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IMPACT OF SOLUTION FOCUSED BRIEF THERAPY ON PSYCHOLOGICAL WELL-BEING AND RESILIENCY ATTITUDES OF WIDOWS IN EBENEZER METHODIST SOCIETY, PRAMPRAM

EBENEZER NOBLE NARTEY

2023

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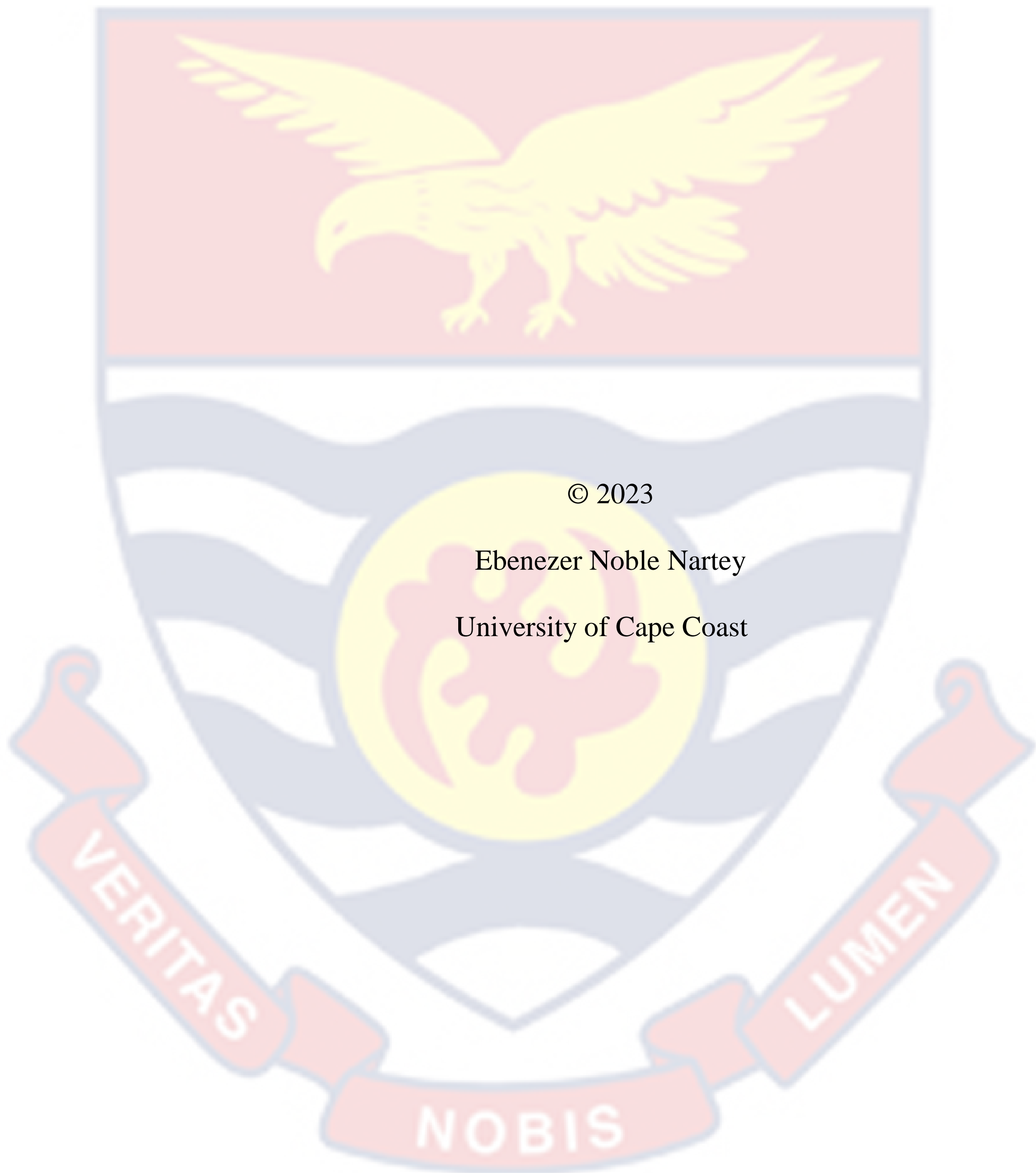

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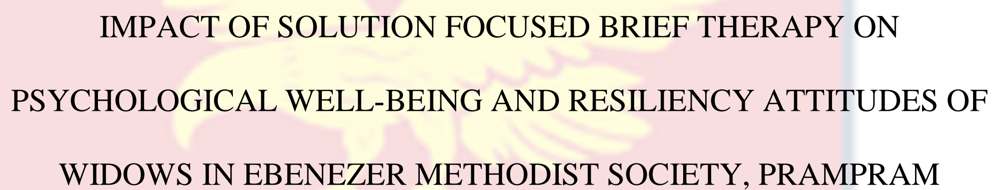

IMPACT OF SOLUTION FOCUSED BRIEF THERAPY ON PSYCHOLOGICAL WELL-BEING AND RESILIENCY ATTITUDES OF WIDOWS IN EBENEZER METHODIST SOCIETY, PRAMPRAM

BY

EBENEZER NOBLE NARTEY

Thesis submitted to the Department of Guidance and Counselling of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast in partial fulfillment of the requirements for the award of Master of Philosophy degree in Guidance and Counselling

JANUARY 2023

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: ……………………… Date: ……………………

Name: ………………………………………………………………………..

Supervisors' Declaration

We hereby declare that the preparation and the presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: …………………. Date: ……..……………..…

Name:……………………………………………………………..…………….

Co-Supervisor's Signature: ……………………… Date: ……..……………..…

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ABSTRACT

This study assessed the impact of Solution Focused Brief Therapy (SFBT) on psychological well-being and resiliency attitudes of widows in the Ebenezer Methodist Society, Prampram. Six hypotheses were formulated to guide the study. Forty widows met the inclusion criteria and were used as the sample. The 40 participants were put into two groups- the experimental and control groups. Each group consisted of 20 participants. The quasi-experimental design was used for the study. The Outcome Questionnaire 45 (OQ 45), Ryff's scales of Psychological Well-Being and the Resiliency Attitudes Scale (SAS) were used in collecting the data. The study found that SFBT was very effective in improving the psychological well-being and resiliency attitudes of widows. The results further indicated that years of widowhood, psychological well-being can be adjusted with the help of SFBT. The study again found that, there was a significant strong positive correlation between the socio-economic status and psychological well-being of widows ($r=.902$, $p<.01$). Finally, the results showed a strong relationship between socio-economic status and Resiliency Attitudes of widows ($r=.823$, $p<.01$). It was recommended that widows in the Ebenezer Methodist Society, Prampram, should be exposed to solution-focused brief therapy to improve their psychological well-being and resiliency attitudes during widowhood.

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KEYWORDS

Widow

Solution Focused Brief Therapy

Psychological Well-being

Resiliency

Resilient factors

Socioeconomic status

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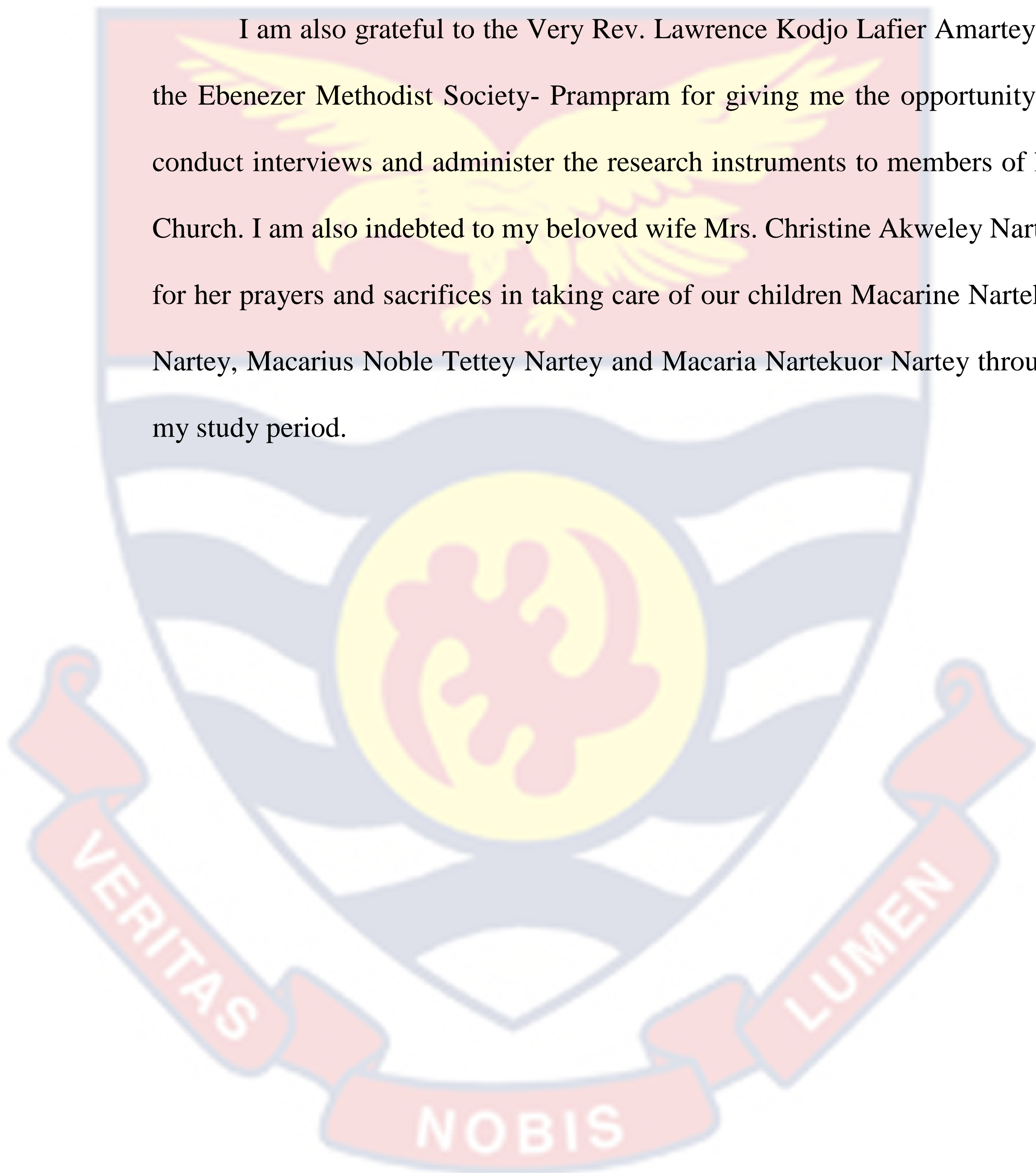
I am also grateful to the Very Rev. Lawrence Kodjo Lafier Amartey of the Ebenezer Methodist Society- Prampram for giving me the opportunity to conduct interviews and administer the research instruments to members of his Church. I am also indebted to my beloved wife Mrs. Christine Akweley Nartey for her prayers and sacrifices in taking care of our children Macarine Nartekie Nartey, Macarius Noble Tettey Nartey and Macaria Nartekuor Nartey through my study period.



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DEDICATION

To my beloved Wife, Christine Akweley Nartey and my daughters and son.

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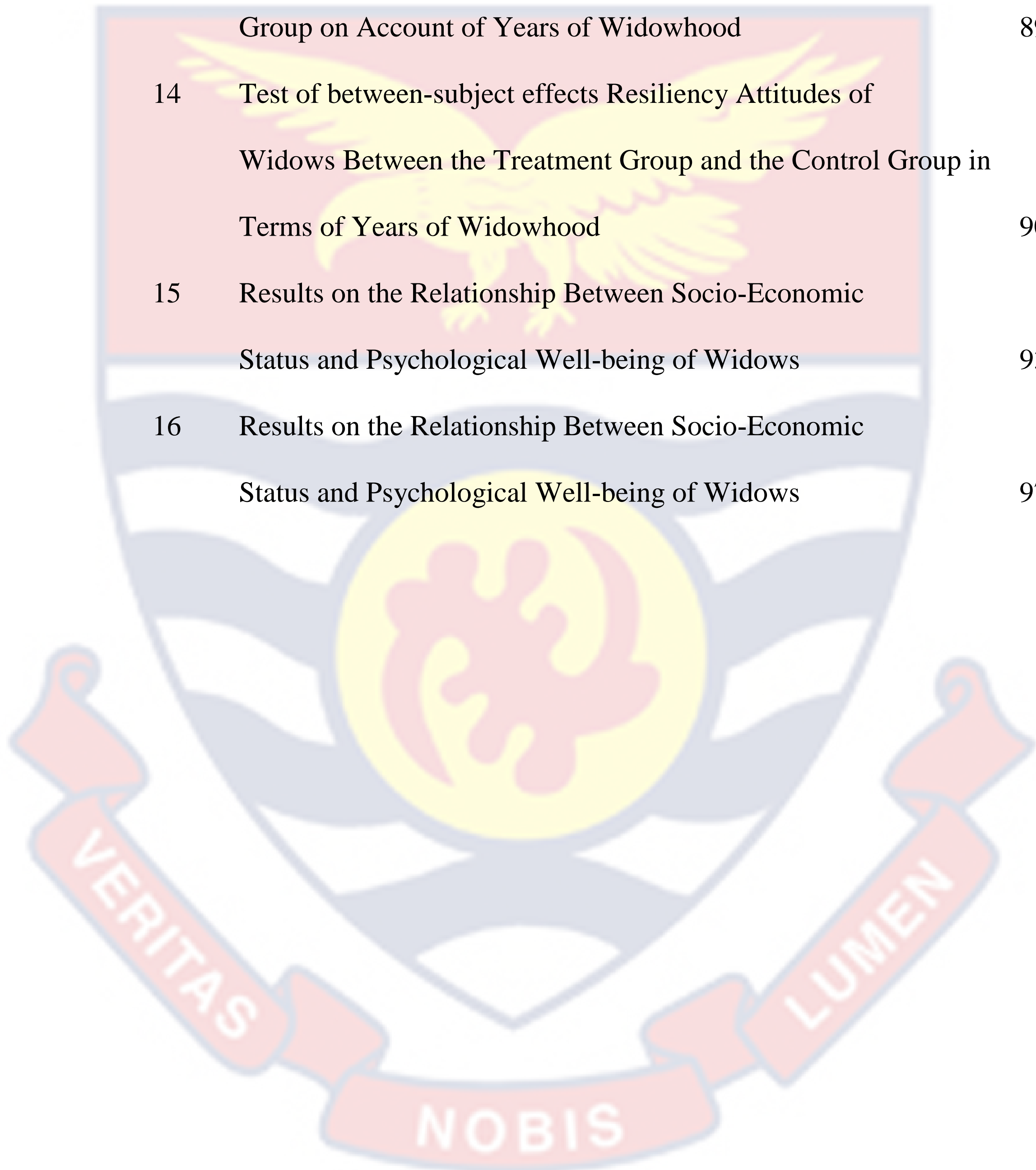

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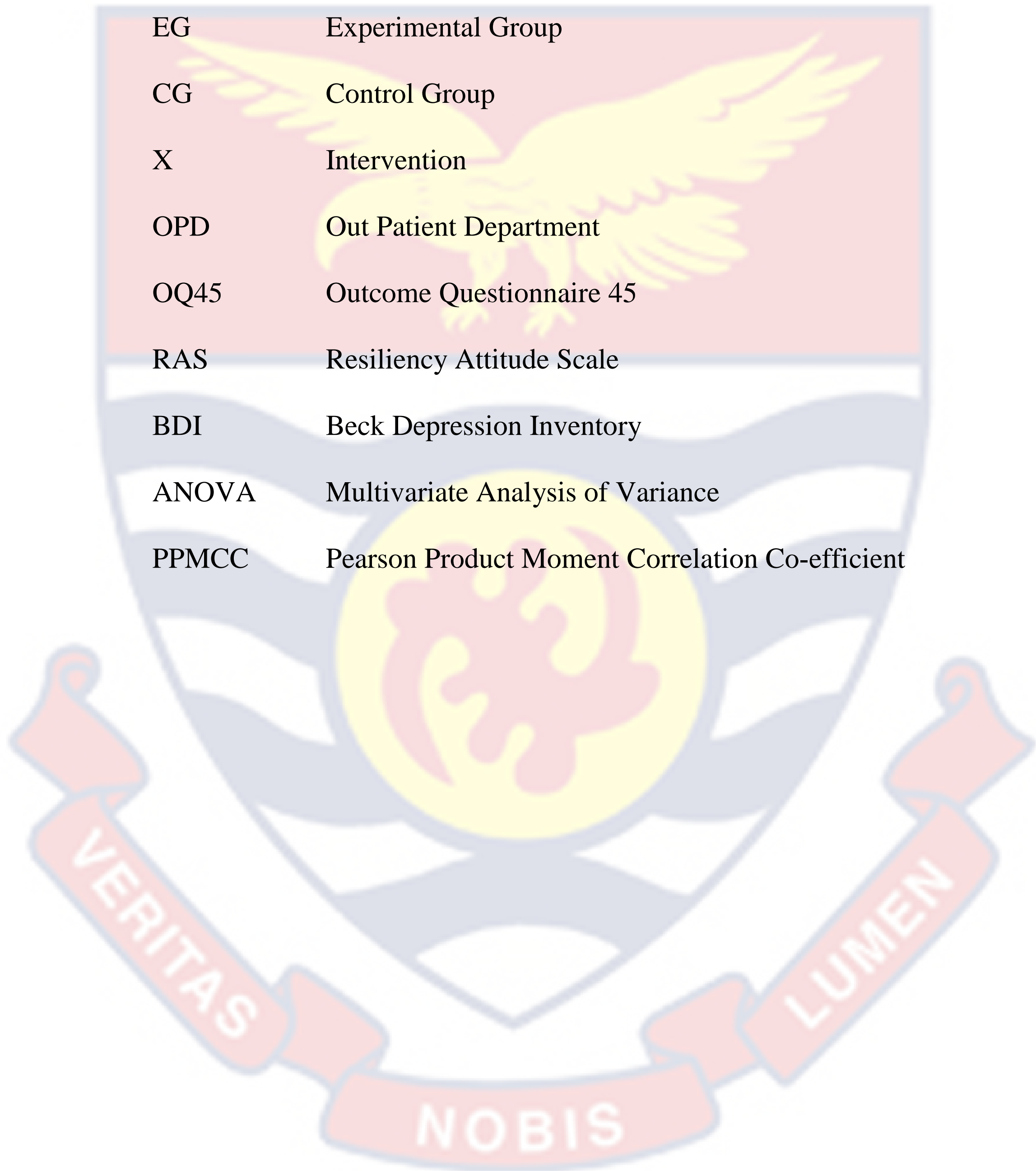

SFBT	Solution-Focused Brief Therapy
NSHAP	National Survey on Health, Aging and Social Life
SFGC	Solution-Focused Group Counselling
EG	Experimental Group
CG	Control Group
X	Intervention
OPD	Out Patient Department
OQ45	Outcome Questionnaire 45
RAS	Resiliency Attitude Scale
BDI	Beck Depression Inventory
ANOVA	Multivariate Analysis of Variance
PPMCC	Pearson Product Moment Correlation Co-efficient

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CHAPTER ONE

INTRODUCTION

Death of a husband is a very painful experience in life. This experience has been with humanity since the world began. Coping, adjusting and adapting to this experience and staying positive about life differs from individual to individual. Making a meaningful life choice in such situations are quite complex and frustrating tasks for most widows as they are characterized by frustration, confusion and stress. Some of the reasons for the aforementioned are that as widows aspire to integrate themselves into society, they are faced with problems such as low psychological well-being and low resiliency attitude. As a result, the researcher seeks to conduct a study examining the impact of Solution Focused Brief therapy on Psychological Well-being and Resiliency Attitudes of Widows in the Ebenezer Methodist Society, Prampram.

Background of the Study

At any point in a married woman's life, witnessing the passing of her husband is a traumatic experience that can drastically alter the course of her life. The death of a husband appears to be mostly related to low level of lower social functioning, reduced level of satisfaction with life, low mental wellbeing, low psychological well-being and resiliency attitudes, reduced desire to live, poor self-esteem, and high level of depression (Bisconti, Bergeman & Boker, 2004).

The death of a husband is an experience that is common and most women at some periods in their lives would have that experience. The way an individual responds to a loss in most cases, not only impacts the emotions of the individual

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but also the bio-psychosocial-spiritual development and the dynamic processes of the ensuing coping mechanisms (Jakoby, 2012). Women who have lost their husbands record high prevalence rates of several mental disorders (Jakoby, 2012). Research conducted in Michigan in the United States revealed that among newly widowed women, clinical depression has been reported to have a prevalence of 15%-30% within the first year, with sub-clinical rise in depression being even more prevalent (Carr & Utz, 2001).

A comparative study was carried out in Western Oregon in the United States and revealed that women were twice more likely to suffer depression than their male counterparts when they lose their spouse (Lewinsohn, Seeley, Rhode & Baldwin, 2001). For anxiety disorders such as phobias, obsessive compulsive disorders, panic disorders and posttraumatic stress disorders, the findings from the study of Kessler, et al. (2005) revealed that women were two to three times susceptible to those disorders compared to their male counterpart.

Census on marital events conducted (Elliott & Simmons, 2011), revealed that, in the United States widows and widowers were approximately 14 million out of a population of 24 million. It has been shown in the literature that at any stage of the lives of individuals who had lost a husband, they experienced diminishing access to various resources and periods of elevated grief (Ball, 1976; Boelen & Prigerson, 2007; Carr, Sonnega, Nesse & House, 2014; Sanders, 1980; Pearlin, 2010; Stroebe & Schut, 1999; Shuchter & Zisook, 1993).

