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Training psychology graduate students to deliver a psychosocial telehealth intervention in Ghana during the COVID-19 pandemic: Training model and processes

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Abstract

This paper is a commentary on how we developed and trained 12 counselling psychology, clinical psychology, and social psychology graduate students to provide basic psychoeducation on COVID-19 in locally adapted forms to vulnerable individuals; and facilitate conversations around stress, anxiety, and distress associated with COVID-19. Training was done online and included didactic lectures as well as practice sessions. Group and individual supervision provided opportunities for trainees to reflect on their training, practice, and receive support. Observations from trainees' self-reflection notes showed areas of professional growth including improvement in basic counselling skills and telehealth competence; COVID-19 advocacy; and cultural competence. Discussions focus on lessons for developing and training psychology graduates to expand the reach of psychological services in Ghana.

Keywords: COVID-19, Ghana, psychology training, telehealth, telepsychology

Introduction

The first two cases of the coronavirus disease 2019 (COVID-19) in Ghana were reported on 12th March 2020 (Ghana Health Service, 2020). The government ordered a partial lockdown in Greater Accra, the Tema Metropolitan area, Kasoa, and Greater Kumasi. A 14-day quarantine was imposed on air travel passengers who arrived in Accra on 22nd March 2020 (Communication Bureau, 2020a, b; Ministry of Health, 2020). Psychologists were engaged to provide counselling to quarantined travellers. Psychologists in Ghana got involved in advocacy programmes to educate the public on risk reduction and management of mental health (Ghana Psychology Association, 2020; UPSA Newsroom, 2020; Waife-Akenten, 2020).

Due to mixed messages and myths about the coronavirus pandemic, public anxiety about coronavirus infection increased. There was a need for communication on risk reduction and behaviour modification that aligned with Ghanaian public understandings of infectious diseases and pandemics. Preliminary assessment with different groups and communities in Accra, the capital of Ghana, and discussions with medical and social scientists and health policymakers suggested that there was the need for an evidence-based model of psychosocial support (de-Graft Aikins & Akoi-Jackson, 2020; de-Graft Aikins et al., 2020, in press).

As part of our advocacy efforts to help communities manage the anxiety around the pandemic, our research team developed a psychosocial intervention for individuals who were living with single or comorbid chronic conditions (e.g., diabetes, hypertension) in Accra. We trained psychology graduate students to deliver the intervention during the period of the lockdown. Our objective was to provide psychoeducation on coronavirus

in locally adapted forms; and provide psychosocial support to individuals who were considered vulnerable or extremely vulnerable. These groups required specific sets of information regarding coronavirus risk reduction and protection because they had a higher risk of infection and fatality (Public Health England and Department of Health and Social, 2020).

Telehealth and Psychological Practice

Telehealth involves the provision of health care services using technological modalities such as telephone and the internet (American Psychological Association [APA], 2013; Lee, Black & Held, 2019). The use of telecommunication technology to provide psychological services (such as counselling and psychotherapy, psychological assessment) is referred to as telepsychology (APA, 2013). In this project, we used telehealth to provide a psychosocial intervention.

McCord et al. (2020a) identified that telehealth can be delivered over mobile applications (i.e., Apps), email, telephone or audio call, text messaging, video conferencing, and web-based modalities. In some parts of the world, access to telephone is relatively easier than access to the internet. This makes telephone a preferable telecommunication option for delivering telehealth in these settings (Baca et al., 2007). According to the National Communication Authority of Ghana (2016), mobile telecommunication services form an integral part of daily life in Ghana. As at the end of the second quarter of 2016, there were over 36 million mobile services subscriptions in a country of about 28 million (National Communication Authority, 2016). This suggests that mobile telecommunication may be a good medium to deliver telehealth in Ghana.

Users of telehealth services may include trainees or service users. Trainees may receive didactic training, supervision, administrative and technical support through telehealth (McCord et al., 2020a). Telehealth may be used to deliver counselling and psychotherapy, psychoeducation, and psychological assessment to service users (McCord et al., 2020a; Péñate, 2012). Settings that use telehealth vary, including community clinics, hospitals, prisons and jails, schools, university counselling centres as well as in private practice (McCord et al., 2020a).

Research suggests that telehealth can address mental health challenges such as availability, accessibility, and acceptability of psychological services (Baca et al., 2007; McCord et al., 2015; Tarlow et al., 2020). Telehealth also has the potential to afford users anonymity and make mental health services affordable (McCord et al., 2020a). Adjorlolo (2015) observed that telehealth may offer an opportunity to expand the reach of psychology practice in Ghana where human resource for mental health is limited.

Adoption of telehealth in psychological practice had been slow the world over (McCord et al., 2015). One major concern about using telehealth in psychology involves competence. Until recently, most training programs in psychology did not provide training in telehealth (McCord et al., 2015; 2020b). Other challenges with the use of telehealth in psychology is related to psychologists' hesitation with the use of technology, concerns about efficacy, as well as ethics and legal regulations (Castelnuovo et al., 2001; Elliot, 2020; Kanani & Regehr, 2003; Manhal-Baugus, 2001; Satalkar et al., 2015). Other barriers are about practical and technical concerns (Barak et al., 2008).

The advent of the COVID-19 pandemic has accelerated adoption and utilization of telehealth (Adepoju, 2020; Duncan et al.,

2020; McCord et al., 2020a, b; Perrin et al., 2020). Evidence from psychosocial interventions developed during the COVID-19 pandemic suggests that telehealth can be delivered by professionals as well as paraprofessionals. The Ghana Psychology Association (2020), for instance, rolled out telephone counselling services to support Ghanaians during the pandemic. This intervention was delivered mainly by licensed and practicing psychologists. On the other hand, an innovative intervention which was rolled out by a diocese of the Roman Catholic church in the Philippines to provide psychosocial support for people overwhelmed by the pandemic was delivered by a team of paraprofessionals (i.e., religious leaders) and professionals (e.g., psychiatrists) (Gomes, 2020).

