Effect of Pastoral Counselling and Social Support on the Management of Psychological Well-Being of Widows in Anglican Communion of Lagos State, Nigeria

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Abstract

Widowhood is a catastrophic event at any stage of life for the surviving partner at any age, with serious repercussions on their psychological well-being. Thus, this study examined effect of pastoral counselling and social support on the psychological wellbeing of widows in Anglican Communion of Lagos State, Nigeria. Six research questions and hypotheses were generated and tested; data were analyzed using descriptive statistics and ANCOVA. The quasi-experimental pretest/posttest control group research design was adopted. The samples consisted of 92 widows. The first stage was the selection of one Anglican Diocese out of the four in Lagos State using simple random sampling, through hat and draw method. The second stage involved using proportionate stratified random sampling technique to select three Archdeaconries from the selected Diocese in Lagos state. The third stage involved selection of widows with psychological wellbeing problems from each of the Archdeaconries selected using "The Bell Global Psychopathology Scale (BGPS)" and the "Widows' Psychological Adjustment Scale (WPAS)" with 0.80 and 0.73 reliability coefficient respectively. The last stage involved purposive sampling technique to select all 92 identified widows with psychological wellbeing problems into experimental groups and control group. The Pastoral Counselling and Social Support were used as treatments in the experimental groups. The findings revealed that: There is significant difference in the post-test mean scores on depression of participants exposed to experimental conditions and there is significant difference in the post-test mean scores on anxiety of participants exposed to experimental conditions. Both pastoral counselling and social support should be used in managing psychological wellbeing of widows

Keywords: *Anxiety Depression, Self-esteem, Social support, Pastoral Counselling, Widow.*

Introduction

The economic, social and psychological problems associated with the death of a spouse cannot be overemphasised. This explains why death is regarded as one of the greatest and

stressful events in the life of the widows. When it happens, many deprivations may occur; it engenders the provision of primary social and emotional support which may lead to social isolation orchestrated by the absence of the spouse as a major attachment figure in a woman's life. This imposes a lot of threats to the psychological wellbeing of the widow. The death of a spouse affects all ages but the older women seem to have a whole lot of difficulties in overcoming the shock than younger women. It provokes an important life change because older women may already have chronic physical health issues that reduce their capacity to adjust with the bereavement coupled with the loss and the financial insecurity that result from it (Yadollah, Tengku-Aizan, Nurizan & Rahimah, 2019).

As part of the issues that result from the loss of the spouse and the attendant financial insecurity, is the issue of self-esteem which is rooted in one's self-evaluation of worth. This is true of the typical African society that sees death as a taboo especially when it happens to a man; the widow left behind is sometimes seen as a 'witch'. In some African societies, the widow is tagged with derogatory epithets; and sometimes, maltreated by the family of the departed. These unwholesome treatments from the family of the husband often times impose threats on the self-worth of the widow which is likely to affect her personality in the long run. If such a widow has no grown-up children to stand by her, the situation may be made worse as she may even be compelled to do things against her conscience due to pressures from the family. Widowhood in African is like hydra-headed phenomenon whose facets cannot be explained in the single sentence because it may impose threats on the entire psyche of the victim (Mburugu, Nyaga, Chepchieng & Ngari, 2015).

Atindanbila, Bamford, Adatara, Kwakye-Nuako and Benneh (2014) noted that widows have to undergo some widowhood rites. These are cultural rituals that any surviving partner undergoes to “honour” the dead spouse and exonerate his or herself. They further noted that, although they are designed for widows and widowers; but widowers go through less ritual when compared with widows. The situation is made worse when there are malicious issues that surrounded the marriage, probably as a result of the family members not supporting the relationship in the first place before the death of the husband, or any other family intrigues. Death, under such circumstance aggravates and gives room for everybody to express their grievances and in the process label the woman as the cause of the death of her husband. The widow in this situation does not only suffer the loss of her husband but also has to battle the emotional trauma caused by the treatments she receives from family members and heartaches due to struggle to be accepted as innocent in the sight of the family (Osborn, 2015). Widowhood is a catastrophic event at any stage of life for the surviving partner at any age, with serious repercussions on their psychological well-

being. Spousal death has a wide range of psychological effects on the widows such as anxiety, depression, low self-esteem, and aggression issues. It is closely related to the risk of death in elderly and increases the mortality of various diseases.

