



(RESEARCH ARTICLE)



The Silent struggle: Psychological impact of widowhood on the life of women in India

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International Journal of Science and Research Archive, 2023, 10(01), 304–315

Publication history: Received on 01 August 2023; revised on 12 September 2023; accepted on 14 September 2023

Article DOI: <https://doi.org/10.30574/ijrsra.2023.10.1.0744>

Abstract

In patriarchal societies, women are subjected to cruel atrocities that affect them psychologically. Most importantly, when a woman falls into the unfortunate state of widowhood in a male-dominated society like India, it is considered as social stigma. Despite advances in living standards, conditions for widows in society remain deplorable. Many conservative families view widows as a liability. The fact that widowed women suffer from various psychological stresses is often ignored. Several studies have found that such stressors can be harbingers of psychiatric illness (e.g., depression, anxiety, drug addiction). They are culturally, socially, economically, and legally marginalized. On one hand, they have lost their spouses, and on the other hand, they face discrimination of various types and degrees. Against this background, this paper is an attempt to describe the vulnerability of widows in India. The paper is largely based on a review of various reports, literature and papers on the status and welfare of widows in India. In this paper, we have also examined the relationship between widowhood and self-rated health (SRH), psychological distress and cognitive ability.

Keywords: India; Women; Widows; Self-rated health; Psychological distress; Cognitive ability

1. Introduction

The current population of India is 1,428,872,313 based on Worldometer, a trusted free reference website. Out of which 737,764,515 are male & 691,107,829 are female. India has a total of 28 states and 8 union territories. The Table 1 shows the state wise total population, number of male & female, total number of widowed women per state & the age range of widowed women. (source: census 2011).

Table 1 State wise details of widow population in different age range, 2011 census

State or UT	Male	Female	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	Widow	Population
Jammu & Kashmir	66,40,662	59,00,640	1,689	3,015	5,280	8,625	13,506	283650	1,25,41,302
Himachal Pradesh	34,81,873	33,82,729	1,011	2,360	5,098	9,274	14,169	293475	68,64,602
Punjab	1,46,39,465	1,31,03,873	4,722	9,702	18,857	35,271	55,737	928158	2,77,43,338
Chandigarh	5,80,663	4,74,787	98	244	501	1,058	1,705	24496	10,55,450
Uttarakhand	51,37,773	49,48,519	1,801	4,147	7,883	14,211	21,240	387215	1,00,86,292

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Haryana	1,34,94,734	1,18,56,728	4,683	10,982	20,926	37,114	53,037	773297	2,53,51,462
Delhi	88,87,326	78,00,615	2,134	4,800	9,769	18,866	29,752	456613	1,66,87,941
Rajasthan	3,55,50,997	3,29,97,440	14,317	27,346	47,921	78,018	1,08,237	1983634	6,85,48,437
Uttar Pradesh	10,44,80,510	9,53,31,831	42,382	70,768	1,16,089	1,99,774	2,75,300	4856188	19,98,12,341
Bihar	5,42,78,157	4,98,21,295	19,624	36,535	63,047	96,289	1,29,390	2238793	10,40,99,452
Sikkim	3,23,070	2,87,507	123	243	360	632	845	13717	6,10,577
Arunachal Pradesh	7,13,912	6,69,815	354	693	1,223	2,027	2,940	31787	13,83,727
Nagaland	10,24,649	9,53,853	419	892	1,761	2,376	3,336	39496	19,78,502
Manipur	12,90,171	12,80,219	628	1,321	2,520	3,987	5,416	77990	25,70,390
Mizoram	5,55,339	5,41,867	387	716	1,095	1,452	1,973	28569	10,97,206
Tripura	18,74,376	17,99,541	1,403	2,685	4,155	7,468	10,880	164969	36,73,917
Meghalaya	14,91,832	14,75,057	1,201	2,051	2,827	4,827	6,902	84825	29,66,889
Assam	1,59,39,443	1,52,66,133	9,797	20,079	32,930	56,870	81,882	1156042	3,12,05,576
West Bengal	4,68,09,027	4,44,67,088	24,851	46,288	74,171	1,34,642	2,17,144	3792184	9,12,76,115
Jharkhand	1,69,30,315	1,60,57,819	9,774	18,841	31,223	49,915	69,145	1027878	3,29,88,134
Odisha	2,12,12,136	2,07,62,082	10,143	22,499	39,054	64,665	92,560	1612627	4,19,74,218
Chhattisgarh	1,28,32,895	1,27,12,303	7,765	15,643	25,703	44,473	61,056	1027878	2,55,45,198
Madhya Pradesh	3,76,12,306	3,50,14,503	18,281	32,952	54,200	88,163	1,25,281	2160609	7,26,26,809
Gujarat	3,14,91,260	2,89,48,432	13,423	22,861	43,626	74,648	1,16,978	2015742	6,04,39,692
Daman & Diu	1,50,301	92,946	27	78	189	293	458	6816	2,43,247
Dadra & Nagar Haveli	1,93,760	1,49,949	76	146	216	387	519	7378	3,43,709
Maharashtra	5,82,43,056	5,41,31,277	38,498	76,724	1,32,262	2,08,403	2,78,378	4520764	11,23,74,333
Andhra Pradesh	4,24,42,146	4,21,38,631	36,077	93,860	1,49,490	2,27,952	2,80,137	4297481	8,45,80,777
Karnataka	3,09,66,657	3,01,28,640	22,486	53,738	87,813	1,49,452	1,91,670	2989429	6,10,95,297
Goa	7,39,140	7,19,405	307	515	1,138	2,470	4,150	77935	14,58,545
Lakshadweep	33,123	31,350	2	18	34	72	123	2448	64,473
Kerala	1,60,27,412	1,73,78,649	4,034	10,126	20,930	44,234	76,808	2010984	3,34,06,061

