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IMPACT OF WIDOWHOOD ON PSYCHOLOGICAL WELLBEING AND QUALITY OF LIFE OF SPOUSES IN ONITSHA, ANAMBRA STATE

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ABSTRACT: *This study examined impact of widowhood on quality of life and psychological wellbeing among widows in Onitsha, Anambra State, Nigeria. Twenty-six (26) widows between the ages 20-70 years were sampled using the purposive and convenience sampling techniques. A cross-sectional survey design was used while the World Health Organization Quality of Life Questionnaire and Psychological Wellbeing Scale were used to collect data from the participants. Statistics was MANOVA. Results showed thus: Widowhood did not significantly impact on the quality of life of widows irrespective of their (widows') biosocial characteristics; and widowhood did not significantly impact on the psychological wellbeing of widows irrespective of their (widows') biosocial characteristics. More researches are recommended to identify specific factors predisposing widows at risk of poor quality of life and psychological well-being.*

KEYWORDS: Widowhood, Psychological Wellbeing, Quality of Life, Spouses

INTRODUCTION

One of the most common stressful events in later life is widowhood, which has significant social and psychological implications on quality of life. It often causes deprivation of the primary provider of social and emotional support, leads to social isolation occasioned by the absence of a major attachment figure (Somhlaba & Wait, 2018) and increases the risk of suicide (Guohua, 2005). It is estimated that 20–40% of widowed persons never fully recover (O'Rourke, 2004). Davidson (2010) addressed that a spouse's death causes an individual's slide towards chaos (sometimes temporarily and occasionally permanently).

While every age group may experience death of a spouse, literature reveals that death of a spouse is known to have a profound effect on the psychological wellbeing and quality of life of the widow/widower, and is an event which provokes important life changes (Bennett, Hughes & Smith, 2005). This is because the spouses may already have a chronic physical illness that decreases their ability to adjust with the bereavement; experience several losses in a short period of time (Curtis, 2007); are more likely to become physically ill after the death of a spouse (Rando, 1984); and may suffer many losses, including financial security. There is considerable consistency in widowhood studies indicating that widowed elderly people experience lower morale and a higher incidence of mental problems in comparison to married older persons (Greene & Sheila, 1989). A fundamental question that remains unclear in this area of research, however, is whether widowhood negatively affects psychological well-being and quality of life of spouse.

Psychological wellbeing is central to life quality in its schema because it serves as an evaluation of an individual's competence and perceived quality of life in all domains of contemporary life and is the ultimate outcome (Lawton, 2011). Well-being in adulthood as a combination of cognitive functioning, behavioral functioning, physical health and mental health (Moore & Keyes, 2013). The cognitive functioning component includes positive thought processes whereas restorative sleeping is an example for physical health. In addition, Keyes and Waterman (2013) stated that the level of well-being also indicates how the individual is being involved in communal activities, such as volunteering and voting, and how one feels responsible to others. Two approaches for well-being; hedonic and eudemonic are defined by Ryan and Deci (2011). Hedonic well-being focuses on happiness and defines well-being in terms of pleasure attainment and pain avoidance, whereas eudemonic well-being focuses on meaning and level of functioning in life and human potential.

On the other hand, well-being literature designated two dimensions for well-being which

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are subjective and psychological well-being. Subjective well-being was defined as the individual's self-assessment related to life events and emerges as a result of the feeling of mastery, experiencing pleasurable activities and positive relations (Ryan & Deci, 2011). Whereas, Bradbum (2013) distinguished psychological well-being between positive and negative affect and defined happiness as the balance between the two parts. When these approaches are considered together, subjective well-being, which emphasizes happiness, overlaps the hedonic approach while psychological well-being, which underlines the use of human potential, matches the eudemonic approach (Ryan & Deci, 2011).

Quality of life is a complex concept that encompasses objective and subjective dimensions such as food, housing, the opportunity to study, health and perceptions about them (Carpio, Pachecho, Flores & Canales, 2000; Novoa, Cruz, Rojas, Wilde, 2003). Diener (1984, cited by Rodriguez, 1998) has defined quality of life as a subjective view of the extent to which happiness and satisfaction have been achieved, or as a sense of personal, subjective view that has also been considered closely related to certain biological, economic, psychological and social factors (Garavito, 2001; Gomez Villegas de Posada, Barrera & Cruz, 2007).

According to the World Health Organization (2002, 2015), quality of life (QoL) can be defined as a subjective perception of the self-positioning in life that combines a person's psychological and PHY—cultural position, value system, expectations, aims and states, independence, and personal beliefs—with the capacity to create relationships. From another viewpoint, the perspective assumed in the theoretical framework of health-related quality of life is based on a complex set of relationships that involves biopsychosocial factors related to well-being (Bowling, 2001; Ekwall et al., 2005; Gerino et al., 2015).

In line with this, Quality of Life is defined as a multidimensional concept with both objective and subjective factors that refer to general satisfaction with life or its components (Lawton, 1991; Bowling et al., 2002; Arkar et al., 2004). In the context of widowhood awareness, it is increasingly clear that individuals' internal and external resources are intrinsically connected, and both these aspects contribute synergistically to physical and their psychological well-being (Ryff & Singer, 2000; Fernández-Ballesteros, 2003, 2008; Fry & Debats, 2010).

Statement of the Problem

Diverse studies have explored widowhood, psychological wellbeing and quality of life, but to the best of the researchers' knowledge no research has investigated these three variables simultaneously to reflect the dynamics in marriage unions in Onitsha, Anambra state. This the researcher found to be a serious gap. This is because in Nigeria today, the poor quality of life of widows cannot be over emphasized. Widowhood and psychological wellbeing are linked to low quality of life and death of some widows if not properly managed.

There is need to research on factors like widowhood and psychological wellbeing to see its influence on quality of life among spouses. This is to ascertain whether working on factors like widowhood and psychological wellbeing will help improve the quality of life of spouses who lost their better-half.