Depression is a common mental illness among older adults and a population-based cohort study also showed that age-standardized depression prevalence in older widows was 6.8% (Alexopoulos, 2015). Widows with depression may have a relatively high rate of disease comorbidity as well as increased mortality and risk of disability and suicide. Widows living independently from family or friends are particularly susceptible to depression (Wilson, 2017); also, social isolation is more likely to cause depression in this population compared with widows who live among other people (Osborn, 2015). Although family support can reduce the difference in depressive symptoms between old widows who experienced spousal death and other young widows, the absence of children does increase loneliness or depression in widowhood. In addition, help from children and the sharing of living arrangements with them yield reduced depression symptoms and favourable self-rated health.

Another study also indicated that spouse loss increases the degree of depression and that it will last for several years (Tseng, 2017). The association between widowhood and psychological problems, such as depression and anxiety, have been examined extensively. Few studies on widowhood such as psychological and social problems, however, have explored the prevalence and incidence of anxiety disorders based on diagnostic criteria after the loss of the partner. In the past decades, adaptation following bereavement has been studied at great length. Surprisingly, however, few of these studies have examined the prevalence and incidence of anxiety disorders after the loss of a spouse. This is in part explained by the fact that anxiety disorders are a normal part of the bereavement process. According to the Diagnostic and Statistical Manual (American Psychiatric Association, 1994), even a full range of depressive symptoms for two or more weeks will not be diagnosed as a Major Depressive Disorder when these symptoms appear shortly after the loss. In the first months after bereavement, the most likely label will be uncomplicated bereavement, regardless of the symptomatology, and so the presence of anxiety disorders may go unrecognized (Jacobs & Kim, 2013; Zisook & Shuchter, 2016). Nevertheless, psychological distress is a normal response to such a stressful event, which may even help the surviving relative to adapt and normal bereavement reactions should not be pathologised. Recognition of anxiety disorders in bereaved spouses is important, as they may involve psychological suffering and problems in daily functioning. Furthermore, it is generally assumed that those anxiety disorders associated with bereavement, Major

Depressive Disorder (MDD) and anxiety disorders, can be adequately treated in many cases with psychological and pharmacological interventions.

Several researchers focused on the changing roles and statuses of widowed women and the impact this has on self-esteem (Walters & Charles, 2017; Van den Hoonaard, 2019). Walters and Charles (2017) found that widowhood and its changing roles related to feelings of unpredictability in their participants' lives. This unpredictability and accompanying powerlessness to control their lives was associated with decreases in women's self-esteem. Fry (2021) suggested that loss of self-esteem during widowhood may occur through a variety of pathways. Loss of a meaningful spouse role, loss of significant relationships with the deceased's associates, and increased physical and social isolation have all been implicated as pathways by which self-esteem may be eroded during widowhood (Arens, 2013; Ferraro, 2014). Widows may be further vulnerable to lowered self-esteem as a result of diminished economic resources and dependency (Fry, 2021). Other studies in the gerontological literature have suggested that self-esteem drops during widowhood as a result of lowered emotional efficacy (Carr, 2020; Lund, Caserta, & Dimond, 2021). Johnson, Lund and Dimond (2016) examined self-esteem in the context of the stress of spousal bereavement in older adults and found that its effects are far-reaching and long-lasting. They also reported that even respondents who reported high levels of self-esteem and seemed to be coping well with the loss of their spouses experienced mediating effects of the stressfulness of the loss on their self-esteem.

Widowhood is also associated with the expression of anger (Kitson, 2017), and the intense aggression is more common among women in widowhood because of denial following the loss of a close spouse through death (Thomas &Shechan,2018). The review by UN Division for the Advancement of Women, (2020), concludes that the widows across the globe share two common experiences: a loss of social status and reduced economic circumstances; the loss also results into changes that affect the woman's living arrangements, affects the financial situation and results in poor health and low living standards.

