Case Report

The Trajectory of Depression through Disenfranchised Grief in Young Widows in Times of COVID-19: A Case Report from the Rural Population in India

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Abstract: The COVID-19 pandemic is one of the past century's deadliest and most widespread viral outbreaks, with higher mortality rates in men than women. Disruptions in funeral rituals and customs, no social recognition of the loss, and limited social support intricate the grieving process and are linked with disenfranchised (not openly acknowledged, socially recognized, or publicly mourned) grief. Depression is also highly comorbid with complicated grief. Losing a spouse can be devastating, but more severe for women with limited or no resources, vulnerable to the patriarchal society. In the current COVID-19 era, increased uncertainty and disenfranchised grief can worsen the clinical scenario and intervention, as highlighted by the present case report of disenfranchised grief with depressive symptoms in a 30 years old woman from rural India who, after a year of her marriage, lost her husband due to COVID-19. This case study emphasizes the impact of multiple axes of disadvantages due to sociodemographic and cultural determinants that can complicate the grieving process in the current context. The bioecological model of grief recovery considered the individual features and the societal/environmental factors to postulate the appropriate intervention. Finding meaning and purpose in life, and restoration-oriented coping were successful for clinical management.

Keywords: disenfranchised grief; widowhood; rural India; COVID-19 pandemic; bioecological model; coping

1. Introduction

Spousal bereavement has been considered one of the most distressing and stressful of all events [1]). Experiencing an adverse event like the loss of a spouse can trigger depressive symptoms [2]. The common symptoms are sadness, loneliness, diminished appetite, disturbed sleep, and frequent crying spells. A meta-analysis study estimated that 41% of adults reported clinical levels of depressive symptoms, and 27% of individuals reported significant anxiety levels in widowhood [3]. Widowhood could be the most disturbing experience in an individual's life, linked with many adverse mental and physical health effects, especially if losing a spouse in the early years of the marriage [4] According to Trivedi et al. [5] younger widows are less prepared emotionally to cope and deal with the loss as compared to older widows. The condition of some groups could be more detrimental, who are socio-economically disadvantaged, who are illiterate, rural residents, and from an underprivileged caste.

The pre-existing inequalities associated with the impact of the COVID-19 pandemic aggravated the risk of mental health issues among women from disadvantaged populations. The mortality rates from COVID-19 were 77% higher in men than women, especially among middle-aged males [6]. A study by Kushwaha et al. (2021)[7] highlighted that the infection and mortality rates were higher in men than women in India. A higher number of mortalities in males resulted in millions of COVID-19 widows. COVID-19 widows may experience an elevated risk of mental health conditions and physical illnesses compared to pre-pandemic widows [8].

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In Indian society, especially the rural backgrounds where widows are generally a disenfranchised group [9] and widowhood is not only a personal status but also a social institution. Frequently, they are subjected to subjugation, discrimination, and social stigmatization in the family and community. Women's responsibilities change after a spouse's demise, and adjusting to a couple-oriented society as a single woman can aggravate emotional distress. Widowed women's condition is worse and more vulnerable in rural regions. Indian studies have identified an association between being a widow, isolation, psychological well-being, and psychiatric illnesses [10]. However, there are relatively few studies done on mental health issues in the rural population.

During the pandemic, it was estimated that approximately 60 million people worldwide were mourning the loss of their loved ones [11]. The shared experience of loss by society has given rise to collective grief, and the grieving process has shifted from individual mourning to societal mourning [12]. Despite this, there were instances where people's losses and grief went unacknowledged by society, which left them feeling unsupported and neglected leading to disenfranchisement grief. Doka (2008) [13] illustrated disenfranchised grief as when a person experiences a significant loss and society can not acknowledge and support the grief and failed to mourn publicly. Stalin Joseph quoted "The death of one man is a tragedy, a million deaths is a statistics". During the pandemic, many have experienced psychic numbing, illustrating the concept of one loss to death is tremendously significant, but as the numbers increase, our feelings would not proportionately increase as well [14]. These limitations can intensify the likelihood of an individual experiencing grief as disenfranchised [15].

