

The Occurrence of Funeral Mania After Bereavement: A Case Report

Yas Döneminde Ortaya Çıkan Cenaze Manisi: Bir Olgu Sunumu

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ABSTRACT

Stressful or traumatic life events can lead to emergence of mood episodes. Events such as migration, relocation, job loss, bankruptcy, economic loss, divorce, natural disasters, accidental injury, or the loss of a loved one can trigger the first episode of bipolar disorder. After such life events, symptoms of depressive episodes often appear. Funeral mania, on the other hand, is defined as the emergence of manic episodes following the death of a close family member. Information on funeral mania, which occurs shortly after the loss of a loved one, is limited with a few case reports. In this study, a 26-year-old female patient who presented with the symptoms of a manic episode for the first time after her father's death and who had no previous psychiatric disease or treatment history was presented in the light of findings in the literature. It is noteworthy that the patient, who was followed up with the diagnosis of bipolar disorder (mania period) according to DSM-5 diagnostic criteria, had a temporal closeness between her mood symptoms and her father's death, and had not developed such a reaction to previous traumatic life events. Therefore, the diagnosis was evaluated as funeral mania. It should be kept in mind that, although rare, symptoms of mania can be seen among possible grief reactions.

Keywords: Bipolar disorder, funeral mania, grief, treatment

ÖZ

Strese neden olan ya da örseleyici yaşam olayları duygudurum dönemlerinin ortaya çıkmasına neden olabilir. Göç, taşınma, yer değiştirme, işini kaybetme, iflas, ekonomik kayıp, boşanma, doğal afetler, kaza sonucu yaralanma ya da yakınıni kaybetme gibi olaylar bipolar bozukluğun ilk hastalık dönemini tetikleyebilir. Bu tür yaşam olaylarından sonra genellikle depresif dönem belirtileri ortaya çıkar. Cenaze manisi ise, yakın bir aile üyesinin ölümünü takiben kişide mani dönemi belirtilerinin ortaya çıkması olarak tanımlanmıştır. Sevilen kişinin kaybından çok kısa bir süre sonra ortaya çıkan cenaze manisi ile ilgili bilgiler kısıtlıdır. Konu ile ilgili az sayıda olgu bildirimi mevcuttur. Bu çalışmada babasının ölümü sonrası ilk kez mani dönemi belirtileri ile başvuran, öncesinde herhangi bir psikiyatrik hastalık ve tedavi görme öyküsü olmayan 26 yaşındaki kadın hasta literatür bulguları eşliğinde sunulmuştur. DSM-5 tanı ölçütlerine göre bipolar bozukluk (mani dönemi) tanısı ile izlenen hastanın duygudurum dönemi belirtileri ile babasının ölümü arasındaki zamansal yakınlık olması ve önceki örseleyici yaşam olaylarına bu şekilde bir tepki geliştirmemiş olması dikkat çekicidir. Bu nedenle olgunun tanısı cenaze manisi olarak değerlendirilmiştir. Olası yas tepkileri arasında nadir de olsa mani dönemi belirtilerinin görülebileceği unutulmamalıdır.

Anahtar kelimeler: Bipolar bozukluk, cenaze manisi, tedavi, yas

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INTRODUCTION

Grief is a state of loss (bereavement) often triggered by the death of a close person. Death is the most painful tangible loss that an individual experiences because of its finality and irreversibility. It is probably the greatest sadness that can occur in an individual's life. The process of grieving is a normal, healthy response to loss; however, grief can lead to a manic episode in some cases. The emergence of a manic episode after the death of a loved one is called "funeral mania"¹. Klein defined funeral mania as the denial of the reality of a loss. According to this view, mourning situations can paradoxically lead to manic defense². In this article, we reported and discussed a case considered as mania and its treatment. Due to the very limited number of case reports in the literature in which the etiological link between grief and a manic episode is evident, we believe that the discussion of this case will give us new insights into the relationship between manic episodes and life events.