Tamil Nadu	3,61,37,975	3,60,09,055	18,608	48,623	91,371	1,67,040	2,32,585	3856398	7,21,47,030
Puducherry	6,12,511	6,35,442	271	823	1,975	3,751	4,978	73579	12,47,953
Andaman & Nicobar Islands	2,02,871	1,77,710	56	184	373	658	936	12525	3,80,581

The data as per Census 2011 is mentioned here. (source: Press Information Bureau Government of India). This information was given by the Minister of Women and Child Development, Smt Srmiti Irani in Lok Sabha. Since the 2021 Census of India, also the 16th Indian Census, has been postponed till October 2023 due to the COVID-19 pandemic in India; so we are dealing with Census 2011 data in this paper. For better visualization purpose Chart 1 is prepared. It is showing the total number of Widows in each state of India. As per the chart we can see Uttar Pradesh, Maharashtra, Andhra Pradesh, Tamil Nadu & West Bengal is having high widow population.

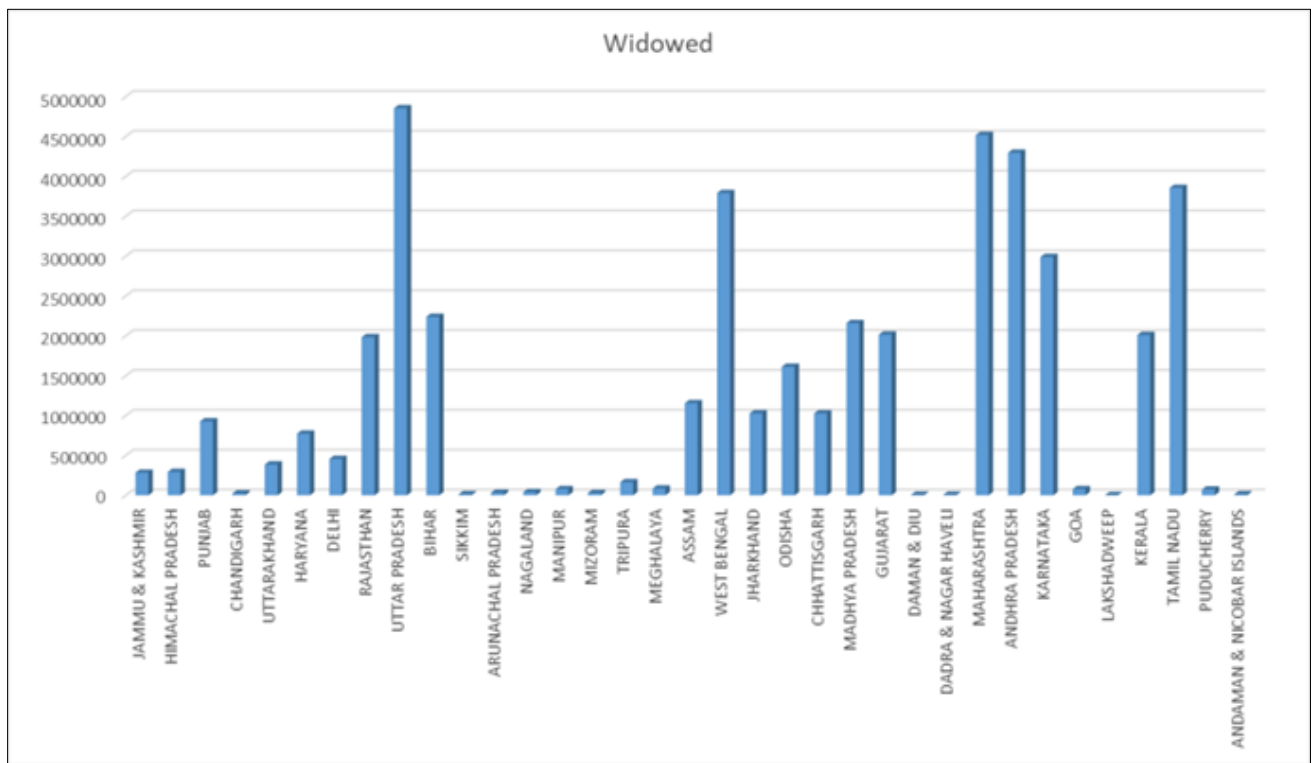


Figure 1 Total number of widows in each state of India

Again a pictorial representation of the number of widows in the corresponding age range is prepared (Chart 2) for better visualization. The legends in the chart is referring to the age range. Here we can see that number of widows in the age range 40 to 44 years is larger than the other age range. But as we can see, in all the age ranges numbers are more or less large. Here we haven't included the immature widows which ranges from 10 years to 19 years which is also there in the census chart. This is because we disrespect illegal marriage. In fact, we have excluded the older bunch, because most of the lot is either having some illness which may have some side-effects related to psychology. That may directly or indirectly affect the novelty of the analysis. This information like charts and tables are given only to have an idea regarding the widow population in India & to know that so many women are in distress, going through hardships and mental trauma. We will discuss about the quality of life among widows in India, sufferings of early widowhood & psychological aspects in detail in Section 2. We will also learn how widowhood is associated with the psychological health & cognitive ability of widowed women. For this analysis we have used data from Census of India 2011 & India Human Development Survey (IHDS).