Widowhood can also affect the individual's health and wellbeing as some widows experience loss of appetite, prolonged and or persuasive stress and stressors, fear, sleeplessness, hopelessness, emptiness, an incessant sense of fatigue and social anxiety (Buckley et al., DiGiulio, 1992). Losing a husband,

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though a natural experience in life, has been connected to several possible harmful psychological and physical health consequences (Ball, 1976; Boelen & Prigerson, 2007; Shuchter & Zisook, 1993).

In Africa, majority of widows suffer emotional, mental, spiritual and psychological problems coupled with poor resiliency attitudes that hinder them from experiencing best mental health and well-being (Boelen & Prigerson, 2007). Other reports in Africa have shown that widows have to strictly adhere to widowhood rites such as staying in the room with the corpse for a period, staying in the room while elders bathe the corpse and in cases where there was a quarrel between the partners, animals are sacrificed to settle the quarrel (Asantewaa, 2017). In some societies, the cultural demands of the family of the deceased on the widows to honour customary requirements brought untold hardship on the widows. These cultural demands usually add to the sufferings of widows. There were also serious sanctions meted out on widows who fell short of the requirements or refused to undergo the various rituals (Asantewaa, 2017). Those widows who refused to undergo the rituals were either accused of masterminding the death of their husbands or branded as witches who had eaten the intestines and brains of their husbands that had resulted in their death (Asantewaa, 2017). In comparison with women who are still married, widows commonly experience reduced socioeconomic status, periods of diminished resources associated with well-being and resiliency (Wilmoth & Koso, 2002), reduced emotional wellbeing (van Baarsen, 2002) and fewer social resources (DiGiulio, 1992).

In Ghana, among most of the ethnic groups, the death of a husband gives opportunity to the family of the deceased to forcibly or sometimes violently

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deprive the widow of all possessions she and her late husband toiled and laboured for, leaving her and the children with nothing to survive on (Fiasorgbor, 2018). The widows' fate in such a case is not only that they have lost their husbands, but providers of the family which further robs them of their status as wives of the deceased (Asantewaa, 2017).

In some other traditional communities, widows are battered, and such battering left social and psychological scars in their minds while in some widows it created stigma and discrimination (Asantewaa, 2017). This seems to suggest that widows not only suffer social stigma and discrimination but also lose their position, self-esteem and identity as persons who were married. There are also situations where the widows experience depression because their goals and future plans with their spouses are curtailed and they have to adjust to widowhood and the less familiar tasks and responsibilities that come with it [Gass-Sternas, 1994; Lopata, 1979; McEwen & Stellar, 1993; Worden & Silverman, 1993].

It appears that interests of widows over the years have been under-represented in the commitments by civil Society and the Government of Ghana (Fiasorgbor, 2018). This situation seems to suggest that if widows are not helped to adequately integrate themselves into the Society, the loss of a spouse would leave the surviving widow in limbo without any proper support system thereby affecting their well-being and that of their children (Worden & Silverman, 1993).

The United Nations Convention in 1979 on the Elimination of All Forms of Discrimination against Women, sought to eliminate all forms of discrimination meted out to women, but appears silent on the plight of widows

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in Sub-Saharan Africa and barely mentions widows in the Convention (United Nations, 1989). However, the plight of widows in Sub-Sahran Africa was highlighted in the twelve major areas of the 1995 Beijing Platform for Action, an indication of awareness (United Nations, 1989). The major areas highlighted included alleviating poverty, reducing all forms of abuse against women and the girl-child. Others were the improvement of good health, quality of education and high employment rates as well as reduction in conflicts and human rights violations (UNICEF, 1999). All of these were indicated as necessary in the efforts to help widows adequately integrate themselves into Society in order to live a self-fulfilled life.

Loss of a husband is most complicated when the death according to social expectation occurred at a much early time. This is because when death occurs much earlier than socially expected, it triggers unexpected emotions and actions intended to adjust and cope with the changes occurring because of the death of the husband. This can lead to the individual asking herself rhetorical questions such as “would I be able to marry again or would remain like that”. Answering such questions are difficult because the individual was not prepared socially, emotionally, physically, spiritually and psychologically for the passing of her husband. However, with time, the individual learns to adjust and adapt to the situation (Erikson & Erikson, 1998).

Data from the Population and Housing Census conducted by the Ghana Statistical Service in the Ningo-Prampram District of the Greater Accra Region revealed that, three out of every four males between 18 to 59 years compared to one out of every three females between 18 to 59 years was married. This accounted for two thirds (63%) of the females compared to less than a fifth (19

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%) of the males within the same age group were formerly married, separated, divorced and widowed. The data again revealed that nearly half (49%) of the females between 18 to 59 years compared to 9 percent of their male counterparts were widows. The data further revealed that majority of males between 18 to 59 years re-married after divorce while fewer female counterparts within the same age group remained unmarried for the rest of their lives (Ghana Statistical Service, 2010).

It appears men usually re-marry so that they would have their household chores, emotional needs and other domestic work performed for them while their female counterparts remain single because it appears they do not need assistance with domestic chores. Marriage and re-marriage protect older people from loneliness and the risk of being ridiculed and accused of witchcraft which many old people faced in some Ghanaian societies at the death of their spouse.

Data from the Population and Housing Census conducted by the Ghana Statistical Service in the Ningo-Prampram District of the Greater Accra Region again revealed that, there were more widows than widowers. This data is presented in Table 1. It appeared the increased number of widows in the data could be attributed to many factors such as life style practices such as robbery, road accidents, imprisonments, drowning amongst others (Ghana Statistical Service, 2010).

Table 1-*Marital Status of the Elderly by Sex*

Martial Statues	Male (%)	Female (%)	Gross Percentage (%)
Married	74.30	33.30	51.40
Widowed	8.83	49.10	31.30

Ghana Statistical Service, 2010

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women it was between the ages of 35 and 44. Male and female rates of death were comparable between the ages of 20 and 24. (Ghana Statistical Service, 2010). This study focused on widows because most widowers re-marry after the period of widower hood rite (Ghana Statistical Service, 2010). Aside this, there have been reports in the literature that the period of widowhood is much stressful and challenging for women than men (Asantewaa, 2017; Fiasorgbor, 2018). This provides further justification for the current study.

Many studies (Ball, 1976; Boelen & Prigerson, 2007; Shuchter & Zisook, 1993) have been extensively conducted on widowhood in other places or societies. However, there seemed to be a gap in our understanding of the various ways that widows in Ningo-Prampram coped with the loss of their husbands and how those widows withstood the numerous challenges experienced. Also, it is unknown as to how widows in Ningo-Prampram adjust and cope before, during and after widowhood and how their psychological well-being and resiliency attitudes are impacted.

Widowhood rite is a ritual performed for every woman who lost her husband at Ningo-Prampram. The main aim of that ritual is to assist widows to adequately integrate themselves into the Society through a traditional and spiritual cleansing process so that they could continue their lives and re-marry if they so wished. Without the ritual, it is believed the spirit of the deceased spouse would disturb the widow, thus, making their lives difficult. However, the rituals and the experiences can sometimes be challenging for the widows.

In spite of this, in Prampram in the Ningo Prampram District of Grater Accra Region, the plight of widows have not received attention from district authorities and other social agencies. Without resolving the issues faced by

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widows and the widowhood rites, widows in Prampram are likely to continue to have struggles coping with the loss of their husbands, ultimately affecting their general wellbeing. To this end, the study employed Solution Focused Brief Therapy to help those widows in the Ebenezer Methodist Society, Prampram in the Ningo Prampram District of Grater Accra Region who could not adequately adapt, adjust and cope with the loss of their husbands and the pressure of widowhood rites in ways that enhance their psychological well-being improve resiliency attitudes that would change their situation and appreciate life. This makes the current study a necessity so as to avoid future and long term negative effects on widows in Prampram.

Purpose of the Study

The study sought to investigate impact of Solution Focused Brief Therapy on the psychological well-being and resiliency attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.

Research Objectives

Specifically, the study sought to;

1. determine whether there was a statistically significant difference in the psychological well-being of widows in the experimental and control group after intervention.
2. investigate whether a statistically significant difference existed between the resiliency attitudes of widows in the experimental control group after intervention.

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3. investigate whether a statistically significant difference existed between the psychological well-being of widows in the treatment group and the control group on account of years of widowhood after intervention.
4. find whether there was a statistically significant difference existed between the resiliency attitudes of widows in the treatment group and the control group on account of years of widowhood after intervention.
5. determine whether there was a relationship between socio-economic status and psychological well-being of widows in the treatment group and the control group after intervention.
6. investigate whether there was a relationship between the socio-economic status and resiliency attitudes of widows in the treatment group and the control group after intervention.

Research Hypotheses

1. H_0: There is no statistically significant difference between the psychological well-being of widows in the treatment group and the control group.

   H_A: There is a statistically significant difference between the psychological well-being of widows in the treatment group and the control group.
2. H_0: There is no statistically significant difference between the resiliency attitudes of widows in the treatment group and the control group.

   H_A: There is a statistically significant difference between the resiliency attitudes of widows in the treatment group and the control group.

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3. H_0: There is no statistically significant difference between the psychological well-being of widows in the treatment group and the control group on the basis of years of widowhood.

   H_A: There is a statistically significant difference between the psychological well-being of widows in the treatment group and the control group on the basis of years of widowhood.

4. H_0: There is no statistically significant difference between the resiliency attitudes of widows the treatment group and the control group on account of years of widowhood.

   H_A: There is a statistically significant difference between the resiliency attitudes of widows in the treatment group and the control group on account of years of widowhood.

5. H_0: There is no relationship between the socio-economic status and psychological well-being of widows in the treatment group and the control group.

   H_A: There is a relationship between the socio-economic status and psychological well-being of widows in the treatment group and the control group.

6. H_0: There is no relationship between the socio-economic status and resiliency attitudes of widows in the treatment group and the control group.

   H_A: There is a relationship between the socio-economic status and resiliency attitudes of widows in the treatment group and the control group.

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Significance of the Study

The study would be significant to several stakeholders. In the first place, the results of the study would be vital for educators, particularly those responsible to teaching and educating mostly marriage counsellors. They would be enlightened on the effects the solution-focused brief therapy can have on the experience of widowhood and thus prepare marriage counsellors to provide such treatments. Secondly, the results of the study would be significant to counsellors since their knowledge on the effectiveness of solution-focused brief therapy would be improved. This can improve their entire practice in dealing with widows.

Further, the results of the study would be significant to Church leaders particularly, the Methodist Church. Specifically, the results would enlighten Church leadership on how they can effectively assist widows during the experience of widowhood. The recommendations of the study would be a source of relevant information to the Church hierarchy to formulate intervention policies and programmes that assisted widows in Ebenezer Methodist Society and all the Societies in the Connexion. Also, widows in general would benefit from the study since they would know how to improve their psychological wellbeing and resiliency.

The findings would add to the existing literature on the usage of Solution Focused Brief Therapy as addition to the interventions for widows in dealing with the experience of widowhood. Thus, the study would add to existing knowledge. Finally, the results would become a reference material for future researchers investigating into Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows.

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Delimitations

The study was delimited to the Ebenezer Methodist Society of Prampram in the Ningo Prampram District of Greater Accra Region. The study focused only on widows in the Ebenezer Methodist Society who had not re-married and gone through the rite of widowhood and had contacted the Society Office on issues that related to widowhood rites.

Limitations

The study was limited in that, the sensitive nature of the topic made it difficult for the widows to open up on how they felt in responding to the questionnaires. However the researcher assured them of confidentiality and that anything they said would not be disclosed anywhere.

Definition of Terms

Widow: This refers to a woman who has lost her husband through death.

Solution Focused Brief Therapy: It is a short therapeutic encounter that assisted clients to deploy their inner potentials to solve their own challenges during counselling.

Psychological Well-being: This refers to a state of wellness which covers issues such as feeling in charge of situations, having pleasure in activities, being admired and loved, not worrying and maintain positive relationships.

Resiliency: This refers to the capacity of an individual to move on in life in the face of challenges. It covers issues such as accepting responsibility, taking charge of situations, remaining calm and seeking to solve problems.

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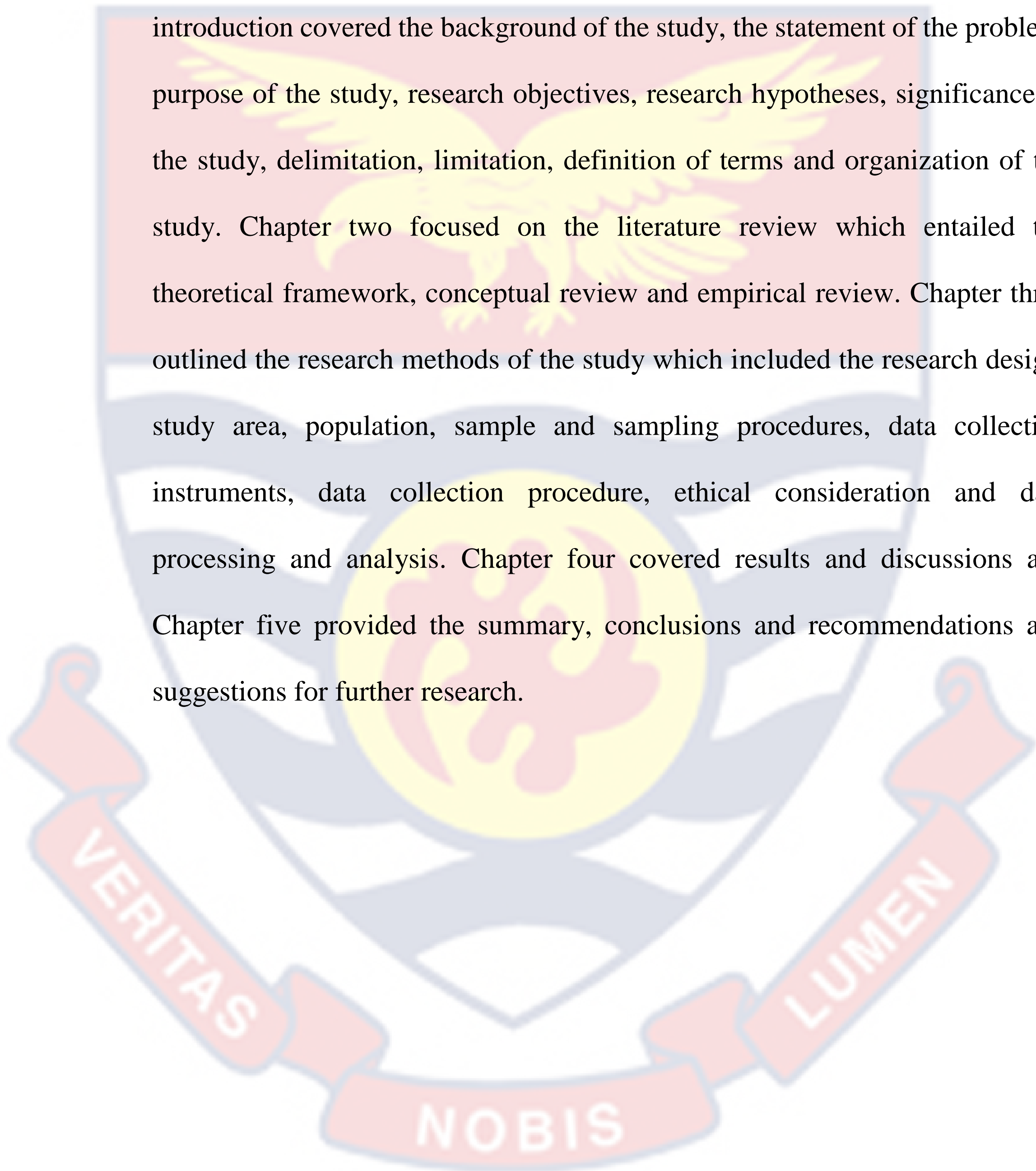
Socio-economic status: This refers to the ability to meet financial obligations, take care of self and significant others from earnings.

Organization of the Study

The study was organized into five main Chapters. Chapter one which is introduction covered the background of the study, the statement of the problem, purpose of the study, research objectives, research hypotheses, significance of the study, delimitation, limitation, definition of terms and organization of the study. Chapter two focused on the literature review which entailed the theoretical framework, conceptual review and empirical review. Chapter three outlined the research methods of the study which included the research design, study area, population, sample and sampling procedures, data collection instruments, data collection procedure, ethical consideration and data processing and analysis. Chapter four covered results and discussions and Chapter five provided the summary, conclusions and recommendations and suggestions for further research.



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CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter primarily reviews literature related to the study. The review was done according to the outline below:

Theoretical Review

a. Ryff's Theory of Psychological Well-Being
b. Theory of Resiliency
c. Solution Focused Brief Therapy

Conceptual Review

a. Psychological Well-Being of Widows
b. Resiliency Attitudes of Widows

Empirical Review

a. Impact of solution-focused brief therapy on resiliency Attitudes of Widows
b. Impact of solution-focused brief therapy on psychological Well-Being of Widows
c. Relationship between socio-economic status and psychological well-being of widows

Theoretical Review

The theories related to the study are the subject of review in this section. The theories reviewed included Ryff's Theory of Psychological Well-Being, Theory of Resiliency and Solution Focused Brief Therapy.

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Ryff's Theory of Psychological Well-Being

Ryff's Theory of Psychological Well-Being is also known as the six-factor model of psychological wellbeing. According to the Six-Factor Model of Psychological Well-being, there are six distinct elements that influence an individual's level of psychological well-being, as well as their level of contentment and happiness (Seifert, 2005). The theory is predicated on the premise that a person's psychological wellbeing can be improved by establishing a state of equilibrium that is influenced in equal measure by stressful and pleasurable experiences in their lives. The theory of Ryff views psychological wellbeing from two perspectives. These are positive functioning perspective and the emotional wellbeing perspective. Positive functioning focuses on human development and the challenges that come along with it while emotional well-being views psychological well-being from the traditional sense, thus, absence of psychological distress (Keyes & Magyar-Moe, 2003). These two perspectives are considered important by Ryff.

From the perspective of positive functioning, Ryff and Singer (1998) argued that the idea emerged from developmental psychological, humanistic theories and existential philosophy. Those theories saw psychological well-being same known as eudemonia, by that it reflected a person's ability and perception to deal and be faced with life's challenges that resulted in the person's positive functioning.

Further, some studies have concluded that when psychological distress is absent, there would be decrease in anxiety or depressive symptoms that would result in improved psychological well-being (Ryff, 1989). Related studies have also shown that the absence of psychological distress could imply psychological

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well-being (Fava, 1997; Keyes, 2005b; Rafanelli et al., 2000; Ruini et al., 2003; Ryff et al., 2006). This is from the perspective of emotional wellbeing.

Ryff (1989) indicated that psychological well-being consists of Autonomy; Personal relations; Environmental mastery; Purpose in life; Positive relations with others and self-acceptance. In the theoretical framework, Ryff made reference to works on positive functioning by researchers such as Allport (1961); Buhler (1935); Jung (1933); Maslow (1968); Rogers (1961) as well as Developmental Tasks ideas of Erikson (1959). According to Ryff (1989), whether a person thrived in life is contingent on how that individual sees himself or herself as adequate and competent functioning in those six dimensions mentioned below:

Autonomy

Autonomy highlighted the degree to which a person was, independent and self-determined, resisted pressure from the social environment, behaved in certain ways by actions and thoughts, internally regulated behaviour and personal standards evaluated self (Ryff, 1989).

Purpose in life

Life was much appreciated when a person existence was perceived to be significant and involved setting, executing and reaching life's goals (Ryff & Keyes, 1995). Mental wellbeing included consciousness that one had higher goals in life and had a strong purpose in life. That purpose in life created direction that eradicated hopelessness. The pursuit of achievement is greatly aided by setting goals for oneself (Miller, 1997). A person's level of maturity may be gauged by their degree of intentionality, or how well they knew where

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they were going in life and how well they felt they were experiencing their present moment (Ryff, 1986, p. 1070).

Positive relations with others

Positive relations with others related to the extent to which a person, "had warmth, experienced trusted relationships with others, was satisfied, thoughts about others that related to their welfare, possessed a strong affection, intimacy, empathy and as well understood human give and take relationships (Ryff, 1989, p. 1072). Relationships that lasted and was trusted as well as hanged on a strong communication networked supported system also enhanced positive relations with others (Ryff & Keyes, 1995). Better consideration of others, promoted maturity and improved interaction with others. Good relations with others, promoted understanding of others, while frustration was as a result of poor relations with others (Ryff, 1989b).

Personal growth

Personal growth measured the extent to which a person "had a feeling of continuous development; saw self as growing and expanding; was opened to new experiences; had sense of realizing his or her potential; saw improvement in self and behaviour over time; and changed in ways that reflected more self-knowledge and effectiveness" (Ryff, 1989, p. 1073). Continuous developments of self through various facets of life improved psychological functioning in the individual (Ryff, 1989) and required a person to expand his or her talents and capabilities through continual evolvement and solving of problems.

Environmental mastery

Environmental mastery focused on the state in which a person had a strong sense of competence and command in managing the immediate

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environment, had control over varied external activities that were complex in nature, took opportunities in the surroundings and created and chose situations that were suitable to personal values and needs (Ryff, 1989, p. 1074). The mature individual was the person who had the ability to relate and interact to different people in many different situations and easily adapted to various contexts (Ryff, 1989).