Studies focusing on telehealth training for psychology trainees in Ghana are nearly non-existent. There have been calls to improve the practice, training, and research of professional psychology practice in Ghana (Asante & Oppong, 2012; de-Graft Aikins et al., 2019). This paper describes how we developed and trained psychology graduate students to deliver a psychosocial telehealth intervention in Ghana during the COVID-19 pandemic.

Developing the Psychosocial Intervention

The authors drew on current scientific evidence on COVID-19 (e.g., Bender, 2020; WHO, 2020), guidelines for risk reduction, coping with self-isolation and quarantine, managing pre-existing conditions (e.g., Ghana Health Service, 2020; Center for The Study of Traumatic Stress, 2020); professional competence and telehealth (APA, 2013; Hughes, 2001); basic psychosocial support (e.g., Inter-Agency-Standing Committee (IASC), 2008; Wier, 2020); ethics (e.g., APA, 2002; Inter-Agency-Standing Committee, 2008), and self-care (e.g., Butler et al., 2019) to guide

the development of a local model for psychosocial telehealth. We also drew on our own work on community-based chronic disease care and competence in psychological practice in Ghana (e.g., de-Graft Aikins et al., 2019, 2020, in press). We organized the psychosocial intervention in a training manual as outlined in Box 1.

Box 1

Outline of training manual

- Module 1: Overview of the training and the intervention
- Module 2: What you need to know about COVID-19
- Module 3: Protective measures for everyone
- Module 4: Protective measures for extremely vulnerable groups
- Module 5: Basic communication skills for telehealth interactions
- Module 6: Ethics in telehealth
- Module 7: Supervision and self-care
- Appendix: Important referral numbers

Module 1 explained the goal of our psychosocial telehealth model, which was to improve knowledge about the coronavirus pandemic and COVID-19; and provide psychosocial support and care to vulnerable communities in Ghana for coping with the pandemic. The module also described the role of trainees which was to provide basic psychoeducation on COVID-19 to vulnerable individuals; facilitate conversations around stress, anxiety and distress associated with COVID-19; and help individuals use problem-solving skills to develop informed contingency plans should they become infected. Module 2 and 3 discussed coronavirus, COVID-19, and common symptoms

of COVID-19. Even though the training manual was in English, the language of instruction in Ghana, we critically discussed and generated local language terminologies for discussing the common symptoms of COVID-19. We discussed definitions of terms such as coronavirus, COVID-19, social distancing, self-isolation, quarantining, and shielding. It was important that trainees understood the terms clearly before they could teach others - especially in languages beside English. The model also covered precautions recommended by the WHO (2020), and the Ghana Health Service (2020).

Module 4 focused on protective measures for people with an underlying health condition and considered at very high risk of severe illness because of COVID-19 (Public Health England and Department of Health and Social, 2020). Module 5 focused on basic communication skills, rapport building in telehealth, active listening skills, communication styles, and technological challenges in telehealth (APA, 2013; Hughes, 2001). The module also provided information on how to provide psychosocial support. We prepared a checklist of topics to discuss in providing psychosocial support— e. g., how to cope with isolation, how to maintain usual routines, how to take up new routines, and what to do when ill (e.g., APA, 2020; Weir, 2020).

Module 6 addressed ethics in professional psychology (see APA, 2017; The Inter-Agency-Standing Committee, 2008), supervision and self-care (APA, 2017; Butler et al., 2019). The appendix included a list of useful numbers - of the community health team, Noguchi Memorial Institute for Medical Research, Ghana Health Service, and other resources. We shared the concept note of the intervention with the Ghana Psychology Council and received support (D. Baah-Odoom, personal communication, March 25, 2020).

Recruitment of Trainees

The first author sent an email to first year graduate students in counselling psychology and clinical psychology at the University of Ghana, a public university, on 19th March 2020 to participate in a collaborative project aimed at preparing communities for coronavirus prevention, treatment and care in Accra, Ghana. Three doctoral psychology students with experience in working with urban poor communities were also invited. Nine students pursuing master's programmes in psychology as well as the three doctoral students accepted the invitation. Table 1 is a presentation of the trainees who were recruited for our telehealth training. Three prospective trainees could not be invited because they expressed interest after the training had already begun.

Table 1: Demographic characteristics of telehealth trainees

Trainee ID	Gender	Training Level	Specialization
1	Female	Masters	Clinical psychology
2	Female	Ph.D.	Social psychology
3	Female	Masters	Clinical psychology
4	Male	Masters	Counselling psychology
5	Male	Ph.D.	Social psychology
6	Female	Masters	Clinical psychology
7	Female	Masters	Clinical psychology
8	Male	Ph.D.	Social psychology
9	Female	Masters	Counselling psychology
10	Male	Masters	Counselling psychology
11	Male	Masters	Clinical psychology
12	Female	Masters	Counselling psychology

The rationale for including the doctoral students was that they were involved in research on community mental health in urban poor communities and therefore could serve as gatekeepers to prospective service users. The master students were in the second semester of their first year of graduate training in their respective programmes and had completed relevant courses including psychopathology, theory and practice of counselling and psychotherapy, and psychological assessment. One doctoral student was in the first year, and the remaining two were in their fourth year.

Besides English, the trainees were proficient in 5 Ghanaian languages (Asante Twi, Fante, Ga, Krobo, and Hausa). They lived in 4, out of the 16, geographical regions in Ghana namely Ashanti, Central, Eastern, and Greater Accra.