Purpose of the Study

The objectives of the study are:

1. To examine the impact of widowhood on quality of life of spouses in Onitsha, Anambra State.
2. To determine the impact of widowhood on psychological wellbeing of spouses in Onitsha, Anambra State.

Research Questions

The study sought to answer the following questions:

1. To what extent will widowhood significantly impact quality of life of spouses in Onitsha, Anambra State?
2. To what extent will widowhood significantly impact psychological wellbeing of spouses in Onitsha, Anambra State?

Significance of the Study

1. The findings of the present study will be so significant and helpful in the improvement of widow's quality of life.
2. The study will be an eye opener to the widow's family and relatives on what to

do to improve the quality of life of widows.

Operational Definition of Terms

Widowhood: The state of having lost one's spouse to death, measured as a demographic variable.

Psychological Wellbeing: It is the combination of feeling good and functioning effectively, as measured with the Psychological Wellbeing Scale by Ryff (1989).

Quality of Life: Quality of Life is defined as a multidimensional concept with both objective and subjective factors that refer to general satisfaction with life or its components, as measured with the WHO Brief Quality of Life Scale by WHO (2015).

LITRATURE REVIEW

Widowhood

Dual Process Model/Theory of Bereavement (Stroebe & Schut, 1999): In 1999, Stroebe and Henk Schut developed a conceptual model to explain the ways in which people adapt to bereavement, and indeed this model was developed originally with widowhood in mind. The Dual Process Model (DPM) of coping with bereavement describes two types of coping behaviors or experiences: loss-oriented coping and restoration-oriented coping. In the former, coping comprises grief work, as described earlier. This may involve avoiding making changes to one's life—for example, continuing to set the dinner table for two rather than for one. Grief may also intrude into everyday life; seeing someone who resembles the deceased, for instance, may lead to tears. This type of coping may also involve moving to a new home or disposing of the husband's or wife's possessions.

In contrast, restoration-oriented coping consists of attending to life changes, such as changing the names on one's bank account. It also involves doing new things, such as joining a club and taking on new roles or beginning new relationships. Finally, it involves avoiding things that remind one of grief; so, for example, people may stay away from the house or keep busy so they have no time to think about how upset they are feeling. Key to the DPM model is oscillation, which is the process whereby coping switches between loss and restoration-oriented tasks. In 2006 the DPM was brought together with cognitive stress theory (Lazarus & Folkman, 1984) to develop an integrative risk factor framework (Stroebe, Folkman, Hansson, & Schut, 2006).

It appears that anticipatory bereavement cannot be understood only in terms of caring for a sick spouse. It may also be explained by the fact that, for women in particular, husbands are generally older and are expected to die sooner. Society does not treat single people, including widowed people, as well or grant them as much status as those who are married. Thus, widowed people are disadvantaged financially, socially, and psychologically.

Psychological Wellbeing

Perma Model Theory (Seligman, 2011): The theory was developed by positive psychologist, Martin Seligman in 2011. "PERMA" stands for the five essential element that should be in place for individuals to experience lasting wellbeing (Seligman, 2011). Although Seligman originally proposed three categories of wellbeing, He has since suggested the last category "meaningful life", be considered as a different category. The resulting acronym is "PERMA", and is a mnemonic for the five elements of Martin Seligman's wellbeing theory, which include:

Positive emotions: This includes a wide range of feelings not just happiness and joy, but also excitement, satisfaction, pride etc. These emotions are frequently seen as connected to positive outcome, such as longer life and healthier social relationships. **Engagement**: This refers to involvement in activities that draws and builds upon one's interest. Engagement involves passion for and concentration on the task at hand and is assessed subjectively as to whether the person engaged was completely absorbed, losing self-consciousness. When we are truly engaged in a situation like terror, task, or project, we experience a state of flow. Time seems to stop; we lose our sense of self, concentrate intensely on the present. **Meaning**: This is also known as purpose, and prompts the question of "WHY". Discovering and figuring out a clear "WHY?" puts everything into context from work to relationships and to other parts of life. Finding meaning is learning that there is something greater than you. Despite potential challenges,

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working with meaning drives people to continue striving for a desirable goal. **Relationship:** This is important in fueling positive emotions, whether they are work related, family, romantic, or platonic. Humans receive, share and spread positively to others through relationships. There are important in not only in bad times, but good times as well. Relationship can be strengthened by reacting to one another positively. It is typical that most positive things take place in the presence of other people. **Accomplishment:** This is the pursuit of success and mastery. Unlike the other parts of PERMA, they are sometimes pursued even when it does not result in positive emotions, meaning, or relationship. Accomplishment can activate the other elements of PERMA, such as pride under positive emotions.

Theory on Quality of Life

Engaged Theory (Magee, James & Andy, 2012): Engaged Theory is a methodological framework for understanding social complexity. Social life or social relationships are taken as its base category, with 'the social' always understood as based on 'the natural', including humans as embodied beings. The Engaged Theory provides a framework that moves from detailed empirical analysis about things, people, and processes in world to abstract theory about the constitution and social framework of those things, people, and processes. Engaged theory is one of the approaches within the broader tradition of critical theory. Engaged Theory crosses the fields of sociology, anthropology, political science, history, philosophy, and global studies. In its most general form, the term Engaged Theory is used to describe theories that provide a toolbox for engaging with the world while seeking to change it.

Empirical Review

Widowhood: Adeyemo (2016) investigates widowhood practices in Nigeria in Southwestern, Nigeria. It particularly examines the influencing factors for the harmful widowhood practices in spite of modernization. The researcher discovered that there are certain cultural imbalances in the practice of widowhood between widows and widowers. And that the disorganizing and traumatic experience which accompanies the death of the husband tends to be greater than that which accompanies the death of the wife. The study revealed that; illiteracy, poverty, male-dominated society, poor socio-economic status of women, religion belief and traditional inheritance laws are factors responsible for the harmful practices. These directly and indirectly have negative effects on widows and their children. This study therefore recommends qualitative education for the girl-child at early stage, enlightenment programmes and vocational skills acquisition for all women, particularly widows, as means of reducing, if not totally eradicated the harmful rites, unjust discrimination and inhuman treatments against widows and the generality of women.

