The Impact of Widowhood on Mental Health: A Study on Rural Widows in Rajshahi, Bangladesh

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ABSTRACT

Widowhood represents a social status that can significantly impact a woman's mental health, particularly in rural areas with limited support systems. This study examines the effects of widowhood on the mental health of women in Parila Union, Paba Upazila, Rajshahi District, Bangladesh. The primary objective of this paper was to compare mental health status before and after widowhood and to identify the key factors influencing these outcomes. The research was conducted across 16 villages and involved a social survey of the experiences of 201 widows. The results indicate a substantial decline in mental health following widowhood, with approximately 75% of widows encountering various mental health issues. Moreover, 80% of the widows reported an escalation in the severity of their illnesses after widowhood. This study highlights the critical need for tailored interventions and support systems, emphasizing the importance of social support networks, economic stability, and individual coping strategies in addressing mental health challenges during this period. The research underscores the necessity for culturally sensitive mental health services to meet the unique needs of widows within their cultural context. Overall, this study contributes to a deeper understanding of the mental health impacts of widowhood and advocates for empowering rural widows to achieve better mental health and well-being.

INTRODUCTION

Widowhood is a deeply impactful event in a woman's life, significantly affecting her physical and, mental well-being. This impact is magnified in rural areas where support systems are often lacking. In Bangladesh society, a woman's marital status is intricately linked to her overall survival and welfare. Consequently, the loss of a husband plunges a woman into a state of extreme hardship and grief. Bereft of her spouse, she may find herself perceived as helpless, lacking a guardian, and even without adequate shelter. The commencement of widowhood brings about profound changes in various aspects of a woman's life. She grapples with newfound responsibilities and practicalities, including shifts in authority, financial insecurity, alterations in familial and communal roles and status, diminished decision-making power, restricted mobility, and even changes in food consumption patterns. Furthermore, the loss of control over household affairs, particularly in the kitchen, not only affects her nutritional intake but also engenders feelings of powerlessness and disconnection from her surroundings (Khanam, 1994). The economic ramifications of widowhood are profound, with a drastic reduction in family income almost inevitable following the death of a spouse. Additionally, widows often contend with numerous societal taboos and restrictions, further exacerbating their physical and, notably, their mental anguish. The ordeal is particularly arduous for young widows, who must endure prolonged periods of mental anguish, socioeconomic hardship, and declining health. While elderly widows may be relatively safeguarded from certain risks, they nevertheless face heightened physical and economic challenges. Overall, widowhood precipitates increased dependency, economic instability, social isolation, loneliness, and a decline in social status for women. Consequently, widows become marginalized, vulnerable, and subjected to various forms of abuse within the population. According to the Asian Development Bank, the prevalence of widowhood or divorce among Bangladeshi women is striking, with an estimated one in four women experiencing such circumstances by the age of 50 (Sharmin, 2014).

However, despite significant prevalence of widowhood in Bangladeshi society, comprehensive data on the socio-economic conditions, health status, and overall well-being of widows remains sparse due to statistical

challenges and a paucity of reliable information. This study aims to address this gap by examining the profound impact of widowhood, particularly on their mental health, in Parila Union, Paba Upazila, Rajshahi District, Bangladesh.

Statement of the problem

The global population of widows is approximately 258 million, with many being vulnerable and often exploited (Orphans in Need, 2023). In Bangladesh, the number of widows rose from 1.5 million in 2001 to 4.5 million in 2018, comprising 2.7% of the population (Amin, 2018). Widows frequently face deprivation of basic comforts, economic dependency, social isolation, loneliness, and a significant loss of social status. The death of a spouse is a major life stressor across diverse cultural backgrounds and age groups (Reddy, 2004). Widowhood is significantly more prevalent in rural areas compared to urban regions, attributed to higher mortality rates and lower remarriage rates in rural areas (Reddy, 2004, quoted in Agarwal, 1972).

In Bangladesh, the challenges faced by widows are exacerbated by entrenched patriarchal norms, which dictate that a widow's existence is heavily reliant on the support and decisions of her in-laws, parents, siblings, children, and other relatives. The dependency experienced by widows is fundamentally linked to the disruption of their previous roles and status within their families. This dramatic shift often leads to physical frailty and mental distress. Recent studies highlight that mental health issues among widows are escalating, with an increasing number reporting symptoms of depression and anxiety due to the compounded stress of economic hardship and social isolation. Additionally, the COVID-19 pandemic has intensified these issues, further isolating widows and exacerbating their mental health challenges (WHO, 2022). According to WHO (2022), “mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.” In this article, the term mental health refers to how widows feel and think after losing their spouses. It includes their emotions (like sadness or anxiety), their ability to make decisions, and their daily behavior. Losing a spouse can be very stressful and emotional for widows, affecting their sleep, eating habits, and interactions with others. Against this backdrop, this article examines the effects of widowhood on mental health by assessing the differences in their mental health conditions before and after widowhood highlighting a complex mix of vulnerabilities made worse by economic dependency, limited educational opportunities, and family dynamics within the study area.

Significance of the Research

This study is significant as it provides a detailed examination of the impact of widowhood on mental health in rural Bangladesh, an area often under-explored by researchers. By highlighting the severe decline in mental well-being experienced by the widows and identifying barriers to accessing mental health care, the study addresses a critical gap in current research. The findings underscore the need for improved, affordable mental health resources and offer valuable insights for policymakers and practitioners to develop targeted support systems. Additionally, the study lays the groundwork for future research on widowhood, particularly in similar rural settings.