Having explained the psychological problems faced by these widows who have lost their husbands, there is need to assist them with interventions that could help them out of these problems. There are a number of counselling interventions such as assertiveness training, cognitive restructuring, reality therapy, mindfulness-based cognitive therapy and social skills training. For the purpose of this study, pastoral counselling and social support techniques will be employed. The two techniques have gained momentum in the recent years especially on the field of counselling for widows in Nigeria to overcome various traumatic experiences associated with the loss of the husband.

Modern pastoral counselling began in the United States of America when Rev Anton Boisen started a clinical training programme in a Boston hospital. He was influenced by the works of Sigmund Freud and William James. He believed people's past experiences and relationship with God could determine their mental health. He believed that some mental illnesses, such as schizophrenia and depression may be indicative of some spiritual disconnect from God Pastoral counselling has since evolved leveraging some skills of psychotherapy, demonstrating rapport, empathy, acceptance and unconditional positive regard. Pastoral Counselling has been a primary duty of all those entrusted with spiritual leadership, as pastors or ministers in a local congregation, since the selection of deacons in Acts of the Apostles chapter 7. The word "Pastor" literally means shepherd, nurturer, watchman, and carer. Pastors have a divine mandate to watch over spirit, soul and body of individuals and families committed to their care. Pam (2013) describes Pastoral Counselling as a type of counselling or psychotherapy wherein knowledge and standards stemming from the disciplines of theology and the behavioural sciences are utilized in working with couples; families, and cultural systems to reach a place of healing and development. Odeleye (2017) submits that Pastoral Counselling is a helping relationship in which a trained therapist (pastor or minister) assists individuals, couples and families resolve their emotional, relational and psychosocial issues, utilising the Bible as primary manual. Pastoral counselling is a unique form of counselling which utilizes spiritual and psychological capital to help individuals to understand possible options to attain the balanced life.

It is imperative to restate that pastoral counselling is a therapeutic relationship between a congruent, stable and coordinated pastoral counsellor and an incongruent, disturbed and confused counsellee (church member, congregants, most importantly, the widows). While it is true that there are times when the counsellee is not exactly disturbed or confused but will just like to seek more information or clarification on particular issues of interest, pastoral counselling concerns cover a range celestial and terrestrial matters. For instance, in the church setting, while homiletics may meet needs of many individuals and families in congregations, there are certain life issues that may be well addressed only by one-to-one interaction with the pastoral counsellor. Also, a couple having marital problems may find succour as they vent their disgust to the pastor, just as a couple seeking healing from marital infidelity may find requisite help in the pastoral counsellor. Pastoral Counselling seeks to help faith adherents who have lost their loved ones to restore and strengthen relationship with the Creator of the human race which is relevant to the study.

Social support is an important coping resource for persons experiencing stressful life changes or persons coping with bereavement and has been identified as contributing to the

effectiveness of general process therapy groups composed of members with a wide variety of presenting concerns (Cohen & Wills, 2015; Leavy, 2019). Social support is defined as the perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations (Wills, 2019). It may come from a partner, relatives, friends, coworkers, social and community ties, and even a devoted pet (Allen, Blascovich, & Mendes, 2022). Social support groups were originally conceived of as small, face-to-face voluntary groups of individuals who came together to solve a problem or help each other cope with handicaps or illnesses, especially through the provision of emotional support (Katz & Bender, 2016). Social support is multidimensional and functions in a stressor-specific manner. Different types of support provide different coping resources, and because stressors vary in adaptational demands, a given type of support will be effective only when the coping resources it provides are matched to the demands of the stressor (Cohen & Wills, 2015; Wilcox & Vernberg, 2015). Mutually exchanged social support is also an important aspect of theme-oriented therapy groups that bring together persons who have experienced the same trauma, life transition, or other presenting problem, for example, victims of incest, domestic violence, mental illness and loss of a spouse which is relevant to this study. (Hall, Kassees, & Hoffman, 2016).

