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Persistent Complex Bereavement Disorder and Culture: Early and Prolonged Grief in Nepali Widows

Jane Kim, Wietse A. Tol, Abina Shrestha, Hari Maya Kafle, Rajin Rayamajhi, Nagendra P. Luitel, Lily Thapa, and Pamela J. Surkan

Objective: Persistent complex bereavement disorder (PCBD) in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM*-5), has not been well studied in socioculturally diverse populations. Thus, this qualitative study examined (a) how widows in Nepal understand grief, (b) whether a local construct of PCBD exists, and (c) its comparability with the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM*-5), terminology. *Methods*: Using an adapted Explanatory Model Interview Catalogue (EMIC) framework, semistructured interviews with 25 widows and 12 key informants, as well as three focus-group discussions (n = 20), were conducted between October 2014 and April 2015. Through an inductive grounded theory–based approach, we used the constant comparative method, iteratively coding transcripts to identify themes and patterns in the data. Also, we created two lists of grief responses, one of early reactions and another all reactions to grief, based on the frequency of mention. *Results*: No single term for grief was reported. Widows reported a local construct of PCBD, which was broadly compatible with *DSM*-5 terminology but with important variation reflecting societal influence. Surviving torture during conflict, economic and family stressors, and discrimination were mentioned as important determinants that prolong and complicate grief. Suicidal ideation was common, with about 31% and 62% of widows reporting past-year and lifetime suicidality, respectively. Findings may not be generalizable to all Nepali widows; participants were recruited from a non-governmental organization, from Kathmandu and its neighboring districts, and were primarily of reproductive age. *Conclusions*: While PCBD symptoms proposed in *DSM*-5 were mentioned as relevant by study participants, some components may need adaptation for use in non-Western settings, such as Nepal.

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In Nepal, many young women became widows during an armed conflict (1996–2006), which resulted in approximately 16,000 people dead and 1,300 missing (United Nations Department of Political Affairs, 2014; United Nations Office of the High Commissioner for Human Rights, 2012). Recent earthquakes resulted in additional 8,800 deaths (Government of Nepal, 2016). In many cultures, including some in Nepal, widows not only face grief over their husbands' deaths but also may bear pervasive societal discrimination (Surkan, Broaddus, Shrestha, & Thapa, 2015; United Nations Division for the Advancement of Women, 2001). Verbal, physical, and sexual abuses (Sabri et al., 2016; Women for Human Rights [WHR], 2010) and discrimination, such as excluding widows from social gatherings because they are viewed as bad omens, are reported (Jolly, 2009). Experiencing grief in a context with compounded stressors (e.g., social exclusion, poverty) may obstruct one's ability to come to terms with major losses.

After the death of a loved one, many people may initially show intense grief responses but usually regain their functioning over time (Maercker et al., 2013). However, a portion of the bereaved population experiences intense grief reactions that persist (beyond what is culturally expected) and causes impairment in normal functioning (American Psychiatric Association [APA], 2013). In the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*), this condition is termed *persistent complex bereavement disorder* (PCBD) and is presented as a condition meriting further research (APA, 2013). Also called *prolonged grief disorder, complicated grief*, and *traumatic grief* in the literature (Prigerson et al., 2009), it is associated with higher rates of suicidal thoughts and acts (Latham & Prigerson, 2004), cancer, high blood pressure (Prigerson et al., 1997), and quality-of-life impairments (Silverman et al., 2000). This condition is reported to have a distinct set of symptoms and treatment that are different from major depressive disorder, persistent depressive disorder, post-traumatic stress disorder (PTSD), and separation anxiety disorder (APA, 2013; Shear, Frank, Houck, & Reynolds, 2005). Whereas the *DSM-5* reports the prevalence of PCBD between 2.4% and 4.8% (APA, 2013), the rate has been higher among the bereaved in conflict-affected populations (Momartin, Silove, Manicavasagar, & Steel, 2004; Morina, Von Lersner, & Prigerson, 2011). As armed conflicts and disaster occur disproportionately in low- and middle-income countries, studying grief in such contexts is important, and verification that PCBD indicators are appropriate becomes especially relevant given potential variations in socially sanctioned grief reactions across cultures (Rosenblatt, 2008). Moreover, while the construct and prevalence of PCBD have been identified in varied sociocultural settings (Shear et al., 2011), currently little qualitative research has been conducted to assess the applicability of PCBD symptoms across diverse populations.

Given the multiple challenges that widows in Nepal may face, with the possibility of these conditions further exacerbating and extending grief, we undertook qualitative research to understand how Nepali widows perceive and experience grief. We also explored participants' perceptions regarding whether a PCBD-like construct may exist in their context and, if so, how compatible that is with the PCBD criteria proposed in *DSM-5*.