REVIEW OF LITERATURE

Widowhood is a significant life transition marked by the loss of a spouse, leading to profound emotional, social, economic, and health implications. Recent studies have underscored the severe negative impact of widowhood on mental health, with loneliness, depression, and anxiety being common among older widows (Zheng and Yan, 2024). Widowhood is identified as the highest risk factor for depression among older adults (Zheng and Yan, 2024). Socio-economic status (SES) plays a crucial role in the relationship between widowhood and health outcomes, with lower SES linked to higher rates of morbidity, functional disability, and mortality (Adler et al., 1994; Antonovsky, 1967; Avendano et al., 2006; Guralnik, Fried, & Salive, 1996; Illsley & Baker, 1991). The challenges widowed women face are compounded by long-standing societal norms firmly rooted in patriarchal structures. In places like Bangladesh, a widow's life becomes closely intertwined

with the expectations and rules set by these patriarchal traditions. This dramatic shift in their place within the family structure forms the basis of the difficulties they encounter, as they navigate a new life filled with uncertainties and reliance on others. The loss of their former roles and socio-economic status can render widows physically frail and emotionally distressed, leading to physical problems and causing them to lose interest in their daily lives. Widowhood is associated with a greater decline in both physical and psychological health, particularly for younger widows who face higher financial stress and a greater need for social program assistance (Sevak et al., 2003; Smith & Zick, 1986). In rural areas, the absence of robust support systems, economic opportunities, and healthcare infrastructure exacerbates the challenges of widowhood, with rural widows facing practical issues related to livelihood, social support, and healthcare access (Rostami, Ghazinour, & Nygren, 2012). Widowhood significantly reduces social capital, negatively impacting mental health. Marriage provides companionship, emotional comfort, and encouragement for healthy behaviors, all of which are lost with widowhood (Milham & Morgan, 2008). Social capital, including social trust and networks, is crucial for mental well-being and helps buffer mental stress (Milham & Morgan, 2008; Zheng & Yan, 2024). However, widowhood deprives older adults of this essential social capital, leading to increased loneliness and grief (Zheng & Yan, 2024; Havas, 2017). Research shows that social capital has stronger effects on mental health than physical health. Individuals with higher levels of social trust and reciprocity are less likely to experience depressive symptoms (Zheng & Yan, 2024). Social capital provides a sense of acceptance, belonging, and security, contributing to physical and mental well-being (Milham & Morgan, 2008). Widowhood is linked to increased risk of mental health disorders such as depression and anxiety and physical health problems, including cardiovascular issues (Chaoxin Jiang, Hao Song & Jiaming Shi, 2023; Tobiasz-Adamczyk et al., 2008; Gary R. Lee & Alfred DeMaris, 2007). The risk of disability in older adults due to widowhood can be categorized as psychological stress and health behaviors (Pang et al., 2023).

The impact of widowhood on mental health is influenced by cultural and contextual factors. In Bangladesh, societal norms and patriarchal structures compound the challenges faced by widows, making them dependent on family members (Omar Rahman, Andrew Foster & Jane Menken, 1992). This dependency and the upheaval of their previous roles within their families contribute to the difficulties widows encounter, leading to emotional distress and physical frailty. Recent data shows that widowhood rates are rising globally, including in developing countries like Bangladesh, where societal support systems are less robust. According to the Bangladesh Bureau of Statistics, the number of widows in Bangladesh is increasing, highlighting the urgency of addressing their mental health needs (BBS, 2023). Despite the global recognition of widowhood's impact, there is limited research on the experiences of rural widows in Rajshahi, Bangladesh. Existing studies focus more on urban settings or broader contexts, highlighting the need for research that addresses the unique challenges faced by rural widows in this specific cultural and contextual setting. This research aims to address this gap by examining the multifaceted consequences of widowhood on mental health in the rural areas of Rajshahi, Bangladesh, and to provide insights that can inform more effective support strategies for this vulnerable population.

METHODS

This study was conducted in Parila Union, Paba Upazila, Rajshahi District, Bangladesh, encompassing all 16 villages within the four wards of the union. The target population included all widows residing in these wards, totaling 217 individuals. Social survey method was employed for this research. The researcher made attempts to include all the widows in the study area; however, due to various constraints such as physical illness, recent bereavement, absence from home, or reluctance to participate, it was not possible to interview the entire population. Ultimately, 201 widows were successfully interviewed. The sample comprised 201 widows, of which 101 were beneficiaries of the government-provided widowhood allowance, while the remaining 100 did not receive this allowance. This differentiation allowed for comparative analysis between those receiving financial support and those who did not. A structured questionnaire was developed for the interviews. The questionnaire included questions designed to assess the mental health status of the widows, such as: "What is your present mental health condition?" "Before widowhood, how was your mental health condition?" "How is your present mental health condition compared to before widowhood?" The responses were recorded on a three-point scale: good, fairly good, and bad. The interviews were conducted over a period from March 14, 2023, to June 5, 2023. The collected data were analyzed to determine the impact of widowhood on the mental

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health of the respondents. Comparative analyses were performed between those receiving widowhood allowance and those who did not to explore any potential differences in health outcomes.

Ethical Consideration

The study adhered to strict ethical standards. Prior to interviews, participants were informed about the research objectives, and their consent was obtained. Respondents were assured of their right to withdraw themselves at any time. They also had the freedom of not answering questions which they did not feel comfortable to answer. All the interviews were conducted privately, and confidentiality was maintained by coding data with no personal identifiers. This ensured the participants' privacy and autonomy were respected throughout the research.

RESULT AND DISCUSSION

Socio-economic Characteristics

This section provides an overview of the study population with respect to various socio-economic characteristics, as summarized in Table 1. The widows surveyed were ranged in age from under 30 to over 80 years. The results show that the largest percentages of widows (25.37%) were aged 41-50 years. The second largest group (22.88%) was aged 61-70 years. Notably, 124 widows (61.68%) were under 60 years, indicating they were still within the biologically active age range and could be considered potential human resources for productive work. Conversely, 32.9% of the widows were elderly and required security and welfare support.

Table 1 further illustrates the poverty and illiteracy in the study area. A significant proportion of the widows (76.61%) were illiterate, having received no formal education. Only 47 widows (23.38%) could write their names, and very few had achieved up to higher secondary education. None of the respondents were college graduates.