Self- acceptance

Self-acceptance focuses on a person who possess good attitude towards self and accepted and acknowledged varied parts of self. That included either good or bad in the person's past and future life (Ryff, 1989, p. 1075). In a study, Moe (2012) identified important factors that influenced women's psychological well-being such as age, marital status, education, race, income, perceived social support and ethnicity.

The theory of Ryff describes clearly what it takes for people to achieve a state of psychological wellbeing. The theory of Ryff is relevant in the current study because its six dimensions of autonomy; personal relations; environmental mastery; purpose in life; positive relations with others and self-acceptance are very significant in the lives of widows. This is because when women lose their husbands all these dimensions are affected. These can ultimately affect their psychological wellbeing. For instance, when a woman loses the husband, autonomy is restricted during the period of widowhood and the widowhood rites imposed on the woman. The widow's personal relations and self-acceptance become affected because she has lost someone she probably trusted in and may begin to feel a sense of loneliness. All of these would lead to the widow having

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reduced psychological wellbeing. This explains why the theory is considered relevant in the current study.

Theory of Resiliency

Garmezy (1985) held an ecological view of resiliency; according that view, resiliency was influenced by factors that emanated from both the internal or individual and family levels as well as those that were external to the family. Those influences included:

a. Internal/ Individual factors- that encompasses attributes of the child that formed the child's temperament. The way the child handled both pleasant and unpleasant situations, their responses and development of cognitive skills.

b. Family factors- focus was directed into the well-being of the child by parents or significant others such as grandparent. That strengthens warmth and family cohesion.

c. Social support- the use of available resources from external support systems by parents, significant others, teachers, Church, social worker amongst others.

Garmezy's study identified three models that explained resiliency (Garmezy, 1985). The models included: Compensatory Model, Challenge Model and Protective versus Vulnerability Model (Immunity versus Vulnerability)

Compensatory Model

Compensatory model stated that when stressors lowered personal and competent attributes, then an individual's adjustment capabilities had improved. Those stressors and attributes combined predicted competence. For instance, a person may enjoy warm relationship from significant others such as

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grandparents but experienced a high-conflict environment at home. Resiliency in that instance would be that, the significant others thus the grandparents warm relationship compensated for the high-conflicted environment at home. Werner and Smith (2001) conducted a study that highlighted characteristics of resiliency that included:

1. a tendency of individuals to be conscious of experiences and saw those experiences in a good way at their own expense even when they suffered.
2. a firm and strong dependence on faith that maintained positive view of life and a problem-solving approach and the ability to attract and gain positive attention from others. Kumpfer and Hopkins (as cited in Ungar, 2004) in a study, identified the Compensatory factors that included: insight, intellectual competence, optimism, direction or mission, empathy, self-esteem, perseverance and determination.

Challenge Model

The Challenge model dwelt on adjustment of the individual. A curvilinear relationship in nature where the stressors of an individual enhanced adjustments at a balanced level. Low levels of stress increases competence whilst very high stress levels lowered competence. According to the model, some level of stress was needful as well as helpful for individual and especially young people that enabled them develop adequate coping skills and further encouraged the mobilization of external and internal resources. The Challenge model suggested that the individual risk factors at a balanced level thus not too extreme or not very low, enhanced the individual’s adaptation that lead to experience. That experience prepared the individual to the next challenge in life.

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The theory of Resiliency is deemed suitable in the current study because the theory as propounded by Garmezy (1985) explains that issues relating an individual and his or her family can affect a person's level of resiliency. In the case of widows, the loss of husbands can affect the level of social support they have and their relationships which are key to their resiliency. As a result, the theory is considered relevant in the study.

Solution-Focused Brief Therapy (SFBT)

In Wisconsin was a small town called Milwaukee. In Milwaukee, was what started small a Brief Family Therapy, developed by Steve deShazer, Insoo Kim and Berg and had grown and spread widely beyond the borders of a state and gained popularity in the therapeutic circles as Solution Focused Brief Therapy (SFBT). SFBT was an innovation of an already existing traditional psychotherapy that was geared towards investigation into the set-up and resolution of problems (Corey, 2005; Iveson, 2002; Malchiodi, 2003; Walter & Peller, 1992; Wheeler, 2001). Solution Focused Brief Therapy emphasized on client's innate abilities, resiliencies and strengths. The therapy delved into client's world of current resources and fished out hopes with little or no attention placed on all that caused or started the problem to solution building (Corey, 2005). The therapist only directed the clients in setting their own goals that determined the road map in the therapeutic process towards reaching client's objectives.

Walter and Peller (1992) stated that "when people moved toward a relativistic and constructivist view as well as toward a future orientation, then the presuppositions away from the traditional linear notions of causality had shifted" (p.11). Like any other therapy, Solution Focused Brief Therapy had

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certain similarities but the innovation of Solution focused brief therapeutic process worked best in the attainment of behavioural goals that were specific in nature without emphasis on client's historical information (Nichols & Schwartz, 2001). The distinction of Solution Focused Brief Therapy Model with other Brief Therapy Models was that Solution Focused Brief Therapy emphasized on efforts client had taken and was already undertaking to solve the problem that necessitated and brought the client to therapy that emphasized on client's innate abilities and strengths rather than client's weakness and threats (O'Hanlon & Weiner-Davis, 1989).

Erickson (1975) stated that clients had inner strength and resources that enabled them to resolve their own problems and that efforts that assisted toward a goal of unearthing those resources ought to be in place. A brief therapy was assessed at the Mental Research Institute in 1975 that focused on specific behavioural goals and concluded that when therapy met those goals then therapeutic process was over. With behavioural model as an example, interventions only targeted problematic patterns in a particular family and geared toward assisting that family change their perception toward that problem that in turn affected behaviour (Nichols & Schwartz, 2001).

The key goal of Solution Focused Brief Therapy dwells on resolving problems that clients presented to therapists. This was achieved with skill that helped clients to reflect on expectations to the presented problems or situations that they presented for therapy. A situation where the problem presented by client was absent, a situation was then created. That absence of the client's problem helped to discover the client's resources that were tapped to resolve the

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problem. Therapist effort in that process was more of collaborator than expert. That collaboration enabled clients to establish their own treatment goals.

According to Nicholas and Schwartz (2001), there was no absolute definition of what constituted normality for clients in therapy; as a result, the therapists do not impose self-beliefs on clients during therapy. Constructivism, the theory on which Solution Focused Brief Therapy was developed, "asserted that realities does not exist as a 'world out there' but that, it was an imaginary formation of the observer". Solution Focused Brief Therapy like any other therapy had its language that explained issues in therapy. Solution focused brief therapist assumed that, clients had already initiated steps in resolving their own problems they brought to the therapist. That was confirmed with questions such as when was the client experiencing changes and admitting solutions rather than if the client was experiencing changes and admitting solutions.

The boost to Solution Focused Brief Therapy is its ability to quickly and effectively address and manage the complaints clients brought into therapy session. DeShazer (1985) at the Brief Family Therapy Center in Milwaukee, Wisconsin, conducted a study that revealed that 72% cases out of 1600 reported from 1978 through to 1983 was randomly selected that indicated improvement in therapy. Thus, average of 6 therapeutic contact per client. The researcher concluded that clients participated fully in shorter therapeutic sessions that solved their problems and that a model be built that addressed client's experience of change with shorter therapy session.

One unique aspect of Solution Focused Brief Therapy Model is complimenting clients for seeking help and reinforcement of little or small changes that had taken place or was taking place in the clients' life. Kral and

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Kowalski (1989) stated that compliments were used by therapist to help recognize what the client was doing differently that brought about the change in behaviour, thoughts or feeling in therapy.

According to Nicholas and Schwartz (2001), first session task was very much important task as it sought to critically observe significant activity or an activity that had happen or was happening in the life of the client. DeShazer and Berg (1997) and O'Hanlon and Weiner-Davis (1989) made mention of coping questions. According to them, coping questions assisted the therapist to monitor progress with clients as they inquire from clients on how they managed to endure all obstacles in the face of a seemingly hopeless situation they brought to therapy. Solution Focused Brief Therapy model allowed for some break in course of therapy session that allowed the therapist to recollect and gather his or her thoughts and consult with the team of therapist behind 'the mirror' that team of expert therapists monitored the entire therapy sessions and unseen by the client. The break enabled the therapist consult the team who like a jury in a court room decided that parts of the session are highlighted to the client when the break resumes.

For DeShazer (1985) and Nichols and Schwartz (2001), Solution Focused Brief Therapy model acted as "skeleton keys" that unlocked the door of solutions that answered a variety of questions in the life of the clients that was presented to therapy. One key advantage of Solution Focused Brief Therapy over other therapies are its ability to address clients' default solution patterns, assessed and evaluated those patterns for efficacy, modify them to a more suitable problem-solving approach that worked for the client (Focus on Solutions, 2013). According to DeShazer (1985), there was no point when much

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focus was placed on previous failed attempts in the quest to finding solution to problems clients presented to therapy. Solution focused brief therapist placed little or no attention on problems of the client, to the extent that problems were sometimes not discussed (George, Iveson & Ratner, 1999). Solution focused brief therapist's interest was how clients be aware and know that the problem they presented to therapy was no more there and that it had been solved. That way therapist only directed clients to unearth inner strengths and resources that solved the problem (DeShazer, 1985).

Basic assumptions of Solution Focused Brief Therapy

Solution Focused Brief Therapy was developed based on the following assumptions that became the framework for operation (DeShazer, 1985):

a. Focus on strengths as well as solutions guaranteed that therapy would be brief.
b. Every individual had the capacity to act effectively, however negative cognitions had blocked that capacity that brought the individual to therapy.
c. Every presented problem had expectation.
d. Clients presented problem from one side, however therapist assisted clients to view presented problem from a different point of view.
e. Little or small change in the individual encouraged bigger change.
f. Clients desired to change, they had the inner capabilities to change and they made efforts that caused that change.
g. Every individual was unique, so was every solution (Deshazer, 1985).

Therapist followed the following rule throughout the therapeutic process (Corey, 2005):

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1. Know the client's view point by asking questions rather than sell answers;
2. Observe, take notice and reinforce traits of clients' positive qualities, strengths, capabilities and resources to resolve their own problems;
3. Highlight client's positive behaviour pattern that helped the client. Explore new means of solving the problem through those behaviour patterns;
4. Focus on what clients could do rather than what they could not do;
5. Focus on solution details rather than problem details;
6. Actions plan ought to work for clients (DeShazer, 1985).

Core Techniques of Solution Focused Brief Therapy

The Brief Family Therapy Center saw the completion of Solution Focused Brief Therapy processes. The therapy was exploratory in nature and it involved a critical observation of therapeutic sessions by a team of therapist through a one-way mirror (DeShazer, 1985). Through critical experimentation and observation and several years of application, the team saw it fit and reviewed several components and techniques that eventually became the fundamental components of SFBT that have been in use till today. The core techniques in the practice and application to Solution Focused Brief Therapy usage during therapy according to (Bavelas et al., 2013; DShazer, 1985; Iveson, 2002; George, Iveson & Ratner, 1999; O'Hanlon & Weiner-Davis, 1989) included:

Pre-session change

According to O'Hanlon and Weiner-Davis (1989) it was recommended that at the first stages of the therapeutic contact, therapist would ask questions

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like "Did you ever do anything that worked for you?" by that, the therapist would focus on questions that were positive in natures such as " What have you tried in the past that had worked for you." In a study by Weiner-Davis, DeShazer and Gingerich (1987), found out that out of 30 clients used for the study who were asked that question during the initial stages of the process, only 20 clients reported instances of improvements in their situation. Mckeel and Weiner-Davis (1995), noted that when clients were asked "What had not changed in the first session," 67 percent reported that their issue was the same.

Goal setting

One key component of goal setting is the ability to set specific, observable and concrete goals. Those goals are set by clients and were simply prompting what the client wanted to be different in the future to live a productive life (Lee, Seebold & Uken, 2003). Solution focused brief therapists posit that clients' goals are essential in the therapeutic process because goals direct the course of successful therapeutic outcomes (Rhodes & Ajmal, 1995). Goal setting is also necessary because it determines where the therapeutic process is going. "If you do not know where you are going, any road would take you anywhere" (DeShazer, as cited in Ajmal & Rees, 2001, p.18).

Asking the miracle question

Analogical scenes are created for the client during a session. The miracle question reveals how the client would like to feel when therapy ends. The client would be asked to imagine one night where after sleep a miracle happens and the problem is no more. This is usually asked in the form of the miracle question. This is where clients are asked "what would be different in your life that would let you know that a miracle had taken place in your life?" What else? (Berg &

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Miller, 1992, p.13). In miracle question, this is required to provide a small but reasonable expectation that the client could meet. In most cases, the response includes particulars about where, when and whom but not why. These responses outline what client will be doing about the responses to achieve those goals (De Jong & Hopwood, 2002). The miracle question enables clients to think into the world of options and alternatives which they would previously have not been conscious of, so as to make a change in their situation (O'Hanlon & Weiner-Davis, 1989).

Scaling question

The client at some point in time during the session would be asked to give rating of some aspects of his or her life on a scale that ranges from 0 to 10. Where 0 indicated worst state of the situation whiles 10 indicated that the situation no more exist. The scaling again encouraged clients to work hard towards achieving the set goals (Berg & DeShazer, 1993). Scaling question bridges the gap between where the client was and client's hope of where he or she would like to be in the future. A client through the scaling question measure, evaluate and assess his or her personal issues (Berg & Dolan, 2001, p.9).

Consulting break and compliments

The therapeutic process at some point in the interaction, allows for some break, after that the therapist would complement the client on the client's decision to participate in the process. Those complements reflect client's past successes (De Jung & Berg, 2008) and often times the complements move the mindset of the client into accepting new things (DeShazer, 1991) and also reinforce client's abilities, skills, strengths, resiliencies and competences (Bavelas et al., 2013).

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Eliciting exceptions

Solution Focused Brief Therapist does not always assume that problems always happened that brought clients to therapy all the time (Berg & Dolan, 2001), but that there are times where problems less occurred and that the therapist would use those times to encourage and assist the client to discover a world of opportunities or even minor steps that would bring about (McKeel, 2012).

What is better?

In Solution Focused Brief Therapy process, the therapist always in the second and succeeding sessions began each session with the question "What is better?" (George, Iveson & Ratner, 1999). The question reminds the clients of the therapist expectation that something had gone right or was better. That acts as prophecy for the client.

Relationship questions

To imaging how significant others would react to the client's presented problem and the possible changes they had made, required the therapist to use relationship questions. Those questions were asked to increase the hope of clients and how significant other like best friends, family teachers and children. When client answers that question the therapist follows with another question What would you do differently? (De Jung & Berg, 2008, p.355).

Coping questions

The Therapist monitors client's performance as well as inner resources and self-efficacy through coping questions. Question such as "How did you do?" and "what could you possibly be doing to move you up on the scale?" Those

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questions enable the client to master and develop inner resources and strengths as well as develop positive solution (De Jung & Berg, 2008 p.355).

Formula first session task

Another key feature of Solution Focused Brief Therapy (SFBT) is a session task as homework. Homework is given and clients are required to complete the homework between the first and second sessions and be presented to the therapist to monitor progress. Those task required the therapist to ask questions like "Before our next meeting what could you be doing to improve your situation and a significant event that would happen in your life thus marriage, relationship and family" (DeShazer & Mohnar, 1984, p.137). Those tasks offered client's hope about their situations.

Conceptual Review

Solution Focused Brief Therapy model adopted from Stobie, Boyle and Woolfson (2005), Solution Focused Brief Therapy was developed on the constructivism model. The model saw the problem that brought the client to therapy as the client's own construction of the problem and the kind of pattern that maintained that problem. Problems existed as a result of the way clients saw and described them. Figure 2 outlined the model

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& Magyar-Moe, 2003). Diener (1997) saw Psychological well-being to mean ways by which individuals evaluated their lives through cognitive, affective and the behavioural domains. The cognitive domain processed information assessed from the appraisal of a person's life based on conscious conclusion on a person's total appreciation with life. The affective domain processes information that was directed at a person's feelings and emotions such as the tendency with which people accommodated pleasant or unpleasant situations and moods that reached to their lives.

Psychological well-being has a wider usage and has been recognized as not just absence of distress but involves positive characteristics individuals possessed that could result in good mental health. Major concepts have been identified that explained key aspects of psychological well-being. Among these are self-determination, optimism, and a sense of direction in life, all of which are crucial to the healing process. Other sources of psychological well-being come from the individual, the environment, and the systems in which they are embedded. Subjectively experienced characteristics of good functioning include things like autonomy, environmental mastery, self-acceptance, positive relation with others and personal growth.

Psychological well-being is based on the basis that individuals mostly evaluate their state of life as either good or bad and that informs their ability to offer judgment on their state of life. Diener (1997) again indicated that people invariably experience either positive or negative emotions and moods conditions in their lives.

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Resiliency Attitudes of Widows

Resiliency is meant to be rebound and stemmed from a Latin word “resilire” (Oxford Dictionary, 1989). The Oxford Dictionary further defined resiliency as an act recoiling or the power of resuming the original position or shape after bending or other shock. On the other hand, for the purpose of this study resiliency is the capacity of an individual to move on in life in the face of challenges.

Resiliency is all about the power or strength that enable an individual to recover from misfortune, frustration and adversity. With that in mind, the basic concept of resiliency is survival, recovery and thriving (Ackerman & Maslin-Ostrowski, 2002). Unpleasant situations which are not only about man-made occurrences such as famine, poverty, accidents and war or natural occurrences such as droughts or floods and earthquakes. Those unpleasant occurrences happen in everyday life and could happen to anybody at any time in life of an individual in the form of illness, divorce, substance abuse, death and change in domestic situation, change in job, education, marriage, widowhood amongst others (Ackerman & Maslin-Ostrowski, 2002; Cash, 2001: Copland, 2001; Greene, 2003; Heifetz & Linsky, 2004; Ledesma, 2012).

There are several ways different disciplines view resiliency: in psychology, resiliency is the strength and power to withstand difficult situations by repairing oneself (Higgins, 1994; Wolin & Wolin, 1993). According to Flach (1988), resiliency in psychiatry, is a biological and psychological strength human engaged that enabled them mastered change successfully. In medicine, resiliency is the strength that enabled the individual to recognize pain, acknowledged its purpose, tolerated for a while till situation normalized (Flach,

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1988; O' Leary & Ickovics, 1995). In social sciences, resiliency is all that go into recovery from negative life experiences and became stronger while overcoming them (Henderson & Milstein, 1996).

According to O' Leary (1998), thriving means that an individual had the power or strength that enable that individual to exceed his or her level of performance, grew as well as function normally irrespective of the individual's exposure to stressful experiences. There are some key variables that characterized resiliency and thriving, that included: a strong sense of coherence, hardness, optimism, strong and positive self-esteem and social resources, self-efficacy, coping ability and skills, risk-taking abilities, adaptability, determination, perseverance, low fear of failure and high tolerance of uncertainty (Bonanno, 2004; Carver, 1998; Masten, 2005; O' Leary, 1998; Patterson et al., 2002; Ungar, 2004). Masten (2005) saw resiliency to be a mechanism that enabled an individual to portray good outcomes irrespective of dangers to development. Individual's response to danger and stress depend on the positive tone of individual differences to resiliency (Rutter, 1987). Resiliency is the ability to withstand frustration, adversity and misfortune (Jonas, 2002). Resiliency was also viewed to be the ability that enabled a person dealt with stressors and that did not alter the person's state of functioning (Perry, 2002).

Resiliency researchers focused on a person's ability to respond to risk. Some individuals cope, adapt and adjust to stressful or unpleasant situations whiles other individuals give in to those unpleasant situations that very much guarantee their survival and sustenance in terms of how the individual responds,

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whether positively or negatively to the unpleasant situations associated with life's hazards (Rutter, 1987).

Some assumptions of resiliency:

1. Resiliency focuses on adapting to situations despite difficulties.
2. It focuses on learning and growth processes that expanded the understanding and acquisition of new knowledge, and new skills.
3. In times of crisis, open lines of communication may prove important in finding a satisfactory resolution.
4. When dealing with adversity, it helps to stay connected and open with others (Beck & Socha, 2015 p. 222).

Protective Factors versus Vulnerability Model (Immunity versus Vulnerability)

The Protective Factors versus Vulnerability Model (Immunity versus Vulnerability) considered the interaction relationship that existed between personal attributes and individual stressors. By that, the association of stressors varied for every individual and that the outcome of the stress varied and dependent on the degree of the characteristic being considered. For instance, a cohesive home environment would accommodate a person in high poverty and that the cohesive home environment interrelates with the poverty to reduce the risk of that person. Based on developmental literature and systems theory, a relationship between risk factors and protection resulted in the Protective factor model of resiliency and that reduced the chance of negative outcome and as well balanced the exposure to risk effect (O' Leary, 1998).

Despite aversive or unfavorable life situations, those protective factors fostered positive consequences and positive personality features (Bonanno,

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2004; Ungar, 2004). Those protective factors encompassed: job skills, introspective self-reflection, academic capability, restored self-esteem and emotional management. Others included: problem solving skills, planning skills and life skills (Ungar, 2004). The efforts of Biscoe and Harris (1999); Garmezy (1985); Werner and Smith (1982); Wolin and Wolin (1993), had advanced the knowledge of protective factors that had helped individuals to cope, adapt and adjust to life situation that initially they found impossible.