Elwert and Christakis (2018) investigated the effect of spousal bereavement on mortality to document cause-specific bereavement effects by the causes of death of both the precedent spouse and the bereaved partner. They obtained data from a nationally representative cohort of 373 189 elderly married couples in the United States who were followed from 1993 to 2002. We used competing risk and Cox models in our analyses. For both men and women, the death of a precedent spouse from almost all causes, including various cancers, infections, and cardiovascular diseases, increased the all-cause mortality of the bereaved partner to varying degrees. Moreover, the death of a precedent spouse from any cause increased the survivor's cause-specific mortality for almost all causes, including cancers, infections, and cardiovascular diseases, to varying degrees. The effect of widowhood on mortality varies substantially by the causes of death of both spouses, suggesting that the widowhood effect is not restricted to one aspect of human biology.

Psychological Wellbeing: Dogan, Totan, and Sapmaz (2017) conducted a study to examine the effects of self-esteem, psychological well-being, emotional self-efficacy and affect balance variables on happiness. The participants of the study are 340 (female n= 213; male n= 109) university students from Turkey. Oxford Happiness Questionnaire-Short Form, Self-Ladling/Self-Competence Scale, Flourishing Scale, Emotional Self-efficacy Scale, and Positive-Negative Events Scale were used as data acquisition tools in the study. The relationships

between the variables were examined via path analysis. According to the analysis it was determined that there are positive and significant relationship between psychological well-being, emotional self-efficacy and affect balance; and that psychological well-being and affect balance have positive effects on self-esteem and happiness, emotional self-efficacy has a positive effect on self-esteem and that self-esteem has a positive effect on happiness. In addition, it was concluded that 46% of the total variance regarding self-esteem is explained by psychological well-being, emotional self-efficacy and affect balance. It was also concluded that psychological well-being, emotional self-efficacy, affect balance and self-esteem explain 51% of the total variance regarding happiness.

Vataliya (2018) conducted a study on the psychological wellbeing in adolescence of gender difference. The random sampling Method was used in this study. The total sample consisted of 60 Adolescent, 30 Girls and 30 Boys of 11th standard students selected from the Bhavnagar city. The research tool for psychological, well-being scale developed by svdha boggle (1995) was used. The result shows that the value of the hypothesis is not accepted. It means girls and boys Adolescent was very far difference in psychological well-being.

Quality of Life: Telles, Gupta, Kumar, Pal, Tyagi and Balkrishna (2019) compared perception, mental wellbeing, and quality of life in yoga-experienced compared with yoga-naïve patients with chronic illness and to determine whether the duration of yoga practice in the yoga-experienced group had any correlation with the perception of illness, mental wellbeing, and quality of life. A cross-sectional comparative study recruited 419 patients with chronic non-communicable disease. Yoga-experienced patients (n=150) (mean age, 41.9±13.6 years) and yoga-naïve patients (n=269) (mean age, 41.2±12.6 years) were assessed for the perception of their illness, mental wellbeing, and quality of life using the Warwick-Edinburgh mental wellbeing scale (WEMWBS) and the World Health Organization quality of life (WHOQOL-BREF) self-reporting questionnaire. The yoga-experienced group had significantly increased mental wellbeing, personal control as a dimension of their perception of illness, and psychological and environmental quality of life compared with the yoga-naïve group (all, $p<0.05$), when comparisons were made using the Mann-Whitney U test. The duration of yoga practiced in months was positively-correlated with mental wellbeing and different aspects of quality of life. There was a negative correlation with the perception of illness suggesting that the illness was perceived to be less severe (all, $p<0.05$) when correlations were made using Spearman's rank correlation coefficient. In patients with chronic illness, yoga improved mental wellbeing, aspects of quality of life, and resulted in a positive perception of illness.

Lee, Lin, Fang and Wang (2018) compared the psychological well-being and Quality of life between spouse caregivers and non-spouse caregivers of patients with HNC over a 6-month follow-up period. This study was conducted using a prospective design with consecutive sampling. We recruited study subjects from the outpatient combined treatment clinic of HNC at a medical center in Southern Taiwan. The Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, fourth edition was carried out by a trained senior psychiatrist to diagnose caregivers. Furthermore, one research assistant collected the caregivers' demographic characteristics, clinical data, and clinical rating scales, including the Short Form 36 (SF-36) Health Survey, Hospital Anxiety and Depression Scale (HADS), and Family Appearance, Pulse, Grimace, Activity, and Respiration index at the patients' pretreatment, as well as their 3- and 6-month follow-up appointments.

Of the 143 subjects that successfully completed the study, two-thirds of caregivers were spouses. During the 6-month follow-up period, spouse caregivers demonstrated significantly higher rates of depression diagnosis ($p=0.032$), higher scores in the depression subscale of HADS (HADS-D) ($p=0.010$), and lower SF-36 mental component summary (MCS) scores ($p=0.007$) than non-spouse caregivers. Furthermore, during those 6 months, HADS-D ($p=0.007$) and the anxiety subscale of HADS scores ($p<0.001$) significantly decreased, while SF-36 MCS scores significantly increased ($p=0.015$). The mental health of spouse

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caregivers of HNC patients was more severely affected than that of non-spouse caregivers during the observed 6-month follow-up period.