In the study area, the husbands of the 201 widows were involved in various occupations. Ninety-eight of them worked in agriculture, cultivating their own land as well as the land of others. Additionally, 27 of the husbands were day laborers, while 28 were engaged in different business activities. Nine husbands held government jobs, seven were rickshaw drivers, and eight were auto drivers. The widows reported that during their husbands' lifetime, they did not have to worry about their livelihoods, as their husbands provided everything for them. In the 'Other' category, which accounted for 11.94% of the husbands, there was a range of occupations. Some were seasonal workers or were involved in seasonal businesses, while others, due to old age, no longer engaged in regular employment. Before their husband’s passing away, the widows relied on their husbands' earnings and did not work outside the home. Their primary responsibilities were caring for the family and their children. However, after their husband’s death, they were compelled to seek employment outside home. Only the housewives in the community aged 60 or above remained at home, as many had returned to being housewives due to the challenges brought about by age.

Table1. Personal information of widows

Personal information		**Number of respondents**	**Percentage**
Age	<30	8	3.98
	31-40	22	10.94
	41-50	51	25.37
	51-60	43	21.39
	61-70	46	22.88

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	71-80	16	7.96
	81+	5	2.48
	Total	**201**	**100**
Education	Not able to sign	107	53.23
	Able to sign	47	23.38
	Primary	32	15.92
	Below SSC	10	4.98
	HSC	5	2.49
	Total	**201**	**100**
Widow's Occupation	Home making	84	41.79
	Maid servant	31	15.42
	Farming	29	14.43
	Handicrafts	13	6.47
	Business	16	7.96
	Poultry	45	22.39
	Others	11	5.47

[Multiple responses accepted regarding widow's occupation]

Husband's occupation	Agriculture	98	48.76
	Government Employee	9	4.48
	Day Labor	27	13.43
	Business	28	13.93
	Rickshaw Puller	7	3.48
	Auto Driver	8	3.98
	Others	24	11.94
	Total	**201**	**100**

The widows in the study were categorized into seven groups based on their current occupations: housewives, those engaged in farming, handicrafts, business, maid service, poultry farming, and other occupations. Poultry farming is significant in Parila Union, supplying a considerable quantity of chicken to the Rajshahi city market and providing employment for many low-income individuals. In the study, 45 widows (22.39%) were employed in poultry farms. Additionally, 22 widows worked as day laborers in crop fields, primarily engaged

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in activities such as harvesting vegetables and chilies. During different seasons, there is a need for crop processing, which requires substantial labor. In this context, 29 widows were involved in crop processing on a daily contract basis during various seasons. Furthermore, 16 widows pursued small businesses independently. Some leased ponds to cultivate fish, others sold clothing purchased from the city market, and some traded livestock such as chickens, pigeons, quail birds, cows, and goats, and also sold eggs and cow's milk. Ten widows were engaged in various handicrafts such as making embroidered quilts, sewing, and crafting hand fans, creating these products according to the demands of the local community. Additionally, 11 widows held diverse positions as Union Councilors, worked as traditional healers, and engaged in other forms of employment.

Living arrangement of the widows

The social norms and values which restrict residence, remarriage, mobility, employment and land ownership put widows in a situation of continuous dependency on the immediate kins. On the other hand, when she is the head of the household, her situation is sometimes even worse, both economically and socially where she is left alone with her dependent children (Shamim and Salahuddin, 1995).

Table 2: Living arrangement and prefer to stay with

Current living arrangement of the widows			**The widow's preferred living arrangement**	
	Frequency	**%**	**Frequency**	**%**
Self	55	27.36	38	18.91
Son	123	61.19	136	67.66
Daughter	14	6.96	23	11.44
Sister	1	0.50	0	0
Brother	1	0.50	1	0.50
Mother-father	2	1.00	3	1.49
Others	5	2.49	0	0
Total	**201**	**100**	**201**	**100**

In the study area, 27.36% of the widowed women with minor, teenage, or unmarried children lived in separate households, often facing financial hardships. The majority of the widows (61.19%) lived with their sons, which indicates a prevalent pattern of cohabitation. Notably, 67.66% prefer the arrangement of living with their sons despite financial incompatibility, accommodation constraints, or disapproval from daughters-in-law being cited as reasons for not residing with their sons. In cases where sons are unwilling or unable to provide support, some widows receive assistance from their daughters, showcasing a shift in familial dynamics. A small percentage (6.96%) of widows lived with their daughters, often due to the absence of sons. Interestingly, 11.44% of the widows expressed a preference for living with their daughters, highlighting a distinct choice in their living arrangements. This choice may be a result of not having a capable son to take care of them. The impact of these living arrangements on mental health is significant. Widows who live alone or in challenging circumstances often experience stress, loneliness, and anxiety. Studies show that social support plays a crucial role in mental well-being. For instance, (Wilcox et al., 2003) found that social support significantly influences mental health outcomes in widows. The lack of sufficient social and familial support can exacerbate feelings of isolation and depression (Wilcox et al., 2003). Additionally, the stress associated with financial instability may lead to mental health issues such as anxiety and depression (Avis et al., 1991). Addressing these challenges requires a comprehensive approach that includes mental health support, financial assistance, and social

integration programs to improve the overall well-being of widows.

Monthly family income of the widows

Income is a key determinant of social inequality within society (Islam, 2014). Income sources include business, crop sales, livestock, rental income, and wages or salaries earned by family members (Padmanabhan, 2006). Many rural individuals tend to keep their income information private due to concerns about potential risks or dangers associated with disclosing financial details. Consequently, they may not provide entirely accurate financial information. Nevertheless, Table 2 presents the monthly income distribution among the surveyed families. Approximately 10.45% of the families of the respondents had a monthly income between 1,001 and 5,000 Taka. Around 28.85% of the families earned between 5,001 and 10,000 Taka per month. There were 49 families with a monthly income between 10,001 and 15,000 Taka, and 23 families earned between 15,001 and 20,000 Taka per month. Additionally, 49 respondents, typically older individuals, reliant entirely on their families for financial support, did not have information about their monthly family income.