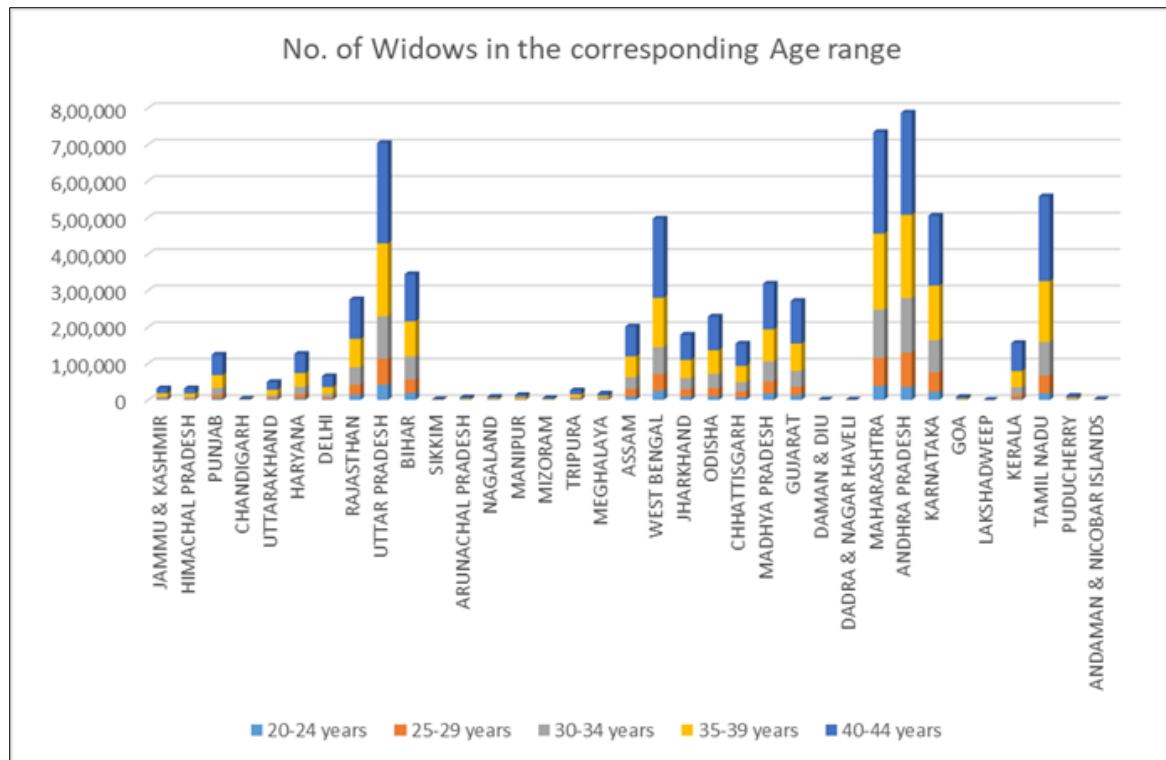


Figure 2 Number of widows in each state of India according to the age range

2. Widowhood – A Bane

2.1. Quality of Life among Widows in India

Widows in India are abused in such a manner that sometimes they are called “it” from “she” when they lose their husbands. It doesn’t stop here; people even use epithets such as “husband eater” against them. “Widowhood is a state of social death, even among the higher castes,” says Mohini Giri, the veteran activist [1]. In India, people don’t like a widow crossing the path in front of them when they are beginning a journey. Unfortunately, widows are considered a sign of misfortune and bad luck. Although widows today are no longer forced to die by ritual sati (burning at their husband’s funeral pyre), they are still generally expected to mourn for the rest of their lives. In a more conservative Hindu tradition, irrespective of age, widowed women abandon their colorful saris, jewellery, and even shave their heads to discourage male sexual desire, according to Meera Khanna, a trustee of the New Delhi-based Women’s Initiative for Peace in South Asia, and a contributor of a book called *Living death: Trauma widowhood in India*. “The widow is ‘uglified’ to deprive her of the core of her femininity,” writes Khanna. “It is an act symbolic of castration. She is deprived of the red dot between her eyebrows that proclaims her sexual energy.” [1]. Widows are seen to follow the rules grounded on tradition, without questioning, such as placing restrictions on their own diets. Orthodox Hindus believe that non-vegetarian food stimulates sexual passions, but they forget that these foods are also necessary to avoid malnutrition or even death. In India, mortality rates among widows are 85% higher than among married women, as per research by the Guild for Service.

2.2. Early Widowhood

Widowhood at a younger age than anticipated age, is very difficult to accept for an individual. It causes, psychological, socio-economic and various other difficulties than loss of a spouse at more matured ages. Youthful widowhood is generally connected with unexpected loss, as compared to matured women. Sometimes they do not get any support from the family and the society. In this way, untimely spousal demise may cause a difficult situation for the survivor which revolves around melancholy, grief, alteration, and adjustment in life. Despite the fact that unhappiness at younger ages has been associated with sudden change in life or dejection, there is little research showing the connections between the bio-psycho-social and spiritual components associated with marital loss.

2.3. Widowhood and its Psychological Aspects