Monica, Rochy and Yagi (2016) assessed psychological well-being and quality of life in 75 patients with post-surgical treatment for thyroid cancer. A descriptive correlational methodology was used in order to perform this task. Psychological well-being was assessed with the Index of Psychological Well-being and Quality of Life was assessed with the Quality of Life Questionnaire SF-36 Health. The instruments were applied to each patient during an interview. Results suggested a high, positive and directly proportional correlation between time after thyroidectomy and the degree of Psychological Well-being and Quality of Life reported by patients. Results also showed a high correlation (significant at the 99% level) between the two instruments used.

Hypotheses

1. Widowhood will not significantly impact on the quality of life of widows irrespective of their (widows') biosocial characteristics in Onitsha, Anambra State**.**
2. Widowhood will not significantly impact on the psychological wellbeing of widows irrespective of their (widows') biosocial characteristics in Onitsha, Anambra State**.**

METHOD

Participants: Participants were 26 widows of age range 20 to 70 years, drawn from Onitsha metropolis, Anambra state, using purposive sampling techniques. Purposive sampling is a type of non-probability sampling method used for special situations where researchers rely on their own judgment when choosing members of the population to participate in their surveys (Goodwin, 2013).

Instruments: The **Ryff psychological wellbeing scale (Ryff, 1989)** was used. It is a 42-item version inventory designed to assess the psychological component of wellbeing. The inventory assesses six components of wellbeing which are: Autonomy, Environmental mastery, Personal growth, Positive relations with others, Purpose in life and Self-acceptance. The scale follows a 6-point Likert response format ranging from strongly agree "6" to strongly disagree"1" for positively worded items. The positively worded items include: 1, 2, 5, 7, 9, 11, 14, 16, 18, 20, 22, 25, 26, 28, 30, 33, 34, 36, 37, 39, 42, while the negatively worded items are 3, 4, 6, 8, 10, 12, 13, 15, 17, 19, 21, 23, 24, 27, 29, 31, 32, 35, 38, 40, 41. For each category, a high score will indicate that the respondents have a mastery of that area in his or her life.

Conversely, a low score will show that the respondent struggles to feel comfortable with that particular concept. Ryff (1989) obtained an alpha coefficient reliability of 0.91, 0.88, 0.83, 0.86, 0.88, and 0.85 for self-acceptance, positive relation with others, autonomy, environmental mastery, purpose in life and personal growth respectively. The second instrument was **World Health Organization Quality of Life Questionnaire.** The World Health Organization QoL (WHOQOL-BREF; World Health Organization, 1993; Italian version, De Girolamo et al., 2000) Questionnaire evaluates QoL in four areas, as follows: psychological health (PSY), physical health (PHY), environment (E), and social relationships (SR). It includes 24 self-report items, and the participant responds to the instrument via a 5-point Likert scale (from 1 = not at all to 5 = completely). It is a shorter version of the original tool, and it may be better adapted for use in big clinical trials or studies. Higher scores show a higher perceived Quality of Life. The WHOQOL-BREF is appropriate for use with older adults (Lucas-Carrasco, 2012). The scale obtained an internal consistency coefficient of 0.85 for the PHY subscale, 0.81 for the E subscale, 0.87 for the SR subscale and 0.78 for the PSY subscale.

Procedure: The researcher contacted some social organizations, religious institutes and residential apartments to get the sample for the study. Each participant was personally contacted and requested to cooperate and participate in the research. The researcher prepared a booklet including all the scales and consent form. Because, most of the subjects had adequate educational qualifications, the questionnaires were handed over to them to help complete it in their convenient time. They were very cooperative and sincere in responding to the questionnaires. The researcher collected the filled in questionnaires from them after the responses.

Certain aspects of ethics issues were employed by the researcher before and during the administration of instruments to avoid variables that are extraneous such as label, bias.

They include: **Informed consent** in which the researcher sought the consents of the respondents before embarking on the research. This was to encourage free choice of involvement and assert to the participants that they weren't under any obligation to join the research. Another is **Openness** in which the researcher told the respondents the nature of the research and essence of the study they were about to embark on. This was done to enable the respondents to be open and sincere in their responses. There was also C**onfidentiality** in which the researcher assured the respondents that the result of the test and questionnaire will remain confidential. This is to give the respondents a relaxed state of mind and avoid any thought of labeling that the participants might have.

Design/Statistics: The study adopted a cross-sectional survey design and Multiple Analysis of Variance (MANOVA) as appropriate statistics. This was because the study is geared towards investigating the influence of widowhood on psychological wellbeing and quality of life of spouse. Multiple Analysis of Variance (MANOVA) was used on the ground that it is one of the most versatile techniques in quantitative method, testing an independent variable with multiple dependent variables at same time.

RESULT

The main findings and other fallout findings from the analyses are presented. Each result is given brief interpretation of it below it.

Table 1: Descriptive Statistics of Widows' Quality of Life and Psychological Wellbeing

	N	Minimum	Maximum	Mean	SD	Skewness	Std Error	Kurtosis	Std Error
Autonomy	26	7	33	22.38	6.15	-.76	.46	.98	.89
Personal Growth	26	14	31	21.64	4.53	.49	.46	-.51	.89
Environmental Mastery	26	8	31	21.88	5.44	-.51	.46	.33	.89
Positive Relations with Others	26	7	32	21.69	7.16	-.35	.46	-.66	.89
Purpose in Life	26	9	31	21.34	5.75	-.35	.46	-.41	.89
Self-Acceptance	26	11	29	20.58	4.63	.00	.46	-.41	.89
PSYCHOLOGICAL WELLBEING	26	78	167	128.00	20.59	-.40	.46	.47	.89
GENDER	26	---	---	---	---	---	---	---	---
AGE	26	22	85	46.14	14.90	.44	.46	.39	.89
EDUCATIONAL LEVEL	26	---	---	---	---	---	---	---	---
HEALTH STATUS	26	---	---	---	---	---	---	---	---
Physical Health	26	3	15	8.38	3.32	.22	.46	-.33	.89
Psychological State	26	34	60	51.27	6.26	-.74	.46	.58	.89
Social Relationships	26	34	60	51.27	6.26	-.74	.46	.58	.89
Environment	26	25	48	39.15	6.94	-.82	.46	-.19	.89
QUALITY OF LIFE	26	72	132	94.96	13.01	.60	.46	1.22	.89
Valid N (listwise)	26								