Table 3. Economic condition of the widows

	Economic condition	**Frequency**	**%**
Monthly Family Income	<1000	00	00
	1001-5000	21	10.45
	5001-10000	58	28.85
	10001-15000	49	24.38
	15001-20000	23	11.44
	20001>	25	12.44
	Cannot say	25	12.44
	Total	**201**	**100**
Widow's Monthly Income	<1000	51	25.37
	1001-5000	42	20.90
	5001-10000	23	11.44
	10001-15000	01	0.50
	No Earning	84	41.79
	Total	**201**	**100**
Economic Status	Dependent	166	82.59
	Independent	37	18.41
	Total	**201**	**100**

A family's monthly income is a crucial measure of its socio-economic status. Essentially, the type of occupation one pursues significantly influences his/her income level. Generally, those in lower-level occupations tend to earn less (Nayar, 2006). According to Table 2, a significant number of widows (n=84) have no personal income, meaning they lack any regular financial support or earnings. These widows depend

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entirely on alternative forms of assistance, such as widow allowances or family support, to meet their financial needs. Specifically, 51 respondents report a monthly income of less than Tk. 1000, relying primarily on widow allowances as their sole source of income. Their economic situation is notably challenging, and they face significant financial difficulties. Approximately 20.90% of widows, with a monthly income between Tk. 1001 and 5000, engage in various income-generating activities such as working in other households, cattle rearing, and embroidery. These additional income sources are essential for their financial stability. Meanwhile, 11.44% of the widows are in a better financial situation, with a monthly income ranging from Tk. 5000 to 10000. Many of these widows are involved in occupations such as farming, tailoring, poultry farming, and small businesses. These diverse income-generating activities contribute to their improved economic well-being, providing a more comfortable financial status**.**

Table 4: Relationship between period of widowhood and mental health

Year	**Frequency**	**%**
1 year	**25**	**12.44**
2-5	**53**	**26.37**
6-9	**46**	**22.88**
10+	**77**	**38.31**
Total	**201**	**100**

The period of widowhood has a profound impact on the mental health of widows, with different stages associated with distinct psychological challenges and adaptations. The analysis of these stages, as detailed in the study from Parila Union, reveals critical insights into how widows' mental health evolves over time.

James Raymond (2019) in "The 3 Stages of Widowhood, and How Advisors Can Help" divided the stages of widowhood into three.

Stage One: Absorbing the Shock of Change:

This initial stage, lasting over twelve months, is characterized by shock, numbness, and an overwhelming sense of paralysis. Widows often struggle with routine financial tasks and face immediate critical responsibilities, leading to mental and emotional exhaustion. The primary focus here is "Financial Triage," assessing cash flow needs and ensuring essential financial requirements are met.

Stage Two: From Feeling Numb to Moving Forward:

This second stage, typically lasting several years, involves the gradual dissipation of shock and numbness. Widows begin to adapt and rebuild their lives, experiencing a renewed sense of possibility. This phase is marked by the "Decision Free Zone," where widows sort, organize, and prioritize tasks to manage, one important thing at a time.

Stage Three: Emerging Into New Self:

Stage Three is when a widow asks: 'When do I get to be me again and stop being a widow'? That question alone is a sign that she is beginning a new chapter (R. James, 2019). In Parila Union, the stages of widowhood have been divided into four:

First stage: Widowhood is characterized by feelings of shock, disconnection, or disbelief. During this period, a widow may struggle to comprehend what is happening or feel as if she is living a nightmare (Melanie, 2022).

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The primary mental health issues during this stage include:

1. **Acute Stress Reaction:** The sudden loss of a spouse leads to an acute stress response, characterized by anxiety, panic attacks, and insomnia.

2. **Depression:** The overwhelming sense of loss and helplessness can lead to depressive symptoms, such as persistent sadness, lack of interest in daily activities, and feelings of worthlessness.

3. **Cognitive Impairment:** The mental fog and difficulty in concentrating are common as widows struggle to process their loss and manage immediate responsibilities, as noted in James Raymond's description of **"Financial Triage."** [‘Financial Triage’ means quickly dealing with urgent financial matters, much like how doctors prioritize patients who need immediate care. It involves focusing on the most critical financial tasks first, such as paying bills or managing expenses, especially during stressful times like after losing a spouse.]

Second stage (2-5 years): During this stage, widows begin to adapt to their new reality, although they still experience significant emotional turmoil. This phase is marked by the "Decision Free Zone," where widows prioritize tasks to manage one important thing at a time. Mental health issues in this period include:

1. **Bargaining and Depression:** Widows often grapple with feelings of anger and bargaining, trying to make sense of their loss and seeking ways to alleviate their pain. This can lead to chronic depression if unresolved (Melanie, 2022).

2. **Anxiety:** The uncertainty about the future and the challenges of adjusting to single-income household or managing finances independently contribute to ongoing anxiety.

3. **Isolation:** Social withdrawal is common as widows might feel misunderstood or overwhelmed by societal expectations, impacting their social support networks and exacerbating feelings of loneliness.

Stage Three: Emerging Into New Self (6-9 Years)

In this stage, widows begin to reintegrate into social life and adapt to new circumstances. While grief remains a challenge, they start forming new relationships and rebuilding their lives. Mental health dynamics during this stage include:

1. **Improved Coping Mechanisms:** Widows develop better coping strategies and resilience, allowing them to handle stress and grief more effectively.

2. **Social Reconnection:** Increased social interactions with relatives, neighbors, and friends provide emotional support and reduce feelings of isolation.

3. **Residual Grief and Emotional Challenges:** Despite improvements, widows still experience moments of intense grief and emotional turmoil, reflecting the long-term nature of their adjustment process (Melanie, 2022).