Social support reduces psychological distress such as depression or anxiety during times of stress It has been found to promote psychological adjustment to chronically stressful conditions, such as coronary artery disease, diabetes, HIV, cancer (rheumatoid arthritis, kidney disease, childhood leukemia and stroke among other disorders). Social support also protects against cognitive decline in older adults, heart disease among the recently widowed (Sorkin, Rook, & Lu, 2012) and psychological distress in response to traumatic events, such as 9/11 (Bright, Greenberg, Nelson, Schmeider, & Hollander, 2015).

The counselling techniques remain aspect of recovery from the loss and grief emerging from the death of the husband of the woman and improve her psychological wellbeing. Hence, there is need for the study of this nature to examine the effect of pastoral counselling and social support on the psychological wellbeing of widows in Anglican Communion of Lagos State, Nigeria.

Hypotheses

The following null hypotheses were tested in the course of this study:

1. There is no significant difference in the post-test mean scores on depression of participants exposed to pastoral counselling therapy, social support therapy and control group.

2. There is no significant difference in the post-test mean scores on anxiety of participants exposed to pastoral counselling therapy, social support therapy and control group.

Sample and Sampling Techniques

Multi-stage sampling process was employed for the study. The first stage was the selection of one Anglican Diocese out of the four Dioceses in Lagos State using simple random sampling, through hat and draw method. The second stage involved using proportionate stratified random sampling technique to select three Archdeaconries from the selected Diocese in Lagos state. The third stage involved selection of widows with psychological wellbeing problems from each of the Archdeaconries selected using "The Bell Global Psychopathology Scale (BGPS)" to determine the level of psychological wellbeing problems of the participants A bench mark was set: any widow that obtains 50% and above were identified to have high psychological wellbeing problems and those that scored below 50%, have low psychological wellbeing problems. The "Widows' Psychological Adjustment Scale (WPAS)" was then administered to the identified and qualified participants for the study. The last stage involved purposive sampling technique to select all 92 identified widows with psychological wellbeing problems into experimental groups and control group. The Pastoral Counselling and Social Support were used as treatments in the experimental groups. There were three experimental groups, namely; Pastoral Counselling and Social Support and Control Group. Registered widows through the records in the Anglican Communion churches were used for this study because of the easy access to the widows.

Selection Criteria

1. The participants were widows who have lost their husbands between four and five years ago.
2. The participants were widows who were between the ages of thirty and forty.

Detailed Treatment Procedures

The treatment packages lasted for six weeks. Each of the treatment sessions lasted for one and half hours, twice a week with the participants. This was to expose the participants for counselling interventions (Pastoral Counselling and Social Support).

Experimental Group One: Pastoral Counselling

Week 1: Establishment of rapport and administration of the instruments to collect pre-treatment data from the participants.

Week 2: Working with cognitive distortions

It is very important for the therapist in dealing with grief, to work with the cognitive structures of these widows in addition to their emotional ones. Cognitive interventions, which can be implemented using a spiritual counselling perspective, can change the person's point of view. The researcher tried to expand the client's thought structure by considering the clients' religious beliefs (such as in Jesus (as), God and God's will). Thus, researcher tried to change the client's thoughts by helping them with their religious beliefs in relation to their psychological disturbance.

Week 3: Acceptance of death.

The researcher worked through the grief of the loss of their husbands, accepting the husband's death is the first step toward readapting to life and finding meaning in it. Since the widow often experiences the death of her husband unexpectedly and have a hard time making sense of it, it can take years to accept, let alone make sense of this death. the researcher talked with the devout clients about stories from the life of the past prophets and their tribulations discussing what the thinks and feel about the anecdotes. This can then work on the client's feelings and thoughts about accepting death.

Week 4: Sense making.