India's situation appeared to be no different compared to that of any other country, but it has been confirmed that India has some of the highest COVID-19 death tolls and confirmed cases in the world. In India, like other low and middle-income countries, COVID-19 affected all sections of society, yet the pandemic and its aftermath have disproportionately impacted the disadvantaged members of society including women, older persons, individuals living in poverty, people with pre-existing physical or mental illnesses and those living in certain geographical locations [16-17]. People living in rural areas face everyday obstacles to their livelihoods and confront barriers in seeking facilities for mental health care. The latest data for the year 2022 underlined that approximately 69% of the Indian population resides in rural areas [18]. One of the largest demographics in the nation experiences impediments to receiving mental health care.

This present case study outlines the psychosocial challenges experienced by a young widow living in a rural environment. This case study endeavours to evaluate spousal bereavement and to comprehend the role of secondary losses in inducing mental health conditions in young women living in rural India. The psychological conceptualization and management will be discussed.

2. Case report

Geeta (pseudonym) is a 30-year-old female, living in a small village in Rajasthan, India, who is living with her parents and siblings after the loss of her husband to death. She presented with complaints of significant conflicts in interpersonal relationships for the last six months. In a clinical interview, she reported low mood, irritability, excessive crying, anhedonia, social withdrawal, dizziness, and excessive worry about the future, with associated disturbances in sleep and appetite for the past year. The onset of symptoms insidiously started with the demise of a husband a year ago after one year of marriage. Geeta was in a content marriage but because of the sudden demise of her husband, she had to move to her maternal family. She reported being blamed for her husband's death and often mistreated by her family-in-law. While living with her parents, she found herself financially dependent on her family for necessities and answerable to the kin members for all little consumptions.

According to Geeta, she felt lonely and neglected at home and often spent most of her time alone. In her family, she is the fourth of nine siblings, out of which three elder sisters are married and living with their husbands. She often felt like missing what her sisters have and feels a hollowness in her life. Moreover, her relationship with her younger siblings is not satisfying and the conversations mostly ended up with verbal quarrels. She also stated that discussions about her second marriage

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and mental health issues make her irritable most of the time and ended up having dramatic arguments with her family members.

During sessions, she often reported being lonely and expressed the desire for a companion in her life. At this moment, she felt ready to have a partner, yet was afraid to go through the same in her life. She feels to be physically attractive to have more marriage proposals if she has a widow status. Regarding her physical appearance, her siblings constantly tell her how sick she looks, and she feels annoyed and irritable. She also stated that she was rejected for marriage because of her widow status. Furthermore, the societal unrealistic beauty standards made her feel inadequate and lowered her self-esteem.

She reported that she is putting effort to forget about her spouse every day as a coping mechanism to deal with overwhelming pain and sadness but she failed to do so. This made her feel helpless and hopeless about her future. She often expressed how meaningless her world seems suddenly, and has no purpose left in her life. The symptoms lasted for more than a year, but the family members only approached the mental health professionals due to interpersonal conflicts at home.

In the initial stages of the illness, the family members failed to recognize the symptoms because of a lack of understanding and when they become aware, there was no psychiatric hospital in the vicinity. In order to receive a consultation from a super speciality or psychiatric hospital, they must travel 150 kilometres. Geeta and her family members acknowledged the reluctance to seek mental health treatment prior because of a lack of awareness about psychiatric illnesses, lack of access to mental health facilities, limited financial resources, expensive transportation, and the associated stigma.

In her personal history, she has a master's degree in Hindi language and is currently preparing herself for public service examinations. Geeta feels discouraged by her family for preparing for higher education and public serving jobs. She is not sexually active and lost interest in sex completely. However, she feels aroused when she thinks about her deceased husband.

The Psychiatrist prescribed tetracyclic antidepressants and Benzodiazepines for a month and she reported a slight improvement in sleep and appetite. Her medical history did not reveal any past psychiatric and medical illnesses. Her physical examinations reported Blood Pressure (130/90 mm Hg), an RR value of 20 per minute, with no abnormalities detected in ECG and routine blood chemistry.