METHODS

The study was conducted through a partnership between the Johns Hopkins Bloomberg School of Public Health (JHSPH) and WHR, a Nepali non-governmental organization (NGO) that advocates for human rights, supporting peacebuilding and women's economic empowerment through livelihood programs (WHR, 2016). Prior to study start, two WHR staff who had been working with widows for more than eight and 15 years, respectively, contributed to revising the Nepali version of interview questionnaires, selecting study sites, and referring key informants. The team purposively sampled widows, while striving for diversity in caste/ethnicity, geography (urbanicity), age

(focusing on younger widows), and length of widowhood. The study coordinator trained WHR staff and interpreters in research methods and ethics.

Through WHR's membership base, participants were recruited from Kathmandu, Lalitpur, Bhaktapur, and Kavrepalanchok districts. Data were collected October 21, 2014, through April 3, 2015, prior to the earthquakes in April 2015. The study coordinator and a Nepali research assistant with a master's degree and experience in qualitative methods conducted in-depth interviews (IDIs) with 25 widows, three focus-group discussions (FGDs) with a total of 20 widows, and key informant interviews (KIIs) with 12 individuals knowledgeable about widows' grief experiences (five of whom both worked in a professional capacity with widows and were widows themselves).

First, we conducted KIIs to learn about the context of widowhood in Nepal, soliciting accurate terminology and a culturally appropriate approach for conducting IDIs and FGDs with widows, in addition to asking the key informants about their own observations regarding grief. Next, we conducted IDIs using semistructured, open-ended questions that were adapted from the Explanatory Model Interview Catalogue (EMIC) framework (Weiss et al., 1992). We began interviews by encouraging informants to share their stories concerning their husbands' deaths, focusing on what they experienced, if/how changes occurred over time, and their current condition. We then asked how most widows experience grief, as well as if they had seen or heard about any widow who showed special/abnormal behaviors that would necessitate consulting a health worker or doctor. In FGDs, we asked the same questions but aimed at learning about social norms concerning grief. Demographic information (e.g., age, locality) was collected from all participants using close-ended questions. In addition, widowed participants were screened for suicidality using the suicide module of the Composite International Diagnostic Interview (Kessler & Ustun, 2004). On average, IDIs and KIIs lasted approximately 60 minutes and FGDs 75 minutes. For privacy, the majority of the FGDs and IDIs were conducted in WHR offices or participants' homes (according to their preference), and FGD and IDI participants received 200 Nepali rupees for travel expenses (equivalent to US$2).

IDIs, KIIs, and FGDs were audiorecorded, transcribed in Nepali, and translated into English. Using methods adapted from grounded theory (Charmaz, 2006), transcripts were inductively analyzed through an iterative process of coding and reconceptualizing codes using the constant comparative method (Glaser, 1965), while concurrently writing memos to theorize about relationships between codes and emerging themes (Saldaña, 2015). Using ATLAS-ti version 7.5, emerging themes were compiled into two codebooks, one based on widows' answers and another based on key informants. We created separate codebooks for widows and key informants to ensure that we were isolating how widows, who themselves had experienced grief, describe it (in case that differed from the perceptions of those who work with them professionally). We also generated lists of grief reactions (i.e., one list for early reactions and another list for all reactions over time, which included answers to questions about reactions generally as well as problematic reactions).

Written consent was obtained from all participants prior to collecting data. The study was approved by the Nepal Health Research Council and the JHSPH Institutional Review Board (IRB).

RESULTS

Key informants included 12 participants: two psychologists, one psychosocial counselor, four community leaders, and five staff from three different NGOs that provide psychosocial support to widows. Five key informants were widows themselves. A total of 49 widows participated in the study: five in KIIs, 25 in IDIs, and 20 across three FGDs (one widow participated in a FGD and also an IDI). Widows of varying age (24 to 60 years) participated, of whom 84% were of reproductive age (15 to

49 years). Time since widowhood varied, with a small proportion of women having been widowed less than one year or more than 15 years (4% and 12%, respectively), while the majority were widowed between one and four years (29%), five to nine years (20%), and 10 to 14 years (33%). Participants came from urban, semiurban, and rural settings, approximately one-third from each. Regarding caste/ethnicity, 31% were Brahmin or Chhetri (traditionally considered high castes: priests and warriors respectively), 59% were Janajati (indigenous groups), and 8% Dalit (traditionally considered the lowest caste, for example, barred from drawing water from communal taps or entering places of worship and high-caste homes) (Bennett, Dahal, & Govindasamy, 2008). In all, 31% (14/45) of widows answering the suicidal ideation and action questionnaire reported having either a suicidal thought, plan, or attempt in the past year; 62% in their lifetimes. These respondents were referred to a psychosocial counselor by WHR (Table 1).

Nepali Term for Grief

Based on our exploration with both widows and key informants, no exact term in the Nepali language captures the emotional process that is usually experienced after the death of a loved one, in other words, an equivalent of the words *grief* or *bereavement*. Words having analogous connotations, such as *pidaa/asahya pidaa* (referring to suffering, anguish, or torment) (see Kohrt & Hruschka, 2010), *asahya* (unbearable), *dukkha* (sadness, grief), and *maanasik chinta* (mental anxiety, worry) (Kohrt & Harper, 2008; Thapa & Hauff, 2005) were mentioned, with *pidaa* being most frequent. However, most respondents suggested that grief is best understood when the situation is described as opposed to using a single term.