A number of researchers and stakeholders in the field had identified some characteristics of resilient people, however there was no consensus in terms of literature (Biscoe & Harris, 1999; Garmezy 1985; Werner & Smith 1982; Wolin & Wolin, 1993). The wider and varied study of resiliency from various fields of study led to the establishment of International Resiliency Project (IRP). They reviewed resilient traits into various categories that highlighted widespread ideas of the characteristics that make an individual robust. The traits included: autonomy, achievement oriented, likeability, attractive temperament, hope, self-concept, trust in God, locus of control, values, emotional intelligence, the ability to empathize and help others, and interpersonal skills. Others included: impulse control, problem solving skills, social skills, seeking trusting relationships, persistence, humor, communication and intellectual skills. Also included in the categories was: trusting relationships: that considered a person's access to education, quality health care, good social assistance; emotional support from others outside the family; parental promotion of independence; household norms; a consistent learning environment at school; positive role models and morality (religious groups).

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Some basic features of resiliency were external support, resources resilient traits, internal personal and strengths that defined resiliency as an occurring problem (Cook & Campbell, 1994). Wolin and Wolin (1998) asserted in a study that young people applied specific behaviours or resiliency attitudes they had learned and modeled in times of trouble. That confirmed the researcher's view on the fact that behaviours could be taught, learned and modeled. Wolin and Wolin (1993) further explained that: "Resiliency" was considered to be in cluster of strengths that were tapped in time of struggle with hardship. Those resiliency strengths included:

a. independence: when a person distance physical and emotional from the sources of trouble in the person's life;
b. insight: tough questions were asked with honest answers given;
c. initiative: being in control over problems;
d. creativity: expression oneself and imaginations artistically;
e. humour: able to make a fun out of a difficult situation;
f. morality: when conscience directs actions and decisions;
g. relationship: able to establish fulfilling connections with significant others.

Empirical Review

Impact of Solution-Focused Brief Therapy on Resiliency Attitudes of Widows

A study by Mills (1993) attracted a lot of attention on tapping resiliency in Dade Country, Florida. That study was conducted on 142 families and 604 youth who met all requirements to be included. After pre-test and post-test assessments, the outcome revealed that a significant improvement existed in

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parent-child relationships that accounted for 87% of the families, 75% decrease in school related behaviour challenges, 65% decrease in drug trafficking, 60% decrease in substance abuse and 80% decrease in teen pregnancy. Resiliency study had undergone developments over the years and had offered academic opportunities for further research. Impact of SFBT on psychological well-being and resiliency attitudes of widows in Ebenezer Methodist Society was dwelt on in the present study.

Riley's (2013) study aimed at examining mechanisms in women's that was intrapersonal in nature that aided resilient responses when exposed to various levels of intimate partner violence, emotional and psychological abuse. A community drawn sample of 184 women were included in a survey-based study that comprised both abused and non-abused participants. Participant's completed questionnaires that collected resiliency, personality, coping, appraisals and thinking processes.

Regression, ANOVA and correlational analyses were used, that assessed the relationships that existed between the constructs. The study revealed that women who reported high degrees of resiliency experienced low degrees of negative symptoms such as appraisals and wrong thinking pattern. The study showed that resiliency was independent of exposure to abuse and that regression analyses further revealed high degrees of resiliency in the women used for the study predicted primarily emotional stability, denial, coping skills, personality factors, positive reframing and planning.

The study further revealed that negative self-view, self-blame and depression was depleted by resiliency. The study seemed to suggest that resiliency could be seen to be a process at the same time a trait. In clinical sense,

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the study outcome meant that resilient traits of the individual translated into resilient processes. For instance, within therapeutic context, a person's coping skill could be reinforced and strengthened when the person was taught. A study by Bonanno et al. (2002) on older adult widows, found out that, 46 percent of the widows recorded low degrees of depression and grief-specific symptoms from pre-loss through to 18 months of bereavement.

Also identified in the study was core patterns of bereavement that included: low degrees of pre-loss depression. That was because participants 18 month pre-loss reactions results were compared to previous 6 months pre-loss reaction results and there was no significant difference in both results. Further study of pre-bereaved functioning of resilient group, indicated negative signs of maladjustments on all measures assessed in the study. That proved that resilient group's coping resources were more than other groups.

Within a one standard deviation, Bonanno, Moskowitz, Papa & Folkman, (2005) demonstrated resiliency of non-bereaved mean total of younger widows who were coping with the death of their husbands. With a multiple outcome measure defined, the study included structured clinical interviews, rating of widows' adjustments obtained from participant's significant others and self-reported adjustments. The study suggested that a key point was that although resilient individuals might have experienced distress in minimal levels, nonetheless they resumed and continued functioning effectively at their usual degree.

According to Bonanno and Keltner (1997); Bonanno et al. (2002); Tugade and Fredrickson (2004); Bonanno et al. (2005); Coifman et al. (2007), continued fulfillment social and personal responsibilities with the ability for

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generative and positive emotions was as a result of a strong resiliency that had been developed over time, that made it possible for the individual to be resilient to a loss of any nature. The study negated an assumption that absence of distress as a result of the death of a husband was a way of denial of the normal process of grieving (Middleton, Moylan, Raphael, Burnett & Martinek, 1993; Rando, 1992) and further negated that idea that individual who experienced major stressors in life did not necessarily suffer from mental health (Bonanno et al., 2010).

Studies had confirmed that most adults would experience one time or another single or multiple traumatic situation possibly during the course of their life (Kessler, et al. 2005; Ozer, Best, Lipsey & Wewass, 2003) and that limited number of people who did experience those distressed situation, most people remarkably coped, adapted and adjusted well (Bonanno, 2004). Researchers advocated different approach to trauma studies. Their approach formulated that prospective researchers considered the heterogeneity of the responses to stress that included good adaptation (Bananno & Mancini, 2010; Bonanno & Clark, 2011) that enhanced and influenced normal and abnormal development that would inform the planning of prevention and intervention strategies.

A qualitative study was conducted by (Korang-Okrah, 2011) on widowhood rites of the Akan people. The study selected twenty widows who ranged in age from 30 to 81 years, situated in the rural or urban dwelling, who were married either monogamous or polygamous, Christian or Islam, employed or unemployed, educated or illiterate and also with varied experience of widowhood. Widows for the study were from two towns and cities from two Regions of Ghana.

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The study used interview technique that elicited the widows' perspective and meaning they made from those live experiences. The study revealed that the social settings of the Akan women was directly influenced widows' vulnerability. The Akan Society was a gender based and that to a very large extent culturally determined the roles of women in marriage and that resulted in poverty. The study however found some factors that the widows relied on as resources that supported their survival. Some widows identified religiosity or spirituality, social support, improved economic status, self-sufficiency, network of family and friends amongst others. The study further found out that five widows were financially handicapped and struggled to survive.

A study conducted by Neill and Kahn (1999) considered and differentiated between extrinsic religiosity thus the social activities the individual engaged in and intrinsic religiosity thus the personal spiritual activities an individual engaged in. The study identified attendance to Church services and meetings, participation in Church volunteer activities as extrinsic religiosity whilst intrinsic religiosity included: daily Bible reading, meditation, praying and personal belief in God. Another study followed up on widows at the early months after the death of their husbands. The study confirmed that adjustment was contextual and an ongoing process but cautioned researchers to be mindful of diverting from concluding at a point or another that assessed change in adjustment over time (Bergeman, Bwasconti & Boker, 2004).

Abdollahi, Sadeghi, Roohafza, Tavakoli, Dadras, and Kouchakzadeh (2020) evaluated the efficacy of solution-focused therapy on mental health and meaningfulness in life. After carrying out a quasi-experimental analysis using a pretest-posttest design in Iran, a significant difference was realized between the

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solution-focused therapy group and control groups in terms of having meaningfulness in life and the strength to carry on with life. In essence, solution focused therapy made people more focused and strengthened for the future.

Also, Bennett, Morselli, Spahni and Perrig-Chiello (2020) examined the stability and adaptation to widowhood among women who lost their husbands. After gathering data from 309 widows through questionnaire, it was found that years of widowhood was significant in widows' ability to cope, adapt and stay resilient.

Additionally, the impact of social support on the resiliency of older widows was studied by Kang and Ahn (2015). They used information from the National Survey on Health, Aging, and Social Life (NSHAP), which had a sample size of 3005, from people aged 57 to 85. The results of a multiple regression analysis showed that older widows had stronger ties to their families and social networks making them more resilient. The researchers concluded that years of widowhood and age of widows were significant in the resiliency of widows.

Moreover, the effects of resiliency education on the mental resources of low-income widows in Fasa city, southern Iran, were studied by Asadollahi, Karimpoor, Kaveh, and Ghahremani (2022). The study was a quasi-experimental involving 120 widows. After the intervention, it was found that there was a statistically significant increase in resiliency among those who received treatment in comparison to those who did not. This increase was also manifested on account of the years of widowhood.

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Impact of Solution-Focused Brief Therapy on Psychological Well-Being of Widows

Flores and Vega (1998), Guarnaccia (1997), McMiller and Weiz (1996), Organwasta (2000) documented several factors that impacted women that ranged from economic status, psychological, sociological state and educational level of Mexican farm workers and their mental health status and well-being. A similar study was conducted by Ximena (2004), investigated the outcome of therapy on resiliency attitudes and mental health status in Mexican women farm workers. Result from a pre-test and post-test revealed that there was significant impact on resiliency attitudes and mental health status of the treatment group. The study further added that participants reviewed their understanding and perspective of resiliency that directed to the availability of solidarity, hope and social networks in many cases.

The Department of Health and Human Services in US developed a model that assisted recovery for women. The model addressed existing issues and challenges women faced in dealing with mental health challenges as they constituted greater majority who suffered various mental disorder compared to their male counterparts. Disorders such as phobic disorders, anxiety and high degrees of depression. Those phobic disorders, anxiety and high degrees of depression amongst women suggested that societal sexism was a major contributor of increased levels of mental health challenges and depression in women (Worell & Remer, 2003; Keith, Jackson, & Gary, 2003).

In Africa, widows constituted a greater majority of destitute and vulnerable in the Region (Owen, 2001). The reason was that, widows were denied right to own their deceased spouse property or properties that she

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struggled with the deceased to acquire. Particularly in Ghana and also common in other settings within Africa, a widow underwent some traditional practices as obligation towards her deceased husband. In other settings the widow remained in her home and allowed to cultivate land or get herself engaged in other economic activity to fend for herself and her children if any (Owen, 2001).

A study by Okrah-Korang (2011), revealed that religious or spiritual activities were protective factors for continuous survival in difficult times. Many Christian widows shared their experience in the study. They spoke about how they relied on God, their strong beliefs in Jesus Christ, prayed regularly, attended Church services and prayer group meetings and occasionally fasted as their spiritual weapon. They also participated in most in-reach and out-reach programmes and other times volunteered and assisted less privileged as well as vulnerable people, especially widows in the Church and in the community.

Those activities widows engaged in were evident that those widows deployed both extrinsic and intrinsic religious mechanisms for survival. Those spiritual activities enabled widows sought meaning and purpose for their own existence and as well depended and trusted God who is “All Knowing.” Most widows when asked how they survived responded “It was by the all-knowing and merciful grace of God that am alive.” That confirmed the widows experience with the supernatural and were convinced enough that God who made humanity and made death and that to them death though inevitable, was natural like a door that everyone will go through it (Okrah-Korang, 2011).

Widows in Okrah-Korang’s (2011) study reported that, their resiliency attitudes towards the death of their spouses were always positive because they prayed and handed over all their problems and challenges, they were confronted

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with to God Almighty who knew their purpose in life and knew what was best for them and that helped and quickened their coping, adapting and adjusting processes. In a related study, it was confirmed that level of religiosity or spirituality and well-being had valuable effects on the coping skills of the person in times of crises (Roff, et al., 2007). Walsh, King, Tookman and Blizard (2002) confirmed in a study that an individual's level of religiosity or spirituality facilitated crises solution. Religious activities aided the construction of meaning in life. Social support from significant others and bond with the deceased made them believe that the deceased person existed in an afterlife (Michael, Crowther, Schmid & Allen, 2003).

In a quantitative study, Hahn et al (2011) compared the experiences of 75 older widows with 125 married women. The result of the study revealed that social support was a prominent element for resiliency in widows. The study further revealed that assistance from family and friends in practical issues facing daily life activities like attending gatherings or hanging out helped widows to cope and adapt to the stress-inducing changes in everyday life. Again, the study indicated that aside social support, time used and well-being correlated positively with resiliency.

Tabatabaei and Bolghan-Abadi (2020) investigated the effectiveness of solution-focused group therapy in helping people with anxiety. The study was semi-experimental and adopted a pretest-posttest design with a sample of 40 people. After the intervention, it was found that there was a significant difference between the control and treatment groups in terms of anxious feelings. The researchers concluded that solution-focused therapy could significantly decrease anxious feelings and improve psychological wellbeing.

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Similarly, Wang et al. (2022) investigated the effectiveness of solution-focused group counselling (SFGC) to minimize depression and improve psychological wellbeing with a focus in China. The study was a cluster randomized controlled trial using 290 study subjects. After the study, it was found that those in the intervention group had reduced depression compared to those in the control group. The researchers concluded by indicating that solution focused counselling improved psychological wellbeing and reduced depressive symptoms.

Javid, Ahmadi, Mirzaei, and Atghaei (2019) investigated the effectiveness of solution-focused group counseling (SFGC) in the promotion of mental health and wellbeing. After conducting an experimental study in Iran using the pre-test post-test design, it was found that the intervention group improved in their mental wellbeing compared to the individuals in the control group. From the results, the researchers concluded that SFBT may improve different aspects of mental health including psychological wellbeing.

Further, Peña-Longobardo, Rodríguez-Sánchez and Oliva-Moreno (2021) examined the health and wellbeing of widows. The researchers used the Survey of Health, Aging and Retirement in Europe from 2004 to 2015. They found that widows usually had poor health and wellbeing without any form of treatment or support.

Moreover, Carr (2020) examined the impact of emotion-focused coping and help-seeking mechanisms on people going through widowhood in terms of their emotional and psychological experiences. The researcher found that through therapy and other coping mechanisms, widows were able to reduce depression and improve their psychological wellbeing. Carr added that this was

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a function of the years of widowhood. As the years passed by, psychological wellbeing was likely to be improved.

Perkins and Lowman (2016) examined the association between widowhood and psychological distress. The sample comprised 9,615 adults who were above 60 years and living in India. The researchers found that widowhood had a connection with psychological distress especially for those who had been long term widows. Thus, the researchers concluded that duration of widowhood was significant in issues related to the psychological wellbeing of widows.

Relationship Between Socio-Economic Status and Psychological Well-being and Resiliency of Widows

The World Health Organization (2009) conceptualized women's mental health in a study conducted by Jacobson and Greenley (2001), that focused on a recovery approach to mental health that education was the key to positive functioning. The result of the study revealed that education impacted positively on women's psychological well-being on levels of positive functioning. The study again stated clearly the advantage education brought as financial prospects and personal development. The study made clear that learning encouraged social interactions, increased feelings of competency, increased self-esteem and facilitated skills development that equipped people to adequately handle life challenges (New Economics Foundation, 2009).

Studies had showed that at every stage of the bereavement process, widows would confront their loss thus loss orientation, whereas in other situations, widows actively ignored or avoided, thinking about the situation by replacing the thought of new ones (Stroebe & Schut, 2001).

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A population of 2,746 women were used for the study. Data was assessed. Ryff's Psychological Well-Being Scale (Ryff, 1989) and Anxiety, Stress, Depression Scales (Lovibond & Lovibond, 1995), demographic questionnaire as well as "Visual Analog of Perceived Social Support" scale were used to collect data for the study. The data revealed that statistically significant difference existed between education, perceived social support, income and psychological well-being. The data further revealed that scores on psychological well-being of women who were married was higher compared to women with different marital status. However, age, race or ethnicity did not cause any difference in the outcome of the scores.

Emotional well-being study was conducted on widows by Bisconti, Bereman and Boker (2004). The study started with 288 widows who were identified through information on death notices from a daily newspaper advertisement in a small city of Northern Indiana and neighboring areas. Seven days after the death of the spouse, the researchers followed up on the widows. The widows were given explanations on the purpose of that study and after 197 widows accepted and participated and made available their full address information with further follow-ups undertaken with phone calls and informed consent letter. Out of 197 who expressed interest, 148 withdrew from the study. Some participants declined before the study started that reduced the widows to 49 that formed 25 percent of the initial widows of 197.

The study period lasted between 18 to 42 days after the death of their husband (M=28.76, SD=7.00; Mdn=24; mode=24). After the first session 9 widows declined, that left 40 widows as sample size for the study and were all included in the study. Widows were assigned to treatment group (n= 19) were

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assessed with battery of Scales and control group (n= 21) underwent orientation and follow-up session. Earlier studies had proved that a significant relationship existed between psychological well-being and writing. Further analyses were conducted with t-test as well as chi-square on age, depression, number of days after spouses' death, number of years of marriage, educational status of the widow and the expectedness of the death.

The results showed that widows that declined from the session were highly educated and younger ($\chi 2=11.18$, p, .05) than those who continued with the sessions (M=64.80; t= -2.65, p, .01) and their ages ranged from 61 to 68 years. Four widows out of five widows who declined resumed work after mourning their husbands that explained the reason why they initially declined from the study. The study revealed no significant difference between the groups on depression, age, number of days after spouses' death, number of marriage, number of years of marriage, educational status of the widow and the expectedness of the death.

Again, there was no significant difference in depression. The study lasted for three months and the results revealed that there was no differential effect on depression outcomes in completing the daily assessments over the period of study.

Ryff and Keyes (1995) conducted a study on 1,108 participants. Out of the population 60 percent were women. Three age groups' psychological well-being scores was assessed. These were young adults, midlife adults, and older adults. The study revealed a significant finding: (i) older adults and midlife adults had high environmental mastery in comparison to younger adults; (ii) younger adults and midlife adults had high score on purpose in life as compared

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to older adults; (iii) younger adults had low scores on autonomy in comparison to midlife adults.

A study on health and aging was conducted during 1995 -1996 with an already existing data in Canada by Clarke, Marshall, Ryff and Rosenthal (2001). Older adults that totaled 4,960 was assessed for the study. Twelve different levels were used to assess income, with a range of $5000. Less than $10,000 was the lowest category and more than $70,000 was the highest category. The study revealed the following: at 25,000, (45 percent); at $25,000-$35,000, (20 percent); at $35,000- $45,000 (13 percent); and at $45,000- $70,000 (11 percent). A linear regression model revealed that income was statistically significant with every one of the psychological well-being subscales. The study concluded that high income predicts high psychological wellbeing. However, income accounted for 10 percent variance on purpose in life subscale.

On education, a study was conducted by (Ryff et al., 1999) that focused on the impact of education on the various subscale of the psychological wellbeing. Data was assessed with Wisconsin Longitudinal Study. A total of 6,306 adults was the population for the study. Respondents completed an 18-itemed Likert Scale on Psychological well-being, demographic data and other instrument that related to the study. The study revealed that high scores on psychological wellbeing predicted higher number of years of education.

A related study was conducted by Clarke et al. (2001) that evaluated the impact of education on all subscales of psychological well-being. A sample of 4,960 was included in the study made up of Canadian seniors. Majority of respondents reported to have had at least 8 to 13 years of education. The findings made it known that years of education influenced significantly psychological

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wellbeing in six aspects except the aspect on self-acceptance. Again, education contributed 12 percent variance on the aspect of purpose in life in psychological wellbeing. Education, age and income together accounted 17 percent of variance in purpose of life scores.

A cross-sectional study was conducted by Soulsby and Bennett (2015) on the topic: "Marriage and psychological well-being: The role of social support". It was revealed that married couples reported high psychological well-being when they were compared to those who were not married. The findings showed that, widows and divorced individuals exhibited significantly lower psychological wellbeing compared to those who were not married at all. The study lacked statistical evidence that confirmed that perceived social support influenced the relationship between psychological well-being and marital status. From the data above, perceived social support had a significant influence on intimate partner relationship and the degree to which an individual was divorce and never married or widowed. That influenced the person's psychological well-being. However, lower levels of perceived social support indicated lower level of psychological well-being. That seemed to suggest that social support could be an intervention to mitigate the negative challenges of marital transition.

Research conducted by Dube (2022) in the Binga District of Zimbabwe focused on the harsh experiences that widows had while taking care of their children, as well as the crucial factors that social workers in practice needed to take into mind. The study was qualitative, specifically adopting phenomenological design. In all, 24 widows were involved in the study with 10 being interviewed individually while 14 were in a group interview. Thematic analysis was employed for the analysis of data. The results demonstrated that

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widows are unable to provide for their children's physiological, psychological, socioeconomic, and educational needs because of their diminished financial resources.

Holm, Berland and Severinsson (2019) explored the factors that impact on the general wellbeing of older widows and widowers. The study was a systematic review of literature from sources such as "Academic Search Elite", "CINAHL", "Medline (Ovid)" and "PubMed". The results showed among other things that the socio-economic background of widows was associated with their general psychological wellbeing.

Further, Hendrickson et al. (2017) explored widows' experiences in Nepal with particular focus on their resiliency. The study was qualitative with interviews conducted and thematic analysis conducted after. It was revealed that widows were more resilient because of the assets they possessed and the support networks they had. This means that socio-economic status of widows influenced their psychological wellbeing.