Numerous studies have been conducted that address the psychiatric aspects following the death of a spouse. Zisook and Shuchter (1991) and Niaz and Hassan (2006) concluded that depressive episodes are common after the death of a spouse [3][4]. Clinicians should maintain a high index of suspicion for the possibility of depression, especially in young widows with such a history. For those who develop a full depressive syndrome shortly after the loss, depression should be assumed rather than bereavement. Zisook et al. (1994) [5] found that subsyndromal symptomatic depression contributes significantly to morbidity in widows during the first two years after loss. It is therefore very important to keep this in mind, rather than viewing the altered behavior of the bereaved as normally expected. Here psychological aspects should also be considered. The predisposition to develop anxiety and substance abuse is also increasing (Collins, 1999; Barrett, 2000) [6][7].

3. Background & Literature Review

Previous research examining the relationship between marital status and health outcomes has highlighted several ways in which marriage and health are causally linked [8][9] [10]. Firstly, marriage can provide economic, social, and psychological benefits that can promote good health. Second, when there is a sudden change in resources, the transition to widow- hood can be a significant burden that has a negative impact [11].

In this context, widowhood can be associated with significant disadvantages for women if the transition involves a loss of resources, especially in the long run, although there may be differences by socioeconomic status and other demographic factors, as well as, by region

[12] [13]. Most studies examining health-related outcomes among adults in India have found worse health among widows as compared to married women [14-19]. These studies, however, made various covariate adjustments, and many of them only looked at the result of self-rated health. In previous studies from other countries relationship between duration of widowhood and self-reported health, psychology, or other health outcomes has been found out, [20], [21], [22], [23-25] though findings have differed across populations and outcomes.

This study attempts to fill these gaps in the literature by providing empirical-descriptive answers to two questions: First, to what extent is widowhood associated with a range of health-related outcomes after adjusting for various demographic and socioeconomic indicators? Second, is there any evidence that duration of widowhood plays a role in these relationships? We hypothesized that widowhood (regardless of duration) would be associated with worse health outcomes, even after adjusting for various indicators of socioeconomic status, living arrangement, and place of residence. In addition, we hypothesized that pro- longed widowhood would be associated with an even greater risk of worse health out- comes.