Source: Questionnaire Primary Data

Table 1 shows the Psychological Wellbeing (-.40) being negatively skewed, indicating that the widows had very poor psychological wellbeing. All the dimensions of psychological wellbeing namely Autonomy (-.76), Personal Growth (.49), Environmental Mastery (-.51), Positive Relations with Others (-.35), and Purpose in Life (.00) were very poor, indicating general poor psychological wellbeing of the widows. The standard deviation (SD) of 20.59 showed so much variations in the psychological wellbeing of the widows. Similarly, the Quality of Life (.60) of the widows was poor. All the dimensions of the Quality of Life namely Physical Health (.22), Psychological State (-.74), Social Relations (-.74), and Environment (-.82) were very poor, indicating deteriorated quality of life. Again, the standard deviation (SD) of 13.01 for Quality of Life showed wide variation (inconsistency) in the widows' quality of life. The kurtosis (.47) for the Psychological Wellbeing indicated wider experience of poor psychological wellbeing among the widows sampled. Ancillary, the

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kurtosis of 1.22 indicated that quality of life experienced by the widows were generally poor.

Table 2: Descriptive Distribution of Widows' Quality of Life and Psychological Wellbeing

	GENDER	EDUCATIONAL LEVEL	Mean	Std. Deviation	N
PSYCHOLOGICAL WELLBEING	Male	None	135.0000	.	1
		Elementary School	140.0000	.	1
		Secondary School	129.5000	10.48332	6
		University	100.0000	.	1
		Total	128.0000	13.87444	9
	Female	None	133.5000	37.47666	2
		Elementary School	146.5000	16.26346	2
		Secondary School	125.6667	25.99744	6
		University	123.1429	22.60847	7
		Total	128.0000	23.79338	17
	Total	None	134.0000	26.51415	3
		Elementary School	144.3333	12.09683	3
		Secondary School	127.5833	19.00458	12
		University	120.2500	22.47379	8
		Total	128.0000	20.58932	26
QUALITY OF LIFE	Male	None	85.0000	.	1
		Elementary School	77.0000	.	1
		Secondary School	97.5000	8.93868	6
		University	91.0000	.	1
		Total	93.1111	10.27673	9
	Female	None	88.5000	7.77817	2
		Elementary School	86.0000	7.07107	2
		Secondary School	103.0000	16.76902	6
		University	94.8571	14.21770	7
		Total	95.9412	14.45887	17
	Total	None	87.3333	5.85947	3
		Elementary School	83.0000	7.21110	3
		Secondary School	100.2500	13.12960	12
		University	94.3750	13.23348	8
		Total	94.9615	13.01839	26

Source: Questionnaire Primary Data

Table 2 shows the descriptive distribution of variables and their performance scores. A total of 26 widows were captured. Nine (9) of them were males while seventeen (17) were females. Their educational levels were also captured. Some samples were to small that their standard deviations could not be performed.

Table 3: Tests of Between-Subjects Effects of Widowhood and Quality of Life

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power
Corrected Model	Physical Health	94.262	8	11.783	1.101	.409	.341	8.810	.352
	Psychological State	176.659	8	22.082	.467	.863	.180	3.733	.157
	Social Relationships	176.659	8	22.082	.467	.863	.180	3.733	.157
	Environment Friendly	391.614	8	48.952	1.025	.455	.325	8.201	.327
	QUALITY OF LIFE	1211.734	8	151.467	.851	.573	.286	6.809	.272
AGE	Physical Health	.322	1	.322	.030	.864	.002	.030	.053
	Psychological State	.758	1	.758	.016	.901	.001	.016	.052
	Social Relationships	.758	1	.758	.016	.901	.001	.016	.052
	Environment Friendly	77.086	1	77.086	1.614	.221	.087	1.614	.224
	QUALITY OF LIFE	103.630	1	103.630	.582	.456	.033	.582	.111
GENDER	Physical Health	.064	1	.064	.006	.939	.000	.006	.051
	Psychological State	11.906	1	11.906	.252	.622	.015	.252	.076
	Social Relationships	11.906	1	11.906	.252	.622	.015	.252	.076
	Environment Friendly	58.078	1	58.078	1.216	.285	.067	1.216	.180
	QUALITY OF LIFE	165.707	1	165.707	.931	.348	.052	.931	.149
EDUCATIONAL	Physical Health	36.228	3	12.076	1.129	.365	.166	3.386	.250
LEVEL	Psychological State	66.145	3	22.048	.466	.710	.076	1.398	.125
	Social Relationships	66.145	3	22.048	.466	.710	.076	1.398	.125
	Environment Friendly	251.524	3	83.841	1.756	.194	.237	5.267	.376
	QUALITY OF LIFE	788.117	3	262.706	1.476	.256	.207	4.429	.320
GENDER &	Physical Health	28.405	3	9.468	.885	.469	.135	2.655	.203
EDUCATIONAL	Psychological State	26.558	3	8.853	.187	.904	.032	.561	.078
LEVEL	Social Relationships	26.558	3	8.853	.187	.904	.032	.561	.078
	Environment Friendly	91.934	3	30.645	.642	.599	.102	1.925	.156
	QUALITY OF LIFE	23.031	3	7.677	.043	.988	.008	.129	.056
Total	Physical Health	2104.000	26						
	Psychological State	69323.000	26						
	Social Relationships	69323.000	26						
	Environment Friendly	41062.000	26						
	QUALITY OF LIFE	238697.000	26						

**** significant @ P≤ .001 or * significant @ P≤ .05 for N = 26**
Source: Questionnaire Primary Data

Hypothesis One: It states that "widowhood will not significantly impact on the quality of life of widows irrespective of their (widows') biosocial characteristics". Table 3 showed that the hypothesis was affirmed for overall Quality of Life (P> 0. .573, F = 0.851, N = 26, df = 8;26, η2=28.6%). There were also nonsignificant impacts for combinations of Quality of Life and widows' biosocial characteristics like age (P > 0.456, F = 0.582, N = 26, df = 1;26, η2=3.3%); Gender (P > 0.348, F = 0.931, N = 26, df = 1;26, η2=5.2%); Educational Level (P> 0. .256, F = 1.476, N = 26, df = 1;26, η2 = 20.7%); as well as Gender and Educational Level (P > 0. .988, F = 0.043, N = 26, df = 1;26, η2=0.8%).