Telehealth Training

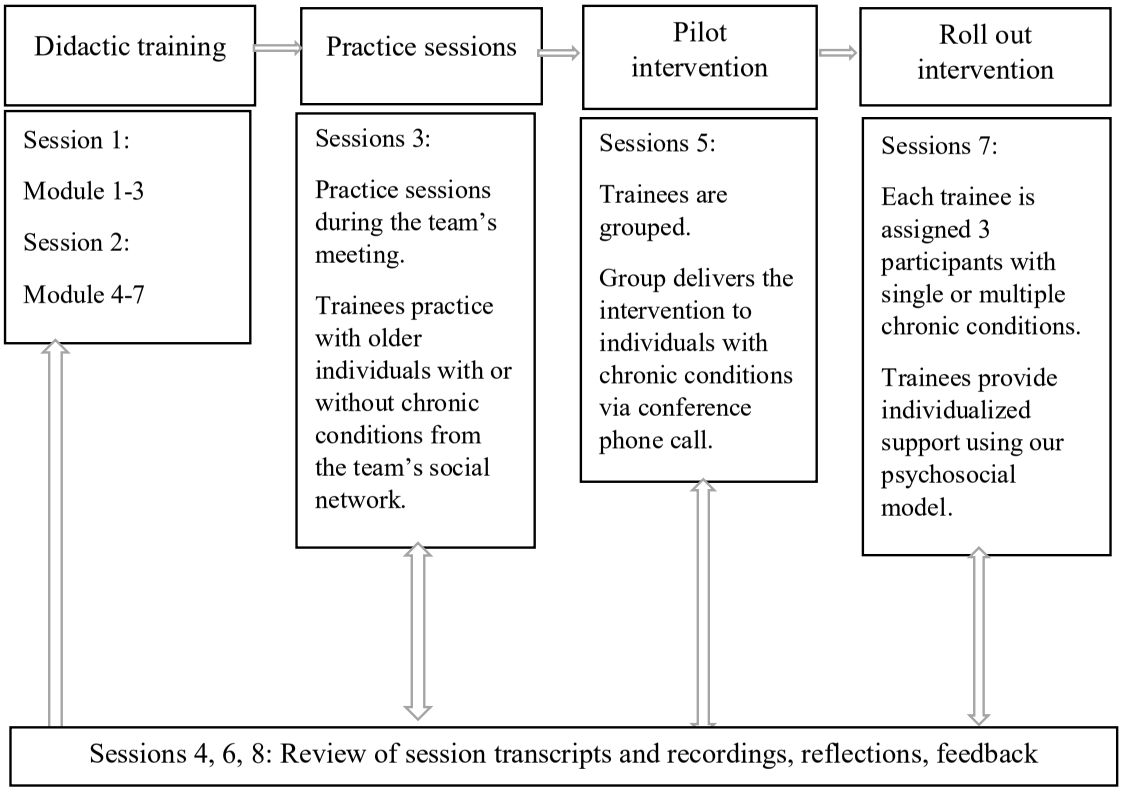
Training began on 25th March 2020, conducted via Zoom, and was led by the authors. The first author is a practicing counselling psychologist and a lecturer at the public university from which the trainees were recruited. The second author is a social and health psychologist with extensive experience on community-based chronic disease care in Ghana.

We used the training manual described in Box 1 above and followed the training framework in Figure 1. Each training session lasted between 2 and 3 hours. We had 8 training sessions. The first two training sessions involved critical engagement with the full set of the training modules discussed in Box 1. We clarified the role of trainees as volunteers, not experts or licensed practitioners. We deliberated key concepts and terms and how they could be translated into Asante Twi, Fante, Ga, Krobo, and Hausa to guide responsive communication with different

linguistic groups. For example, we discussed the local terms for COVID-19 symptoms such as fever; cough, sore throat, and running nose in the various languages. We also discussed local language terminologies for social distancing, quarantine, and shielding.

Session 3 was a practice session in which trainees rehearsed how they would provide psychoeducation on COVID-19. Trainees were paired and conducted mock sessions during the training session. The rest of the team served as observers when a pair was presenting; and subsequently provided feedback. The experience offered opportunities for the trainees to learn from each other in real time. Trainers used the opportunity to identify areas of strength as well as areas where trainees needed help with their basic counselling and telehealth skills. Trainees were also given a take-home practice session assignment. They practiced delivering the intervention with at least one person in their social networks. The practice session was recorded with the participant's consent and the tapes were shared with the trainers, who prepared the tapes for use in supervision (Session 4).

Fig. 1. Model of the training process



Session 5 involved piloting the psychosocial intervention at the community level to vulnerable groups in Accra as they managed life through the early period of the 14-day partial lockdown. Trainees were grouped into three and each group was assigned to two participants drawn from a self-help group based in two urban poor communities (see de-Graft Aikins et al., 2020, in press). Because of the pandemic, the self-help group's meetings had been interrupted. Our research team has an ongoing relationship with the self-help group and offered to provide psychosocial support during the pandemic.

Each group of trainees had one doctoral student to facilitate the group process. The participants were familiar with the doctoral students from previous research engagements with the self-help group. The doctoral students coordinated communication between the group and the participant; and helped the group schedule a time to make their phone call to an assigned participant. Prior to calling an assigned participant, each member of the group chose a portion of the intervention they would like to speak to during the phone call. For instance, one trainee could talk about "What you need to know about COVID-19"; and another trainee could talk about "Protective measures for extremely vulnerable groups."