4. Methodology

4.1. Sample

Data from the India Human Development Survey (IHDS) and data from Census 2011 was used in this analysis.

We used the above data and created the dataset we needed based on adults (20 to 44 years) from seven Indian states (Himachal Pradesh, Kerala, Maharashtra, Odisha, Punjab, Tamil Nadu, and West Bengal). These states were purposely selected for this analysis because they represent all regions of India. In each state, participants were drawn from 40 rural and 40 urban primary sampling units (PSUs), which were systematically selected based on probability proportional to population size. 16 households were sampled per PSU, resulting in a sampling frame of 1,280 households.

8329 household survey were conducted in 560 PSUs (representing a 95% response rate), and 9852 women were interviewed individually (representing a 93% individual response rate). We included only adults who were either currently married or widowed ($n = 9615$), because the sample size for divorced, separated, cohabiting, or never-married women was 1% or less for each. The final samples for each outcome included respondents with no missing values for explanatory variables or the outcome.

Fig 1 shows a flowchart of the final sample sizes and the number of excluded participants. We chose to exclude individuals with missing data rather than impute values for missing data because the number of missing data was relatively small.

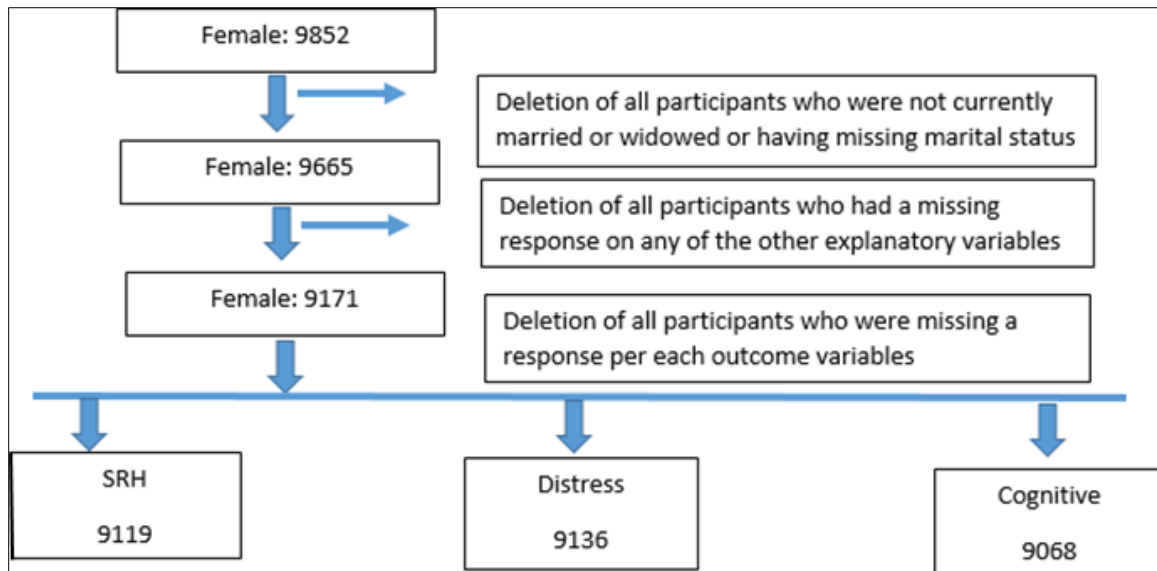


Figure 3 Final sample size & excluding participants

4.2. Outcomes

To assess self-rated health (SRH), people were asked to rate their current health status on a 5-point scale, where 1 = excellent, 2 = very good, 3 = good, 4 = fair, and 5 = poor. For ease of interpretation, the order was reversed, with a score of 1 representing poor health and a score of 5 representing excellent health. A binary variable for 'poor health' was also created, with responses of fair and poor = 1 and excellent, very good, and good = 0.

Psychological distress was measured with the General Health Questionnaire, a screening device for identifying minor psychiatric disorders in the general population, having 12 questions [26,27]. This method is widely used in mental health research, and previous studies have demonstrated its validity and usefulness in various countries, including India [28],[29],[30]. The items ask whether the respondent has recently experienced a specific distressing symptom or behavior. Each item was scored on a 4-point scale (0 = "less than usual," 1 = "no more than usual," 2 = "rather more than usual," or 3 = "much more than usual"). Items were rescored with 0-0-1-1 responses, as has been done in other studies. The items were then summed to give a total possible score between 0 and 12, which was treated as a continuous variable. A higher score indicated greater levels of psychological distress. In the same way 'frequent mental disorder' was derived from the mental distress score by creating a dichotomous variable with a cut-off value of 5 or less or 6 or higher, with the later value indicating likely frequent mental disorder' .[31].