In the mental status examination, she was a thin-built female who was looking very tired, dressed appropriately for the weather and the context. She was crying throughout the session and had restricted facial expressions. Her psychomotor activity was decreased, with a depressed mood and restricted affect. Her thought content was predominant with depressive themes and issues related to interpersonal conflicts but denied any suicidal ideation. Her cognitive functions were intact.

Investigations:

The client met the criteria of a depressive episode but not an anxiety disorder based on the International Classification of Diseases (ICD-11). A few tests and self-report measures were administered to evaluate the signs and symptoms. On Beck Depression Inventory, she scored 30, which indicated moderate depression; on Beck Anxiety Inventory (BAI), she scored 23, indicating moderate anxiety. The score of MMSE was not indicative of any cognitive problems. On the Inventory of Complicated Grief, she scored 38 points indicating a significant impairment in social, general, mental, and physical health functioning and bodily pain. Some other psychological measures were used to assess the purpose of life and social support of the client. On the Meaning in Life Questionnaire, she scored 15 points for the presence of meaning and 16 points on the search for meaning, which indicates that there is no value and purpose in her life, and she may not be very optimistic about the future.

Psychological and social difficulties are a frequent occurrence amongst women who have lost their husbands, and the situation is further exacerbated for women living in rural India because of

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socio-economic issues. We considered these obstacles while planning the right clinical management of the client. As a result of the psychiatric history and investigations, her psychotherapeutic management has been planned for once in two weeks and finding meaning and purpose in life, and restoration-oriented coping strategies were used in the context of COVID-19.

3. Discussion

3.1. Grief and Mourning

Grief is a common response to loss; it is a non-linear, complex, and unique reaction that has personal, social, and cultural relevance [19-20]. Most people adapt to the death of a loved one naturally, not easily, along with the accompanying changes in life circumstances [21]. Losing a loved one is a primary loss, and the losses stemming from the primary are secondary losses. Secondary losses are more prominent in all death-related losses [22]. Initially, individual deals with the external part of the grief like performing rituals and customs, but later deals with the internal world of the grief, and how they feel [23]. Alongside, non-death losses during the pandemic have stricken together and made it more complex. With a loss of a closed one to death, the non-death losses and secondary losses become significantly invisible. However, the grieving experiences could be similar in any paradigm. These losses have been seen as unobserved altogether and considered as disenfranchised.

When someone dies, the pattern of thoughts and routines builds up for years, and assumptions about the self and the world change, these transitions are called Psycho-Social Transitions (PST). These alterations could be intricate in the grieving process which could lead to considered levels of Prolonged Grief Disorder as well as depression, anxiety, and PTSD. It could also become difficult for people who are more vulnerable to anxiety and depressive mood/pre-existing symptoms of disorders [24].

3.2. Death and mourning process during the Pandemic

The pandemic has devastated and had a lasting influence on many lives globally. Many countries have imposed national lockdowns and implemented strict movement restrictions to curb the spread of the infection. The COVID-19 pandemic and the prolonged lockdown portrayed a gruesome and terrifying picture of the future and have brought unprecedented uncertainty regarding physical and mental health, financial security, cognitive ambiguity, and social relationships. Although uncertainty is a natural and inevitable part of human lives, it is a persistent and predominant state during ongoing health crises [25]. It is not wise to quote that uncertainty is directly associated with psychological distress and mental illnesses. Moreover, intolerance of uncertainty affects the individual's capacity to handle uncertain situations and stressors effectively [26]. At the pandemic's beginning, uncertainty about the future was considered a known risk for developing severe emotional responses, anxiety, and stress-related symptoms in individuals [27]. It was further exacerbated by the growing number of active cases and death rates globally [28].