Stage Four: 4. Acceptance and New Identity (10+ Years): Widows in this final stage reach a level of acceptance of their loss and begin to redefine their identity beyond widowhood. They may still experience moments of anger and frustration, but they generally have a more balanced emotional state. Key mental health aspects of this stage include:

1. **Acceptance**: Widows come to terms with their loss and find ways to honor their past while embracing the future.

2. **Identity Reconstruction**: They stop identifying primarily as widows and start focusing on personal growth and new life goals.

3. **Emotional Stability:** While moments of grief and anger persist, they are less frequent and less intense, allowing for greater emotional stability (Melanie, 2022).

The study highlights that the largest group of widows (26.37%) is in the second stage, with 22.88% in the third stage, indicating prolonged periods of adjustment and adaptation. This prolonged process reflects societal attitudes towards widows and the support systems available. In many cultures, especially in rural areas like Rajshahi, Bangladesh, patriarchal norms and limited social support exacerbate the mental health challenges faced by widows. These factors include:

1. **Stigma and Social Exclusion:** Widows may face social stigma and exclusion, leading to increased feelings of loneliness and depression.

2. **Economic Dependency:** Financial dependency on in-laws or relatives can limit widows' autonomy and increase their anxiety and stress.

3. **Limited Access to Mental Health Services:** In rural areas, access to mental health services is often limited, making it difficult for widows to receive the support they need.

The study indicates that the largest group of widows (26.37%) is in the second stage, followed by 22.88% in the third stage. These prolonged stages highlight societal attitudes towards widows and the support systems available, raising questions about social perceptions and assistance for widows enduring extended periods of widowhood (Ainapur & Biradar, 1999).

The period of widowhood significantly impacts mental health, with each stage presenting unique challenges. Understanding these stages can help in developing targeted interventions and support systems to address the specific needs of widows at different points in their journey. Societal attitudes and support structures play a crucial role in either mitigating or exacerbating these mental health issues, highlighting the need for comprehensive policies and programs to support widows through their bereavement and adaptation process.

Health condition of the widows

Good health depends on a person's physical, mental, and social condition, with mental and physical health being inextricably linked. This relationship is bidirectional, with each influencing the other (Crinson 2007, Martino 2017). Widowhood can result in significant loss and depressive states, which are strong predictors of poor health (Wan, 1982). Additionally, the mortality rate for many causes of death is much higher among widows and widowers compared to married individuals of the same age (Parkes, 1964). Fillenbaum (1984) suggests that self-perceived health status may be a better indicator of potential service use than actual health condition. Moreover, self-assessments of health are common components of population-based surveys (Munsur, Tareque & Rahman, 2010). Before experiencing widowhood, 146 widows reported good health, with only 36 widows indicating poor health. Currently, 76% (152) of widows report being in poor health, struggling with various illnesses and emotional distress. Only 29 widows are in relatively good health, and just 21 are considered to be in good condition. This comparison highlights a stark decline in their well-being, underscoring that a substantial majority of widows now endure poor health conditions.

Table 5: Mental health condition of the widows

Mental health condition of widows	**Mental health condition before widowhood**		**Present mental health condition**		**Present mental health condition compared to before**	
	Frequency	**%**	**Frequency**	**%**	**Frequency**	**%**
Good	146	72.64	18	8.96	21	10.45
Fairly good	19	9.45	31	15.42	29	14.43

Bad	36	17.91	152	75.62	151	75.12
Total	**201**	**100**	**201**	**100**	**201**	**100**

Whether suffered from disease(s) relating to mental health	**Before**		**After**	
	Frequency	**%**	**Frequency**	**%**
Yes	30	14.93	183	91.04
No	171	85.07	18	8.96
Total	**201**	**100**	**201**	**100**

[18 respondents were healthy and did not need medication]

Mental health before widowhood			**Mental health after widowhood**		
Taking medication	**Frequency**	**%**	**Taking medication**	**Frequency**	**%**
Yes	13	45.45	Yes	54	29.51
No	17	54.55	No	129	70.49
Total	**30**	**100**	**Total**	**183**	**100**

Whether widowhood is responsible for present illness	**Frequency**	**%**
Yes	101	78.29
No	28	21.71
Total	**129**	**100**

In the present study, it is evident that the mental health condition of the widows was notably better before widowhood, with 85.07 (n=171) experiencing sound mental health. Out of the 201 widows surveyed, 30 had encountered various illnesses at different times before becoming widows, although these illnesses were generally not of a severe nature. Marital status plays a substantial role in the physical and mental well-being of women, as supported by previous research (Wilcox et al., 2003). However, widowhood appears to have a major impact on a person's mental health. After the death of a spouse many widows begin to take more prescription medications for mental health issues (Avis, Brambilla, Vass, & Mckinlay, 1991)). This is exemplified in the present study by the mental illnesses experienced by 183 widows after the death of their husbands. Among these 183 respondents, 129 (70.49%) reported that they did not have any mental health issues before becoming widows. A significant 101 (78.29%) of the widows attributed their mental health problems directly to widowhood. Prior to their husband's deaths, they led lives supported by their husband's income, which allowed them to maintain a decent standard of living. After losing their spouses, they faced uncertainties about the future, their children's well-being, and financial stability. This anxiety and worry manifested in mental health issues such as insomnia, anxiety, loneliness, trauma, and depression. These health challenges were often exacerbated by financial difficulties, family problems, and social issues, making their mental health problems more visible. The interplay between physical and mental health is complex; physical ill-health can lead to mental health problems like anxiety and depression, while psychological distress can

impede the recovery or stabilization of physical health conditions.