Early Responses to Grief

To understand persistent and complex grief, it is critical to understand early and general reactions to grief. Widows reported numerous early reactions, with the most frequent reactions presented in Table 2. It was common for a recently widowed woman to cry, worry over her children's survival and future education, faint, lose sense of her surroundings, not eat, struggle to accept the death, be unable to think, and be unable to do anything, because she was deeply saddened and affected by the loss. One widow explained: "If I think about my husband, then I cannot do anything. And if I stayed in the room, then I felt like crying. I could not even speak, even though I wanted to speak. But this happens to all women like me, not only to me" (LA-IDI-1).

General Responses to Grief

When we looked at how widows generally respond to grief irrespective of time, the 49 widows mentioned a total of 151 reactions to grief. (See Table 3 for those reactions mentioned by six or more respondents.) The nine most frequently mentioned responses corresponding to early stages were also among the top 17 frequently mentioned general responses. (See Table 4 for example quotations.) The findings from widows were also supported by data from 12 key informants, whose five most frequently mentioned reactions included crying, suicide/suicidal thoughts, unable to sleep, headache, and losing memory/consciousness. Two key informants who are both widows and leaders in their communities gave similar comments about suicidality that widows think about or attempt suicide when they perceive themselves to be neglected by everyone, without any support (KTM-KII-7, LA-KII-8).

It is also worth noting that some of these grief responses may not be universally common, yet they may be relevant among cultural groups in Nepal because they are expressed in ways that reflect how the widows conceptualize the self, their surroundings, and life contexts at large. When talking about issues related to mental health, studies in Nepal have documented common ethnopsychologies to conceptualize different dimensions of the self, such as the "brain-mind,"

TABLE 1. Characteristics of Participants from In-Depth Interviews (IDIs), Focus Group Discussions (FGDs), and Key Informant Interviews (KIIs) (N = 56)
A. Participating Widows From IDIs, FGDs, and KIIs (N = 49 Widows)

Answer Categories	Frequency (%)
Location (urbanicity)	
Kathmandu (urban)	18 (36.7)
Bhaktapur (semiurban)	9 (18.4)
Lalitpur (semiurban/rural)	8 (16.3)
Kavrepalanchok (rural)	13 (26.5)
Refused to answer	1 (2.0)
Age (years)	
20–29	6 (12.2)
30–39	20 (40.8)
40–49	15 (30.6)
50+	7 (14.3)
Refused to answer	1 (2.0)
Duration of widowhood (years)	
< 1	2 (4.1)
1–4	14 (28.6)
5–9	10 (20.4)
10–14	16 (32.7)
15 +	6 (12.2)
Refused to answer	1 (2.0)
Caste/ethnicity	
Brahmin/Chhetri	15 (30.6)
Janajati	29 (59.2)
Dalit	4 (8.2)
Refused to answer	1 (2.0)
Cause of husband's death	
Illness	22 (44.9)
Conflict affected	9 (18.4)
Accident	7 (14.3)
Other	6 (12.2)
Did not ask KII/refused to answer	5 (10.2)
Suicidal thoughts in lifetime (yes/no)	
Yes	28 (57.1)
No	17 (34.7)
Refused to answer/lost to follow-up	4 (8.2)
Suicidal thoughts in the past year (yes/no)	
Yes	14 (28.6)
No	31 (63.3)
Refused to answer/lost to follow-up	4 (8.2)
Suicidal plan in the past year (yes/no)	
Yes	2 (4.1)
No	42 (85.7)
Refused to answer/lost to follow-up	5 (10.2)
Suicide attempt in the past year (yes/no)	
Yes	2 (4.1)
No	42 (85.7)

(*Continued*)

TABLE 1. (*Continued*)

Answer Categories	Frequency (%)
Refused to answer/lost to follow-up	5 (10.2)

B. Characteristics of Participating Key Informants (N = 12)

				If Nepali Female			If Widow,
Participant ID	Location	Role in the Community	Nepali Female	Age (Years)	Caste/ Ethnicity	Widow	Duration of Widowhood (Years)
KTM KII 1	Kathmandu	NGO staff	Yes	54	Brahmin	Yes	20
KTM KII 2	Kathmandu	NGO staff	Yes	35	Chhetri	No	—
KTM KII 3	Kathmandu	NGO staff	Yes	33	Chhetri	No	—
LA KII 4	Lalitpur	NGO staff	No	—	—	—	—
KTM KII 5	Kathmandu	NGO staff	Yes	40	Brahmin	No	—
KTM KII 6	Kathmandu	Psychosocial counselor	Yes	45	Newar	No	—
KTM KII 7	Kathmandu	Community leader	Yes	40	Brahmin	Yes	13
LA KII 8	Lalitpur	Community leader	Yes	27	Newar	Yes	4
BA KII 9	Bhaktapur	Community leader	Yes	33	Newar	Yes	11
KTM KII 10	Kathmandu	Psychologist	Yes	36	Chhetri	No	—
KTM KII 11	Kathmandu	Psychologist	No	—	—	—	—
KTM KII 12	Kathmandu	Community leader	Yes	40	Brahmin	Yes	10

Note. Percentages do not always add up to 100% due to rounding.