The researcher engaged the clients to find meaning in the experience of loss and continue life without the lost person in question in order to reduce the suffering of the bereaved person and helped them heal. The researcher let them realize that, losing a spouse is extremely difficult for all people, and religious resources support it. To find meaning is not to view suffering as unimportant; on the contrary, the aim is to help them gain a new point of view in order to find consolation from this sadness.

Week 5: Bonding with God.

The researcher worked assiduously in making sure the widows have belief in life after death in order to continue their relationship with their husbands, and such are more easily able to cope with the death of their husbands. Those people who believe that the body merely died for a temporary period of time whereas the soul does not die are more likely to continue communicating with their husbands. In doing this, the researcher consoled them with the Biblical words.

Week 6: Benefit finding.

According to the researcher, benefit finding refers to widows accepting their losses and recognizing the positive changes in their lives from finding meaning in the losses. Some of these changes are appreciating the meaning of life and improving relationships with other people. Some people experience a religious awakening after their spousal's death causing them to become more religious. The researcher mentioned various benefits in the loss: (i)

gaining a new perspective and appreciation of life, (ii) understanding what is really important in life, (iii) living life more meaningfully, (iv) having positive effects on others, (v) dealing more closely with other people and (vi) deeper spiritual and religious understanding. There was general review of the treatment process, to determine the effectiveness of the training on the participants.

Revision of the previous therapy session was done before the commencement of every other therapy session.

Experimental Group Two: Social Support

Week 1: Establishment of rapport and administration of the instruments to collect pre-treatment data from the participants.

Week 2: Involving spirituality in the sessions.

Various strategies were used by the researcher by introducing spirituality into the session as follows: i. Asking whether the clients' religious beliefs help them to understand the loss and, if so, how they help. ii. Including a religious chaplain who can provide accurate information on religious matters during consultation. iii. Ensuring that the researcher fully understands the spiritual point of view and beliefs of the client in order to avoid prejudice and insensitivity. iv. By avoiding presenting the researcher's own religious ideas or worship style as this is often not beneficial whereas arrangements and interventions made in the direction of client's own beliefs will work. v. Investigating what family members believe regarding the nature of the death in question and learning what rituals they need to perform, as failure to conduct rituals believed to be necessary in the client's belief system may cause unresolved and prolonged grief.

Week 3: Spiritual journaling.

Spiritual journaling (i.e., recording one's meaning about the loss or writing about the search for it) is one of the ways to find meaning in the loss, to calm oneself and to make the loss more bearable. A spiritual diary allows bereaved people to use meaning as a tool within their own religious framework and harmonize the cognitive functioning with the mental experience. The widows who mourn according to the meaningful construct model can compare their religious or spiritual perceptions before and after the loss through such a diary technique. This enables them to make their religious perceptions more useful to themselves (such as resolving inconsistencies between what they believe and what they experience). The purpose of keeping a spiritual diary is to facilitate the grief process, to increase resilience, to comfort the person and to provide spiritual care.

Week 4: Spiritually based rituals.

Spiritual rituals therefore aim to transform the old painful self, which is directly related to the spousal's death, in order to find meaning. This was done by creating intensive, experiential, and symbolic structures for the formation of a new self. Such rituals help parents create a new self by externalizing the feelings of guilt and isolation experienced by the old self. The ritual was developed and conducted in four stages. First, the symptom to be changed was identified and defined, which required the clients to be fully cooperating and motivated. After this, a ritual was planned. The clients were asked to choose both a physical symbol that symbolizes their old selves (e.g., clothes, books, photographs, etc.) and one to symbolize the new self, along with a relevant ritual (e.g., burial, burning, or sealing) and a suitable time, place and number of attendees. To prepare for this ritual, the researcher widened the clients' experiential and symbolic focus (e.g. by reading religious texts, meditation, prayer, or spiritual journal writing). In the third step, the ritual was performed, and in the final stage, the client talked about the remains of their old self and decided on structures (e.g. a new outfit, activity, or symbol) to express their new selves.

Week 5: Writing letters.