On the agreed date and time, the telehealth group made a conference telephone call to the participant. Because of their acquaintance with the participants, the doctoral students made the call and introduced the other trainees. Trainees delivered our psychosocial intervention to each assigned participant. Trainees took turns to deliver the messages based on their previous assignments. The remaining group members listened in, followed along the delivery of the intervention, and filled in where another trainee had missed some part of the delivery.

The experience afforded trainees opportunities to learn from each other. Trainees who were initially shy or uncomfortable delivered relatively small portions and benefited from other colleagues. After the telephone conference call, a debriefing exercise was held among the trainees and feedback was given to the authors. The authors used the feedback to improve aspects of the training model. The feedback also helped the trainers identify deficits in basic counselling and telehealth of the trainees and provided further training.

During Session 7, we rolled out the psychosocial intervention to a total of 36 individuals with single or multiple chronic conditions recruited from the same self-help group we previously described. Each trainee was assigned three individuals. The participants had earlier been notified of the intervention to support them in view of the pandemic. As much as possible, we paired participants to trainees based on the primary local language of choice of the participant. In a few cases where a trainee and participant spoke different local languages, the participant used a family member as an interpreter.

Each participant received a maximum of 4 individual sessions: one initial session and up to 3 follow-up sessions depending on the need. In the initial session, trainees used the psychosocial intervention guide which included: (i) an introduction and consenting; (ii) psychoeducation using Module 2 (Basic information on coronavirus and COVID-19); (iii) psychosocial support—based on Module 3 (Protective measures for everyone), Module 4 (Protective measures for vulnerable groups), and stress/distress management—; and (iv) debriefing with the participant about the phone call to find out if there were other issues they wanted to discuss.

For each section of the telehealth guide, we had prompts to guide the trainees. Each session lasted between 20 and 30 minutes. Sessions were conducted over the telephone and were recorded with the participant's permission. Where recording was not possible because of technical challenges, the trainees took detailed notes on what they discussed. Follow-up sessions were shorter in duration and served as a brief check-in to find out how the participants were faring since their last session.

Logistical and Practical Considerations

The project made practical accommodations for the trainees as well as the service users. For the trainees, the project covered the internet cost since training was done on-line. The project also covered the cost of phone calls. For practical purposes, trainees offered services from home.

Several logistical and practical considerations were made related to the service users. Even though phone ownership is high in Ghana, not everyone in the target service users owned a telephone. For such ones, an allowance was made for them to receive the service through others. Some service users used telephones belonging to members of their households. Others used telephones belonging to their neighbours. Service users did not bear the call cost. The cost of making calls to service users was borne by the authors. Depending on the call duration and the telecommunication network used, cost per phone session ranged between 3 and 5 Ghana Cedis.

Online Supervision and Self-Care

Even though supervision was interlaced throughout the 8 training sessions, 3 specific sessions were set aside to provide targeted supervision. Trainees recorded the sessions with

participants' consent. The recordings were shared with the trainers who listened to the audio recordings and identified areas for discussion in the group supervisions. Trainers discussed areas of strengths and well as areas needing improvement.

Trainees wrote case notes following each session. They provided participant details; and documented the date, time, and duration of the phone calls. Trainees also provided a summary of the call and assessment of the participant's well-being. Further, trainees wrote reflection notes of their clinical competence during each call. Finally, trainees wrote about their own well-being, indicating how they felt after each call. The case note template directed trainees to get in touch with the trainers if a call leaves them overwhelmed, sad, and/or troubled. Two trainees utilized this support. Each had an individual supervision session with the first author.

Supervision addressed practical and logistical issues that the trainees had encountered during the delivery of the intervention. Some trainees consulted the trainers when their assigned participants called to indicate they needed help meeting livelihood demands. As a result of the lockdown, some participants who were low-income workers in the informal sector indicated that they were experiencing financial stress. In such cases, trainees worked with the trainers as well as the participant to obtain necessary support from appropriate social services.

We included discussions about good self-care practices in our training sessions and processed how we were being impacted by the pandemic throughout the course of the project. We also took practical steps to support self-care. We spaced training and practice so that our team did not become overwhelmed. We supported group members who experienced family emergencies during the project and allowed such team members to take time off to manage the emergency situations. We discussed how the

pandemic had interrupted personal routines (e.g., sleep, dietary practices; school schedule) as much as team members were comfortable discussing these issues. We provided space for members to discuss how they were managing the uncertainties around the pandemic.

Trainees' Reflections

Observations from our trainees' reflection notes suggest that trainees benefited in three areas of competence: (1) basic counselling and telehealth skills; (2) COVID-19 advocacy; and (3) attention to local adaptation of interventions. With regards to basic counselling skills, trainees indicated that they had observed improvements in their listening skills, use of questions, and rapport building. In this regard, one trainee wrote: "The systematic guidelines provided helped me in the telehealth counselling sessions by [guiding me to] ask relevant questions'' (Telehealth Trainee # 2). Other trainees reflected on their basic counselling skills as follows:

> Some reflections from the call were the fact that I had to reduce the speed with which I spoke, allow the client to express herself and then be able to probe into certain things she said to get better insight into what she was saying. (Telehealth Trainee #11).

> As a telehealth volunteer, I have seen the importance of having a listening ear for clients to express their feelings during this pandemic. This has equipped me to be able to decipher when clients' emotional wellbeing become worse or better under different circumstances. (Telehealth Trainee #5).

> Providing psychosocial support to these three clients was generally a good experience. I was able to establish a good rapport with them, with an enhanced skill from previous practice. I was also able to improve my skill of expressing empathy. Lastly, I was also able to build on my interview skill for assessment. (Telehealth Trainee #3).