TABLE 2. Common Grief Responses Immediately Following a Husband's Death (N = 49 Widows)

	Initial Responses	Number of Widows Who Mentioned the Response
1	Crying	18
2	Concerns about survival/ future/child's education	13
3	Fainting	12
4	Losing memory/ consciousness/attention	11
5	Feeling sad	8
6	Not eating food	7
7	Denial/difficulty accepting the loss	6
8	Unable to do anything	6
9	Brain "stops working" or is affected/unable to think	5

"heart-mind," "physical body," "spirit," and "social-self" (Kohrt & Harper, 2008). These concepts were reflected in the ways widows reported grief responses, for example, noting that "brain stops working," "playing things in one's heart." Some widows described grief in close connection with physical health (e.g., falling sick, fainting), and some described the sudden shock of bereavement to be capable of pushing the soul out of the body (*saato gayeko*). Such descriptions relate directly to idioms of distress which include somatic complaints and spiritual phenomenon (soul loss), which have been reported in research exploring psychological trauma among conflict-affected Nepali adults (Kohrt & Hruschka, 2010).

Experiences of Grief Considered Problematic

Participants were asked if there are any signs of problematic or abnormal grief that may necessitate consulting a health worker/ doctor. Notably, almost 30% (14/49) of widows responded there were no such conditions. However, among those who did describe problematic signs, most mentioned crying excessively/easily, habitually forgetting things due to being lost in their own thoughts,

TABLE 3. Common Responses to Grief Irrespective of Time, Based on Answers From 49 Widows (Showing Responses Mentioned by at Least Six Respondents)

	Response to Grief	Number of Widows Who Mentioned the Response
1	Crying	23
2	Concerns about children's education	15
3	Not eating food	14
4	Unable to sleep	14
5	Having stress/tension	13
6	Losing memory/ consciousness/attention	13
7	Fainting	12
8	Remembering the past	12
9	Concerns about survival	11
10	Brain "stops working" or is affected/unable to think	9
11	Experiencing pain	9
12	Concerns about the future	8
13	Denial/difficulty accepting the loss	8
14	Feeling alone	8
15	Feeling sad	8
16	Not sharing problems with others	8
17	Unable to do anything	8
18	Unable to work	8
19	Headache	7
20	Taking medication[a]	7
21	Playing things in one's heart	7
22	Suicide/suicidal thoughts	7
23	Thinking too much	7
24	Eye problem from crying a lot	6
25	Feeling weak	6
26	Staring idly	6
27	Wanting to be alone	6

[a] Four out of seven widows who reported "taking medication" as a response to grief specified the medication as sleeping pills.

difficulty interacting with others, panicking/ becoming shocked easily, and not eating (KTM-FGD-2).

Others suggested that the duration and frequency of the usual responses determine whether a widow is experiencing complicated grief: "Within six months or one year, if that tension [due to grief] comes, remembering might last for the whole day … Having [that tension] constantly is a mental problem" (KTM-FGD-1). Eight widows in a FGD came to the consensus that experiencing grief responses is common in the context of reminders of the loss; however, even after a year since loss, if a widow is still experiencing these grief reactions daily then that was considered abnormal and problematic.

Duration of Grief

When widows were asked how long grief usually lasts, responses ranged from 13 days (during which mourning rituals are performed for some cultural groups) (Acharya, 2014) to lifelong, with most widows saying that feelings of grief initiated through reminders never end. We also explored how long widows face impairments in their daily functioning due to grief. Examples of impairment included one woman who described sometimes forgetting the alphabet at work, where she is a typist (KTM-IDI-5). Another described being unable to cook food for herself and her children due to falling sick with fever and chills (KTM-IDI-7). To this question of facing problems in their daily functioning, answers ranged from nine days to 15 years, with a median of one year. Finally, regarding the time for widows to return to work (inside or outside the home), responses ranged from 13 days to two years, with a median of three months. However, the consensus among participants in all three FGDs was that widows are commonly forced by economic circumstances to start working to make ends meet, despite not being ready emotionally.

Social Factors Influencing Grief: Conflict, Poverty, and Discrimination

Conflict

Some widows who survived torture during Nepal's conflict period described grief as being a lower priority compared to the psychological impacts of their conflict experience. A 40-year-old Brahmin widow shared that during the conflict her husband went missing and she was brutally tortured.