Bhowmik et al., (2020) analysed the socio-economic status of widows in the Jhenidah district and how this affected widows' livelihood in Society. Data were gathered using questionnaire and it was found that widows suffer from multiple social problems and restrictions. Also, widows experienced psychological problems because of their poor socio-economic background and this affected their ability to cope and be resilient in their widowhood period.

In Ghana, a survey was conducted on 450 women on gender and socio-economic growth. Empirical analyses showed that gender impacted the business environment in Ghana. The survey revealed that 32% of the respondents felt that being a woman made no difference in conducting business in Ghana and that

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21% of the respondents felt their experience as businesswomen was positive with 22% respondents experienced negative feelings. The study further revealed that 57% respondents felt it was more challenging as women combined business and family commitments. Again 33% felt that due to corruption and bureaucratic processes with regards to formal credit, women felt disadvantaged (Agboli, 2007).

Chapter Summary

The literature reviewed confirmed the need to make counselling services accessible to all widows in our communities especially widows in the Ebenezer Methodist Society, Prampram of the Methodist Church Ghana. That would fasten the rate for the widows to be adequately integrated into Society so they would make the best out of life. Widows had specific needs that must be addressed. The study on impact Solution Focused Brief Therapy was initiated that facilitated the reaching out to the population who endured many forms of maltreatment from Society and still remained underserved.

Furthermore, study on impact of Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows would further enhance Solution Focused Brief Therapy use to improve their psychological well-being and resiliency attitudes.

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CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter presents the procedures used in the conduct of this research. The chapter covers the research design, population, sample and sampling procedure, instrument, data collection procedure, and data processing and data analysis.

Research Design

According to Burns and Grove (2003), research design may be thought of as a plan for carrying out an investigation in a manner that allows for a greater degree of control over the factors that could potentially affect the validity of the findings. The current study employed the quasi-experimental design. The design was suitable in this study because as defined by Creswell (2014), "quasi-experimental design determines if the outcome of a specific study was influenced by the treatment" (p. 13). However, quasi-experimental design is different from true experiments because it lacks random assignment.

Specifically, the non-equivalent pre-test, post-test quasi-experimental design was adopted for the current study. The pretest-posttest nonequivalent control group design describes the situation where data is collected and analyzed for both experimental and control groups before the intervention is introduced. Then after introducing the intervention to the participants in the treatment group, another data was collected and analyzed from both the treatment group and control to observe if any significant difference existed between the two groups

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was as result of the intervention or otherwise. The adoption of a pretest and a posttest in this non-equivalent control group design allowed the researcher to make comparison between the treatment group and the control group because of the presence of a baseline pretest score.

Experiments carried out in natural settings, as opposed to those conducted in labs where every variable can be precisely controlled, do not face the limitations associated with artificiality because threats to external validity are minimized. Therefore, findings from quasi-experiments can be applied to other settings, subjects and situations due to the natural nature of experiments (Shuttleworth, 2008). This was an advantage of the quasi-experimental design.

Participants involved in this type of quasi-experimental research are grouped into two, with one group being the treatment group and the other being the control group. Individuals in the treatment group are those who have encountered the independent variable of interest whilst the control group are those who have not had any encounter with the independent variable. In the current study, the treatment group would be treated using the solution-focused brief therapy while the control group would receive no treatment.

For the study the treatment intervention was Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows. During the orientation period widows' psychological well-being and resiliency attitudes were assessed prior to intervention with therapy. The widows were already pre-determined because random assignment of subjects to groups was not possible (Ross & Morrison, 2003).

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The design for the study is depicted below:

EG	01	X	02
CG	03	-	04

Figure 3: Design for study

It can be seen in Figure 3 that both the experimental group (EG) and control group (CG) were pre-tested (01 and 03) respectively. After this, the experimental group received the intervention (X) which was the Solution Focused Brief Therapy. After the intervention, both groups were post-tested (02 and 04).

Study Area

According to Justesen, (2005) the name Great Ningo naturally followed the people wherever they went. The people preferred to be called "Nugoli" that meant "Nugo People" , a name that was locally accepted and pronounced Nugo as its been corrupted and pronounced Ningo. The life and history of the Chiefs and people of Nugo now Ningo was linked to the Ga-Dangme history. The District as the capital, made up the sixteen Districts of Greater Accra Region (Ghana Statistical Service, 2010).

The District shared boundary to the North with "Shai Osudoku District", East by "Ada West District", to the South by the "Gulf of Guinea" and West by "Kpone Katamanso District". With a total area of 622.2 square kilometers, the District according to the Ghana Statistical Service, the 2010 Population and Housing Census, estimated the population to be 70,923, with 33,514 males and 37,409 females that included children. The District boasted with 107 public schools- 32 Junior High Schools, 42 Primary, 2 Senior High School and 31

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Kindergarten and pre-schools. There were about 93 private educational institutions in the District (Ghana Statistical Service, 2010).

The District has 15 healthcare facilities. Five private and 10 public. Services provided included: Out Patient Department (OPD) cases, general consulting services, laboratory services, reproductive health, pharmacy, child and maternal health services. Critical cases were referred to Tema General Hospital, 15 kilometers drive from Prampram, the District capital Ghana Statistical Service (2010). With a largely rural population, the occupational distribution of the District was predominantly agricultural (Ghana Statistical Service, 2010).

Population

According to Baker (1999) and Majumdar (2005), population of a study comprised all the individual groups, cases, objects, items, articles or things that had common characteristics or attributes that existed over a period of time. All widows in Prampram formed the target population for this study. Target population is viewed as the population that researchers dwell on to generalize results whilst accessible population refers to the population that researchers practically choose for the study (Asamoah-Gyimah & Duodu, 2007).

The accessible population was 60 widows out of which 40 were included in the study. For inclusion in the study, widows were required to agree to be available for the study, signed a consent form, reside within the society, not re-married and had gone through widowhood rites. The population was justified on the basis of their connection to the issue that was found. In essence, at the period of the study, those widows met the inclusion criteria.

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Sample and Sampling Procedure

Sidhu (2002) stated that a sample is a small portion selected out of the entire population for observation and analyses. Sampling refers to the process involved in selecting individuals to be involved in a study (Burns & Grove, 2003). A sample size of 40 widows was used for the study. Krejcie and Morgan (1970) provided the guideline that the researcher used to select the sample size. According to Cohen, Manion and Morrison (2004), "there was no exact answer or cut off point for sample size determination, for a perfect sample size depended on the researcher's purpose, nature and availability of the population under scrutiny" (p. 93). The above-mentioned explanation for the sample size was presented in a clear and convincing manner in Krejcie and Morgan's writing (as cited in Cohen et al., 2004). In order to enhance the number of people that participated in the data collecting, I raised it from 40 to 60.

Each group comprised 20 widows. This means that there were 20 widows in the treatment group and 20 were in the control group. The widows in general were sampled using purposive sampling. Purposive sampling is based on the view that sampling is based on some already determined criteria. In this study, widows who had not remarried and had gone through widowhood rites were included in the study. The two groups were intact groups.

Data Collection Instruments

The study adopted the Outcome Questionnaire 45 (OQ 45). An instrument developed by the efforts of Lambert, Hansen, Umpress, Lunnen, Okiwashi, Burlingame, Huefner & Rewasinger (1996). Ryff's Psychological Well-Being Scales were also adopted. This research instrument was developed by Ryff in 2005. The study again adopted the Resiliency Attitudes Scale (RAS),

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developed by Biscoe and Harris in 1999. These instruments were used for the collection of data. The reason for the adoption of these instruments was that they have been widely used in many research works both locally and internationally. Thus, they helped in obtaining adequate information about resiliency and psychological wellbeing of widows.

Outcome Questionnaire 45 (OQ 45)

The Outcome Questionnaire (OQ 45) used for adult's behavioural treatment, was made up of 45 items structured on a 5-point Likert Scale that measured progress of the client in therapy and was repeatedly administered in course of treatment and also at termination. The Outcome Questionnaire was used to assess physical complaints and general functioning in the widows.

Client's progress was assessed on (a) symptom distress (clinical significance), (b) interpersonal relationships and (c) social role. Those areas monitored the client throughout the therapeutic process. They covered how clients felt within, how the client got along with significant others in their life and how the client executed important tasks in everyday life such as school, work, Church, community amongst others. Outcome Questionnaire was used in gross treatment assignments decisions during baseline screening. It also assessed mental health disorders and syndromes that were stress related (Lambert et al., 1996).

Psychometric Properties of Outcome Questionnaire (OQ 45)

Scores on the Outcome Questionnaire ranged from 0 to 180. Higher score indicated greater degrees of distress whilst lower score indicated lower degree of distress. A score of 64 and above represented a clinical population and score of 64 and below represented a non-clinical concern. On face validity,

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Outcome Questionnaire 45 (OQ 45) was consistent with interpersonal challenges in an employee assistance programme, inpatient and outpatient samples (Lambert et al., 1998). Internal consistency score was {r = .93}, an adequate three week test-retest reliability score was {r = .84} and a concurrent validity ranged from moderate to high {r = .50; r = .85}.

Outcome Questionnaire 45 (OQ 45) also correlated with General Severity Index, Symptom Checklist – 90-R and Beck Depression Inventory that assessed psychotherapeutic outcome (Lambert, Burlingame et al., 1996; Lambert, Hansen et al., 1996; Lambert et al., 1998). The instrument was responded to counselling related issues over short periods of time (Vermeersch, Lambert & Burlingame, 2000). In non-treated clients the OQ 45 was stable and was sensitive to change to clients who underwent psychotherapy (Lambert et al., 1998; Lambert, Thompson, Andrews, Kadera & Erikson, 1996).

Ryff's Psychological Well-Being Scale (1989)

The Psychological Well-Being Scale assessed positive functioning on a theoretically-based dimensions on a 42 item Likert Scale. The Ryff Scales of Psychological Well-Being is a theory-based tool useful in assessing psychological well-being. Its validity and reliability in measuring psychological wellbeing has been seen over the years. It can also shed light on a person's level of self-acceptance, goal-directedness, social connectedness, independence of thought and behaviour, competence in adapting to novel contexts, and capacity for further development (Seifert, 2005).

The subscale included a 14 item measures that covered: Autonomy, Purpose in life, Positive relations with others, Personal growth, Environmental mastery, and Self-acceptance. Clients responded to specific statement that best

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described how client felt and experienced. Those responses were rated on Likert Scale that ranged from (1) Strongly Disagree, (2) Moderately Disagree, (3) Disagree, (4) Weakly Agree, (5) Moderately Agree, (6) Strongly Agree. Some statements were reversely scored so that higher scores for all 42 statements indicated overall higher psychological well-being. Subscales ranged from 14 to 42 whilst the overall instruments ranged from 42 to 252.

Psychometric Properties of Ryff's Psychological Well-Being Scale

Ryff's Psychological Well-Being Scale had proven to be strong and its internal consistency ranged from 0.83-0.91. The coefficient for internal consistency for the subscales included: Autonomy {a = .83}; Purpose of life {a = .88}; Positive relations with others {a = .88}; Personal growth {a = .85}; Environmental mastery {a = .86} and Self-acceptance {a = .91}. Despite decreased in test item in consistent testing of constructs, subscales and the original 20-item subscale ranged from 0.97–0.99 when correlated with the 14-item. A test-retest coefficient of the 42-item scale ranged from .81-.88 for all subscales (Ryff, 1989). Psychological well-being scale was developed with a normative sample of 321 men and women. Total scores had been recorded as high, moderate and low (Keyes et al., 2002). Reliability coefficient for the overall 42-item scale was strong in previous study {a=.97} (Urry et al., 2004) as well as recent study {a=.89}.

Resiliency Attitudes Scale (RAS)

Wolin and Wolin (1993) efforts brought Resiliency Attitude Scales to being that assessed resiliencies. In their book titled "The Resilient Self" Wolin and Wolin developed items that tapped attitudes that reflected each of the seven resiliencies whilst working with clients. The items included: independence,

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insight, initiative, relationship, humour, creativity and morality. Persistence at managing through difficult situations with the belief that a person survived and made situation better was a subscale added and termed general resiliency (www.projectresiliency.com). Those subscales were further broken down into "skill" that constituted statements that tapped basic resiliency skills within each resiliency.

The RAS can be used to determine how far an individual has come in terms of acquiring the mental and behavioural skills necessary to maintain composure in the face of chaos and to recover from traumatic experiences with minimal impairment. In this regard, the RAS helps to ultimately identify how individuals come out of crisis situations with their wellbeing intact. Half of the statements were framed so that if an individual agreed with them indicated high resiliency, however the other half of the statements were reversed so that if an individual disagreed indicated low resiliency. The scales were also available in child, adolescent and adult version (Biscoe & Harris, 1999). The present study adopted the adult version of the Resiliency Attitudes Scales (RAS).

Psychometric Properties of Resiliency Attitude Scale

The instrument that consisted of 72-item statements that tapped attitudes that reflected every one of the seven components of resiliency that included: independence, insight, initiative, relationship, humor, creativity and morality (Wolin & Wolin, 1993). Individual responded to statements such as 1-Strongly disagree and 5-Strongly agree. Scores ranged from 72 to 360 where high scores indicated high resiliency and low scores indicated low resiliency. The instrument was divided further into skill subscales that constituted statements that tapped basic resiliency skills within each resiliency and demonstrated

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reliability and the coefficient for internal consistency was {r =.85} in repeated treatment settings (Biscoe & Harris, 1994).

Resiliency Attitude Scale correlated with self-esteem and depression. A study conducted from a treatment center in Oklahoma for women and their children on chemical dependency, sampled 107 females who completed the Resiliency Attitude Scale, Beck Depression Inventory (BDI) and Rosenberg Self Esteem Scale revealed that increased depression levels. Higher scores on Rosenberg Self Esteem indicated higher self-esteem. Resiliency scores had negative association with depression. In essence, females with high resiliency scores had low depression scores. That indicated that self –esteem correlated positively with resiliency.

Data Collection Procedure

The researcher received a letter from the Department of Guidance and Counselling, Faculty of Educational Foundations of the College of Education Studies, University of Cape Coast and presented to the Superintendent Minister-in-charge of Ebenezer Methodist Society, Prampram that sought permission to undertake the study in the Society. The permission was granted.

Ethical Consideration

The researcher received ethical clearance from the Institution Review Board. The study also considered:

Informed Consent- permission was sought from the respondent in writing to participate in the research having understood the risk involved.

Confidentiality- Respondents were assured that any data provided were solely for the purpose of research and academic work and would not be revealed to anyone without the respondent's approval.

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Freedom of Withdrawal- Respondents were assured of being at liberty to withdraw anytime from participating in the research, if they so wished. The instruments were administered by the researcher with support from research assistants from the University of Cape Coast. These assistants were colleagues MPhil students. We used six weeks for the gathering of the data. The purposive sampling technique was used to assign widows into treatment and control groups. The treatment modalities for the research followed in the Table 2:

Table 2-*Treatment Modalities*

Treatment Modalities			Control Group (4 Weeks)	
Session	**Action**	Time	Materials	Remarks
1	Group orientation, what, when, who, what, where about the study. Setting ground rules	1 hour	Confidentiality Consent participation OQ-45 Ryff's Scale Resiliency Attitudes Scale	No Treatment
2	Completion of forms	1 hour	OQ-45	No Treatment
3	Completion of forms /Post-Test	1 hour	Ryff's Scale Resiliency Attitudes Scale	
Treatment Group				
1	Group orientation, what, when, who, what, where about the study. Setting ground rules	1-2 hours	Confidentiality Consent participation OQ-45 Ryff's Scale Resiliency Attitudes Scale	
2	Group Counselling	1 hour	Semi-structured interview relating to psychosocial history- Demographic, Education, Occupation among others.	Solution focused brief therapy treatment
3	Group Counselling	1 hour	Solution focused brief therapy Experience	Solution focused brief therapy treatment
4	Group Counselling	1 hour	Solution focused brief therapy Experience	Solution focused brief therapy treatment
5	Group Counselling / Preparation for termination	1 hour	Participants sharing Solution focused brief therapy Experience	Solution focused brief therapy treatment
6	Debriefing/Finalizing the study and to complete forms	2 hours	OQ-45 Ryff's Scale Resiliency Attitudes Scale Control group	Termination

The treatment activities for the experimental group are described below:

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Session 1: Group Orientation

In the first session, the researcher dealt mainly with group orientation. The researcher made the participants aware of what would be done within the group and discussed with them to set some ground rules. In this session, the group members were informed to keep everything discussed confidential. The participants also gave their consent in this first session. After this, the participants were given the instruments in the study to respond to. They responded to the OQ-45, Ryff's Scale and Resiliency Attitudes Scale.

Session 2: Group Counselling

The second session began the actual treatment process for the participants in the treatment group. In the first place, semi-structured interview was conducted for the participants relating to their psychosocial history. This interview was to help guide the treatment process.

After the interview, the next thing that was done in the treatment group was to set goals for the counselling process. These goals were set by clients and involved eliciting what the clients wanted to be different in the future to live a productive life (Lee, Adriana & Seebold, 2003). Solution focused brief therapist hold the view that a client's goals are central in the therapeutic process because goals direct the course of successful therapeutic outcomes (Rhodes & Ajmal, 1995). The goal formulation set the tone for the treatment procedure using solution focused brief therapy.

The main goals which were set were that at the end of group counselling sessions, psychological wellbeing and resiliency of widows would have improved. After the goals were set, the participants together with the researcher discussed how to achieve the goal. One technique that was used by the

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researcher was asking the miracle question. The researcher asked the participants to imagine how they would feel if they woke up and all their issues were gone. It was in question form like: What would be different in your life that would let you know that a miracle had taken place in your life?

After the miracle question, the researcher tasked participants with some homework. This was put in the form like: Before our next meeting what could you be doing to improve your situation? What each participant indicated was given as the homework. The researcher then summarized the entire session and ended the session.

Session 3: Group Counselling

The third session began with a recap of the second session. After the recap, the researcher asked for the feedback of the homework given in the second session. From the feedback, it was realized that most of the participants took steps in resolving some of their issues. The homework that the participants engaged in included opening up to friends, reaching out to children and other family members instead of keeping to themselves. These tasks offered client's hope about their situations.

After checking on the homework, the researcher engaged the participants in the activity for the third session. In the third session, the researcher mostly focused on the individual problems that participants had which affected their psychological wellbeing and resiliency. This was done mostly through the use of the scaling question. Scaling question as a technique in Solution Focused Brief Therapy involves asking the client to rate some aspects of their lives on a scale that ranged from 0- worst state of the situation to 10- the situation was no more as a way that measure clients' perception of their lives.

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Through the scaling questions, the issues with participants were identified and they were encouraged to work hard towards dealing with the issues. Scaling question bridges the gap between where clients are and where they hoped to be in the future.

Session 4: Group Counselling

In the fourth session, the researcher began by doing a revision of the previous session. After this, the researcher also examined the progress that the participants have made since the last session. This mainly involved going through the scaling questions to find out what progress still needs to be made in improving the psychological wellbeing and resiliency of the widows.

The fourth session also focused on the use of coping questions. The researcher engaged the participants in questions such as: "How have you coped and managed so far?" and "What could you possibly be doing to move you up on the scale?" Those questions enabled clients to master and develop inner resources and strengths as well as develop positive solutions (De Jung & Berg, 2008). All of these contributed to improvement in the psychological wellbeing and resiliency of widows.

Session 5: Group Counselling/Preparation for Termination

This session was the last but one session. In this session, the researcher recapped the previous sessions. The participants were also asked to share their experiences through the previous sessions. This helped to highlight all the important issues discussed in the group counselling sessions. After the experiences, any other issues were addressed and participants were prepared for the end of the intervention.

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Session 6: Debriefing

This session was the final session. In the final session, the participants were provided with all the details of the study which they were not exposed to from the start of the treatment. The process of debriefing enabled the researcher to clarify and provide answers to any questions that the participants had. After this, the post-test data was collected from the participants using the instruments OQ-45, Ryff's Scale and Resiliency Attitudes Scale.

Data Processing and Analysis

According to Patton (1990), the analyses of empirical data helped to reduce the volume of information, identify patterns that were significant, made sense of large volumes of data and constructed a structure that communicated the meaning of what the data revealed. After the widows have completed the questionnaires, I sorted, coded, and entered the data into the Statistical Package for Services Solutions for analyses. Hypotheses 1 and 2 were tested using independent samples t-test at 0.05 level of significance. That statistical tool was appropriate because it gave information on whether Solution-focused brief therapy impacted on psychological well-being and resiliency attitudes of widows. Hypotheses 3 and 4 were tested using One Way Analysis of Variance (ANOVA). The use of ANOVA was because it helped in comparing the impact of the treatment on the dependent variable among more than two groups.

Hypotheses 5 and 6 were tested using Pearson Product Moment Correlation. This is because the hypotheses were focused on finding out the relationships that exist between variables.

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Chapter Summary

The Chapter 4 reviewed the Research Design, Study Area, population used for the study, Sample and Sampling Procedures. Other areas reviewed included the Data Collection Instrument thus: Outcome Questionnaire (OQ 45) Ryff's Psychological Well-Being Scale and Resiliency Attitude Scale and Data Processing and Analysis. Also featured in Chapter 3 was participants taken through Group Counselling.

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CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

This chapter presents the results of the study along with discussions. The main purpose of the study was to investigate impact of Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region. Six hypotheses were formulated and tested in this study.

Results

Research Hypothesis One

H_0: There is no significant difference between the psychological well-being of widows in the treatment group and the control group.