Trainees also reflected on their telehealth competencies. One trainee wrote, "I have learnt very critical skills on how to project empathy over the phone, regardless of whether I am closer to the person or not" (Telehealth Trainee #8). Two others made the following observations about their telehealth skills:

> From the start of the programme till now, I have had the opportunity to practice offering counselling services over the phone and I have learnt the relevance of being prepared before speaking to a client and debriefing with supervisors after speaking to clients. (Telehealth Trainee #6).

> Clinical competencies during this call were optimal…Even though the call was relatively short, I believe that I have improved my skills at doing such enquiries from clients, as opposed to the question-and-answer I had at the beginning of the programme when I did my first calls. I felt satisfied at the end of the calls, knowing that I had a good idea about the clients' post-lockdown feelings and how they were going about their activities. I have also been able to satisfactorily probe into client's concerns when they [that is the concerns] come up during a call to better understand them. (Telehealth Trainee #11).

Some trainees commented on competence related to COVID-19 advocacy. As an example, a trainee noted, "The knowledge gained in the training has helped me educate my family and friends on the risk and protocols of the COVID-19" (Telehealth Trainee #2). Another trainee discussed transfer of the knowledge to other groups. He stated:

> Going through the five Modules, especially, Modules 4 and 5 namely Protective Measures for Extremely Vulnerable Groups and Basic Communication Skills for Telehealth Interactions, I felt equipped to respond to the needs for my drivers' group.
>
> Another issue that was re-emphasized since I had already been taught in class, was the idea of social intervention. After the second session, I began to fish out some avenues to assist some of the drivers and mechanics who complained [about food] during the partial lockdown. (Telehealth Trainee #4).

As a background, the trainee had been involved in an outreach programme for commercial transport drivers in a suburb of Accra (See UPSA Newsroom, 2020).

One of the key emphases of our training model was to help trainees tailor their services in locally adapted forms for Ghanaians. Even though we adapted services to various linguistic groups, delivering psychoeducation in Ghanaian languages remained a challenge as noted by this trainee:

> I feel my clinical competence has improved. I had a comfortable and more engaging conversation with the participant. However, I feel I still struggle with finding the right words and coming down to the most basic level the client can understand. For example,

> I kept trying to find the local term for words like "lockdown" or "restrictions". But generally, there has been significant improvement in my skills and clinical competence. (Telehealth Trainee #1).

Another trainee wrote, "Communication with [the service user] was a bit challenging due to language barrier. She speaks Ga but understands Twi and speaks a little, but I don't understand nor speak Ga, so I had to use her grandson as an interpreter." (Telehealth Trainee #4).

Knowledge and feedback gleaned from these notes and from supervision were fed back into improving the training manual. For instance, based on the feedback regarding the use of interpreters, the training manual was revised to include use of interpreters.

Conclusions

We used current scientific evidence on COVID-19, traumatic stress management, as well as telepsychology and psychological practice to develop a psychosocial telehealth intervention to support people with chronic conditions in Accra, Ghana, during the initial phase of the COVID-19 pandemic. We recruited 12 graduate students in psychology at the University of Ghana, Legon, and trained them to deliver the intervention via telephone calls to adults with chronic conditions in Ghana during a partial lockdown of major cities in the country because of the COVID-19 pandemic. Training was offered online and included didactic lectures and several practice sessions. Observations from our project show that extensive work is needed to develop locally adapted psychosocial interventions for various segments of the Ghanaian people. Doing so requires critical engagement with

evidence-based knowledge as well as local knowledge. Linguistic adaptation of interventions would be easier if we have lexica of basic psychological concepts in local Ghanaian languages. In our project, we relied on our cultural knowledge as well as elders in our social networks in translating certain concepts into Ghanaian languages.

The training component of our project suggests that telehealth is an essential competence that requires extensive engagement with students and relevant service users. It is important to make telehealth an explicit focus in psychology training programmes in Ghana. Training can be tailored toward delivering services to specific groups (e.g., people with psychosocial disabilities, youth groups) in urban and rural communities who have challenges with availability and affordability of psychological services. Our intervention was focused on providing psychosocial support. This is different from providing psychotherapy or conducting psychological assessments. Trainees would require additional training in telepsychology to be able to provide advanced telepsychological services. Our trainees were readily available and able to accommodate our training programme into their routines because schools had closed as consequence of the pandemic. Training programmes would need to consider how to incorporate such training modules into their regular teaching schedule.

McCord et al. (2020b) have observed that supervising telehealth trainees requires good planning and clear communication. In our project, we used group supervision, individual supervision, and consultation. Doing so ensured that trainees did not feel isolated when they delivered the telehealth intervention. The inclusion of the doctoral students with knowledge of the contexts into our project served an important purpose. The doctoral students

were able to provide logistical support to other trainees who encountered challenges in contacting their assigned participants.

The potential for telehealth to increase access, acceptability, and affordability has been well documented (Adjorlolo, 2015; Baca et al., 2007; McCord et al., 2015; Tarlow et al., 2020). Our project demonstrates that through telehealth, it may be possible to meet the needs of individuals in urban poor communities in Ghana who may have limited access to psychological services. It is worthy to note that the beneficiaries of our telehealth intervention were in a self-help group. They may have been more open to receiving psychosocial support. It would be important to assess the acceptability of our intervention with other people in the general population.

Telehealth is fast becoming an essential part of psychological practice. The need for telehealth in psychology practice in Ghana is especially important in the immediate term where the country is managing the psychosocial impacts of the COVID-19 pandemic. In the long term, Ghana needs psychologists to expand the reach of psychological services to people in remote and rural communities who have challenges with availability as well as access. One way to prepare psychologists for this role is to equip trainees with telehealth skills. Our project demonstrates that such training is possible both in the short and long-term.