Table 4: Tests of Between-Subjects Effects of Widowhood and Psychological Wellbeing

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power
Corrected Model	Autonomy	238.374	8	29.797	.718	.674	.252	5.742	.231
	Personal Growth	142.203	8	17.775	.817	.598	.278	6.535	.261
	Environmental Mastery	157.238	8	19.655	.575	.785	.213	4.597	.188
	Positive Relations with Others	429.721	8	53.715	1.072	.426	.335	8.576	.342
	Purpose in Life	469.219	8	58.652	2.796*	.036	.568	22.365	.792
	Self-Acceptance	132.574	8	16.572	.698	.689	.247	5.582	.224
	PSYCHOLOGICAL WELLBEING	2723.622	8	340.453	.735	.660	.257	5.880	.236
AGE	Autonomy	48.316	1	48.316	1.164	.296	.064	1.164	.175
	Personal Growth	.311	1	.311	.014	.906	.001	.014	.051
	Environmental Mastery	2.608	1	2.608	.076	.786	.004	.076	.058
	Positive Relations with Others	34.064	1	34.064	.680	.421	.038	.680	.122
	Purpose in Life	103.858	1	103.858	4.950*	.040	.226	4.950	.555
	Self-Acceptance	.775	1	.775	.033	.859	.002	.033	.053
	PSYCHOLOGICAL WELLBEING	790.312	1	790.312	1.706	.209	.091	1.706	.234
GENDER	Autonomy	24.315	1	24.315	.586	.455	.033	.586	.112
	Personal Growth	5.281	1	5.281	.243	.629	.014	.243	.075
	Environmental Mastery	47.475	1	47.475	1.388	.255	.075	1.388	.199
	Positive Relations with Others	12.824	1	12.824	.256	.619	.015	.256	.077
	Purpose in Life	35.411	1	35.411	1.688	.211	.090	1.688	.232
	Self-Acceptance	17.129	1	17.129	.721	.408	.041	.721	.126
	PSYCHOLOGICAL WELLBEING	7.249	1	7.249	.016	.902	.001	.016	.052
EDUCATIONAL LEVEL	Autonomy	141.024	3	47.008	1.132	.364	.167	3.397	.251
	Personal Growth	95.411	3	31.804	1.461	.260	.205	4.384	.317
	Environmental Mastery	50.964	3	16.988	.497	.689	.081	1.490	.130
	Positive Relations with Others	312.113	3	104.038	2.076	.141	.268	6.229	.438
	Purpose in Life	155.830	3	51.943	2.476	.096	.304	7.427	.512
	Self-Acceptance	113.701	3	37.900	1.596	.227	.220	4.787	.344
	PSYCHOLOGICAL WELLBEING	1330.350	3	443.450	.957	.435	.145	2.872	.217
GENDER & EDUCATIONAL LEVEL	Autonomy	26.760	3	8.920	.215	.885	.037	.645	.082
	Personal Growth	43.766	3	14.589	.670	.582	.106	2.011	.162
	Environmental Mastery	60.400	3	20.133	.589	.631	.094	1.766	.147
	Positive Relations with Others	102.814	3	34.271	.684	.574	.108	2.052	.164
	Purpose in Life	89.706	3	29.902	1.425	.270	.201	4.276	.310
	Self-Acceptance	51.339	3	17.113	.721	.553	.113	2.162	.171
	PSYCHOLOGICAL WELLBEING	737.210	3	245.737	.531	.667	.086	1.592	.136
Total	Autonomy	13972.000	26						
	Personal Growth	12660.000	26						
	Environmental Mastery	13191.000	26						
	Positive Relations with Others	13516.000	26						
	Purpose in Life	12673.000	26						
	Self-Acceptance	11545.000	26						
	PSYCHOLOGICAL WELLBEING	436582.000	26						

**** significant @ P≤ .001 or * significant @ P≤ .05 for N = 26;**
Source: Questionnaire Primary Data

Hypothesis Two: It states that "widowhood will not significantly impact on the psychological wellbeing of widows irrespective of their (widows') biosocial characteristics". Table 4 showed that the hypothesis was affirmed (nonsignificant) for overall Psychological Wellbeing (P>0.660, F = 0.735, N = 26, df = 8;26, η2=25.7%), except the "Purpose in Life" dimension of Psychological Wellbeing which was significant (P>0.036, F = 2.796, N = 26, df =