Immediate recall of words was used to measure cognitive ability [32]. A list of 10 frequently used words were read out to the subjects, which they were then asked to recall within two minutes. The number of words recalled (0 to 10) was recorded. Thus, a higher score corresponded to better cognitive ability.

4.3. Explanatory variables

For this study, marital status was reported as either currently married (reference group) or widowed. We also created a second marital status variable in which the widowed category was divided into three groups according to the duration of widowhood: 0-4 years, 5-9 years, or 10+ years. The division between 4 and 5 years was based on previous research showing differences between the recently widowed and being widowed for long term [33], and the division between 9 and 10 years was chosen because about half of the individuals were widowed beyond that point. Age was divided into five-year intervals: 20-24 years (reference), 25-29 years, 30-34 years, 35-39 years, and 40- 44 years. Respondents indicated a caste (Scheduled Caste (reference), Scheduled Tribe, Other Backward Caste, and Other Caste) and whether they lived with children in the same household (reference) or not. Edu- cation completed was categorized as none (reference), 1-5 years, 6-10 years, and 11 or more years. Work status was a binary variable categorized as "worked in the last year and " not worked. Household wealth quintiles were calculated using information on 30 assets and housing characteristics [34,35]. Rural or urban location and state were also recorded.

4.4. Analysis

Multivariable, multilevel linear and logistic regression analyses were used to estimate the association between an outcome and widowhood (versus being married), accounting for clustering of observations at the PSU and district levels. Model 1 used the binary marital status and adjusted for age, caste, living with children, location, and state. Model 2 included socioeconomic variables such as education, work status, and household wealth in addition to those included in Model 1. Finally, Model 3 was similar to Model 2 except that it used the marital status variable, which was further categorized by duration of widowhood of less than 5 years, 5 - 9 years, and 10 + years

5. Results

Table 2 represents descriptive statistics on the sample and mean scores for self-reported health status, psychological distress, and cognitive ability by subcategories of socio- demographic characteristics. Nearly two-thirds of the sample population was between 20 and 29 years of age, while approximately 10% was between 35 and 39 years of age. In addition, 14% had been widowed for 0-4 years, 13% for 5-9 years, and 34% for 10 years or more.

Table 2 Descriptive characteristics of a representative sample across seven states in India in 2011 (N = 9,171)

MaritalStatus	Female		Self-Rated Health		Psychological Dis- tress		Cognitive Ability	
	N	%	Mean	S.D	Mean	S.D	Mean	S.D
CurrentlyMarried	3577	39	3.5	1	3.1	3.6	4.3	1.6
Widowed 0 to 4 years	1302	14.2	3.7	1	4.3	3.9	3.8	1.6
Widowed 5 to 9 years	1192	13	3.5	0.9	3.5	3.9	4.2	1.6
Widowed10+ years	3100	33.8	3.8	1	4.5	3.9	3.5	1.6
Age Group								
20-24	3247	35.4	3.4	1	3	3.5	4.4	1.6
25-29	2504	27.3	3.6	1	3.6	3.8	4	1.6
30-34	1550	16.9	3.7	1	4.4	4	3.7	1.5
35-39	880	9.6	3.8	1	4.5	3.8	3.4	1.6
40- 44	990	10.8	3.9	1	5.1	4.1	3	1.7
Living with Children								
No	2513	27.4	1	3.6	3.8	3.9	4	1.7
Yes	6658	72.6	1	3.6	3.7	3.8	3.9	1.6
Caste								
Scheduled Caste	1834	20	3.7	1	4.3	4	3.6	1.5
Schedule Tribe	477	5.2	3.5	0.9	4.8	4	3.7	1.5
Other Backward Caste	3219	35.1	3.6	1	4	3.9	4	1.7
None of them	3641	39.7	3.5	1.1	3.2	3.6	4	1.7
Work status								
No	8208	89.5	3.6	1	3.7	3.8	3.9	1.7
Yes	963	10.5	3.4	1	4	3.7	4	1.5
Education								
None	5567	60.7	3.7	1	4.4	3.9	3.6	1.5
< 5 years	1825	19.9	3.6	1.1	3.4	3.6	4	1.6