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Mitigating the psychosocial impact of disasters: The case of Apam drowning incident in Ghana

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Abstract

Disaster, be it natural or manmade, leaves deleterious consequences for lives and properties. Over the years, countries have instituted early warning systems to forestall its occurrences as well as established emergency services to deal with its psychosocial and socioeconomic ramifications on people. Ghana has faced disasters in recent past, mostly, with human factors as key triggers. However, approaches to disaster management and relief have mostly been fashioned in a reactionary mode while specific interventions are generally oriented towards addressing the material losses for short term relief. Such approaches often leave the psychological impact of disasters on people unattended with the potential for leaving permanent psychological and psychiatric sequelae. This paper outlines measures adopted to close this gap in disaster management in Ghana by the Ghana Psychological Association focusing on a recent drowning disaster in Apam, a town in the Central Region of Ghana. The paper makes recommendation for fostering interagency collaboration and the sharpening of the responsiveness of governmental and non-governmental agencies towards timely, culturally responsive, and effective disaster response measures.

Keywords: Ghana Psychological Association; Disaster, Apam, Drowning, NADMO.

Introduction

History is replete with both large scale, natural and manmade disasters and catastrophes that are estimated to have brought about the loss of a billion lives (Furedi, 2007). Catastrophic natural or man-made events could affect life, property, livelihood or industry leading to grave consequences including permanent changes to human societies, ecosystems and environment (Quarantelli, 1998). A natural disaster is observed to be a consequence or effect of a hazardous event that occurs when human activities and natural phenomenon such as volcanic eruption, earthquake, and landslide become enmeshed (Abbott, 2005). Man-made disasters therefore are those having an element of human intent, negligence, and error or involving a failure of a system (Egshi & Larsen, 2008).

For over more than 30 decades, the World Health Organization's (WHO) Collaborating Centre for Research on the Epidemiology of Disasters (CRED) has been maintaining an Emergency Events Database (EM-DAT), which contains essential core data on the occurrence and effects of mass disasters in the world from 1900 to present. Accordingly, the EM-DAT's definition of disaster primarily focuses on consequential impact on human lives thus: an event or act resulting in great loss and widespread destruction and at least two of the following criteria to be fulfilled in terms of its consequence: ten or more people reported killed; 100 or more people reported affected; a call for international assistance or a declaration of a state of emergency from government (The International Disaster Databse, n.d.). The EM-DAT data reveal further that the deadliest disasters in the last century were genocide and war. That is, more than 100 million people were

killed in war or genocide in the twentieth century implying that humanity has been a danger to itself in the past century. The preceding point is anchored on the assumption that whereas certain events with grave consequences to humans may occur with less to no human control, there are some disasters in which human agency can be implicated, even if it originated from natural sources.

Disasters are increasing just as their effect on humans since the rise of modernity. Some have made attributions to industrialization, progress, technology, manufactured risk and human arrogance (Kuipers & Welsh, 2017). The elevation of effects of disasters are also being blamed on the combination of factors such as rising populations, higher concentrations of people and assets in vulnerable areas, the modification and degradation of natural environments, coastal exploitation, wetland destruction, river channeling, deforestation, soil erosion, and fertility decline (Djimesah, Okine & Mireku, 2018).

Disaster and Vulnerabilities Paradigm

According to the International Federation Global Agenda (IFIS, 2007), nearly 6000 disasters accounting for about 900000 deaths were recorded between 1995 and 2004 alone. The net effect was material losses to the tune of US$738 billion and 2500 million persons being affected. For those affected, a growing body of evidence points to psychological and mental health sequelae of disasters. Baez, de la Fuente, and Santos (2010) posited that psychological reactions to a natural disaster or an extreme event vary across individuals depending on their age, developmental level, personality, intellectual capacity and social network. For example, following natural disasters such as Hurricane Andre and Hugo, category 4 hurricanes, moderate levels of Post-Traumatic Stress Disorder (PTSD) were found among children (Vernberg

et. al, 1996). Post-Traumatic Stress Disorder and depression symptoms were also found among both children and adults during the Asian tsunami (Baezet al., 2010). Due to preexisting psychosocial stressors including homelessness, socioeconomic status, poverty, foster care, exposure to violence, trait anxiety, prior mental illness among others, it is argued that some persons may be particularly vulnerable to post disaster trauma reactions that may not manifest themselves until well after the event and could persist for years (Baez et al., 2010; Madrid, et. al, 2006).

In the past couple of years, the psychological dimensions of disasters and the damage to the individual's state of mental health and his or her identity has gained importance particularly in the way the public respond to disasters. These concerns are premised on an emerged cultural narrative of vulnerability (Furedi, 2007). Vulnerability as a concept in disaster literature became central to a new discourse that regarded a disaster from an ecological perspective. That is, 'Disasters occur because a community is vulnerable to the vagaries of the environment' (Westgate & O'Keefe, 1976). It is noted that several factors influence vulnerability to disasters such as location, state of housing, level of preparedness and ability to evacuate and carry out emergency, and that different populations have different levels of vulnerability (Eshghi & Larsen, 2008). Thus, as the hazard and disaster landscape evolved, some societies have been adapting mitigation and preparedness measures.

Management of Disasters

So far, this paper has established that when disaster strikes, people and communities are gravely affected due to an array of factors including social, political and financial elements (Benson, Twigg, & Myers, 2001). For this reason, it is recommended that diverse sorts of disasters should be managed in distinctive ways

(Owusu-Kwarteng, Hamid, & Debrah, 2017). Managing disasters is an exercise that encompasses all aspects of planning for and responding to disasters, including hazard analysis, vulnerability reduction (preparedness), prevention, mitigation, response, recovery and rehabilitation (Criss & Shock, 2001). These measures dovetail into four main distinct phases: Prevention; Preparedness; Response; and Recovery. While the prevention and preparedness phases occur in time before a hazardous event, the response and recovery phases are put in place during and after the disaster. Most of the activities that go into the prevention phase focus on reducing individual and collective vulnerabilities through activities such as physical planning, technical measures, training, and community participation. Strengthening the capacity of societies to act by early warnings towards mitigating the impact of disasters on individuals and the community marks the second phase which is preparedness. In the response phase, actions and measures are taken as the disaster happens and directly in the aftermath. Rebuilding and reconstructing society towards reducing risks, liability and enhancing human functionality occurs at the recovery phase.