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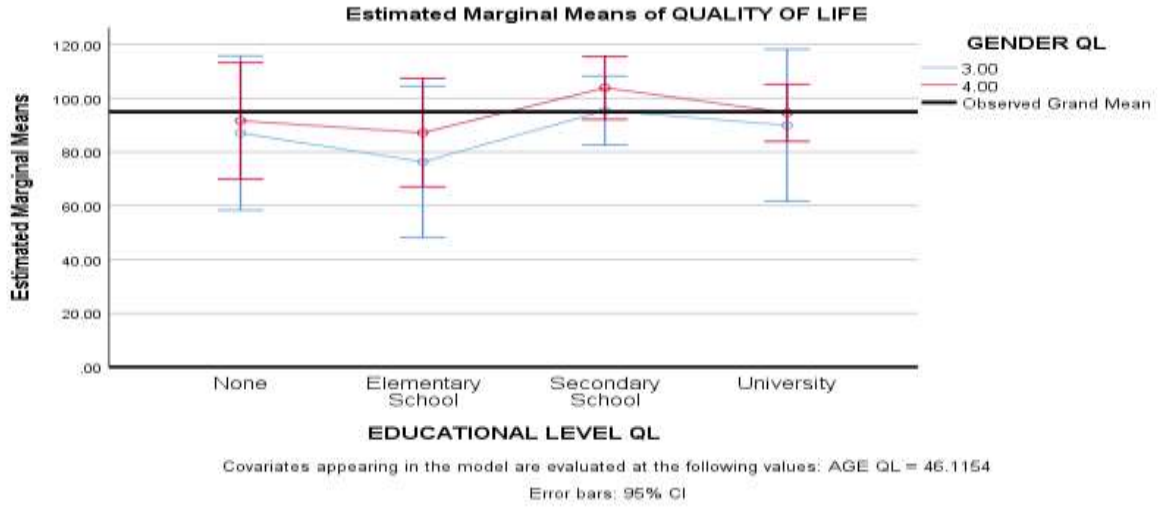
8;26, η2=56.8%). A combination of widowhood and age (P ≤ 0..209, F = 1.705, N = 26, df = 1;26, η2=9.1%)showed nonsignificant impact. Again, the hypothesis was not affirmed where it concerned widows' gender and psychological wellbeing (P> 0.902, F = 0.016, N = 26, df = 1;26, η2 = 0.1%); widows' educational level and overall psychological wellbeing (P> 0.435, F = 0.957, N = 26, df = 1;26, η2 = 14.5%); as well as widows' age, educational level, and overall psychological wellbeing (P> 0.667, F = 0.531, N = 26, df = 1;26, η2 = 8.6%).

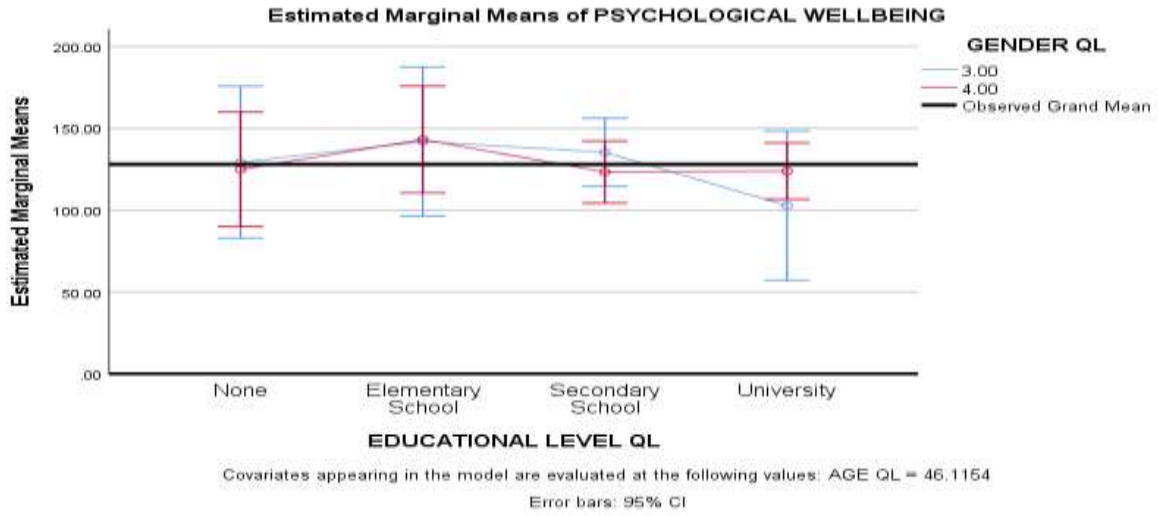
Figure 1: Widows' Gender and Educational Variations in Quality of Life



3 = Male; 4 = Female; Source: Questionnaire Primary Data

Figure 1 shows male widows with elementary school, university, and no levels of education having below average quality of life. Those with secondary school had average quality of life. Female widows with elementary school, and no formal education levels had below average quality of life, while those with secondary school educational level had above average, university level average quality of life.

Figure 2: Widows' Gender and Educational Variations in Psychological wellbeing



3 = Male; 4 = Female; Source: Questionnaire Primary Data

Figure 2 shows male widows with elementary school and secondary school levels of education having above average psychological wellbeing. Those with no education had average

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psychological wellbeing, while male widows with university education level had below average psychological wellbeing. Female widows with elementary school had above average psychological wellbeing, those with no education had average psychological wellbeing, while those with secondary school and university levels of education had below average psychological wellbeing.

Summary of Findings/Results

Results of Hypotheses Tested

1. Widowhood did not significantly impact on the quality of life of widows irrespective of their (widows') biosocial characteristics.
2. Widowhood did not significantly impact on the psychological wellbeing of widows irrespective of their (widows') biosocial characteristics

Interaction Effects Findings/Results

3. Combination of widowhood and age had nonsignificant impact on widows' quality of life.
4. Combination of widowhood and gender had nonsignificant impact on widows' quality of life.
5. Widowhood and educational level had nonsignificant impact on widows' quality of life.
6. Widowhood, Gender and educational level combined had nonsignificant impact on widows' quality of life.
7. Widowhood had significant impact on "Purpose in Life" dimension of Psychological Wellbeing.
8. There was no significant impact of widowhood and age on widows' psychological wellbeing.
9. There was no significant impact of widowhood and gender on widows' psychological wellbeing.
10. Widowhood and educational level did not significantly impact widows' psychological wellbeing.
11. Widowhood, age, and educational level combined had no significant impact on psychological wellbeing.