H_A: There is a significant difference between the psychological well-being of widows in the treatment group and the control group.

In the first hypothesis, the researcher was interested in finding out whether a statistically significant difference existed between the psychological well-being of widows in the treatment and control groups. To test this hypothesis, the Independent sample t-test was used. This was used because the researcher wanted to find out whether there was a statistically significant difference between the psychological wellbeing of the participants in the experimental and control groups. This invariably involved the comparison of the two groups.

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to establish the difference between the experimental group and the control group with respect to psychological well-being of widows.

Table 4-*Results of Independent Samples T-test of significant difference in the Psychological Wellbeing of Widows in Experimental Group and Control Group*

Group	Mean	SD	t-value	df	p-value
Experimental	19.90	2.234	0.902	38	0.002*
Control	9.55	4.196			

Source: Field Data (2020) *Significant, p<.05

The results in Table 4 show a statistically significant difference between the psychological wellbeing of widows in the experimental and control groups. The experimental groups recorded a results of M = 19.90, SD = 2.234 and control group produced a results of M= 09.55, SD = 4.196. The differences in the mean scores were significant at t (df=38) =.902; Sig.=.0002*, $p < .05$, 2-tailed). Based on this result, the null hypothesis, that is there is no significant difference between the psychological well-being of widows in the treatment group and the control group is rejected. The results imply that the Solution Focused Brief Therapy was very effective in adjusting and treating the psychological well-being of widows.

Research Hypothesis Two

H_0: There is no significant difference between the resiliency attitudes of widows in the treatment group and the control group.

H_A: There is a significant difference between the resiliency attitudes of widows in the treatment group and the control group.

In hypothesis two, the researcher was interested in finding out whether a statistically significant difference existed between the resiliency attitudes of

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gives the indication that equality can be assumed for the variances. Table 6 shows the results of the independent samples t-test seeking to establish the difference between the resiliency attitudes of widows between the treatment group and the control group.

Table 6-*Results of Independent Samples T-test of Significant Difference in the Resiliency Attitudes of Widows in the Experimental and Control Groups*

Group	Mean	SD	t-value	Df	p-value
Experimental	20.01	1.738	0.952	38	0.000*
Control	11.55	3.160			

Source: Field Data (2020) *Significant, p<.05

The results show that there is statistically significant difference with the experimental and the control group. The experimental groups recorded a results of (M = 20.01, SD = 1.738 and control groups indicated a results of M= 11.55, SD = 3.160 both with a t-value of t (df=38) =.952; Sig.=.000*, $p < .05$, 2-tailed). The results basically imply that the Solution Focused Brief Therapy was very effective in adjusting and treating the resiliency attitudes of the widows. Based on the results, the null hypothesis that is there is no significant difference between the resiliency attitudes of widows in the treatment group and the control group is rejected.

Research Hypothesis Three

H_0: There is no significant difference between the psychological well-being of widows in the treatment group and the control group on account of years of widowhood.

H_A: There is a significant difference between the psychological well-being of widows in the treatment group and the control group on account of years of widowhood.

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In hypothesis three, the researcher sought to identify whether a significant difference existed between the psychological well-being of widows in the treatment group and the control group on account of years of widowhood. The years of widowhood were categorized using intervals of 3 years. Therefore, the ranges included 0-3 years, 4-6 years, 7-10 years, and 11 years and above. In the analysis, one-way between-groups multivariate analysis of variance (MANOVA) was employed. Prior to conducting the MANOVA test, certain statistical assumptions were estimated. In conducting MANOVA, it beholds that some assumptions be met. Firstly, the Multivariate Central Limit Theorem argues that if the samples are large enough (at least 20 items for each dependent independent variable combination), then the theorem holds and that MANOVA can be carried out.

Further in using one-way between-groups multivariate analysis of variance (MANOVA), it is stated that sample should be random and independent, the dependent variable should be on interval scale, normally distributed and equality of variances established. These were all verified using normality assumption (Kolmogorov-Smirnov[a] and Q-Q Plot), and test for homogeneity of variance. Table 7 shows the test for the assumptions.

Table 7-*Normality Test Results of the Variables (Psychological Well-Being)*

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
Age Ranges	Statistic	Df	Sig. value	Statistic	Df	Sig. value
0-3 years	.468	12	.606	.342	12	.612
4-6 years	.297	18	.492	.405	18	.832
7-10 years	.201	08	.242	.743	08	.923
11 years and above	.293	02	.970	.791	02	.375

Source: Field Data (2020) *Significant P<0.05.

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It is also established in the histogram that normality and linearity of the data can be confirmed. This therefore, means that conducting dependent sample t-test was justified and statistically reasonable.

Table 8-*Levene's Test of Equality of Error Variance Among the Years in Widowhood*

Levene's Test of Equality of Error Variances[a]					
		Levene Statistic	df1	df2	Sig.
Treatment	Based on Mean	.305	1	38	.556
	Based on Median	.00	1	38	.852
	Based on Median and with adjusted df	.076	1	37.948	.854
	Based on trimmed mean	.670	1	38	.565
Control	Based on Mean	4.498	1	38	.152
	Based on Median	1.979	1	38	.279
	Based on Median and with adjusted df	1.089	1	4.595	.253
	Based on trimmed mean	3.610	1	38	.445

Source: Field Survey (2020)

From the Levene's test of Equality of Error Variance Across years in widowhood in Table 8, it can be seen that equality of variance was assumed across the years in widowhood of the widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region. This implies that Levene's Test of Equality of Error Variances[a] have not been violated F(df=1, df2=38)=.305, sig.=. 556).

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Table 9-*Multivariate Test of Difference Between the Psychological Well-being of Widows in the Treatment Group and the Control Group on Account of Years of Widowhood*

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.991	472.914[b]	2.00	38.00	.000*	.996
	Wilks' Lambda	.008	472.914[b]	2.00	38.00	.000*	.996
	Hotelling's Trace	108.547	472.914[b]	2.00	38.00	.000*	.996
	Roy's Largest Root	108.547	472.914[b]	2.00	38.00	.000*	.996
Years	Pillai's Trace	.180	.417[b]	2.00	38.00	.655	.180
	Wilks' Lambda	.880	.417[b]	2.00	38.00	.655	.180
	Hotelling's Trace	.186	.417[b]	2.00	38.00	.655	.180
	Roy's Largest Root	.186	.417[b]	2.00	38.00	.655	.180

a. Design: Intercept + Years in widowhood

b. Exact statistic

Source: Field Survey (2020) *Significant difference exist at $P<0.05$.

As shown in Table 9, reporting the Pillai's Trace test, it is observed that there is a significant multivariate effect, the between-subject effects were analysed to find out which of the years in widowhood showed psychological well-being of widows between the treatment group and the control group when Solution Focused Brief Therapy is used. The Levene's test of equality of variance (Table 9) indicated the years in widowhood were significant F (df1=2.00, df2=38.00) =472.914[b], sig.=.000, $\eta^2 = .996$).

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Table 10-*Test of Between-Subject Effects Psychological Well-Being of Widows Between the Treatment Group and the Control Group in Terms of Years of Widowhood*

Tests of Between-Subjects Effects							
Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Treatment	.200[a]	1	.100	.054	.000	.009
	Control	20.000[b]	1	10.000	1.325	.289	.149
Intercept	Treatment	2188.100	1	1188.100	642.216	.000	.988
	Control	2299.600	1	1299.600	172.132	.000	.956
Years in widowhood	Treatment	.200	1	.100	.054	.000	.009
	Control	20.000	1	10.000	1.325	.289	.142
Error	Treatment	24.800	38	1.850			
	Control	70.400	38	7.550			
Total	Treatment	2203.000	40				
	Control	2370.000	40				
Corrected Total	Treatment	24.900	20				
	Control	80.400	20				

a. R Squared = .008 (Adjusted R Squared =.118)

b. R Squared = .152 (Adjusted R Squared=.035)

Source: Field Survey (2020) *Significant difference exist at $P<0.05$.

Table 10 shows results on between-subject effects psychological well-being of widows between the treatment group and the control group in terms of years of widowhood. From Table 10, significant difference was observed between years of widowhood of the widows with respect to treatment group and the control group in terms of years of widowhood solution focused brief therapy. For example, Treatment group produced a significant results of F (df1=1, df2=8) =.054, p = . 000, $\eta^2 = .009$; while control group also produced an insignificant result of F (2, 10) = 1.325, p =. 289, $\eta^2 = .149$). The results gives ample evidence to settle that years

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of widowhood psychological well-being can be adjusted with the help of solution focused brief therapy. This therefore means I need to reject the null hypothesis that "There was no significant difference that existed on psychological well-being of widows between the treatment group and the control group in terms of years of widowhood and accept the alternate hypothesis that there was a significant difference that existed on psychological well-being of widows between the treatment group and the control group in terms of years of widowhood.

Research Hypothesis Four

H_0: There is no significant difference between the resiliency attitudes of widows the treatment group and the control group on account of years of widowhood.

H_A: There is a significant difference between the resiliency attitudes of widows in the treatment group and the control group on account of years of widowhood.

In hypothesis four, the researcher examined the significant difference between the resiliency attitudes of widows in the treatment group and the control group on account of years of widowhood. The years of widowhood were categorized to include 0-3 years, 4-6 years, 7-10 years, and 11 years and above. To test the hypothesis, one-way between-groups multivariate analysis of variance (MANOVA) was used. Prior to conducting the MANOVA test, certain statistical assumptions were estimated. In conducting MANOVA, there is the need to meet some assumptions. In the first place, the Multivariate Central Limit Theorem argues that if the samples are large enough (at least 20 items for each dependent independent variable combination), then the theorem holds and that MANOVA can be carried out. In testing for these assumptions, Kolmogorov-Smirnov[a] and Q-Q Plot as well as Levene's test for homogeneity of variance were used. Table 11 shows the normality results.

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Table 11-*Normality Test Results of the Variables (Resiliency Attitudes)*

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
Age Ranges	Statistic	Df	Sig. value	Statistic	Df	Sig. value
0-3 years	.448	12	.736	.342	12	.354
4-6 years	.497	18	.342	.935	18	.332
7-10 years	.505	08	.442	.335	08	.523
11 years and above	.493	02	.975	.381	02	.275

Source: Field Data (2020)

Table 11 presents results of the normality of the data of resiliency attitudes of widows between the treatment group and the control group in terms of years of widowhood. The Kolmogorov-Smirnov[a] was reported because it handles data with less sample size (N< 50). The Kolmogorov-Smirnov[a] produced a statistic of (Kolmogorov-Smirnov[a], t= .448, n=12, p>0.05, Sig. =.736) for the 0-3 years, Kolmogorov-Smirnov[a], t=.497, n=18, p>.05, Sig. =.342) for the widows within 4-6 years and (Kolmogorov-Smirnov[a], t=.493, n=02, p>.05, Sig. =.975) for the widows who have been in widowhood for 11 years and above. After the normality test, it was appropriate to run the one-way between-groups MANOVA test.

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Table 12-*Levene's Test of Equality of Error Variance Among the Years (Resiliency Attitudes)*

Levene's Test of Equality of Error Variances[a]					
		Levene Statistic	df1	df2	Sig.
Treatment	Based on Mean	.405	1	38	.536
	Based on Median	.00	1	38	.852
	Based on Median and with adjusted df	.075	1	37.948	.859
	Based on trimmed mean	.675	1	38	.565
Control	Based on Mean	3.498	1	38	.452
	Based on Median	1.479	1	38	.579
	Based on Median and with adjusted df	1.089	1	4.595	.259
	Based on trimmed mean	3.210	1	38	.475

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Years in widowhood (Resiliency Attitudes)

Source: Field Survey (2020) *Significant difference exist at P<0.05

From the Levene's test of Equality of Error Variance Across years in widowhood with respect to their resiliency attitudes in Table 12, the results show that a significant multivariate effect, the between-subject effects were analyzed to find out which of the years in widowhood indicating that there is a significant effect of the Resiliency Attitudes of widows between the treatment group and the control group. The Levene's test of equality of variance (Table 12) indicated that all showed equality of variance across the year in widowhood of the widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region. This implies that Levene's Test of

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Equality of Error Variances[a] have not been violated F(df=1, df2=38)=.405, sig.=. 536, p>0.05, 2-tailed).

Table 13-*Multivariate Test of Effect of Differences Between Resiliency Attitudes of Widows in the Treatment Group and the Control Group on Account of Years of Widowhood*

Multivariate Tests[a]							
Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.951	4745.914[b]	2.00	38.00	.000	.946
	Wilks' Lambda	.005	574.914[b]	2.00	38.00	.000	.946
	Hotelling's Trace	128.547	473.914[b]	2.00	38.00	.000	.946
	Roy's Largest Root	138.547	472.914[b]	2.00	38.00	.000	.946
Years	Pillai's Trace	.180	.417[b]	2.00	38.00	.655	.140
	Wilks' Lambda	.880	.417[b]	2.00	38.00	.655	.140
	Hotelling's Trace	.186	.417[b]	2.00	38.00	.655	.140
	Roy's Largest Root	.186	.417[b]	2.00	38.00	.655	.140

a. Design: Intercept + Years in widowhood (Resiliency Attitudes)

b. Exact statistic

Source: Field Survey (2020) *Significant difference exist at P<0.05.

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As shown in Table 13, reporting the Pillai's Trace test, it is observed significant multivariate effect, the between-subject effects were analyzed to find out which of the years in widowhood showed Resiliency Attitudes of widows between the treatment group and the control group when Solution Focused Brief Therapy is used. The Levene's test of equality of variance (Table 14) indicated the years in widowhood were significant F (df1=2.00, df2=38.00) =4745.914[b], sig.=.000, $\eta^2 = .946$).

Table 14-*Test of Between-Subject Effects Resiliency Attitudes of Widows Between the Treatment Group and the Control Group in Terms of Years of Widowhood*

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Treatment	.203[a]	1	.100	.082	.004	.000
	Control	20.023[b]	1	11.000	1.425	.289	.234
Intercept	Treatment	3188.100	1	2188.100	642.216	.000	.934
	Control	3299.600	1	1299.600	172.132	.004	.456
Years in widowhood	Treatment	.203	1	.100	.084	.908	.098
	Control	20.300	1	10.001	1.325	.654	.132
Error	Treatment	25.800	38	1.850			
	Control	72.400	38	7.550			
Total	Treatment	2203.000	40				
	Control	2370.000	40				
Corrected Total	Treatment	24.900	20				
	Control	80.400	20				

a. R Squared = .006 (Adjusted R Squared =.198)

b. R Squared = .162 (Adjusted R Squared=.055)

Source: Field Survey (2020) *Significant difference exist at P<0.05.

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Table 14 shows results of between-subject effects of Resiliency Attitudes of widows between the treatment group and the control group in terms of years of widowhood. From Table 14, the results show that there was significant difference between years of widowhood of the widows with respect treatment group and the control group in terms of years of widowhood Solution focused brief therapy. For example, Treatment group produced a significant results of F (df1=1, df2=8) =.082, p = . 000, η^2 = .000; while control also produced an insignificant results of F (2, 10) = 1.425, p =. 289, η^2 = .234). The results gives ample evidence to settle that years of widowhood psychological well-being can be adjusted with the help of Solution focused brief therapy. This implies that the null hypothesis that there is no significant difference between the resiliency attitudes of widows the treatment group and the control group on account of years of widowhood is rejected.

Research Hypothesis Five

H_0: There is no relationship between the socio-economic status and psychological well-being of widows in the treatment group and the control group.

H_A: There is a relationship between the socio-economic status and psychological well-being of widows in the treatment group and the control group

In research hypothesis five, the researcher aimed to find out if a relationship existed between the socio-economic status and psychological well-being of widows in the treatment group and the control group**.** In testing this hypothesis, Pearson Product Moment Correlation Co-efficient (PPMCC) was used for the analysis. Pearson Product Moment Correlation Co-efficient (PPMCC) was used based on the assumption that each variable was continuous.

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The results in Table 15 show that socio-economic status and psychological well-being of widows, the results depicted a significant positive correlation between the two variables (socio-economic status and psychological well-being of widows). The results is reported as (r = .902**, sig. =.000** $p < .01$, n=40, 2-tailed). The two variables share a variance of .902 (90%). The results infer the relationship between two variables is very strong and this practically means that the socio-economic status has a relationship with psychological well-being of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.

On the basis of the results, the researcher rejects the null hypothesis that "there was no relationship on socio-economic status and resiliency attitudes of widows between the treatment group and the control group and accept the alternate hypothesis that "there was a relationship on socio-economic status and resiliency attitudes of widows between"

Research Hypothesis Six

H_0: There is no relationship between the socio-economic status and resiliency attitudes of widows in the treatment group and the control group.

H_A: There is a relationship between the socio-economic status and resiliency attitudes of widows in the treatment group and the control group.

In research hypothesis six, the relationship between socio-economic status and resiliency attitudes of widows in the treatment group and the control group was tested. In testing this hypothesis, Pearson Product Moment Correlation Co-efficient (PPMCC) was used for the analysis. Pearson Product Moment Correlation Co-efficient (PPMCC) was used based on the assumption that each variable was continuous.

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The Figure 16 show that the results on socio-economic status and resiliency attitudes of widows. The results show that most of the bars are divided equally which approves that the data was assumed normal and as such Pearson Product Moment Correlation Co-efficient (PPMCC) could be performed. Table 16 presents the correlation coefficients between the variables.

Table 16-*Results on the Relationship Between Socio-Economic Status and Psychological Well-being of Widows*

Correlations			
		Socio-Economic Status	Resiliency Attitudes
Socio-Economic Status	Pearson Correlation	1	.823
	Sig. (2-tailed)		.000*
	N	40	40
Resiliency Attitudes	Pearson Correlation	.823	1
	Sig. (2-tailed)	.000*	
	N	40	40

**. Correlation is significant at the 0.01 level (2-tailed)

Source: Field Data, 2020

The results in Table 16 show that socio-economic status and resiliency attitudes of widows, the results depicted a significant positive correlation between the two variables (socio-economic status and resiliency attitudes of widows between the treatment group and the control group). The results is reported as (r = .823**, sig. =.000** $p < .01$, n=40, 2-tailed). The two variables share a variance of .823 (82%). The results infer the relationship between two variables is very strong and this essentially means that the socio-economic status

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could influence or predict Resiliency Attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.

Discussion

Difference in Psychological Well-being of Widows Exposed to Solution Focused Brief Therapy (SFBT) and those Without Exposure to SFBT

The study found that there was a statistically significant difference between the psychological wellbeing of widows in the experimental and control groups. The null hypothesis that there is no significant difference between the psychological well-being of widows in the treatment group and the control group was rejected. The results gave the indication that the Solution Focused Brief Therapy was very effective in adjusting and treating the psychological well-being of widows.

From the results, it was clear that widows who received SFBT had improved psychological wellbeing. The results are in line with the findings of Tabatabaei and Bolghan-Abadi (2020) who examined the effectiveness of solution-focused group therapy and found that solution-focused therapy could significantly reduce generalized anxiety and improve psychological wellbeing. In this sense, the current study's findings confirmed existing literature.

Similarly, the findings of the current study support the findings of Wang et al. (2022) that people who were exposed to solution focused therapy had reduced emotional and depressive symptoms and improved psychological wellbeing. Also, Javid, Ahmadi, Mirzaei, and Atghaei (2019) explored the effectiveness of solution-focused group counseling (SFGC) in the promotion of mental health and wellbeing and revealed that solution-focused group

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counselling improved mental health and psychological wellbeing. This was confirmed in the current study.

Additionally, the findings of the current study give the indication that widows who do not receive any treatment (in this study SFBT) are likely to remain in a state where their psychological wellbeing is poor because of their loss. This confirmed the finding of Peña-Longobardo, Rodríguez-Sánchez and Oliva-Moreno (2021) who examined the health and wellbeing of widows and found that widows usually had poor health and wellbeing without any form of treatment or support. In this sense, widows who are not given any form of counselling treatment or support are likely to remain in poor psychological state.

The similarity observed among the findings of the various studies implies that solution focused therapy is effective in improving psychological wellbeing. This is more particular among widows who generally have reduced or poor psychological wellbeing without any intervention as noticed in the control group in the current study.

Difference in Resiliency Attitudes of Widows Exposed to SFBT and those Without Exposure to SFBT

The study revealed that there was a statistically significant difference with the experimental and the control group in their resiliency attitudes. The results basically imply that the Solution Focused Brief Therapy was very effective in adjusting and treating the resiliency attitudes of the widows. The null hypothesis that there is no significant difference between the resiliency attitudes of widows in the treatment group and the control group was rejected.

From the results, SFBT is effective in helping widows improve their resiliency attitudes. The results support the findings of Riley (2013) that women

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who reported high degrees of resiliency were mostly those who had received some form of counselling treatment or support. Riley added that the high degrees of resiliency in the women predicted primarily emotional stability, denial, coping skills, personality factors, positive reframing and planning.

Also, the findings support the findings of Ximena (2004) which showed that there was significant impact of therapy on resiliency attitudes and mental health status of the treatment group. Additionally, the findings support those of Abdollahi, Sadeghi, Roohafza, Tavakoli, Dadras, and Kouchakzadeh (2020) who found that solution-focused therapy made people more focused and strengthened for the future. This was the case for the widows in the treatment group in the current study. Thus, resiliency among widows is enhanced through the provision of solution focused counselling.