The researcher saw that the clients have a special connection with the deceased husbands, the researcher then supported this bond and helped maintain the relationship, for example through prayer, internal speech, meditation, or letters. The letter is both a way of relaxing by typing and a means of both maintaining connection with and talking to the late husbands. Such letters were written both to the late husbands and to God in order to express clients' feelings about the death of the widows and what they want to say to God. The writing provided comfort, improve physical and psychological well-being and facilitated coping.

Week 6: Working with guilt.

As already noted by the researcher, some widows often feel guilty when husband died. Conversely, if this sense of guilt is not operating, it can also block positive memories and delay healing. Therefore, research-client relationship was established, this feeling of guilt was normalized. It was emphasized that it is normal after a spousal's death to feel guilty as a sign that the relationship with the husband was meaningful and loving. Following this, the sense of guilt was investigated a little more by asking some questions: “Is this real guilt or do you feel guilty for surviving,” or “Did you do something that caused their husband's death?” The client's feelings of guilt were accepted and allowed while various religious or spiritual resources were used to alleviate them. When the widows believed that they really played a role in the death, they were asked whether they would like to ask to repent or for

forgiveness. The spiritually orientated technique was employed by the researcher, they were asked to list the following: "What else could you have done?" "What could you have done better?" "What did you do at that moment?" and "What did you know now but did not know then?" After writing their answers, a deep breath and a simple sentence was required to request God's forgiveness. The process ended by praying for remorse and healing for their regrets.

There was general review of the treatment process, to determine the effectiveness of the training on the participants. Revision of the previous therapy session was done before the commencement of every other therapy session.

Control Group

The participants in this group were pre-tested in order to get base-line assessment data, for the purpose of comparison. They were given a dummy treatment on assertiveness training.

Method of Data Analysis

Descriptive and inferential statistical tools were used. Mean, mean difference, standard deviation will be computed where applicable with the aid of SPSS version 23. All the formulated hypotheses were tested at 0.05 level of significance using the Analysis of Covariance (ANCOVA) statistical tool.

Results

Research Hypothesis 1: There is no significant difference in the post-test mean scores on depression of participants exposed to pastoral counselling therapy, social support therapy and control group.

Table 1: ANCOVA Result for Depression Based on Experimental Conditions

Source	Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	2004.76	3	668.253	70.698	.000
Intercept	156.199	1	156.199	16.525	.000
Covariate	197.102	1	197.102	20.853	.000
Group	1571.418	2	785.709	83.124	.000
Error	831.794	88	9.452		
Total	71589.000	92			
Corrected Total	2836.554	91			

A F-calculated value of 83.124 was derived and observed to be greater than the critical value of 3.10 given degrees of freedom 2 and 88, at 0.05 level of significance. Thus, the null hypothesis was rejected, and it was concluded that there is significant difference in the post-test mean scores on depression of participants exposed to pastoral counselling

therapy, social support therapy and control group. A pair-wise comparison was carried out to determine the pair with the significant difference. The result is displayed in Table 2.

Table 2: Pair-wise Comparison of Depression Based on Experimental Groups

(I) Experimental Groups	(J) Experimental Groups	Mean Difference (IJ)	Sig.[b]
PCT	SST	3.522*	.000
	CGP	-6.481*	.000
SST	PCT	-3.522*	.000
	CGP	-10.004*	.000
CGP	PCT	6.481*	.000
	SST	10.004*	.000

Based on estimated marginal means

*.The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

The pair of PCT and SST ($t = 3.522$; $p < 0.05$); PCT and CGP ($t = -6.481$; $p < 0.05$); as well as SST and CGP ($t = -10.004$; $p < 0.05$) were observed to be significant.

Research Hypothesis 2: There is no significant difference in the post-test mean scores on anxiety of participants exposed to pastoral counselling therapy, social support therapy and control group.

