CASE REPORT

Grief in a Depressed Elderly with Pathological Jealousy and Major Vascular Neurocognitive Disorder: A Case Report

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Abstract

Introduction: Grief may be complicated in patients with dementia, posing a challenge to caregivers and healthcare professionals. A case of major vascular neurocognitive disorder with pathological jealousy and major depressive disorder in grief is reported. Case: A 73 year-old Malay lady with diabetes mellitus, hypertension, dyslipidemia, and right cerebrovascular accident developed major vascular neurocognitive disorder with pathological jealousy and major depressive disorder. She presented with unmanageable agitation and depression after her late husband’s death. She also experienced a bizarre delusion of her husband’s resurrection and infidelity. Her psychotropic medications were optimised and her bizarre delusion was challenged daily using validation and distraction techniques. Combined pharmacotherapy and behavioural therapy managed to resolve her psychiatric symptoms and facilitate her grief process. Conclusion: Grief reaction in major vascular neurocognitive disorder patients is often atypical. Individualized treatment comprising both pharmacotherapy and behavioural therapy should be offered to treat atypical grief and the underlying disease.

Keywords: Grief, Major Vascular Neurocognitive Disorder, Pathological Jealousy, Vascular Dementia

Introduction

Grief is the reaction to the perception of loss which happens to anyone at any phase of one’s life. However, grief can be complicated in an elderly with major neurocognitive disorder as cognitive impairment affects a person’s ability to process the loss and they may even not register any memories of the death. Grief and Myran had reported significant challenges faced by the caregivers and healthcare professionals while helping the patient to grief\(^4\).

There is limited literature on how these
patients who also have pathological jealousy mourned their spouses’ death; and its evidence-based treatment is also lacking. Hence, the management of a patient with major vascular neurocognitive disorder, with pathological jealousy and major depressive disorder, in grief is reported.

Case

Madam R was a 73 year-old Malay lady with underlying diabetes mellitus, hypertension, and dyslipidaemia. She had a cerebrovascular accident (CVA) with left sided hemiparesis 3 years earlier, soon after one of her sisters died. After the CVA, her memory deteriorated significantly. She also exhibited pathological jealousy, believing that her husband had an affair with their housemaid. She became verbally and physically abusive towards her husband and their housemaid. The patient also experienced depressed mood, anhedonia, insomnia, anorexia, hopelessness, worthlessness, and suicidal thoughts. She was treated with rivastigmine patch 10 mg daily, sertraline 25 mg daily, and quetiapine 200 mg daily.

Her condition improved until her husband died due to ischemic heart disease. The patient’s depressive symptoms worsened and her pathological jealousy reappeared. Her grief became complicated when she started to believe that her husband had come back to life and was living with another lady nearby to their house. She expressed sadness when talking about his death and funeral but exhibited anger when talking about his resurrection and infidelity. Patient insisted that her children search for her unfaithful husband, much to the dismay of her children.

The effort of reminding her about the death of her late husband by the family members, including bringing her to his grave proved to be futile. The patient became more agitated until hospitalization was warranted.

Physical examination revealed an overweight elderly lady with residual left hemiparesis and no other significant findings. Mental state examination on admission revealed a tearful depressed lady with delusion of infidelity as well as the bizarre delusion of her husband’s resurrection. Her Mini Mental State Examination score was 21 out of 30. Her blood investigation results were unremarkable. Computed tomography scan of the brain showed encephalomalacic changes at the right corona radiata and right temporoparietal lobe with volume loss and brain atrophy.

The patient was diagnosed to have major vascular neurocognitive disorder with major depressive disorder, pathological jealousy, and complicated grief reaction. Her medication was optimised accordingly, i.e. oral sertraline 25 mg in the morning and 50 mg at night daily, oral quetiapine extended release titrated up to 350 mg at night, and rivastigmine patch titrated to 15 mg daily.

Her bizarre delusion of her husband’s resurrection was challenged daily by asking for his whereabouts. Whenever the patient gave an answer that her late husband was still alive and staying somewhere, she would then be asked to verify this fact. Then she would be gradually led to recall the date of her late husband’s death and the event that happened (the funeral) on that date. Once the patient acknowledged that her late husband had passed away, empathetic and comforting words would be given regarding his passing. She was encouraged to talk about her late husband and relate on her fond memories of their marriage. Positive reinforcement would be given for every correct answer. This process was repeated.
daily throughout her three weeks ward admission. Family intervention was also done by providing psychoeducation on patient’s illness and training the family members on appropriate techniques of handling the patient’s behavioural disturbances due to her cognitive impairment. Validation and distraction techniques were frequently adopted to allay patient’s depression and suspicions about the husband’s resurrection and his infidelity.

The combination of pharmacotherapy and psychological therapy managed to reduce her depressive symptoms, as well as her delusional belief about her husband’s infidelity, thus making it easier for the patient to undergo the grieving process. She was discharged for outpatient care when she ceased to pressure her children to look for her late husband and her pathological jealousy started resolving.

**Discussion**

Harry R Moody once said:

*Both remembering and forgetting are unpredictable, in mid-stage Alzheimer disease, no less than at other stages of life. The best approach is not to opt for abstract principle but to plunge into the tangled web of communication and keep all channels open*.  

The grieving process of a patient with dementia may be different and unpredictable from normal people due to their cognitive deficits. Nevertheless, they do share some similarities, like irritability, anorexia, somatic complaints, less physical activity, and less interest in happy events. A grieving person with dementia does not tend to isolate themselves and help-seeking behaviour is rather common.

Different approaches are proposed by different authors in the attempt of helping the mourner with dementia. Lewis and Trzinki have proposed two innovative approaches, i.e. group buddy and spaced retrieval. Spaced retrieval is a technique that facilitates the learning and recall of new information by individuals with dementia. For our patient, similar approach was applied although the duration was not spaced out. The aim of the approach was to reinforce the patient’s memory about the passing of her late husband while helping her undergo the grieving process.

In conclusion, there is no definite method in helping a person with dementia to grieve and so, innovative approaches are needed, customised to the needs of the individual patient. Grief therapy, together with pharmacotherapy would help resolve some of the issues affecting grief in depressed, psychotic patients with moderate cognitive impairment.

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**References**


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