TABLE 4. General Responses to Grief Based on Interviews and Focus Group Discussions With 49 Widows

Response	Quotation
Crying	I cried so much, as I remember. I cried for ten to twelve years after the death of my husband. Now also from time to time I cry. We feel like crying because we are hurt by our own family members, as they blame and suspect that we will elope with a man. (KTM-IDI-2)
	From time to time I cried. Crying is natural, but he has gone, making us cry. (LA-IDI-1)
	I used to cry the whole day, so I was caught with a disease. For one year I sat crying. (KTM-FGD-1-6)
Loss of interest in eating	The way it affects is, at that time when we have grief and stress, we do not feel like eating and do not feel like working ... At that time, we feel so weak that we cannot get up. (KAV-FGD-1-6)
	I only eat once a day, that's it. Before I used to eat, but nowadays I don't eat much ... When it hurts, I don't feel like eating. In the evening, we [she and her two children] don't eat dinner. It's been about two years since we don't eat dinner. When it's evening time I don't know why or what happens to me. I don't feel like eating meals, and now I only take medicine for this sickness. I don't eat, and I have dizziness. (BA-IDI-6)
Difficulty or inability to sleep	Regarding my stitching work, I don't know ... When my brain became ... something, something ... I could not sleep, and I became short-tempered, so due to this problem I stopped stitching. (KTM-IDI-3)
	I fall asleep only sometimes. When I remember him [deceased husband] a lot, then I don't sleep. I only sit in bed and keep sitting there ... Sometimes I fall asleep for one and a half hour, sometimes two hours ... I get less sleep, not much. When my husband was there I slept a lot. Now, I don't. (LA-IDI-3)
Stress/tension	The main stress which everyone has is regarding one's household, how to run the house, how to educate their children. Main stress is this, how to educate the children, how to invest in their higher studies, and how to solve the hand-to-mouth problem. Stress is about earning an income ... If there is lack of income, no proper earning, ah ... no one in the house who can earn, who can support, then in that house there is more grief and tension ... That tension means having *chinta* [worries]. (KTM-KII-7)
	What happens at that time with single women is, when they are experiencing little stress, they become annoyed. If they speak with anyone, then they feel like not talking with them. Even if they speak, they speak being annoying ... This happens due to stress. But others do not know that they are experiencing mental tension. (KTM-FGD-1-4)
Losing memory/ consciousness/ attention	Decrease in memory power is due to grief. Headaches and all other [problems that were mentioned earlier] are due to grief. Due to grief our bodies do not function properly in so many ways. (KTM-FGD-1-Participants 2, 3, 4)
	Feelings that they [widows] have ... about [their] experience ... When someone is saying something, they will be in their own world. This kind of thing will be there. Initially they cry, just keep on thinking, recalling memories. If someone says something, widows will say, "Okay, that's what it is," [and] keep silent if they don't understand. If you say something, then they will suddenly come back from their flashback and ask you, "What were you saying?" (KTM-IDI-1)
	While she is working, she keeps forgetting. That also happened to me a lot. When I was cooking, like while making a curry, I missed all the spices that have to be put in to make the food taste better. If I put salt, then I forgot to put cumin powder. If I put cumin powder, then I forgot to put turmeric powder. (KTM-IDI-5)
Fainting	Until now I have been doing my husband's ritual work, and even if I am doing ... at that time, I kept on fainting, and I used to also urinate in my clothes. At that time, because my elder sister-in-law supported me I was able to do my husband's ritual work. My condition was like that. (KTM-IDI-2)
	Wherever we remember them [deceased husbands], we faint. I fainted for three months. Three months. Wherever we remember them, we just faint there. Some people sprinkled water on us. Sometimes it will be difficult. For three months it happened like that. (KAV-FGD-1-5)

(*Continued*)

TABLE 4. (*Continued*)

Response	Quotation
Dwelling on the past	Now while living at home, I only dream of him. While talking, eating, I recall the hospital and all those things, and all my friends told me not to stay in the house. They told me to work. I can't weave carpets. I feel like puking ... Now when friends come, then we talk, laugh, cook meat, and eat. It reminds me of the earlier times, and then I don't know what happens ... That memory comes quite often, so I don't fall asleep at night. Sometimes I don't fall asleep for an hour. (LA-IDI-4)
	That might last for four to five years. Let's say ten years. It is there in our memory, and we cannot forget our past. So later if family can give that kind of love, then only ... When they give that care and affection, then slowly we will forget. So, when we become able to forget that [husband's memory], then we can bring change and will not be in grief ... If he [deceased husband] cared and loved a lot, then we keep on remembering the past. (BA-IDI-1)
Concerns about survival	They don't experience stress while engaging in work. But what some women experience is, they go to work during the day, and at morning and nighttime they experience some stress. In the morning and nighttime they don't feel like eating, and they lack sleep. When they are in grief, they can't sleep. When they are engulfed in worries, that kind of condition will be there with many women ... In the morning and evening time ... to solve the problem of food, like, "Today, with how much difficulty I will manage with this, and this money will be gone after buying books and copies for the children. Now how will I bring salt and cooking oil for the house?" Those *chinta* [worries] will be there ... Worries of the morning make [a person] sleepless at night. I myself have gone through these worries, and other sisters also have the same kinds of worries ... How to manage food for the day, how to educate their children, they worry more about this. (KTM-KII-7)
Brain "stops working" or is affected/ unable to think	How I dealt [with my husband's death] at that time was, for one or two months, I didn't feel anything. I didn't have the ability to think, "Now, what do I do? Where do we go?" or "With whom do I share this kind of feeling?" (KAV-IDI-4)
	For me ... I was not able to think from my heart [-mind]. I was not able to think. For too long, like two to three months, I was like that. (KAV-IDI-3)
	I became very sick ... I felt very scared, and I felt like crying. When that happened, then automatically it affected the brain [*dimaag*]. (KTM-FGD-2-2)
	I remember everything before that, but after I touched him [husband's dead body], I don't remember anything. My elder sisters-in-law were standing there. I suddenly held them by their hair, and I jumped over their heads [facial expression suggesting that something strange had happened]. This kind of thing happened, so with my brain ... Since that time it impacted my brain, so ... if I have not made any mistakes, if my children also have not done anything [wrong], but if someone says anything [negative], then my temper became short. And this happened with me after that incident ... I gave birth to my daughter when I was 18 ... So, [people] said if I wish to study, then study, because I did not get a chance to study. But I cannot study. I could not concentrate on studies, because my brain from that time ... something has happened in my brain. Otherwise, it was okay before. (KTM-IDI-3)
Having pain	Her [another widow's] problem is that she is having pain all over her body. (BA-IDI-5)
	I was in pain ... Villagers told me, "Don't stress when you are in pain. We also have to go in the same way. Don't become more tense." People will get thin. So they should not cry, or else their eyes will become even weaker. I had more pain, and I said to myself, "Why am I taking so much pain?" (KTM-IDI-7)