Table 3: ANCOVA Result for Anxiety Based on Experimental Conditions

Source	Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	973.9	3	324.633	52.138	.000
Intercept	290.942	1	290.942	46.727	.000
Covariate	27.868	1	27.868	4.476	.037
Group	886.906	2	443.453	71.221	.000
Error	547.926	88	6.226		
Total	68374.000	92			
Corrected Total	1521.826	91			

The F-value calculated (71.221) was found to be greater than the critical value of 3.10 given degrees of freedom 2 and 88, at 0.05 level of significance. Therefore, the null hypothesis was rejected, and it was concluded that there is significant difference in the post-test mean scores on anxiety of participants exposed to pastoral counselling therapy,

social support therapy and control group. A pair-wise comparison was carried out to determine the pair with the significant difference. The result is displayed in Table 4.

Table 4: Pair-wise Comparison of Anxiety Based on Experimental Groups

(I) Experimental Groups	(J) Experimental Groups	Mean Difference (IJ)	Sig.[b]
PCT	SST	-.258	.688
	CGP	-6.759*	.000
SST	PCT	.258	.688
	CGP	-6.501*	.000
CGP	PST	6.759*	.000
	SST	6.501*	.000

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Observation from Table 6 shows that the pair of PCT and CGP ($t = -6.759$; $p < 0.05$); as well as SST and CGP ($t = -6.501$; $p < 0.05$) were significant.

Discussion of Findings

Research hypothesis one which states that there is no significant difference in the post-test mean scores on depression of participants exposed to pastoral counselling therapy, social support therapy and control group was rejected. This shows the positive impact the pastoral counselling and social support has on the widow. In a related study, Muthangya (2019) identified depression as one of the psychological challenges faced as a result of spousal death and reported social support as one of the key interventions to overcome the psychosocial challenges. Similarly, Adebowale (2015) revealed a positive relationship between psychosocial support given to widows and their adjustment to life. However, Omozusi, Ebere, Banjo, Olaoye and Okondu (2018) concluded that widows in churches do not actually receive the full social support needed from their churches.

Research hypothesis two states that there is no significant difference in the post-test mean scores on anxiety of participants exposed to pastoral counselling therapy, social support therapy and control group. The study observed that both PCT and SST were very effective in the management of anxiety of widow. This may be as a result of the support gain using the two intervention. In a related study by Senyah (2021) identified anxiety among other factors such as depression, self-care, pain/discomfort, etc. as affecting the quality of life of young widows. The researcher identified families, friends and religious bodies as sources of support to widows. Sydney-Agbor (2021) observed a that social support, length of

widowhood and higher the age at husband's death respectively, the lower psych ache among widows in Imo State.

Conclusion

The study focused on pastoral counselling and social support on the management of psychological well-being of widows in Anglican Communion of Lagos State, Nigeria. The findings from this study revealed that, there is significant difference in the post-test mean scores on depression of participants exposed to pastoral counselling, social support and control group and there is a significant difference in the post-test mean scores on anxiety of participants exposed to pastoral counselling, social support and control group.

Recommendations

Both pastoral counselling and social support should be used in managing psychological wellbeing of widows and Pastoral counselling should be employed by Counsellors to improve their counsellees' self-esteem.

References

Abd Elalem, S. M., Shehata, O. S. M. H., & Shattla, S. I. (2018). The effect of self-care nursing intervention model on self-esteem and quality of life among burn patients. *Clinical Nursing Studies, 6*(2), 79-90.

Adebowale, T. A. (2015). Counselling intervention in the provision of psycho-social support for widows: empirical evidence from Nigeria. *Gender and Behaviour, 13*(1), 6540-6546.

Adeyemo, F. O. (2016). Widowhood and its harmful practices: Causes and effects. *World Journal of Educational Research, 3*(2), 380-393.

Afolayan, G. E. (2011). Widowhood practices and the rights of woman*:* The case of South Western Nigeria. *International Institute of Social Studies (ISS), 2*(3), 33-44.

Aguado, R. (2007). Psychiatrist properties of an emotional adjustment measure. *European Journal of Psychological Assessment, 23* (1),39-46.

Akinbi, J. O. (2015). Widowhood practices in some Nigeria societies: *"A retrospective examination." International Journal of Humanities and Social Sciences,5*(4), 67-74.