6 to 10 years	1366	14.9	3.4	1	2.1	3	4.8	1.6
≥ 11 years	413	4.5	3.3	1.1	1.9	3	5.4	1.9
Place								
Urban	4393	47.9	3.5	1	3.4	3.7	4.1	1.7
Rural	4778	52.1	3.7	1	4.1	3.9	3.8	1.5
Household Wealth								
Bottom	1889	20.6	3.8	0.9	5.4	3.8	3.6	1.5
Second	1908	20.8	3.6	1	4.4	3.9	3.7	1.5
Third	1871	20.4	3.6	1	3.5	3.8	3.9	1.6
Fourth	1715	18.7	3.5	1	3	3.7	4.2	1.7
Top	1788	19.5	3.5	1.1	2.5	3.2	4.4	1.8
State								
Himachal Pradesh	1339	14.6	3.3	1.1	2.8	3.9	4.2	1.7
Punjab	1321	14.4	3.8	0.9	1.9	3	4.2	1.6
West Ben- gal	1045	11.4	4.2	0.8	4.7	3.1	3.1	1.2
Odisha	1348	14.7	3.4	0.9	5.1	3.7	3.7	1.5
Maharashtra	1330	14.5	3.2	1	3.9	3.8	4.1	1.5
Kerala	1394	15.2	3.9	1.1	3.2	3.6	3.7	1.9
Tamil Nadu	1394	15.2	3.5	0.8	4.8	4.3	4.4	1.5

Table 3 shows the estimated associations between widowhood and linear health-related outcomes (self-rated health, psychological distress, and cognitive ability scores, separately) and between widowhood and binary health-related outcomes (poor health and probable mental disorder, separately). Relationships between widowhood and all outcomes were statistically significant in model 1 for women, with widowhood associated with worse outcomes. Adjustment for socioeconomic factors in model 2 attenuated the relationships between widowhood and outcomes, although most estimates remained statistically significant and in the predicted direction.

Table 3 * p < 0.05; ** p < 0.01; ***p < 0.001. Notes: For all models, estimates also accounted for survey design as a three-level (individual, primary sampling unit and district) random intercepts model was used. (b: Coefficient; AOR: Adjusted odds-ratio; CI: Confidence interval)

Linear Outcome		Model 1		Model 2	
		b	(95% CI)	b	(95% CI)
Self-Rated Health(higher = worse)	Widowed (vs married)	0.11 ***	(0.06, 0.17)	0.08 **	(0.02, 0.14)
Psychological Dis- tress (higher=worse)	Widowed (vs married)	0.48 ***	(0.26,0.69)	0.33 **	(0.12, 0.55)
Cognitive Ability(higher = worse)	Widowed (vs married)	-0.22 ***	(-0.31, 0.31)	-0.11 *	(-0.20, -0.02)
Binary Outcome		AOR	(95% CI)	AOR	(95% CI)
Being in PoorHealth	Widowed (vs married)	1.17 *	(1.01, 1.35)	1.08	(0.93, 1.25)
Having a ProbableMental Disorder	Widowed (vs married)	1.38 *	(1.18, 1.61)	1.25 *	(1.07, 1.48)

When the widowhood category of marital status was categorized using duration of widow- hood, the estimates from model 3 showed that only some categories of widowhood differed significantly from those of married individuals in

terms of outcomes (Table 4). There was evidence of a role for duration in most outcomes. For example, women who had been widowed for 4 years or less or more than 10 years were more likely to report poorer self-rated health ($b = 0.14$, 95% CI = 0.06 to 0.22 and $b = 0.09$, 95% CI = 0.02 to 0.15, respectively) and worse psychological distress ($b = 0.51$, 95% CI = 0.21 to 0.80, and $b = 0.37$, 95% CI = 0.12 to 0.62, respectively) and recall fewer words ($b = -0.13$, 95% CI = -0.26 to -0.01, respectively $b = -0.15$, 95% CI = -0.25 to -0.04) than married women, separately. Overall, the results indicated that recently widowed women and long-term widowed women in particular had worse health risk compared with married women, whereas women who had been widowed for 5-9 years did not differ from married women. Age was a strong predictor of all outcomes. Women with higher education and wealth were more likely to have better health. None of the results were linked to living with kids.