The similarities among the findings imply that resiliency among widows can be improved through the provision of solution focused brief therapy. This could mean that by receiving the therapy, widows can be equipped to recover quickly from the loss they experienced so that they can cope better and move on in life.

Difference in Psychological Well-being of Widows Exposed to SFBT and those Without Exposure to SFBT on Account of Years of Widowhood

The study showed that there was a significant difference between years of widowhood of the widows with respect to treatment group and the control group in terms of years of widowhood solution focused brief therapy. This meant that the null hypothesis that "There was no significant difference that existed on psychological well-being of widows between the treatment group and the control group in terms of years of widowhood" was rejected. This gives

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the indication that years of widowhood played a significant part in the effectiveness of SFBT in improving psychological wellbeing of widows.

The findings confirm the findings of Carr et al. (2020) who found that through therapy and other coping mechanisms, widows were able to reduce depression and improve their psychological wellbeing. Carr et al. (2020) added that this was a function of the years of widowhood. As the years passed by, psychological wellbeing was likely to be improved.

Additionally, the findings support that of Perkins and Lowman (2016) who used a cross-sectional representative sample of 9,615 adults aged 60 years or older from seven states in diverse regions of India examined the relationship between widowhood and psychological distress. Perkins and Lowman (2016) found that widowhood was associated with psychological distress especially for those who had been long term widows. Thus, the researchers concluded that duration of widowhood was significant in issues related to the psychological wellbeing of widows.

The evidence from the discussion gives the indication that widows who are exposed to treatment would have their psychological wellbeing impacted and the impact would vary on account on the years of widowhood. This has been confirmed by the findings of the current study and those of the other studies discussed.

Difference in Resiliency Attitudes of Widows Exposed to SFBT and those Without Exposure to SFBT on Account of Years of Widowhood

The results revealed that there was significant difference between years of widowhood of the widows with respect treatment group and the control group in terms of years of widowhood Solution focused brief therapy. Thus, years of

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widowhood psychological well-being can be adjusted with the help of Solution focused brief therapy. This implies that the null hypothesis that there is no significant difference between the resiliency attitudes of widows, the treatment group and the control group on account of years of widowhood was rejected.

From the results, it can be said that years of widowhood played significant part in the effectiveness of SFBT in improving resiliency attitudes of widows. The results confirm that of Kang and Ahn (2015) who examined the relationship of family and friends to the resiliency of older widows and revealed greater resiliency was possible in widowhood and that years of widowhood and age of widows were significant in the resiliency of widows.

Similarly, the findings support that of Bennett, Morselli, Spahni and Perrig-Chiello (2020) who examined the stability and adaptation to widowhood among women who lost their husbands and found that years of widowhood was significant in widows' ability to cope, adapt and stay resilient. Another study by Asadollahi, Karimpoor, Kaveh and Ghahremani (2022) found that there was a statistically significant increase in resiliency in the experimental group compared to the control group and that the increase was evident on account of the years of widowhood.

The findings discussed have all confirmed that years of widowhood was significant in the resiliency of widows mostly after being exposed to treatment. This means that years of widowhood cannot be ignored in improving the resiliency of widows.

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Relationship Between Socio-Economic Status and Psychological Wellbeing of Widows

The study found that there was a significant positive correlation between socio-economic status and psychological well-being of widows. It was shown that the relationship between two variables is very strong and this practically means that the socio-economic status has a strong relationship with psychological well-being of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region. The null hypothesis that "there was no relationship on socio-economic status and resiliency attitudes of widows between the treatment group and the control group" was rejected and the alternate hypothesis that "there was a relationship on socio-economic status and resiliency attitudes of widows "between" was accepted.

The relationship was a positive one which meant that as socio-economic status improved, psychological wellbeing was enhanced while a reduction in socio-economic status led to decline in psychological wellbeing. The results confirm the findings of several researchers. For example, Flores and Vega (1998); Guarnaccia (1997); Organwasta (2000) documented several factors that impacted women that ranged from economic status, psychological, sociological state and educational level of Mexican farm workers and their mental health status and well-being.

In a similar vein, Dube (2022) examined widows' painful experiences of caring for their children in Binga District in Zimbabwe and found that due to dwindling resource bases, widows are bound to fail to meet the physiological, psychosocial, economic and educational needs of their children. Dube added

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that a relationship exists between the socio-economic background of widows and their psychological wellbeing.

Additionally, the findings confirm the findings of Holm, Berland and Severinsson (2019) that the socio-economic background of widows was associated with their general psychological wellbeing. It can be seen from the findings discussed that socio-economic status of widows is related to their psychological wellbeing. This is likely to be due to the fact that when widows lose their husbands, usually, a part of the livelihoods is taken from them. This can sometimes make their lives difficult and thus worsening their psychological wellbeing.

Relationship Between Socio-Economic Status and Resiliency Attitudes of Widows

The study revealed that there was a significant positive correlation between socio-economic status and resiliency attitudes of widows between the treatment group and the control group. The results showed that the relationship between two variables was very strong and this essentially means that the socio-economic status could influence or predict Resiliency Attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.

The relationship was a positive relationship meaning that an increase in socio-economic status could lead to an improvement in resiliency attitudes while a decrease in socio-economic status could lead to a decline in resiliency attitudes. The results confirm that of Hendrickson et al. (2018) who explored widows' experiences in Nepal with particular focus on their resiliency and found that individual assets and social resources contributed to widows' resilient

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outcomes. This means that socio-economic status of widows influenced their psychological wellbeing.

In a similar vein, the results are in line with the results of Bhowmik, Hossain and Chowdury (2020) who found that widows experienced psychological problems because of their poor socio-economic background and this affected their ability to cope and be resilient in their widowhood period. The results of the current study and the others discussed are similar and give the indication that poor socio-economic background would affect widows negatively.

The results in connection with socio-economic status is realistic in the Ghanaian setting and particularly in Ningo Prampram. The reason was that, widows were denied right to own their deceased spouse property or properties that she struggled with the deceased to acquire. Particularly in Ghana and also common in other settings within Africa, a widow underwent some traditional practices as obligation towards her deceased husband. In other settings the widow remained in her home and allowed to cultivate land or got herself engaged in other economic activity to fend for herself and her children if any (Owen, 2001).

Chapter Summary

This chapter focused on the results and discussion of the study. Specifically, six hypotheses were tested. The results showed generally that psychological wellbeing and resiliency were different in the experimental and control groups. Specifically, the experimental group had improved psychological wellbeing than the control group. Also, psychological wellbeing and resiliency were impacted by the treatment on account of years of

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widowhood. Finally, socio-economic status had significant relationship with psychological wellbeing and resiliency of widows.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents an overview of the impact of Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region. Based on the findings, conclusions were drawn and recommendations were provided which enabled appropriate suggestions to be made for further research.

Overview

Reading previous works, it appears that, in Ghana and among most of the ethnic groups, death of husband gave license to the family of the deceased to forcibly or sometimes violently deprive the widow of all possessions she and her late husband had toiled and laboured for, leaving her and the children with nothing to survive on. Widowhood in many Ghanaian traditional communities represented “social death” on the path of the widow. Widows’ fate in such a case was not only that they had lost their husband, but that the provider of the family needs was no more and that further robbed them of their status as wife of the deceased. In some other traditional communities, widows were battered, that left social and psychological scars in their minds while some were subjects of social stigma and others were discriminated upon. Some of these assertions made the researcher to investigate the impact of Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows in Ebenezer

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Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.

The study specifically sought to determine whether there was a significant difference on psychological well-being of widows between the treatment group and the control group, investigate whether a significant difference existed on resiliency attitudes of widows' between the treatment group and the control group, investigate whether a significant difference existed on psychological well-being of widows between the treatment group and the control group in terms of years of widowhood, find whether there was a significant difference on resiliency attitudes of widows between the treatment group and the control group in terms of years of widowhood, determine whether there was a relationship on socio-economic status and psychological well-being of widows between the treatment group and the control group, investigate whether there was a relationship on socio-economic status and resiliency attitudes of widows between the treatment group and the control group.

To achieve this, the study was rooted in the quantitative research method. Data were collected using Outcome Questionnaire 45 (OQ 45). An instrument developed by the efforts of Lambert, Hansen, Umpress, Lunnen, Okiwashi, Burlingame, Huefner & Rewasinger (1996). Ryff's Psychological Well-Being Scales was adopted, developed by Ryff, 2005. The study again adopted Resiliency Attitudes Scale (RAS), developed by Biscoe and Harris (1999). A total of 40 widows were used for the study. Widows were assigned into a groups of (20) for treatment and (20) for control with a purposive sampling technique. The data were analysed using inferential statistics (Pearson Product Moment Correlation Coefficient-PPMCC, Independent sample t-test,

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one-way between-groups multivariate analysis of variance-MANOVA) and descriptive statistics (means, standard deviations, frequencies, and percentages). The research instruments were pre-tested to ensure, their reliability and validity.

Key Findings

The following findings emerged from the study.

1. From hypothesis one, the results show that there is statistically significant difference between the experimental and the control group. The experimental groups recorded a result of (M = 19.90, SD = 2.234 and control group produced a result of M= 09.55, SD = 4.196 both with a cal. t-value of t (df=38) =.902; Sig.=.0002*, $p < .05$, 2-tailed). The results practically imply that the Solution Focused Brief Therapy was very effective in adjusting and treating the psychological well-being of widows.
2. From hypothesis two, it was evident that there is statistically significant difference in the experimental and the control groups. The experimental groups recorded a results of (M = 20.01, SD = 1.738 and control group indicated a results of M= 11.55, SD = 3.160 both with a cal. t-value of t (df=38) =.952; Sig.=.000*, $p < .05$, 2-tailed). The results basically infer that the Solution Focused Brief Therapy was very effective in adjusting and treating the resiliency attitudes of the widows'.
3. From hypothesis three, the results gives ample evidence to settle that during years of widowhood psychological well-being can be adjusted with the help of Solution Focused Brief Therapy F (df1=1, df2=8) =.054, p = . 000, η^2 = .009; while control also produced a insignificant results of F (2, 10) = 1.325, p =. 289, η^2 = .149).

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4. In hypothesis four, the results show that there was significant difference between years of widowhood of the widows with respect treatment group and the control group in terms of years of widowhood Solution focused brief therapy. For example, Treatment group produced a significant results of *F* (df1=1, df2=8) =.082, *p* = . 000, η^2 = .000; while control also produced an insignificant results of *F* (2, 10) = 1.425, *p* =. 289, η^2 = .234). The results gives ample confirmation to settle that years of widowhood psychological well-being can be adjusted with the help of Solution focused brief therapy.
5. In hypothesis five, it was found that, there is a significant positive correlation between the two variables (socio-economic status and psychological well-being of widows). The results is reported as (*r* = .902**, sig. =.000** p < .01, n=40, 2-tailed). The two variables share a variance of .902 (90%). The results deduce the relationship between two variables is very strong and this practically means that the socio-economic status could influence or predict psychological well-being of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.
6. In hypothesis six, the results was reported as (*r* = .823**, sig. =.000** p < .01, n=40, 2-tailed). The two variables (socio-economic status and Resiliency Attitudes of widows) share a variance of .823 (82%). The results means the relationship between two variables is very strong and this essentially means that the socio-economic status could influence or predict Resiliency Attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region.

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Conclusions

The reasoning and remarks are made from the study. Results of independent t-test for comparing control and experimental and following up the scores of resiliency and psychological well-being of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region showed that the therapeutic effects of Solution Focused Brief Therapy on widows. Regarding the results it is observed that the solution-focused therapy has well changed the amount of resiliency in problem-solving dimension. Changes in such dimension could be related to the concentration of solution-focused therapy on creating solutions and methods which result in solving the individual's problem.

In fact, the solution-focused therapy has been designed in a way that the increase of individual's capabilities in the dimension of problem-solving has become justified and clear. The process of change in solution-focused therapy includes therapists-visitors cooperation for detecting, highlighting and increasing the exceptions in order to solve the problem. The fundamental criteria for solving the problem in solution-focused therapy consists of agreement of both therapist and the visitor in a language-based system that the problem has been solved or it has been considerably improved. One of the other results of this research is that the solution-focused therapy has well changed the amount of resiliency and psychological well-being in the dimension of the widow's life.

Also the results showed that the solution-focused therapy has well changed the amount of resiliency and psychological well-being in the field of social relationship and interpersonal competence. From the study, I can point to two main reasons of increasing the social relationship and interpersonal

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competence. The first reason is concentrating on the nature of solution-focused therapy. The second reason is concentrating on the features of group therapy. In explaining the solution-focused approach it could be said that individuals who previously used to think that their problems are complex and terrible, now participate in these sessions and they have hope and they figure out that they have the required abilities for solving their problems. By performing some of the techniques they would understand that they have the same amount of ability to have weak social relationships and also they have the same amount of ability to increase it.

Recommendations

Based on the findings obtained and the conclusions reached, the following counselling implications and recommendations are made:

For implication for counselling and recommendations, for widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region is the resiliency and psychological well-being to be managed, It recommend that widows in the Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region should be exposed to more adjustment strategies such as counselling, self-orientation, capacity building aside the ones that they know to help them overcome stressful moments and to adjust to resilience and psychological well-being. They are not used to counselling and they should be encouraged to go to professional licensed counsellors for counselling. This hopefully will improve their quality of life.

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Implications for Counselling

The findings of the study have implications for the practice of counselling. First and foremost, counselling of widows should be given pre-eminence in all Churches and should be paid the utmost attention. This means that those who provide counselling services to widows should not just be Ministers but should be those who are trained in the field of counselling so that they can provide the best of service. This is necessary since a successful reintegration of a widow back into her community can be determined by the counselling provided.

Secondly, areas treated in the widow's counselling should be such that they can address all the pertinent and current issues affecting widowhood rite. This can help ensure that widows who receive counselling are well prepared to integrate themselves into their communities to meet new challenges facing widows today. Finally, instead of counselling widows being a routine, Ministers who are trained to counsel widows could make widows aware that the benefits of counselling are immense and as such, it would be advantageous to them to commit fully throughout the period of the counselling.

Suggestions for Further Research

The study examined the impact of Solution Focused Brief Therapy on psychological well-being and resiliency attitudes of widows in Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region. Subsequent research efforts should be concentrated on:

1. A comparative study on the quality of life of widows and married women in relation to psychological well-being and resiliency attitudes in other Society

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or Church other than Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region could give a wider results

2. Further, determining the influence of other demographic variables such as income and social status among others, on the impact of the quality of life of widows of Ebenezer Methodist Society, Prampram, in the Ningo-Prampram District of Greater Accra Region could also be beneficial.

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APPENDICES

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APPENDIX A

Table for Determining Sample Size from a Given Population

N	*S*	*N*	*S*	*N*	*S*
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3500	346
85	70	440	205	4000	351
90	73	460	210	4500	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367

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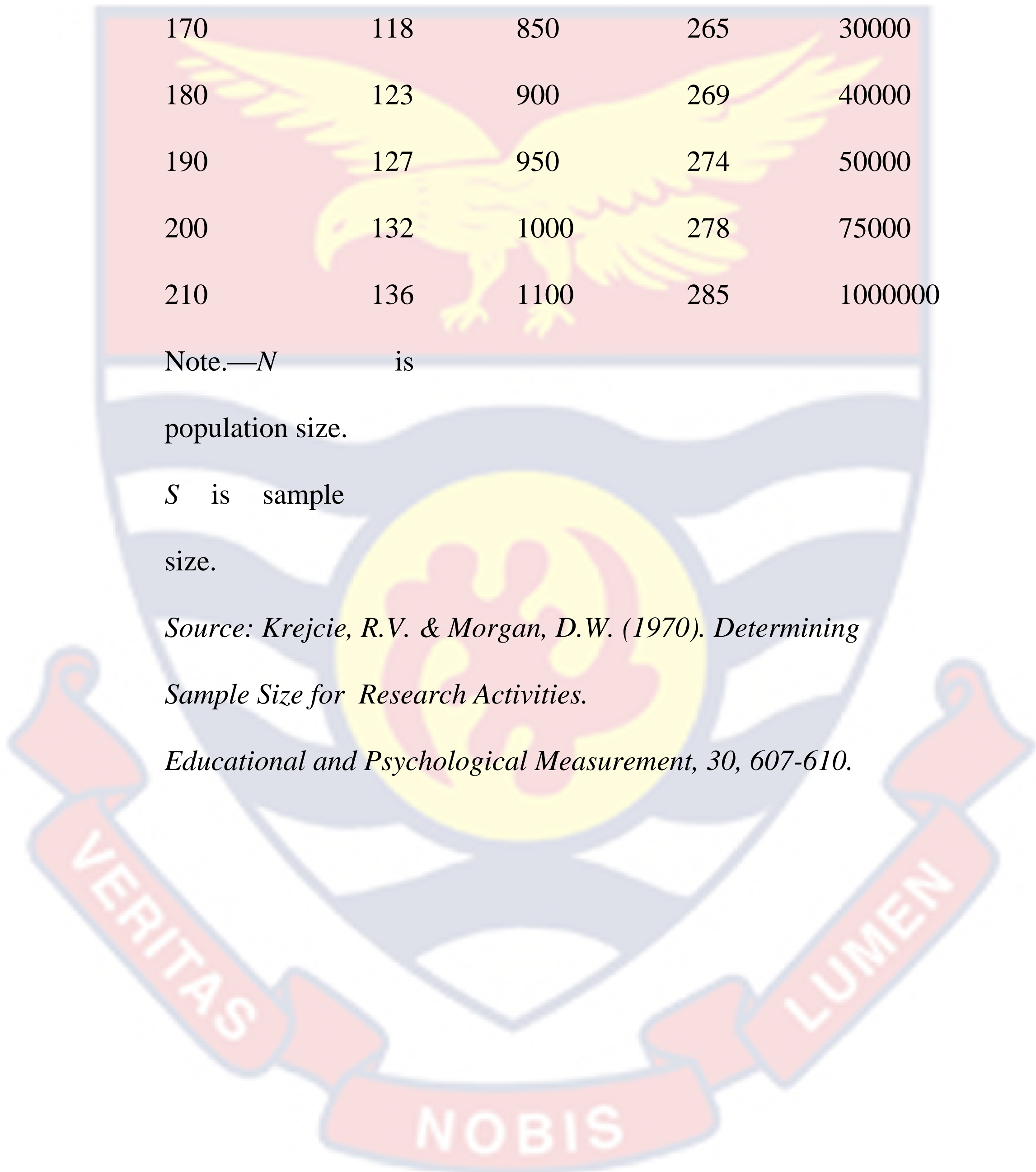
130	97	650	242	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379
180	123	900	269	40000	380
190	127	950	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	1000000	384



Note.—*N* is population size. *S* is sample size.

Source: Krejcie, R.V. & Morgan, D.W. (1970). Determining Sample Size for Research Activities. Educational and Psychological Measurement, 30, 607-610.

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APPENDIX B

INFORMED CONSENT FORM

UNIVERSITY OF CAPE COAST

June, 2019.

Dear Participant

DECLARATION OF CONSENT

I am an M.Phil Student of the Faculty of Educational Foundations, University of Cape Coast. As part of requirements for completing my course of study, I am undertaking a research on the Topic: **Impact of Solution Focused Brief Therapy on Psychological Well-Being and Resiliency Attitudes of Widows in the Methodist Church Ghana: A study of Ebenezer Methodist Society, Prampram**.

I would be grateful if you could respond to the various issues raised in the questionnaires attached. Please be assured that any information you will provide will be solely for the purpose of research and academic work and will be treated with utmost confidentially. Please tick only one answer except where you are directed to give more than one answer to a particular question. (No name(s) required) You are, however, free to decide whether to participate in this research exercise or not.

Kindly sign in the space provided below as an indication of your willingness and consent to participate in the research based on the information provided, and respond to the attached questionnaires.

Signature ………………… Date ……………………………

(Research Participant)

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APPENDIX C

UNIVERSITY OF CAPE COAST

DEPARTMENT OF GUIDANCE AND COUNSELLING

QUESTIONNAIRE

This questionnaire is intended to gather data which would be used for academic purposes in partial fulfillment for the award of Master of Philosophy (Guidance and Counselling), any information provided would be treated confidential.

Impact of Solution Focused Brief Therapy on Psychological Well-Being and Resiliency Attitudes of Widows in the Ebenezer Methodist Society, Prampram

Demographic Data

Please provide / tick {√} the appropriate answers where applicable

1. Age: ………………………years
2. Type of Marriage:

   Christian [ ] Customary [ ] Co-habitation [ ]

3. Number of Years of Marriage:…………………………
4. Age at Marriage: …………………………..
5. Position as Wife: ……………………………

   1st Wife [ ] 2nd Wife [ ] 3rd Wife [ ] 4th Wife [ ]

6. Number of Children before marriage: ……………………………....
7. Number of Children in Marriage: ……………….
8. Residence:

   Together [ ] Apart [ ] Other (Specify)……………………….

9. Place of residence:

   Own House [ ] Rented [ ] Family House [ ] Other (Specify)……..

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10. Number of years since spouse death? ……………………………………..

11. Staying with Children:

Together [ ] Apart [ ] Other (Specify)……………………….

12. Educational Level:

Basic [ ] Junior High School [ ] Senior High School [ ] O/ A Level [ ] Tertiary [ ] Other (Specify)……………….