Table 6: Suffering from mental diseases

Types of mental disease	**Before widowhood**		**After widowhood**	
	Frequency	**%**	**Frequency**	**%**
Tension	23	11.44	172	85.57
Loneliness	3	1.49	110	54.73
Insomnia	12	5.97	116	57.71
Anxiety	1	0.50	103	51.24
Stress	0	00	89	44.27
Trauma	0		62	30.85
Depression	0	00	33	16.42

[Multiple response]

This interaction may create a vicious cycle, making overall well-being challenging to achieve (Evans et al., 2000). Furthermore, behavioral and social risk factors for physical and mental health issues often overlap, making it difficult to ascertain whether mental illness precedes physical ailments or vice versa. Research by the King's Fund suggests that more than four million people in England with long-term physical health problems also experienced mental health issues (Naylor et al., 2012).

Above tables also provide valuable insights into the mental health dynamics of widows before and after the loss of their spouses. Prior to widowhood, only 30 individuals reported experiencing various mental health issues, but this number surged to 183 during post-widowhood. Many widows attributed their mental health challenges directly to the loss of their husbands. This increase in mental health concerns is further highlighted by medication usage data. While 13 out of 30 individuals used medication before widowhood, this number rose to 54 out of 183 after becoming widows. Financial constraints have emerged as a primary barrier to accessing necessary medications for mental health. Many widows expressed an inability to afford these medications, preventing them from addressing issues such as insomnia, anxiety, restlessness, loneliness, and tension. This reluctance to allocate funds for mental health treatment stems from a societal tendency to prioritize physical health over mental well-being. Despite these challenges, there is a subset of widows who prioritize their mental health. Among these, 54 consistently take medication, underscoring the persistent impact of mental health challenges following the loss of their husbands. This emphasizes the need for greater attention to mental health issues and the importance of making mental health care more accessible and affordable for widows.

Age VS health condition of the widows

Widowhood introduces a series of emotional, social, and economic changes that contribute to this health decline. The loss of a spouse is a traumatic event, causing grief, anxiety, and a deep sense of loneliness. In Bangladesh, for women in rural settings, where societal roles are often rigid and heavily reliant on marital status, the emotional weight of widowhood is even heavier. The transition from being a wife to being a widow involves not only personal grief but also a profound shift in social status, often leading to marginalization. Many widows find themselves excluded from decision-making processes within their families, face economic hardship, and become dependent on others for financial and social support. This lack of autonomy and increased vulnerability greatly contributes to feelings of depression and anxiety, which deteriorate their mental

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health, regardless of their age.

Table 7: Age VS health condition of the widows

	Health condition before widowhood			Health condition after widowhood		
Present age in years	**Good**	**Fairly good**	**Bad**	**Good**	**Fairly good**	**Bad**
<30	5 (2.49)	3 (1.49)	0 (0)	6(2.99)	2 (0.99)	2 (0.99)
31-40	16 (7.96)	0 (0)	3 (1.49)	6(2.99)	3 (1.49)	7 (3.48)
41-50	39 (19.40)	3 (1.49)	14 (6.96)	6(2.99)	11 (5.47)	34 (16.92)
51-60	36 (17.91)	6 (2.99)	10 (4.98)	2 (0.99)	8 (4.48)	46 (22.89)
61-70	25 (12.44)	9 (4.48)	9 (4.48)	3 (1.49)	4 (1.99)	40 (19.90)
71-80	11 (5.47)	0 (0)	3 (1.49)	2(0.99)	0 (0)	12 (5.97)
81+	4 (1.99)	2(0.99)	3 (1.49)	0 (0)	0 (0)	7 (3.48)

The findings from Table 7 provide a significant contribution to the understanding of how widowhood affects the mental health of women, particularly in rural contexts, where traditional social roles and economic dependencies are deeply entrenched. This analysis challenges the commonly held belief that age is the primary determinant of mental health decline in older individuals. While aging undeniably brings physical and emotional challenges, the data clearly show that widowhood acts as a critical factor that accelerates mental health deterioration across various age groups.

The impact of widowhood on mental health has been well-documented in literature. Research consistently shows that the loss of a spouse is one of the most stressful life events a person can experience, with widows often suffering from heightened rates of depression, anxiety, and loneliness (Lee et al., 2001). In rural settings, where widows may face additional challenges such as economic hardship and social isolation, these mental health outcomes can be even more pronounced. The findings in Table 7 strongly support this narrative, showing that even younger widows, typically expected to maintain better mental and physical health, experience significant declines after losing their spouses.

For instance, women aged 41-50 experienced a dramatic drop in reported good health from 39 women (19.40%) before widowhood to only 6 (2.99%) after widowhood. This pattern is echoed across other age groups, such as the 51-60 age bracket, where 36 women (17.91%) reported good health before widowhood, compared to only 2 (0.99%) afterward. These findings highlight that widowhood, not merely age, introduces stressors that critically impact women's mental health. The emotional toll of losing a life partner often leads to social marginalization, further isolation, and increased responsibilities, all of which compound the sense of loss and grief, eventually deteriorating mental health.

Moreover, studies suggest that the role shift widows experience from being a wife to becoming a socially and economically marginalized individual adds further layers of emotional strain. Widows often face exclusion from decision-making processes within their families and communities, which erodes their sense of autonomy and self-worth. This dynamic is reflected in other research showing that the reduction of control over one's life circumstances is closely associated with increased levels of anxiety and depression (Wilcox et al., 2003).

In the case of older widows, who might naturally expect a decline in health due to aging, the added stress of widowhood exacerbates these issues. The sharp drop in reported good health among those in the 61-70 age group from 25 women (12.44%) to just 3 (1.49%) illustrates how widowhood compounds age-related health

challenges. The responsibility of becoming the sole provider or caregiver, often without adequate financial or social support, introduces a level of stress that manifests as heightened anxiety, insomnia, and sometimes trauma (Lloyd-Sherlock et al., 2012). These factors significantly worsen mental health conditions, beyond what could be attributed to aging alone.

Additionally, the decline in health among younger widows, such as those under 30 or between 31-40 years old, further supports the argument that widowhood itself plays a far more critical role in mental health deterioration than age. Women in these age groups are generally expected to maintain better health due to their relative youth. However, the data show that even in these groups, widowhood leads to significant declines in reported good health, underscoring the profound emotional and psychological impact of losing a spouse.