In particular, the establishment of Early Warning System (EWS) is vital not only for preventing disasters but for adequate preparation, effective response and sustainable rebuilding efforts. Four mechanisms have been proposed for effective EWS by the United Nations' International Strategy for Disaster Reduction (ISDR), namely, *risk knowledge*, which comprises systematic collection, analysis and assessment of disaster risks; *monitoring and warning service*, which consists of making available systems to monitor hazards and send early warning services; *dissemination and communication* in which there is speedy delivery of risk information and early warning messages and finally, *response capability* which entails putting in place systems to respond to disaster events (Djimesah et al., 2018).

Among the vital components of disaster mitigation efforts, logistics is critical, which leads scholars including Van Wassenhove (2006) to assert that "logistics makes the difference between a thriving and a fizzled process in the event of disaster". It is for this reason that countries mobilize logistical support both from within and without to deal with disasters. While resource and logistical mobilization is essential, there have been some arguments in support of adopting community participation in disaster risk management as well increasing awareness, improving preparedness, empowerment, and enhancing community self-reliance (Samaddar et al., 2015). The point in local participation in disaster management is based on the awareness that disasters, their nature, patterns, and meanings are context specific. They could also be linked to wider attitudes about the local believes and meaning of misfortune, blame and social expectations and remedial measures (Furedi, 2007). For instance, the relevance of traditional and local knowledge in sustaining natural resources and improving disaster preparedness has been identified in different socioecological regions of the world including communities of Meghalaya in Northeast India. There, they preserve patches of forests in their local landscape as sacred forests. These forests are noted to have provided multiple values to locals in times of disasters (Tiwari, Barik, & Tripathi, 1998). Evidence also abound that suggest that in some communities, the reliance on local practices, norms, and customs for dealing with natural and human-induced disasters are particularly helpful (Boafo, Saito, Kato et al., 2015; Bonye & Jasaw, 2011; Geis, 2000).

Having early warning systems, mobilizing logistics and resources, and incorporating local participation are thus critically important to disaster management. However, given the fact that vulnerabilities give rise to prolonged psychological and mental health sequelae in the event of disasters, incorporating psychosocial interventions, particularly in the aftermath of

disasters could be an added incentive for effective mitigation measure.

In Ghana, the official response to disaster is devoid of the psychological component. This situation has been mitigated for some time now by the Ghana Psychological Association through the provision of psychosocial interventions in emergency response to disasters.

Disaster and Disaster Management in Ghana

Recent times have witnessed major disruptions in the socio-economic life of the people of Ghana due to varying forms of disasters. The death of over 120 people and many lives affected in what has become known as the May 9th stadium disaster that was caused by a stadium stampede in 2001 is one of such. Through perennial flooding and fire, we had the June 3rd disaster in 2010, with over 100 lives lost. Incidents of industrial, household, and market fires have also become common disaster experiences in Ghana. Records from the Ghana National Road Safety Commission (NRSC) suggest that more than 700 lives have been lost to road traffic accidents between January to April 2021. The Northern part of Ghana is also notable for perennial droughts and flooding disasters. Some have attributed the frequency of disasters partly to the inability to cope effectively with natural hazards and risks created by socio-economic and political developmental processes (Dash, 2004). The rising spate of disasters in Ghana could therefore be seen to arise from inadequate preparation and measures to tame the natural cycle of events, as well as human-level factors such as negligence.

Following the Yokohama strategy for a harmless world and an action plan to deal with disasters and emergencies, Ghana, in 1996, established a disaster management and emergency

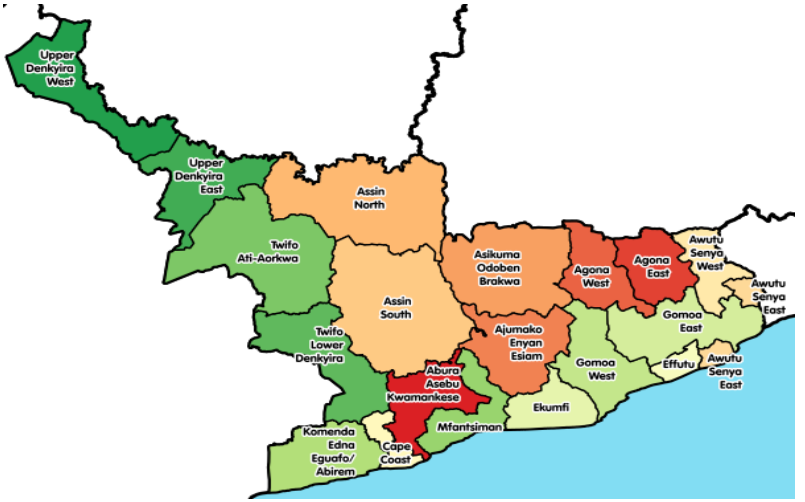
relief unit called National Disaster Management Organization (NADMO) under Parliamentary Act 517 (United Nations Development Programme (UNDP, 2010). NADMO's vision has been to enhance the "capacity of society to avert and manage disasters and to improve the poor's livelihood and vulnerable in rural communities through effective disaster management, social mobilization, and employment generation". In terms of its mission, NADMO manages disasters by "coordinating the resources of governmental institutions and non-governmental agencies and developing the capacity of communities to react effectively to disasters and improve their livelihood via public mobilization, employment generation, and poverty reduction projects."

