatric medical care. As previous studies have noted, some PGD patients experience symptoms ranging from significant physical symptoms (e.g., headaches, dizziness, indigestion, chest pain) (17,18). Indeed, in our case, the physical symptoms (severe headaches and hypertension, which can lead to cardiac disease) have existed. Regarding medical visits by the bereaved, some papers mention an increase in hospital visits (17-20), while others, on the contrary, find that those who grieve too much are reluctant to see a doctor (14,19), especially during the acute phase of the disease when physical symptoms are more common (21). The patient, in our case, also went to an internal medicine department. However, her condition was treated as a general symptom

and did not improve.

Second, these patients may see improvement in their physical symptoms with psychotherapy that combines behavioral activation therapy and exposure therapy, based on the dual-process model of grief. According to a 2015 review article (8), a short-term intervention called complicated grief treatment was the most widely studied treatment approach up to that time. For patients without access to this treatment, intervention should provide information about grief adjustment and include strategies to reduce avoidance of reminders of the loss and strategies to activate behavior. One recent randomized controlled trial (RCT) comparing behavioral activation therapy with exposure therapy found that exposure therapy was superior in both effects and feasibility (22). Additionally, another RCT demonstrated that short-term treatment with a combination of exposure therapy and cognitive behavioral therapy (CBT) is more effective for PGD (23) than CBT alone. In our case, in addition to exposure therapy, such as revisiting the situation that we implemented, the meeting with the medical professional at the previous hospital where her deceased husband had stayed may have functioned as exposure therapy for the painful memory.

An interesting point in this case is whether the physical symptoms (headache and hypertension) are due to grief or anger. As described in a recent paper, initial feelings of guilt, blame, shame, and anger often manifest themselves as physical, psychological, and psychosomatic difficulties (24). Another paper mentioned somatosensory amplification in relation to alexithymia (25). Bradbeer *et al.* found that bereaved individuals were three times more likely to report current severe pain compared to a non-bereaved control group (21). Expressing anger and blaming others at the hospital visit contributed to symptom relief, but grief scores remained unchanged throughout the intervention.

Symptom relief occurred more or less independently of reductions in grief scores and appeared to be primarily associated with anger and blaming others. Since there is a report that recent bereavement is associated with persistent somatization (26), we could consider the facsimile illness as an embodiment of anger, or if the grief score decreases in the near future, it could be considered masked grief. Regardless, it is definitely a physical symptom triggered by bereavement.

Many patients with PGD present with psychiatric symptoms, but some are likely to have physical symptoms. Although Zisook and de Vault report the existence of such symptoms in a review on grief-related facsimile illness (27), very few case reports are available that include treatment details. To our knowledge, this case report is the first to describe in detail the clinical course of facsimile illness in PGD and successful treatment for physical symptoms based on the dual process model of grief, which prompts the patient's grief response to oscillate repeatedly between loss-oriented grief and restoration-oriented grief during the grieving process and offers a good prognosis. Stroebe *et al.* stated that not many recent papers have been published on somatic symptoms (19). We emphasize the importance of our paper because the association with somatic symptoms has been pointed out for a long time, but prior studies are old and very few recent ones have been published.

Limitations

Our case report has several limitations. First, this is a case report as a research methodology generalizability and establishing a cause-effect relationship. Second, treatment was initiated in the post-bereavement period when depressive and other symptoms were expected to improve spontaneously. However, because of COVID-19, she was only seen once a year, and was in the same condition when she returned a year later (2nd visit). Third, although there was no history of headache and hypertension in the patient, considering that these symptoms are a common and nonspecific stress response, this cannot be definitively determined to be a facsimile illness. However, it is noteworthy that the patient interpreted her headaches as a transference of her husband's illness, recognized the need for a return visit to the hospital through dual-process therapy for grief reactions, and resolved her symptoms after the visit. Finally, although the patient's PHQ-9 score, which reflects depression, dropped below the cutoff, her ICG and PHQ-9 scores continue to fluctuate, indicating that her

condition is not yet stable. A return visit to her deceased husband's hospital forced her to confront her lack of a sense of reality (which was also her main complaint at the time of her first visit) (Worden's first stage). It is possible that her mental state did not improve because the reality of her husband's death hit her hard. Alternatively, she may have somatized her headaches as a defense mechanism, and her psychological symptoms may have become unstable during the improvement process. Further, she may be experiencing other distress (such as loneliness) in addition to anger and regret toward the hospital, which may not have alleviated the symptoms sufficiently. Thus, even if the loss-oriented part is solved, the restoration-oriented part still needs to be dealt with. This suggests the importance of addressing both dual processes.

We designed a short-term intervention based on the dual-process model which decreased the physical symptoms. Regular follow-up is needed, and the number and content of psychotherapy sessions required for PGD itself are not yet clear. It is essential to establish simple, systematic care for facsimile illness in PGD based on available evidence, and the details of this case can help to accumulate evidence for this purpose.

Implications

Physical symptoms (in particular, facsimile disease) in PGD are a clinical syndrome that has not been well described in the literature. Yet, recognition and appropriate management of this syndrome is clinically essential. First, PGD is associated with other health problems, such as sleep disturbances, substance abuse, suicidal ideation and behaviors, and immune dysfunction (2-5), and with increased risks of physical disease (e.g., cardiovascular disease, hypertension, diabetes, chronic obstructive disease, and pain) (6,7). Sleep disturbances may contribute to other adverse health consequences of PGD.

Second, PGD is often overlooked in medical practice, and patients with physical symptoms (especially facsimile disease) of PGD are at particular risk of being treated only for their physical symptoms in general practice or being referred to psychosomatic medicine for medically unexplained physical symptoms (8). Finally, these patients can be diagnosed based on medical history alone and, if properly managed, may have a good prognosis, at least for physical symptoms. Our case highlights a condition that can be easily overlooked because patients with facsimile illnesses tend to seek non-psychiatric medical care, but it is treatable

once diagnosed and should be kept in mind by all healthcare professionals.

Conclusions

This case report sheds light on the physical symptoms experienced by those who are bereaved by a deceased loved one. In reducing the physical symptoms of facsimile illness, exposure therapy and behavioral activation approaches based on the dual-process model of grief response were effective. Physical symptoms of grief are often overlooked and are associated with other health problems; both healthcare providers and patients need to be aware of them.

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Footnote

Reporting Checklist: The authors have completed the CARE reporting checklist. Available at <https://apm.amegroups.com/article/view/10.21037/apm-24-53/rc>

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Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at <https://apm.amegroups.com/article/view/10.21037/apm-24-53/coif>). The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The patient is aware that this report might not benefit her directly, but this information can benefit other potential patients. All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committees and with the Helsinki Declaration (as revised in 2013). Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the editorial office of this journal.

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