Causes of mental illness

Decision making in a family depends on the nature of family. In the joint family, decision making is centered in the hands of the eldest male person. But in the nuclear family, decision making is dispersed and women are also supposed to take part in it. In the extended family system, women tend to participate more in the family decision making (Srinath, 2000). The findings in Table 8 vividly highlight the profound shifts in female headship, family dynamics, and decision-making power that follow widowhood, all of which significantly accelerate the decline in widows' mental health. Before widowhood, the vast majority of women (95.52%) held the position of female head within their households, allowing them a certain level of control and autonomy over household affairs.

Table 8: Change of female headship in the family

	Before widowhood		**After widowhood**	
Female head in the family	**Frequency**	**%**	**Frequency**	**%**
Self	192	95.52	102	50.75
Daughter-in law	8	3.98	89	44.28
Others	1	0.50	10	4.97
Total	**201**	**100**	**201**	**100**

Family member’s behavior towards widow

Family member’s behavior towards widow	**Before widowhood**		**After widowhood**	
	Frequency	**%**	**Frequency**	**%**
Satisfactory	136	67.66	115	57.21
Average	58	28.86	49	24.38
Dissatisfactory	7	3.48	32	15.92
Widows live alone	0	00	5	2.49
Total	**201**	**100**	**201**	**100**

Decision making power

Is decision taken about treatment, selling/purchasing assets, marriage?	Before widowhood		After widowhood	
	Frequency	%	Frequency	%
Yes	144/15	79.10	125/12	68.16
No	51/11	30.88	70/09	39.30
No comments/Others	6/23	14.43	6/32	18.91

[Multiple Responses]

Other Causes of mental illness after widowhood	Frequency	%
Lack of sufficient food	43	21.39
Lack of medicine and proper treatment	62	30.85
Lack of rest	31	15.42
Lack of caring	35	17.41
Lack of mental support	74	36.82
Family crisis	8	3.98
Economic problem	29	14.43
Cultural impact	15	7.46
others	7	3.48

[Multiple Responses]

However, after the death of their spouse, this figure plummets to 50.75%. In nearly half of the cases (44.28%), the role of family headship is transferred to the daughter-in-law, highlighting a significant cultural shift that robs widows of authority and decision-making power. This abrupt change leaves many widows feeling powerless and disconnected, leading to a loss of identity. The psychological impact of such a loss of authority and social standing can manifest in anxiety, depression, and a profound sense of worthlessness. The deterioration in family behavior post-widowhood is another important factor affecting mental health. While 67.66% of widows experienced satisfactory treatment from family members prior to widowhood, this percentage drops to 57.21% after the death of their husbands. More concerning is the sharp increase in dissatisfactory treatment, which rises from a mere 3.48% before widowhood to 15.92% afterward. This decline in familial support leads to feelings of isolation and emotional neglect, which are often precursors to depression and anxiety. Widows who no longer receive the same level of care and respect from their families are more likely to feel marginalized, contributing to their mental health struggles. The 2.49% of widows who report living alone face even greater risks, as the absence of social interaction and familial support exacerbates their loneliness and emotional distress, further worsening their mental health.

Another major challenge is the significant reduction in decision-making power. Prior to widowhood, 79.10% of widows were involved in decisions related to important family matters such as treatment, marriage, and asset management. However, this figure decreases to 68.16% after widowhood, reflecting their diminished role in the household. The reduction in autonomy and the inability to participate in decisions that directly affect their lives contributes to a sense of helplessness and lack of control. This lack of agency can severely impact mental well-being, as studies have shown that individuals who feel they have little control over their lives are

more likely to experience anxiety and depression (Wilcox et al., 2003).

Furthermore, the study highlights additional stressors that contribute to the worsening mental health of widows. The data reveals that 36.82% of widows suffer from a lack of mental support, while 30.85% struggle with inadequate access to medicine and proper treatment. These figures reflect the lack of adequate healthcare and emotional support for widows, which can lead to mental health disorders such as insomnia, anxiety, and chronic stress. In addition, 21.39% of widows face food insecurity, and 14.43% report significant economic challenges. The strain of not being able to meet basic needs exacerbates mental health issues, leading to higher levels of anxiety and emotional distress. Cultural restrictions also play a role in the mental health struggles of widows. In 7.46% of cases, cultural expectations impose additional burdens on widows, forcing them into roles of submission and isolation. These societal pressures not only limit their social mobility but also contribute to feelings of alienation, increasing the likelihood of mental health problems. The table paints a clear picture of the decline in autonomy, family support, and decision-making power that widows face, all of which contribute to their deteriorating mental health. The psychological toll of losing control over their lives, coupled with the added burden of economic insecurity and cultural pressures, creates an environment in which widows are highly susceptible to mental health disorders such as depression and anxiety. These findings underscore the importance of addressing the mental health needs of widows through targeted interventions and social support mechanisms.

DISCUSSION

The findings of this study provide a comprehensive look into the profound impact of widowhood on women's mental health in rural Bangladesh highlighting that widowhood, rather than age, is the key factor driving mental health deterioration. This challenges the traditional assumption that aging alone is the primary cause of mental health decline. Instead, the study demonstrates that the emotional, social, and economic disruptions following the loss of a spouse significantly contribute to poor mental health outcomes across all age groups. The mental health challenges experienced by widows are not uncommon, as many studies have documented the severe emotional toll of losing a spouse (Lee et al., 2001). However, in rural settings like Parila Union, these challenges are often compounded by additional factors, such as economic hardship, social isolation, and diminished autonomy. The findings indicate that even younger widows, such as those in the 41-50 age group, who are generally expected to enjoy better physical and mental health, experience a significant decline in well-being after their husbands' deaths. For example, before widowhood, 39 women in this age range reported good health, but this number dropped sharply to just 6 women afterward. Similarly, in the 51-60 age group, the number of women reporting good health fell from 36 to just 2 after widowhood. These sharp declines emphasize that widowhood, rather than the natural process of aging, triggers the decline in health. The loss of a life partner often brings financial instability, increased responsibilities, and emotional strain, which contribute to mental health challenges like depression, anxiety, and loneliness.