THE CASE

A 26-year-old single, primary school graduate, unemployed female patient was brought to the psychiatry outpatient clinic accompanied by her mother. The patient who had lost her father to pancreatic cancer four days ago had increased speech volume, nonsensical speaking and laughing, hyperactivity, insomnia, aggressive attitudes, and symptoms of tension. During the bilateral meeting with the healthcare provider, she stated that she had lost her most significant asset, she was always with her father in his last days, she took care of her father in this final period and witnessed her father's death. She stated that she could not sleep at night and went to her father's grave, she could not express her pain, she heard her father's voice and talked to him. According to the information received from her family, the patient never slept at night, talked to herself, laughed, could not sit still, and acted

aggressively towards the people around her. The patient, born via a normal delivery in the hospital assisted by health personnel and had no serious disease in childhood. As a child, the patient's toilet training, walking, and speaking took place at a normal developmental pace. She had had no serious illness, accident, and physical or mental trauma since childhood. There was no family history of any other mental or neurological disease. Her neurological examination and other system examinations were not remarkable, and results of her hemogram, biochemical, and hormonal tests were within normal ranges. The mental status examination revealed the following details. The 26-year-old female patient's clothing was compatible with her socioeconomic level. Her hair was messy, and her self-care was worse. The patient did make eye contact and was willing to talk, but the speech speed and volume increased above the normal level, and she had pressured speech. Her mood was elevated and had euphoric affect. She was conscious, oriented, and cooperative. Her memory functions were unaffected. She had auditory hallucinations, and her ability to think abstractly was impaired. Her ability to judge reality and to reason was impaired, and there were racing thoughts and flight of ideas in her thought process and associations. The contents of her thoughts were longing for her father, feeling of a loss of her most significant asset, a belief that her father was still alive, and thoughts of loneliness. Expressive behaviors had increased. The psychiatric examination of the patient, who did not have any previous psychiatric diagnosis or treatment history, and the psychometric evaluation made us to conclude that the patient met the criteria for a manic episode (with mixed features) according to DSM-5 criteria. The case was thought to be bereavement/funeral mania because the patient had no psychiatric disorders before the death of her father, and the current clinical picture emerged after his death. Considering that outpatient follow-up of the patient would be difficult, the patient was admitted for inpatient treatment. Intramuscular

injections of 10 mg of haloperidol, 25 mg chlorpromazine, and 2.5 mg biperiden were made to control her aggression and irritability. Electroencephalography (EEG), brain tomography, and magnetic resonance (MR) examinations performed to investigate organic pathology did not reveal any pathological findings. The results of the psychometric evaluation were as follows: Brief Psychiatric Rating Scale (BPRS), 12 points; Hamilton Depression Rating Scale (HAMD), 23 points; Young Mania Rating Scale (YMRS), 27 points; Positive Symptoms Rating Scale (PSRS), 28 points; and Negative Symptoms Rating Scale (NSRS), 16 points. The patient was started on a treatment of 500 mg/day of valproic acid and 100 mg/day of quetiapine. After a week, the patient's treatment was adjusted to 1000 mg/day of valproic acid and 200 mg/day of quetiapine. After two weeks, the symptoms decreased. The results of the psychometric scales performed before discharge were as follows: BPRS, 6 points; HAMD, 10 points; YMRS, 8 points; PSRS, 10 points; and NSRS, 11 points. In response to the family's request, the patient was discharged, and her treatment was continued on an outpatient basis. The patient was followed up regularly in the outpatient clinic, and her symptoms decreased significantly after one month.