13. Employment:

Employed [ ] Self Employed [ ] Unemployed [ ]

14. Which of the following do you use for medicinal or other purposes? (Tick As Many As Applicable)

Wee [ ] Cocaine [ ] Alcohol [ ] Tobacco [ ] Nicotine [ ] Heroine [ ]

Other (Specify)…………………………

15. What is your monthly salary?

GH¢ 100 - GH¢500 [ ] GH¢ 600- GH¢1000 [ ] GH¢ 1100 - GH¢1500 [ ] GH¢ 1600 - GH¢2000 [ ] GH¢ 2100 - GH¢2500 [ ] GH¢ 2600 - GH¢ 3000 [ ]

Other (Specify)…………………………

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APPENDIX

Outcome Questionnaire 45 (OQ 45) by Lambert, M., Hansen, N., Umpress, V., Lunnen, K., Okiishi, J., Burlingame, G., Huefner, J., & Reisinger, C. 1996

Please indicate your degree of agreement from Never, Rarely, Sometimes, Frequently or Almost Always (using a score ranging from 0-4) to the following sentences.

No.	Item	Never	Rarely	Sometimes	Frequently	Almost Always
1.	I get along well with others.	[ ]	[ ]	[ ]	[ ]	[ ]
2.	I tire quickly.	[ ]	[ ]	[ ]	[ ]	[ ]
3.	I feel no interest in things.	[ ]	[ ]	[ ]	[ ]	[ ]
4.	I feel stressed at work/ school.	[ ]	[ ]	[ ]	[ ]	[ ]
5.	I blame myself for things.	[ ]	[ ]	[ ]	[ ]	[ ]
6.	I feel irritated.	[ ]	[ ]	[ ]	[ ]	[ ]
7.	I feel unhappy in my marriage / significant relationship.	[ ]	[ ]	[ ]	[ ]	[ ]
8.	I have thoughts of ending my life.	[ ]	[ ]	[ ]	[ ]	[ ]
9.	I feel weak.	[ ]	[ ]	[ ]	[ ]	[ ]
10.	I feel fearful.	[ ]	[ ]	[ ]	[ ]	[ ]

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11.	After heavy drinking, I need a drink the next morning to get going. **(if you do not drink, mark "never")**	[ ]	[ ]	[ ]	[ ]	[ ]
12.	I find my work/school satisfying.	[ ]	[ ]	[ ]	[ ]	[ ]
13.	I am a happy person.	[ ]	[ ]	[ ]	[ ]	[ ]
14.	I work or study too much.	[ ]	[ ]	[ ]	[ ]	[ ]
15.	I feel worthless.	[ ]	[ ]	[ ]	[ ]	[ ]
16.	I am concerned about family troubles.	[ ]	[ ]	[ ]	[ ]	[ ]
17.	I have an unfulfilling sex life.	[ ]	[ ]	[ ]	[ ]	[ ]
18.	I feel lonely.	[ ]	[ ]	[ ]	[ ]	[ ]
19.	I have frequent arguments.	[ ]	[ ]	[ ]	[ ]	[ ]
20.	I feel loved and wanted.	[ ]	[ ]	[ ]	[ ]	[ ]
21.	I enjoy my spare time.	[ ]	[ ]	[ ]	[ ]	[ ]

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22.	I have difficulty concentrating.	[ ]	[ ]	[ ]	[ ]	[ ]
23.	I feel hopeless about the future.	[ ]	[ ]	[ ]	[ ]	[ ]
24.	I like myself.	[ ]	[ ]	[ ]	[ ]	[ ]
25.	Disturbing thoughts come into my mind that I cannot get rid of	[ ]	[ ]	[ ]	[ ]	[ ]
26.	I feel annoyed by people who criticize my drinking or drug use **(if not applicable mark "never")**	[ ]	[ ]	[ ]	[ ]	[ ]
27.	I have an upset stomach.	[ ]	[ ]	[ ]	[ ]	[ ]
28.	I am not working/ studying as well as I used to.	[ ]	[ ]	[ ]	[ ]	[ ]
29.	My heart pounds too much.	[ ]	[ ]	[ ]	[ ]	[ ]
30.	I have trouble getting along with friends and close acquaintances.	[ ]	[ ]	[ ]	[ ]	[ ]
31.	I am satisfied with my life.	[ ]	[ ]	[ ]	[ ]	[ ]

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32.	I have trouble at work/school because of drinking or drug use **(if not applicable, mark "never")**	[ ]	[ ]	[ ]	[ ]	[ ]
33.	I feel that something bad is going to happen.	[ ]	[ ]	[ ]	[ ]	[ ]
34.	I have sore muscles.	[ ]	[ ]	[ ]	[ ]	[ ]
35.	I feel afraid of open spaces, of driving, or being on buses, taxi and so forth.	[ ]	[ ]	[ ]	[ ]	[ ]
36.	I feel nervous.	[ ]	[ ]	[ ]	[ ]	[ ]
37.	I feel my love relationships are full and complete.	[ ]	[ ]	[ ]	[ ]	[ ]
38.	I feel I am not doing well at work/ school.	[ ]	[ ]	[ ]	[ ]	[ ]
39.	I have too many disagreements at work/ school.	[ ]	[ ]	[ ]	[ ]	[ ]
40.	I feel something is wrong with my mind.	[ ]	[ ]	[ ]	[ ]	[ ]
41.	I have trouble falling asleep and staying asleep.	[ ]	[ ]	[ ]	[ ]	[ ]

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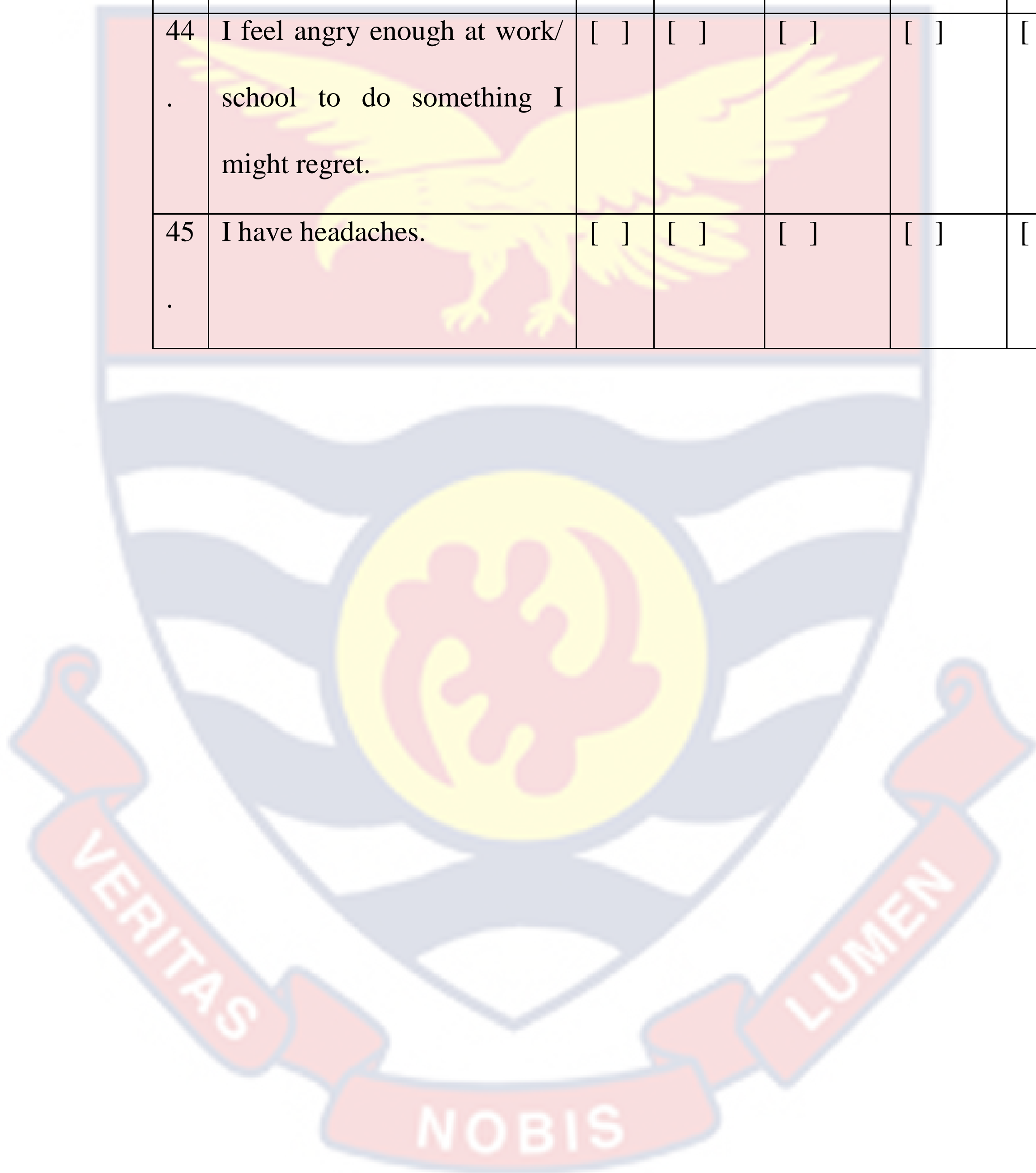
42.	I feel sad.	[ ]	[ ]	[ ]	[ ]	[ ]
43.	I am satisfied with my relationship with others.	[ ]	[ ]	[ ]	[ ]	[ ]
44.	I feel angry enough at work/ school to do something I might regret.	[ ]	[ ]	[ ]	[ ]	[ ]
45.	I have headaches.	[ ]	[ ]	[ ]	[ ]	[ ]



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APPENDIX

Ryff's Psychological Well-Being Scales by Carol Ryff, 2005

Please indicate your degree of agreement (using a score ranging from 1-6) to the following sentences.

Strongly Disagree 1 Moderately Disagree 2 Disagree 3 Weakly Agree 4 Moderately Agree 5 Strongly Agree 6

No.	Item	1	2	3	4	5	6
1	I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.						
2	In general, I feel I am in charge of the situation in which I live.						
3	I am not interested in activities that will expand my horizons.						
4	Most people see me as loving and affectionate.						
5	I live life one day at a time and don't really think about the future.						
6	When I look at the story of my life, I am pleased with how things have turned out.						
7	My decisions are not usually influenced by what everyone else is doing.						

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8	The demands of everyday life often get me down.						
9	I think it is important to have new experiences that challenge how you think about yourself and the world.						
10	Maintaining close relationships has been difficult and frustrating for me.						
11	I have a sense of direction and purpose in life.						
12	In general, I feel confident and positive about myself.						
13	I tend to worry about what other people think of me.						
14	I do not fit very well with the people and the community around me.						
15	When I think about it, I haven't really improved much as a person over the years.						
16	I often feel lonely because I have few close friends with whom to share my concerns.						
17	My daily activities often seem trivial and unimportant to me.						
18	I feel like many of the people I know have gotten more out of life than I have.						

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19	I tend to be influenced by people with strong opinions.						
20	I am quite good at managing the many responsibilities of my daily life.						
21	I have the sense that I have developed a lot as a person over time.						
22	I enjoy personal and mutual conversations with family members or friends.						
23	I don't have a good sense of what it is I'm trying to accomplish in life.						
24	I like most aspects of my personality.						
25	I have confidence in my opinions, even if they are contrary to the general consensus.						
26	I often feel overwhelmed by my responsibilities.						
27	I do not enjoy being in new situations that require me to change my old familiar ways of doing things.						
28	People would describe me as a giving person, willing to share my time with others.						
29	I enjoy making plans for the future and working to make them a reality.						

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30	In many ways, I feel disappointed about my achievements in life.						
31	It's difficult for me to voice my own opinions on controversial matters.						
32	I have difficulty arranging my life in a way that is satisfying to me.						
33	For me, life has been a continuous process of learning, changing and growth.						
34	I have not experienced many warm and trusting relationships with others.						
35	Some people wander aimlessly through life, but I am not one of them						
36	My attitude about myself is probably not as positive as most people feel about themselves.						
37	I judge myself by what I think is important, not by the values of what others think is important.						
38	I have been able to build a home and a lifestyle for myself that is much to my liking.						
39	I gave up trying to make big improvements or changes in my life a long time ago.						

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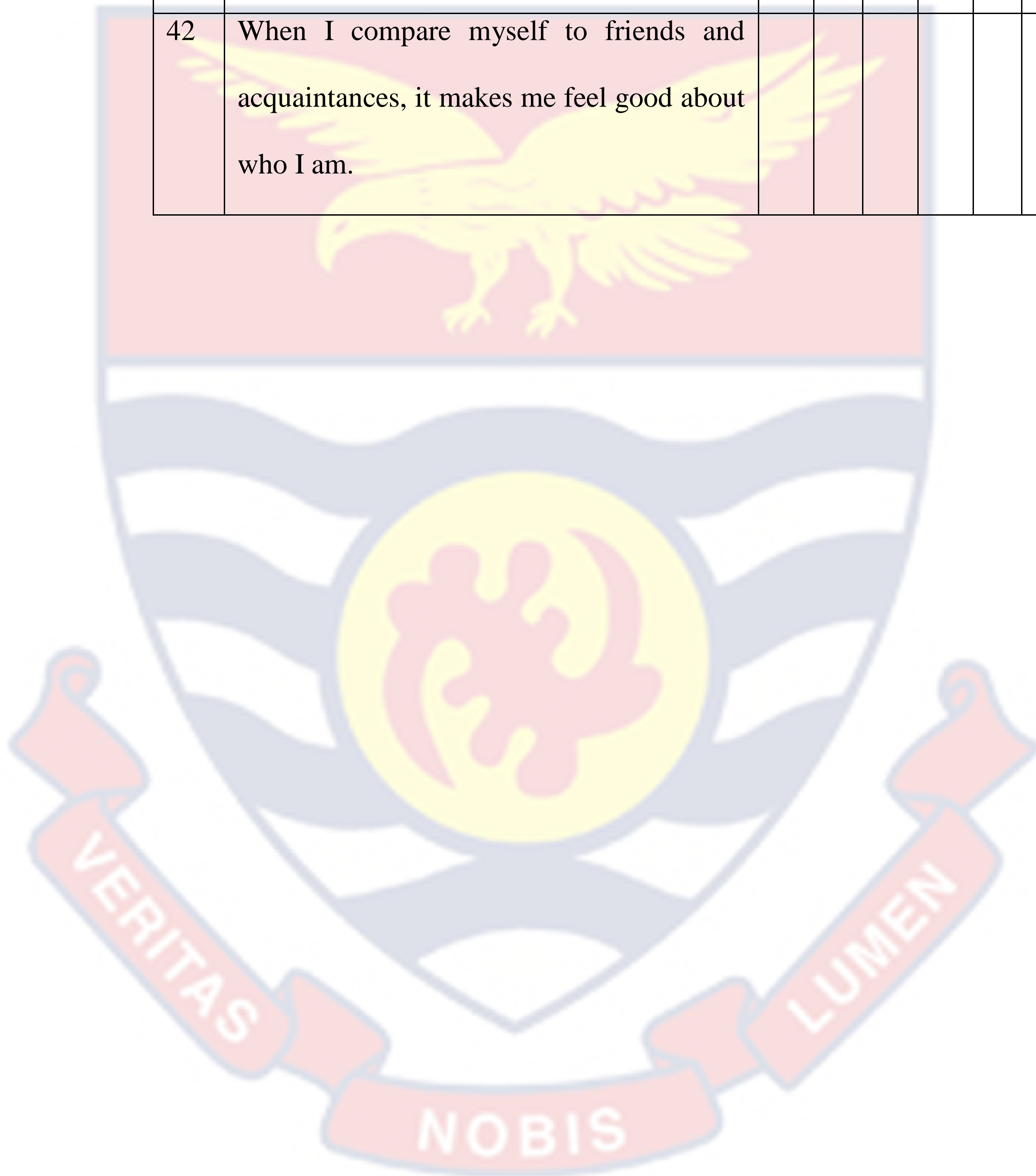
40	I know that I can trust my friends, and they know they can trust me.						
41	I sometimes feel as if I've done all there is to do in life.						
42	When I compare myself to friends and acquaintances, it makes me feel good about who I am.						



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APPENDIX

Resiliency Attitudes (R.A.S.) by Biscoe & Harris, 1999

Please indicate your degree of agreement or disagreement (using a score ranging from 1-2) to the following sentences.

No.	Item	Agree	Disagree
1.	I usually cannot predict what other people will do.	Agree	Disagree
2.	I avoid accepting responsibility for other people's problems.	Agree	Disagree
3.	When other thinks badly of me, there's probably a good reason for it.	Agree	Disagree
4.	I try to notice signals from other people that spell trouble.	Agree	Disagree
5.	It doesn't do any good to try and figure out why things happen.	Agree	Disagree
6.	Often I find myself taking responsibility for other people's problems.	Agree	Disagree
7.	I am willing to ask myself tough questions and answer them honestly.	Agree	Disagree
8.	I have a hard time telling what someone new is like until I get to know the person well.	Agree	Disagree
9.	I can fix hurts from my past that could keep me from letting people get close to me.	Agree	Disagree

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10.	I try to figure out why people act the way they do.	Agree	Disagree
11.	I will often stay with someone even though I know that person is bad for me.	Agree	Disagree
12.	I am able to step back from troubled family members and see myself as OK.	Agree	Disagree
13.	If you care about someone, you should try to do what the person wants, even if it seems unreasonable.	Agree	Disagree
14.	I can't help acting like a child around my parents.	Agree	Disagree
15.	I am able to recognize when I'm in a bad relationship and end it.	Agree	Disagree
16.	I can stay calm around troubled people because I understand why they act the way they do.	Agree	Disagree
17.	I realize that I can't change other people; they have to change for themselves.	Agree	Disagree
18.	It's hard for me to stay calm when someone I care about is being unreasonable.	Agree	Disagree
19.	If I love someone, I can put up with that person hurting me.	Agree	Disagree
20.	I often find myself around people who aren't well adjusted.	Agree	Disagree

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21.	There are few people who I can really count on.	Agree	Disagree
22.	I am good sizing up people.	Agree	Disagree
23.	I try to figure out why a relationship is not healthy and avoid repeating it.	Agree	Disagree
24.	I am good at starting relationships with other people.	Agree	Disagree
25.	I can’t do anything about whether other people like me or not.	Agree	Disagree
26.	It’s hard for me to believe that I’ll ever find a good relationship.	Agree	Disagree
27.	I’m shy around people I don’t know.	Agree	Disagree
28.	I can’t really tell if a relationship is going to be good until I try it.	Agree	Disagree
29.	I am good at keeping relationships going.	Agree	Disagree
30.	I am able to love others and be loved by them.	Agree	Disagree
31.	It’s beyond me how most things work.	Agree	Disagree
32.	I often talk myself through a problem.	Agree	Disagree
33.	I can learn from the past and use that information to make the future better.	Agree	Disagree
34.	I have hobbies and other activities I take seriously.	Agree	Disagree

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35.	I often get really frustrated when dealing with problems and can’t figure out what to do.	Agree	Disagree
36.	I am successful at taking care of my physical and emotional needs.	Agree	Disagree
37.	I don’t like to find out how things work.	Agree	Disagree
38.	There are few things that I am good at doing.	Agree	Disagree
39.	I do enough to get by, but not much more.	Agree	Disagree
40.	I enjoy getting involved in constructive activities.	Agree	Disagree
41.	Sometimes I forget my problems when I’m pursuing creative activities.	Agree	Disagree
42.	I don’t think that I’m creative.	Agree	Disagree
43.	I ‘am good at finding new ways to look at things.	Agree	Disagree
44.	One way I express my feelings is through my art work, dance, music or writing.	Agree	Disagree
45.	The positive feelings I get from creating help make up for the pain of my past.	Agree	Disagree
46.	Usually my imagination doesn’t help to solve problems.	Agree	Disagree
47.	It’s hard for me to see the humor in a bad situation.	Agree	Disagree

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48.	One has to take life very seriously to get by.	Agree	Disagree
49.	I am good at using humor to reduce tension between myself and others.	Agree	Disagree
50.	Most problems have only one solution.	Agree	Disagree
51.	I find it easy to choose between right and wrong.	Agree	Disagree
52.	It's a dog eat dog world where one has to do what it takes to get by.	Agree	Disagree
53.	I can't help repeating the mistakes that my parents made.	Agree	Disagree
54.	I like to help other people.	Agree	Disagree
55.	There's no way I could make a difference in other people's lives.	Agree	Disagree
56.	I don't always do what I know is right.	Agree	Disagree
57.	I stand up to people when I see them being dishonest, pretty or cruel.	Agree	Disagree
58.	I am willing to take risks for the sake of doing what I think is right.	Agree	Disagree
59.	Sometimes I feel like I'm just drifting along with no purpose in life.	Agree	Disagree
60.	I almost always stand up for underdogs.	Agree	Disagree
61.	I like to help others even if they are not willing to help themselves.	Agree	Disagree

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62.	I am involved in things that will make people's lives better.	Agree	Disagree
63.	No matter what happens, if I keep trying I'll get through it.	Agree	Disagree
64.	There are things that I can do to make my life better.	Agree	Disagree
65.	Sometimes it's hard, but I don't let things keep me down.	Agree	Disagree
66.	Even if bad things happen, I can handle with them.	Agree	Disagree
67.	It's not the hand you are dealt, it's how you play it.	Agree	Disagree
68.	No matter how hard I try, I can't make things right.	Agree	Disagree
69.	I am willing to go with any approach that will work.	Agree	Disagree
70.	I' am good at making the most of a bad situation.	Agree	Disagree
71.	When life gives me lemons, I make lemonade.	Agree	Disagree
72.	Failure is something you learn from rather than feel guilty about.	Agree	Disagree

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