Ali, A. (2016). *Conducting research in education and social sciences.* Enugu: Tashima Net Works Limited.

Alutu, A.N.G. (2007). *Theory and practice of guidance and counselling.* Ibadan: University Press Publishing House, University of Ibadan, Nigeria.

American Psychiatric Association (1994). *Diagnostic and statistical manual for mental disorders*. 4th ed. American Psychiatric Association; Washington, DC: Washington.

Anastasia, G. C. (2015). Student success skills: Impacting achievement through large and small group work. *Research & Practice, 11,* 283-292.

Atindanbila, S., Bamford, V., Adatara, P., Kwakye-Nuako, C., & Benneh, C.O. (2014). Effects of widowhood rites on the psychosocial well-being of women in Nadowli district (Upper-West Region-Ghana). *The International Journal of Social Sciences and Humanities Invention, 1* (6)*,* 430-436.

Behera, S., & Bhardwai, A.K. (2015). Effect of widowhood on personality. *Journal of Multi-disciplinary Research, 1(*1), 6-11.

Bennet, K. M., & Soulsby, L. K. (2019). Well-being in bereavement and widowhood: *Illness, Crisis & Loss, 20(4), 334-312.*

Bennett, K. M. (2019). "Can't do enough for you." Why do older men get more social support than women following bereavement? *Bereavement Care*, 28(3), 5-14.

Berardo, F. M. (2018). Widowhood status in the United States: Perspective on the neglected aspect of the family life- cycle. *The Family Cordinator,17,* 191- 203.

Bowlby, J. (2007). Attachment and loss. *Journal on Loss, Sadness and Depression, 3*(1*),* 213-219.

Ellis, A. (1965). *Overcoming destructive beliefs, Feelings and behaviours: New directions for rational emotive behaviour therapy*. Promotheus Books.

Eremie, M. D. (2012). Effects of individual counselling on social adjustment of registered widows in Rivers State of Nigeria. N*ational Forum Journal of Counselling and Addiction 1(*1*), 123-134.*

Dryden, W. (2023). *The fundamentals of rational emotive behaviour therapy*: *A training handbook.* 3rd edition. Chichester: Wiley.

Ezejiofor, A. (2011). 'Patriarchy, Marriage and the Rights of Widows in Nigeria. *Unizik Journal of Arts and Humanities* 12(1), 139-157.

Fakunle, S., & Lazarus, R. S. (1990). If it changes it must be a process: A study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*, *48*, 150-170.

Falana, B. A. (2013). *Impact of length of marriage on grief experienced by widows in Yoruba land. Lagos.* E. K. Publishers.

Fasoranti, O. O., & Aruna, J. O. (2017). A cross cultural comparison of practice relating to widowhood and widow inheritance among Igbo and Yoruba in Nigeria. *Journal of World Antropology: Occasional papers. 111* (2):53-73.

George, A.G., & George-Genyi, M. E. (2013). Widowhood and Nigerian womanhood: another context of gendered poverty in Nigeria. *Research on Humanities and Social Sciences, 3*(7), 124-136.

Mathias, T., Jacob, J., & Shivakumara, J. (2014). A description study to assess psycho-social adjustments of young widows in Mangalore. *International Journal of Scientific Research,3*(11), 412-413.

Mburugu, B. M., Nyaga, V.K., Chepchieng, M. C., & Ngari, S.N. (2015). Self-esteem as a social effect of widowhood in Meru County, Kenya. *Journal of Education and Social Policy, 2* (5), 1-10.

Omozusi, M. O., Ebere, K. M., Banjo, Olaoye, O. O., Emmanuel, O. O., & Okondu, O. E. (2018). Social supports and widows in churches: An empirical assessment in Nigeria context. *Journal of Education and Practice, 9*(27), 8-15.

Victor, M. (2019). Social disconnectedness among widows in Nigeria: probing the effects of self-monitoring intervention. *The European Research Journal, 5*(5), 894-904. https://doi/org/ 10.18621/eurj.430761