Though she survived and received treatment for three years, she explained her condition up to that point: "I was mentally ill. I had almost become *paagal* ("crazy"). *Afno masu aafai khane* ("I would eat my own flesh") [roughly equivalent to "feeling torn up" or "being eaten from the inside"]. And whenever someone came, I would scream, shout, and cry. I didn't feel like living in society." When she learned about her husband's death, after three years of treatment, she fainted and was taken to a hospital where she was given sleeping pills. She said her *dimaag* ("brain-mind") had been damaged from torture even before learning about her husband's death and suggested that these experiences have inhibited her ability to process the grief and the death of her husband.

Another conflict-affected 31-year-old woman from the Magar ethnic group explained how the pain from witnessing violence and surviving torture overshadowed and complicated her grief:

> It took me exactly one year [of having abnormal grief responses to the husband's death] ... After that, they killed my friend in front of me. Because my child was with me, they couldn't kill me ... Then they took away my child. After this happened, the other pain became more painful than the death of my husband ... Later on, they gave back my child and tortured us. Now, when we have experienced this, what is that grief? What have I not forgotten? Because of the torture, I feel I am again abnormal. I always have a problem with my backbone and can't walk. The other kind of grief [from these experiences] also comes frequently. (KTM-FGD-2-5)

Poverty and Family Stresses

Half of the widows said that immediately following their husbands' deaths they were most concerned about how they would survive and educate their children without the family's breadwinner. A 44-year-old widow from the Newar ethnic group shared, "There is pain. How can I pay back my loan [crying] and take care of my children? I have to educate them, though I am illiterate. I do not earn much, but I have to at least feed my children ... Now I am taking care of my children with 100 rupees per day (equivalent to $US1), but my heart asks me how I am managing with that amount" (LA-IDI-1).

Due to these concerns about survival and providing for their children with few economic resources, it is common for widows to return to work though not emotionally ready. Participants reported experiencing difficulties living with their in-laws (most women in the study areas are expected to move in with their husbands' families after marriage) but also in their maternal homes, especially if the family is financially struggling. A 40-year-old Brahmin widow who was not allowed to continue to stay with her in-laws explained:

> I stayed at my maternal home with my two children. It was impossible to go back to the in-laws' house. I have a feeling they may kill me [crying] ... I feel that is the only grief I have. I didn't receive love and affection from my [in-law] family. When they did not accept me again, I was scared and frightened, and my children also refused to go in that house ... That kind of feeling has created *a maanasik tanaab* ("mental stress") in me ... My maternal home kept on telling me to go to my own [in-laws'] home ... I couldn't tell my father and mother that I have this kind of difficulty ... like mentally ... mental stress. What I feel inside is that due to the poor economic condition, this situation has also been created. (KTM-FGD-2-2)

A psychosocial counselor who has been working with vulnerable women for 20 years confirmed this phenomenon—that grief is multiplied in widows who face poverty (KTM-KII-6).