The process of death and dying has become an everyday phenomenon due to the COVID-19 outbreak. Even when the mortality rates were decreasing, several deaths were reported daily. However, losing a loved one cannot be quantified. Each loss or death of a loved one could be the most devastating experience of a person's life. COVID-19 deaths or losses are associated with sudden deaths, intensive care treatment, social isolation, lack of opportunities of performing funeral rites with their religious practices, and stigma related to COVID-19 infections [29]. A few pre-pandemic studies about the grieving process already showed that circumstances like limited opportunities for shaping death rituals, receiving adequate social support, and increased isolation can derail the grieving process [30].

The loss of a loved one is usually accompanied by other losses (loss of income, sense of purpose and identity, loss of companionship, loss of faith, loss of confidence, etc.) [22]. In addition to this, experiencing multiple losses has shaped the idea of grief that arose in a wider context of loss. The losses were not limited to experiencing a death of a loved one, but losses included the sense of predictability, protection, control, and justice [31]. In these uncanny times, the multiple mourning

has also intricated the grieving process [32]. The pandemic has caused social and economic disruption worldwide, people have not only lost their loved ones but also their livelihoods and a disadvantaged population is at risk of falling into extreme poverty [33].

Experiencing a recent loss during the pandemic elicited a more severe acute grief reaction than before the pandemic, suggesting that dealing with loss may be more difficult during this ongoing health crisis. A study by Gimenez-Llort (2022) [34] explained the difficulties faced by individuals in the grieving process before and after the pandemic and highlighted how sudden and unexpected scenarios can make grief more difficult. A dual process model by Stroebe and Schut (2021) [35] could provide a better understanding of the complexity of the grieving experience and a shift from Individual to societal mourning during the pandemic. The dual process model (DPM) also emphasizes meaning-making during bereavement. Finding meaning and building a new life can be challenging yet considered a central part of healing in response to both death and non-death losses [36], especially in the context of the COVID-19 pandemic [37].

3.3. Widowhood for young women in Times of the COVID-19 Pandemic in India

As evident in the present case, living as a widow for a woman is disadvantageous in numerous ways in normal times, and the COVID-19 pandemic has exposed them to more vulnerabilities. After the loss of a spouse, women experience economic and emotional shock. Losing a partner who is also the primary breadwinner in the family, women normally experience monetary consequences. The household faces an economic burden due to losing the primary earner and elevated financial responsibilities. These financial burdens and responsibilities tend to fall on women entirely, with little or no assistance from family members. In rural settings, women/widows have fewer economic resources and endowment as compared to their male counterparts, which makes them more vulnerable to dealing with the economic consequences and put them at a high risk of mental health problems [5].

On the contrary, women's higher education levels, upper-class stature, and caste affiliations not necessarily be an advantage. Despite this, they often face employment restrictions, including limited opportunities, low wages, and many times not being allowed to go out of home for work [38]. Like in the present case report, Geeta's education level can be considered a protective factor, but the societal and familial dynamics were totally against it. The family never supported her in being financially independent. For her family, sending the daughter to earn money is a matter of indignity. Nevertheless, these are the reasons why widows experience substantial levels of poverty as compared to another ménage.

It's not uncommon for young widows to be blamed for their husband's death. They are also shamed and stigmatized for their widowhood status. The level of social stigmatization can also differ from culture to culture; however, it was found to be more in rural backgrounds comparable to urban ones. They may also be restricted from attending social and religious gatherings. Correspondingly, remarriages are also not so common, even the remarriage happens, the impediments are quite evident, including the demands of dowry, bride price, and what more to offer. These psycho-social issues are often associated with psychological impacts and could trigger psychiatric illnesses [10].