The transition from being a wife to becoming a widow also has significant implications for women's social standing and decision-making power within the family. As highlighted in this study, widowhood often leads to a loss of control over family matters and a diminished role in decision-making. This is particularly evident in rural Bangladesh, where traditional gender roles place men in the dominant decision-making position within families. The study found that prior to widowhood, most women (95.52%) had some level of authority as the female head of the household. However, after the death of their spouse, this figure dropped to 50.75%, with many widows seeing their role taken over by their daughter-in-law or other family members. This loss of autonomy not only affects their social standing but also exacerbates feelings of worthlessness and helplessness, contributing to their mental health struggles. Research supports this, showing that a lack of control over one's life is closely linked to increase anxiety and depression (Wilcox et al., 2003).

Another significant finding from this study is the decline in family support after widowhood. Before losing their husbands, 67.66% of widows reported satisfactory treatment from family members. However, this number fell to 57.21% after widowhood, while reports of dissatisfactory treatment increased from 3.48% to 15.92%. This shift in family behavior plays a crucial role in the worsening mental health of widows, as emotional neglect and isolation can lead to feelings of depression and anxiety. Furthermore, a small percentage of widows (2.49%) reported living alone, which only intensifies the risks of loneliness and poor mental health

due to the absence of social and familial support.

The study also revealed the financial struggles widows face, which further exacerbate their mental health challenges. Financial difficulties emerged as one of the primary barriers to accessing necessary medications and healthcare services. Widows who were once dependent on their husbands for financial stability often find themselves unable to afford medication for mental health conditions like anxiety, insomnia, and depression. Only 54 of the widows consistently took medication after becoming widows, despite the high number of them experiencing mental health problems. This underscores the pressing need to make mental health care more accessible and affordable for widows, especially in rural settings where financial resources are limited. The study also highlighted other stressors like food insecurity (21.39%) and economic difficulties (14.43%), both of which significantly contribute to the worsening mental health of widows. The cultural restrictions placed on widows further compound their mental health struggles. The study found that 7.46% of widows faced additional cultural pressures, which often forced them into more isolated and submissive roles within society. These societal norms limit widows' ability to actively engage in their communities and often confine them to roles of dependency. As a result, many widows feel alienated, and this social isolation increases the risk of developing mental health disorders.

A key aspect of this study is the significant contribution it makes to advance the understanding of widowhood in rural Bangladesh. While previous research has addressed the emotional and financial struggles widows face (Avis et al., 1991; Wilcox et al., 2003), this study provides specific insights into how widowhood affects women's mental health in rural settings where traditional roles and economic dependencies are deeply entrenched. By focusing on how widowhood, rather than age, drives the decline in mental health, this study adds a new dimension to the discourse on aging and mental health. Additionally, it highlights the need for targeted mental health interventions that address the unique challenges widows face in these settings, such as the loss of decision-making power, reduced family support, financial insecurity, and cultural restrictions. The findings underscore the importance of developing policies and programs that provide emotional, financial, and medical support to widows, helping them navigate the complex challenges they encounter after the loss of a spouse.

Policy and Program Implications for Supporting Widows in Rural Bangladesh

The findings of this study emphasize the need for targeted policy and program development to address the mental health and socio-economic challenges widows face. Key areas for policy and program formulation include mental health accessibility, financial support, social protection, and cultural reforms.

Informing Policy Development

1. Mental Health Accessibility and Affordability: Policies should prioritize accessible mental health services for widows, particularly in rural areas, with community-based programs offering counseling, mental health screenings, and subsidized medications.

2. Financial Support Mechanisms: Governments should introduce targeted social protection schemes, such as widow allowances, financial aid, and income-generation programs to enhance widows' economic independence.

3. Social Protection and Family Support Policies: Policies should promote stronger family and community support systems, encouraging family care and addressing emotional neglect through community support groups and educational campaigns.

4. Cultural and Legal Reforms: Legal protections should ensure widows retain property rights and decision-making power, with social campaigns challenging traditional gender norms that isolate widows.

Informing Program Development

1. Widow-Specific Mental Health Programs: Programs should offer widow-specific counseling, peer

support, and mental health workshops to address the emotional challenges of widowhood.

2. Capacity Building and Skill Development Initiatives: Vocational training and microfinance initiatives should empower widows economically, reducing dependence on family members.

3. Family Counseling and Education: Family counseling programs should foster empathy and support for widows, improving family dynamics and reducing social stigma.

4. Healthcare Access and Outreach: Mobile health clinics and telemedicine services should improve access to healthcare for widows, with outreach programs educating them on available services.

5. Community Integration and Social Engagement: Community centers and social clubs should create spaces for widows to connect and participate in communal activities, reducing isolation and enhancing their well-being.

CONCLUSION

The study titled "The Impact of Widowhood on Mental Health: A Study on Rural Widows in Rajshahi, Bangladesh" underscores that widowhood is a critical determinant of mental health decline, surpassing age as a factor. The research reveals that the death of a spouse precipitates profound emotional, social, and economic challenges, leading to heightened rates of depression, anxiety, and social isolation among widows. In rural settings, where resources are limited, these challenges are exacerbated by financial insecurity, diminished autonomy, and reduced familial support. By shedding light on the multifaceted difficulties faced by widows, this study highlights an urgent need for comprehensive policy and program development. Addressing the mental health needs of widows requires an integrated approach that includes accessible mental health services, targeted financial support, robust social protection, and legal reforms. Effective interventions should aim to empower widows, mitigate their mental health struggles, and enhance their quality of life. This research provides a crucial foundation for shaping future policies and programs, ensuring that the specific needs of widows are met in a meaningful and sustainable manner.

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