Discrimination

Most widows reported they experienced discrimination and victimization because of their widowed status. Both widows and key informants expressed that such discrimination and victimization have negative effects on widows' mental status and can impair their grief process. A 40-year-old widow from the Newar ethnic group commented, "If a woman has grief and the family causes more [pain] ... then it will accumulate and there will be more grief" (BA-IDI-1). A key informant who provides training to conflict-affected women linked how the grieving process is different for widows because of the blame and discrimination they face simultaneously:

> In the Nepali context, the condition will be slightly different for widows. If a woman lost her husband at a young age, then she will have the grief of losing her husband on one side ... while additionally, she has to suffer from false blaming [that she caused the husband's death], from the husband's and even her own family, because of our traditional superstitions. They even use abusive words like *witch*. We find this kind of mentality. Even if the family is nice and does not blame her, in some situations, she feels like she is the cause. One questions when the family will start blaming her, because one has seen the treatment of other widows. This kind of grief experienced by widows is of a different type. (LA-KII-4)

DISCUSSION

Through qualitative research, we explored how widows experience and understand grief, and we compared these findings to interviews with experts familiar with their experiences in Nepal. Participating widows reported numerous negative psychological reactions in response to bereavement, and suicidal ideation was common. Strikingly, more than half of our sample had contemplated suicide at some point. Widows' local understanding of problematic grief generally reflected the concept of persistent complex grief identified in high-income countries, but important differences emerged. Bereavement among widows was perceived to be complicated by several coexisting stressors that are atypical in high-income countries, including co-occurring psychological effects of armed conflict (e.g., surviving torture), societal discrimination, and economic hardship. These three factors were also mentioned by Rosenblatt (2008) as factors that have a major influence on grief processes across cultures.

The most common and initial response to grief was crying; however, other responses were related to problems with basic daily functioning (e.g., not eating, not sleeping, lacking concentration) and somatic symptoms (e.g., pain). Worries (e.g., about survival, children's education), preoccupation with thoughts of the deceased, and the brain-mind dysfunctions (e.g., inability to think) were often expressed. Responses that were thought to be signs of problematic grief included crying excessively/easily, not eating, habitually forgetting things due to preoccupation of the mind, inability to interact with others, and hyperarousal. Some widows explained that problematic grief may also be distinguished from normal grief by longer duration and higher frequency of the usual responses. Regarding the duration of grief, most widows said that grief from remembering the deceased husband (in the heart-mind) lasts for a lifetime, while the duration of experiencing intense psychological problems (in the brain-mind) and somatic responses varied, on average lasting about one year. The time before returning to work also varied but was on average about three months, with most widows emphasizing that they had to return to work prematurely out of economic necessity. While the majority resumed their daily functioning despite having problems due to grief, a few described experiencing impairments that were perceived as socially unacceptable and stigmatizing (e.g., unable to take care of their children or seeming mentally unstable).

Contextual Considerations in the Application of the Proposed *DSM-5* PCBD Criteria to Widows in Nepal

According to the widows, grief reactions considered problematic were also distinguished by persistence over time. They broadly matched with the criteria proposed for PCBD in *DSM-5* (APA, 2013), but two main issues arose. First, participants reported some grief reactions through idioms of distress, which may be more locally prominent, for example, making distinctions between distress in the brain-mind and heart-mind, and potential soul loss. Although these reactions were not

necessarily mentioned as symptoms of problematic grief, future research should further investigate whether these reactions have the potential to be signs of problematic grief if persistent. The second issue is with the symptoms that are seen in both PCBD and among our participants but may have different meanings and underlying causes. These include a desire to die in order to be with the deceased; confusion about one's role in life, or a diminished sense of one's identity; difficulty trusting other individuals since the death; and maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame). For these, a contextual understanding of the widows' experiences can inform the interpretation and applicability of the proposed diagnostic criteria.

Suicidality was highly salient among our sample of Nepali widows; 31% and 62% reported suicidal thoughts, plans, or attempts in the past year and in their lifetimes, respectively. Although ours was not a representative sample, a Ministry of Health and Population study among 1,060 households in four districts of Nepal (Pradhan, Poudel, Thomas, & Barnett, 2011) found suicide to be the number one cause of death among women of reproductive age and showed that widows were more likely to contemplate or attempt suicide compared to married women. However, what remains unknown is the reason behind suicidality among Nepali widows, whereas in the *DSM-5* the reason is to be with the deceased. Our data suggest that among Nepali widows the reason may be more related to poor treatment and ostracism, suggesting that more research is needed to ascertain reasons for suicidal ideation in this population and whether high rates of suicidality associated with PCBD (Latham & Prigerson, 2004) may be stronger in this context.

Based on our findings, the diagnostic criterion "confusion about one's role in life or a diminished sense of one's identity" applies to almost all widows given the social consequences of widowhood in Nepal. Within many Nepali cultural groups, married women's identities and value are closely tied to their husbands, such that by losing a husband widows lose their status within the family and society (Jolly, 2009; Sabri et al., 2016). They may be rejected and displaced from the husband's home immediately following his death (Dahal, 2007). While such attitudes favoring patriarchal gender roles marginalize gender equality and human rights of some widows (Thapa, 2007), they may be forced to become breadwinners if they need to support themselves and young children (Adhikari, 2015). Such new demands can cause confusion among widows over their role in society; though they are treated as having diminished value, their role in supporting themselves and children becomes more important. Therefore, including confusion over one's role or diminished sense of self as one of the symptoms of PCBD may result in overdiagnosing PCBD among widows in Nepal.