Descriptive Findings/Results

12. Male widows with elementary school, university, and no levels of education had below average quality of life.
13. Male widows with secondary school education had average quality of life.
14. Female widows with elementary school, and no formal education levels had below average quality of life.
15. Female widows with secondary school educational level had above average, while those with university educational level had average quality of life.
16. Male widows with elementary school and secondary school levels of education had above average psychological wellbeing.
17. Male widows with no education had average psychological wellbeing, while male widows with university education level had below average psychological wellbeing.
18. Female widows with elementary school had above average psychological wellbeing.
19. Female widows with no education had average psychological wellbeing.
20. Female widows with secondary school and university levels of education had below average psychological wellbeing.

DISCUSSION

The present study is one of the few to assess mechanisms that explain linkages between widowhood and quality of life and their psychological wellbeing. The first hypothesis tested showed that widowhood did not significantly impact on the quality of life of widows irrespective of their (widows') biosocial characteristics (P> 0. .573, F = 0.851, N = 26, df = 8;26, $\eta 2$=28.6%). There were also non-significant impacts for combinations of Quality of Life and widows' biosocial characteristics like age (P > 0.456, F = 0.582, N = 26, df = 1;26, $\eta 2$=3.3%); Gender (P > 0.348, F = 0.931, N = 26, df = 1;26, $\eta 2$=5.2%); Educational Level (P> 0. .256, F = 1.476, N = 26, df = 1;26, $\eta 2$ = 20.7%); as well as Gender and Educational Level (P > 0. .988, F = 0.043, N = 26, df = 1;26, $\eta 2$=0.8%). This finding supports the findings of Sreerupa & Rajan (2020) who conducted a study on Gender

and Widowhood: Disparity in quality of life, health status and health care utilization among the aged in India.

Despite an increasing feminization of India's older population marked by a high incidence of widowhood among aged women, women's health in later life and the health consequences of widowhood has received little attention in the existing gender and gerontological scholarship in India. Based on data of a nationally representative survey by the National Sample Survey Organization (N = 34,831, ages 60 and over), the study analyzed marital status, gender, quality of life and health care utilization, and examined the gendered nature of aging and widowhood in India. Significant differences were found in health status, quality of life and utilization of health care services by gender and marital status. Widowed persons of either gender was found to be the most vulnerable and, overall, widows emerge as the most disadvantaged group.

The second hypothesis tested showed that the hypothesis was affirmed (non-significant) for overall Psychological Wellbeing (P>0.660, F = 0.735, N = 26, df = 8; 26, η2=25.7%), except the "Purpose in Life" dimension of Psychological Wellbeing which was significant (P>0.036, F = 2.796, N = 26, df = 8; 26, η2=56.8%). A combination of widowhood and age (P ≤ 0.209, F = 1.705, N = 26, df = 1;26, η2=9.1%) showed no significant impact. Again, the hypothesis was not affirmed where it concerned widows' gender and psychological wellbeing (P> 0.902, F = 0.016, N = 26, df = 1;26, η2 = 0.1%); widows' educational level and overall psychological wellbeing (P> 0.435, F = 0.957, N = 26, df = 1;26, η2 = 14.5%); as well as widows' age, educational level, and overall psychological wellbeing (P> 0.667, F = 0.531, N = 26, df = 1;26, η2 = 8.6%). This finding contrasts the finding of Maciejewski, Prigerson and Rosenheck (2000), who found that people who are widowed had more problems with depression, chronic illnesses and functional abilities than married individuals.

Furthermore, the finding supports Greene and Sheila (2009) who examined the relationship between widowhood and psychological well-being and found that the former is not associated with the latter among widowed, older persons. Similarly, findings of a study by Bankoff (2013) on the psychological well-being of 245 widowed women indicated that the role of social support to the widows' psychological well-being is complex and depends on some factors such as the type of support given and its source. Therefore, social support may play a helpful, harmful or inconsequential role toward psychological well-being.

Implications of the Study

The findings of the present study provide empirical evidence and add to the research literature showing the non-significant role of widowhood on quality of life and psychological wellbeing on sampled widows based on the study findings. This has important implications to theory and practice, to sort other possible factors contributing or exposing these widows to poor psychological wellbeing and quality of life. Women in African society are meant to suffer stressful situation when the husband dies, this stressful situation makes African women to suffer a lot of emotional physical, mental and spiritual problems. Health involves ability to function physically emotionally, mentally, spiritually, psychologically and socially in an environment African widows do not enjoy the best of health due to pressure of conforming to widowhood practice. A lot of sanctions placed on widow by the society make it difficult for women to express their view point in widowhood.

Limitations of the Study

The present findings should be viewed in the context of study limitations. First, characteristics of our sample limit the generalizability of results to similar populations. It will be important for future research to test the current hypotheses with a broader range of participants impacted by widowhood. For example, given possible gender differences in the cycle of violence, further investigations are needed in incarcerated females as well as community and clinical (i.e., psychiatric) samples of widows from different geographic locations. Second, although participant responses remained anonymous, the sensitive nature of the survey may have made some individuals hesitant to disclose certain maltreatment experiences (e.g., sexual offending), resulting in underreporting of either of these activities.

Conclusion

Although quality of life and psychological wellbeing are not an inevitable consequence of widowhood, early widowhood does heighten the risk of such outcomes. The current study explicates this link by highlighting the contributions of widowhood-related problems to poor psychological wellbeing (purpose in life). This study may be the first to suggest that early widowhood, operate as part of a more coherent whole. As such, the present findings have several treatment implications.

Recommendations

The following recommendations are proffered:

1. Community and culturally based practices that work against the quality of life and psychological wellbeing of widows in Anambra State, Nigeria need to be eradicated.

Suggestions for further studies

The researcher suggests that future studies should include official records in conjunction with self-report measures on an increased number of samples, so as to provide a more comprehensive appraisal of widowhood and its impact on quality of life and psychological wellbeing.

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