3.4. Psychotherapeutic approaches

The psychotherapeutic approaches could be effective to deal with complicated grieving experiences and associated psychiatric illnesses. Many conventional approaches to grief intervention have been considered beneficial to the grievers, like Interpersonal Therapy, Supportive Psychotherapy, Cognitive Behavioral Therapy, and Bereavement support groups [39]. In addition, many modified interventions are designed to help individuals deal with their grieving process. Literature suggests the other two approaches seem splendidly promising to help individuals to deal with death or non-death disenfranchised grief during COVID-19 times. A dual process model proposes that an individual engages in oscillating between a *loss-oriented approach* when a focus is on acknowledging and addressing the emotion related to grief and a *restoration-oriented* when a focus is on making adjustments and attending to the life changes [35]. In a recent study of widows, it has been

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found that women possibly gain benefits with restoration-oriented interventions as compared to their male counterparts [40]. The second approach is meaning-centered *grief therapy* where a sense of meaning and purpose plays a crucial role in dealing with the loss of a loved one. This approach helps to recognize meaningful experiences and live with grieving experiences and cherish the memories [41]. The meaning of life has been found advantageous in times of the COVID-19 outbreak [42].

3.5. Challenges in Rural or remote areas of India and the bioecological model

Despite the utility and advancements of these interventions, there may be several challenges in delivering the intervention regardless of treatment modality in rural or remote areas. The obstacles in providing intervention could be inexhaustible; it begins with a lack of awareness or information among rural residents, perception about mental health treatment, attitudinal barriers, general hesitation in reaching out and seeking help, inaccessibility of MHPs in a town and also unaffordability of the sessions. The feasibility issues are realistic and could range from travelling far-flung for proper treatment to skipping a day off from work to have a consultation.

Mental health workers should be innovative in their approach to providing psychological support for grief and bereavement, particularly for those from rural areas. Considering the cultural and demographical backgrounds, it is pivotal to contemplate an all-over approach to assist the client. The *bioecological model of grief recovery* postulates the risk and protective factors preceding the loss, as well as redefining and reintegrating the self into life and adapting to the changes in everyday existence [43-44]. In the current COVID-19 pandemic context, this socio-ecological analysis can be helpful to understand the severe adversities that individuals and society confront in dealing with grief's complexity under adverse scenarios and the pressure of the chronosystem [45].

The *microsystem* is the individual's immediate environment, including close friends, immediate family, grief counsellors, workplace, peers' groups, and involvement in religious or spiritual groups and practices. Identifying supportive factors in the immediate setting for the griever to feel safe, understood, and belonged. Brief family psychoeducation or counselling can be planned to address the needs of the client to keep the individual's mental and physical health intact. *The mesosystem* is the interaction between two or more microsystems, including a connection between friends and family, family and religious involvement, religious groups, and people with similar experiences. This benefit having intrapersonal interactions and connections to strengthen the support. Moving forward, the exosystem focuses on the environment that the individual does not impact directly but influences indirectly. It includes government policies, employment opportunities, and safety and security. It is imperative for MHPs to be aware of the Government (Central, state, or regional) schemes and policies of pensions, job opportunities, and financial assistance, for widows. These supports can help widows manage financial burdens and may work on secondary losses. In addition, regular visits to the villages and rural areas could be planned by MHPs and institutions and organizations in a form of community outreach programs to increase the accessibility of mental health treatments. The active role of district mental health programs and the involvement of NGOs in sensitization and awareness programs. Community-wide strategies need to be employed to enhance awareness of the benefits they can get from mental health treatments and timely consultation. Lastly, *the macrosystem* refers to values, traditions, and a broad socio-cultural concept. These conditions could be beyond the clinician's capacity to influence directly. However, drafting social policies, laws about mental health for rural or remote areas, healthcare resources, and educational and research resources will impact this capacity's social, political, and financial development [46].

4. Conclusions

This case report highlights the sudden deaths and non-death losses during the COVID-19 outbreak that may obscure the grieving process. It has also been found a lack of recognition of the loss, social isolation and physical distancing has been linked to disenfranchised grief. Moreover, the intricacies in the grieving process and psycho-social challenges can complicate the grief process and put an individual at a higher risk of developing other psychiatric illnesses like depression.

To plan an effective treatment for grief, Mental health professionals must employ community-wide therapeutic strategies while considering the cultural and demographical backgrounds. The bioecological model of grief recovery can be used on rural populations from individual characteristics to the community level.

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