Table 4 * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$. Notes: Model 3 also accounted for survey design as a three-level (individual, primary sampling unit and district) random intercepts model was used (b: Coefficient; AOR: Adjusted odds-ratio; CI: Confidence interval)

Linear Out- come	Widowhood Status (vs. married as the reference)	Model		
		3 b	(95 % CI)	p- value
Self-Rated Health	Widowed 0 to 4 years	0.14 **	(0.06, 0.22)	0.001
	Widowed 5 to 9 years	-0.01	(-0.09, 0.08)	0.899
	Widowed 10+ years	0.09 *	(0.02, 0.15)	0.013
Psychological Distress	Widowed 0 to 4 years	0.51 **	(0.21,0.80)	0.001
	Widowed 5 to 9 years	0.06	(-0.26,0.37)	0.717
	Widowed 10+ years	0.37 **	(0.12,0.62)	0.004
Cognitive Ability	Widowed 0 to 4 years	-0.13 *	(-0.26,-0.01)	0.037
	Widowed 5 to 9 years	-0.01	(-0.14,0.13)	0.940
	Widowed 10+ years	-0.15**	(-0.25,-0.04)	0.007
Binary Out- come		AOR	(95 % CI)	p- value
Poor Health	Widowed 0 to 4 years	1.4 **	(1.13,1.72)	0.002
	Widowed 5 to 9 years	0.77 *	(0.62,0.95)	0.017
	Widowed 10+ years	1.11	(0.93,1.31)	0.242
Probable Mental Order Dis-	Widowed 0 to 4 years	1.43 **	(1.14, 1.78)	0.002
	Widowed 5 to 9 years	1.09	(0.86,1.38)	0.472
	Widowed 10+ years	1.25 *	(1.04,1.50)	0.018

6. Discussion

This analysis of marital status and health-related outcomes suggests that widowhood (as opposed to being married) may be a risk factor for women for poor self-rated health, psychological distress, and decreased cognitive ability, as well as for a likely common mental disorder. Looking at the associations in terms of duration of widowhood shows that the relationship between widowhood and health outcomes may be more nuanced than a simple binary effect (widowed vs. not widowed). Women who were widowed for a short period of time or for the long term appeared to have worse health outcomes compared with married women. Women who are recently widowed may face significant new losses in access to financial resources and a new (often diminished) social role in their in-laws' households, which can negatively impact their health. With the transition to widowhood, women not only lose their regular economic support, they may also be deprived of inheritance rights and lose overall importance within the household. In contrast, the health of women who are widowed for a longer period of time (e.g. 5 to 9 years) may not differ from the health of married women because these widowed women have been able to cope (at least temporarily) with the death of their spouse. Perhaps they have developed new social connections or have taken on new responsibilities within their husband's family in order to live. Additionally, survival selection might be at work; women who have been widowed for 5 to 9 years on average might be healthier than the same cohort who have been widowed for 4 years or less, as the sickest members of the former

cohort might have passed away by the time the latter group had been widowed for 5 to 9 years. Finally, compared to married women, the health of women who have been widowed for ten or more years may have once again deteriorated merely because they have continued to be financially and physically without a spousal support system.

Our findings about self-rated health are similar to previous studies in China and India [36- 38]. However, the present results indicating a negative relationship between widowhood and a number of health outcomes for women are inconsistent with many studies from high- income countries [39-42]. If different mechanisms are at work to link widowhood and health outcomes in various contexts, the findings might vary in some instances. In terms of gender standards, economic mobility, marriage customs, and inheritance customs, India differs significantly from high-income nations like the United States, United Kingdom, and the Netherlands, and the degree to which the government looks out for particular segments of its citizens (e.g. the widowed, the poor, the backward classes, the aged etc.)

Limitation

This study's inability to look at unbiased indicators of health and illness was a significant flaw. As a result, our sample probably contains unrecognized instances of chronic illness and mental distress. Moreover, we were unable to adjust for pre-widowhood disease status, which is very important for assessing determinants of health outcomes after widowhood [43]. The impact of widowhood and the duration of widowhood on general health, as indicated by mortality, is also not covered by this research. In interpreting these findings, we can admit that widows may have a higher mortality rate than non-widows. Finally, we cannot infer causality from our associational estimates. Future studies may clarify the relevance of marital status to health outcomes among widowed women in India by collecting longitudinal data and biomarkers as well as information on the women's roles and customs in the home as well as the quality of conjugal relationships

7. Conclusion

This research examines the relationship between widowhood and a variety of mental health outcomes as well as self-rated health in a large sample of women from all over India while adjusting for a variety of socioeconomic and demographic variables. Our research indicates that widowed having both short-term and long-term widowhood predict worse health for women in terms of self-rated health and psychological distress among widows in India. After a loss, women frequently exhibit altered behavior. These changes are often overlooked and assumed to be a normal response to an adverse life event. It is now understood that the changes could result from a psychiatric condition that lies beneath. To ensure that the suffering women receive the proper care and treatment, this problem needs to be brought to light. The people providing care and the NGOs operating in this area need to be educated on these realities.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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