Regarding "difficulty trusting other individuals since the death," Shear and colleagues (2011) explained that "[p]eople with complicated grief are mistrustful because they feel that others don't understand them or are critical of them" (p. 24). According to our participants, mistrust is a reciprocal response to the societal discrimination they face. As aforementioned, social isolation can be a problem for widows (Houston et al., 2016), and they are prone to various types of abuses because of their marital status (Sabri et al., 2016). In our study, many widows reported feeling victimized, and some reported being unable to trust other people because of this situation. Although other participants reported no change in their ability to trust others since the loss, including this item may also overestimate the presence of PCBD among widows in Nepal.

Concerning "maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)," this criterion may be conceptualized quite differently in Nepal compared to other contexts where widowhood is not stigmatized. According to

our participants, most widows feel upset that other people are blaming them (including accusing them of causing their husbands' deaths) rather than blaming themselves. A careful analysis of the source of the maladaptive self-appraisals may be helpful in formulating appropriate treatment for widows with a PCBD-like condition in Nepal.

Our participants perceived that discrimination toward widows prolonged their grief. This report parallels findings from West Papuan refugees from Indonesia who relocated to Papua New Guinea, where a sense of injustice relating to past persecution and human rights violation was associated with complicated grief (Tay, Rees, Chen, Kareth, & Silove, 2016). Although the complicating factors are different in two settings, they may operate similarly in that they impact the grief process through the local collective experiences of these marginalized groups. The extent to which contributing factors, such as discrimination, poverty, and the lingering effects of conflict, can be addressed may improve the grief process for widows in Nepal. These issues exist at a societal level, beyond the influence of individual health care providers caring for women with PCBD, and may be best addressed by governmental policies that help reduce abuse against widows and enhance efforts to change societal norms around how widows are perceived.

Some participants who are survivors of torture from armed conflict reported that grief from their husbands' death was overshadowed by other traumatic events they experienced. Supporting this idea, a study of tsunami survivors in India found that physical injury was significantly associated with higher risk of PTSD symptoms but significantly associated with lower risk of PCBD (Rajkumar, Mohan, & Tharyan, 2015). In our study, data suggest that the negative psychological impacts of torture may inhibit widows' abilities to grieve after their husbands' deaths. A study of orphaned and widowed genocide survivors in Rwanda suggested that the severity of PTSD and PCBD symptoms was associated and that PTSD may interfere with the grief process and increase the risk of PCBD (Schaal, Jacob, Dusingizemungu, & Elbert, 2010). Therefore, to provide appropriate treatment to widowed torture survivors, who may be suffering from both PTSD and PCBD, it might be necessary to address PTSD first or treat both simultaneously.

The association between indicators of poverty, such as food insecurity and low levels of education, and common mental disorders has been well documented (Lund et al., 2010). In our study, coexisting hardships caused by the husband's death, including poverty after loss of the breadwinner, were perceived to prolong grief. Regarding PCBD, in a qualitative study conducted in Togo, West Africa, where culturally elderly parents are typically taken care of by adult children, poor elderly parents who lost an adult child to AIDS reported grieving over the loss of their children as well as the loss of financial support (Moore, 2007). Current economic empowerment programs (through skills training in income-generating activities) that civil society organizations, such as WHR, provide may help to reduce PCBD among women accessing such services in settings where economic hardships appear to complicate the bereavement process.

The present study has strengths and limitations. Our partnership with WHR, an organization dedicated to supporting widows, provided a unique opportunity to access and gain the trust of many women from diverse backgrounds who had experienced loss and grief. Recruitment of widows through WHR likely fostered more comfort and candidness in sharing sensitive and emotional issues. We gathered data from both widows and key informants to obtain different perspectives, enhancing the credibility of our data.

Given our recruitment protocol, findings are probably not transferable to all Nepali widows, and more research is needed with women representing a wider range of ages, ethnicities, and cultural contexts. All participants were recruited from Kathmandu and its neighboring districts located in the Central Development Region. Also, all widowed participants were members of WHR, whose sociodemographic characteristics do not mirror those of

the country on a whole. WHR members who are willing to share their stories may be more exposed to WHR empowerment activities. Notably, our results are particularly relevant to widows of reproductive age. Although these experiences may also not be entirely transferable to cultural contexts beyond those of our participants, it is possible that some issues we found relevant to the applicability of the proposed PCBD definition (APA, 2013) may be similar in other groups of widows in the region also facing discrimination, conflict, or poverty.

CONCLUSION

Findings from widows and key informants in this study in Nepal generally support the concept of PCBD—a grief response that is considered prolonged, problematic, and responsible for hindering widows' daily functioning. Levels of suicidality among participating widows were notably high. Social marginalization, conflict-related traumatic events, poverty, and family stressors were reported as co-occurring important determinants influencing persistent complex grief. Government policies that provide protection, societal norms that uphold widows' equal standing, and economic empowerment services that build widows' financial capacity may contribute to preventing PCBD in this setting. At the same time, local adaptations of the *DSM-5* criteria for PCBD, as well as the validation of a culturally relevant grief scale, may be necessary for cultural groups in Nepal.

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