DISCUSSION

Various studies have been conducted to date to show the frequency with which severe life events occur in the period immediately preceding the onset of psychiatric disorders. The main purpose of these studies was to reveal whether life events were among etiologic factors of psychiatric disorders³. Although Bleuler & Schneider stated that mania never occurred reactively, case studies have emphasized that the onset of mania may be associated with a series of stressful life events such as bereavement, natural disasters, and traffic accidents^{4,5}. Today, the literature reveals that there are a limited number of case reports in which the first manic episode of the person's life

occurred after a loss of loved one in patients without a previous psychiatric diagnosis. These people experienced a psychotic manic episode after the death of a relative¹. In our case, there was also no previous psychiatric disease. Four days after her father's death, she entered a manic state. To date, many associations between stressful life events and the onset or recurrence of mood disorders have been shown. It has been determined that severe life events increase the risk more than four times and can extend the duration of mood disorders up to three times⁶. The effects of negative life events on mania have been less well explained. However, case studies and small sample studies have indicated a relationship between negative life events and the first manic episode⁷. Sayar reported a 55-year-old female patient who had mania two days after her husband committed suicide by hanging. Sayar stated that this situation can be transformed into denial, euphoria, and mania by means of manic defense. At the same time, he emphasized that the death of the patient's husband and the way he died in the case he reported was a very traumatic situation for the patient. He stated that patients use manic defense mechanisms in such traumatic events⁸. Onishi et al.⁹ reported a manic episode in a lung cancer patient four days after the death of a close friend who also had lung cancer. Krishnan et al.¹⁰ reported three cases of mania after losing their loved ones. In these cases, escaping from reality because of not being able to cope with the loss of a loved one was found to be the common denominator. However, some cases presented differently. Berlin et al.¹¹ reported a male patient who experienced mania immediately after the death of his mother although he was being treated with lithium at the time. Rosenman & Tayler reported a 28-year-old female patient who had mania in the days following her husband's death¹². Singh et al.¹³ described post-grief mania, possibly as a manifestation of recurrent mania, in a mentally disabled person with a 20-year history of aggression and hyperactivity. Morgan et al.¹⁴ reported a 37-year-old female

patient with a history of neither manic nor depressive episode who fell into psychotic mania after losing her husband to cancer. As stated in the literature, funeral mania is not clinically different from other types of manic episodes. In reported cases, symptoms included affective instability, dysphoria, enthusiasm, hostility, aggression, sudden mood swings, increase in energy levels, lack of a need for sleep, increase in the amount and speed of speech, pressured speech, flight of ideas, increase in goal-directed activity, excessive spending, and meaningless speech and laughter. Symptoms could also include increased sexual interest and hostility towards family members. Also, they sometimes had the belief that they were still in contact with the dead and might talk to the dead¹. In our case, most of the symptoms reported in the literature were present. There was no history of psychiatric illness in the patient's first-degree relatives. Our patient's condition significantly impaired her social functioning. The manic episode occurred shortly after she witnessed her father's death. Our patient had not developed a similar reaction to previous challenging life events. The occurrence of the manic episode immediately after the death of her father suggested a condition called burial or mourning mania. It may be concluded that the patient could not accept her father's death and reacted pathologically. According to the psychodynamic explanation, mania is a defense that sometimes protects the person from the destructive effects of depression and gives the person time to adapt to the environmental stressors. Through a manic defense, a person can transform grief into denial, euphoria, and mania. In this case, the death of father and the way he died was very hurtful for her. Thus, a manic state could have acted as a shield to make this traumatic event less emotionally painful. Manic defenses act as a gate, helping the person to avoid the painful meaning of inner reality². Toder-Goldin discussed the importance of manic defenses in adolescents in the grieving process and suggested that manic defenses can be a

source of strength for coping with grief in this age group¹⁵.

CONCLUSION

The temporal closeness between the patient's manic episode and the loss of her father, and the fact that the patient did not have any affective disorder, and had not developed such a reaction to previous challenging life events made us think that the case we reported was an incidence of funeral mania. We concluded from this case report that funeral mania should be considered among the possible grief reactions, and hopefully this case presentation will bring the attention of clinicians to this issue.

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