Since its establishment, NADMO has been functioning mainly in the reaction mode towards relieving affected persons who are displaced after disasters (Nguese et al., 2018). Their response actions are sometimes made alone or with NGOs and philanthropists, largely by providing logistical support in terms of food packages, mattresses, and some basic items to meet the immediate material needs of the displaced. While such efforts do help bring short term relief to affected persons, a key gap seen in the operations of the NADMO has been the neglect of measures to mitigate the long term psychological and mental health impact on persons affected by disasters. The reason is not far-fetched because the organization is found not only to lack general staff trained in disaster management (Djimesah et al., 2018), but is also bereft of specialized staff trained in managing disaster related psychological and mental health outcomes. Consequentially, NADMO's operations have been more reactionary than anticipatory, and its interventions more material-based than psychologically oriented. Aware of this gap and the deleterious effects of lack of psychosocial help for victims and families of

disasters, the Ghana Psychological Association (GPA) initiated psychosocial support services for victims of disasters.

Recently, GPA mobilized a team of psychologists and mental health experts to render psychosocial intervention services for a recent drowning disaster in Apam, a town in the Central Region of Ghana. The disaster claimed the lives of 13 young children between the ages of 12 to 19. The aim of GPAs intervention was to mitigate the impact on four main groups that were directly and indirectly affected by the disaster: survivors, families of the deceased, the local rescuers and the general community. The next sections will highlight the nature, pattern and consequences of the disaster known as 'Apam Drowning Disaster', followed by the specific roles and interventions rendered by GPA to mitigate the impact. Based on the insights from the GPAs intervention, key recommendations and plan for managing future disasters in Ghana are outlined.

The Apam Drowning Disaster



Apam is a coastal town and capital of the Gomoa West District of the Central Region of Ghana. It is approximately 45 kilometers east of the Central Regional capital, Cape Coast and 80km west of Accra, Ghana's capital. The population of the town is about 26,466 as at 2013 (https://en.wikipedia.org/wiki/Apam). Fishing and trading are the major economic activities of the town. Typical of coastal communities, swimming remains one of the major recreational activities among the youth of the town.

Following the presidential directive towards managing the COVID-19 pandemic in Ghana, organized beach events, including swimming, were banned across the country. This directive was strictly enforced by the local police in Apam with the assistance of local fishermen. This directive brought an abrupt end to a weekly recreational swimming activity popularly called "Sunday Special" among the youth of Apam and neighbouring communities. Multiple accounts have it that on that fateful day of the disaster, there were strong tidal waves of the sea that made it dangerous for recreational swimming activity. Apart from that, there was also power outage in the community for most part of the day. Notwithstanding these events, a group of young people mostly boys between the ages of 12 and 19 from Apam and its neighbouring communities defied the presidential directive against recreational swimming and went to swim at a location far away from the usual swimming location. They did so ostensibly to outwit the law enforcement officials. Later in the day, news came out that some of the children had drowned. Local rescue team that was mobilized found two survivors and 13 dead bodies after three days of intensive rescue mission. The event generated a wider public interest including swift delegation sent by the President of Ghana to find at first hand the extent of the situation and to provide immediate assistance to bereaved families concerning the burial of the deceased.

Role of Ghana Psychological Association (GPA): Mitigating Measures.

The deceased teenagers of the Apam drowning incident were buried on March 16, 2021. To the untrained eyes, activities leading to the burial and the burial ceremony may seem to bring some closure to the unfortunate incident, but that is not so. As an Association of Psychologists and members of the Mental Health fraternity, the leadership and members of the Ghana Psychological Association know that there is so much buried under the iceberg that needed to be dealt with to help the affected families and the community as a whole, to deal with the crisis, loss and bereavement. On this note, the Association set out to support the families and community. This was informed by the knowledge that experiencing distress, anxiety, flashbacks, angry outburst and problems with concentration are amongst the ensuing symptoms after an exposure to any event considered traumatic. Depending on the interpretations a person assigns to these symptoms, healing could be progressive or delayed. Delayed healing results in what is termed as "sense of current threat" (Ehlers & Clark, 2000). The sense of current threat is the state where the ensuing symptoms become chronic, and a person is eventually diagnosed with posttraumatic stress disorder (PTSD). The GPA's community intervention was mobilized along five-step process:

Stage 1. Mobilizing the team.

The GPA used the top-down collaborative approach by engaging the Government through the Ministry for Gender, Children and Social Protection, the Member of Parliament of that Constituency as well as the Municipal Chief Executive, the Municipal Assembly, the District Department of Social Welfare,

Department of Community Development, the Chiefs, Queens and opinion leaders of the Community.

The main intervention team consisted of 30 professionals made up of counselling psychologists, community psychologists, clinical psychologists, social psychologists, workplace (Industrial and Organizational) psychologists, community psychiatric officers and psychiatric doctors and nurses.

Stage 2. Team brainstorming.

The team was well trained in their respective fields and most members had responded to many disasters in the past. These included the collapse of the Malcom Shopping Mall building, the 'June 3rd Circle' flood/fire disaster, Atomic Gas blast, the collapse of Banks and the recent spate of suicides among the Police Service Personnel. In spite of this, it is best practice to always brainstorm and plan for each response. This was done and it helped in deciding on what approach would be the best fit for this particular intervention.

Stage 3. Community entry and identification of affected families.

The GPA reached out to the community and worked with the Municipal Chief Executive, the District Security Council, and the Assembly members to identify and get a detailed profile of the affected families. All other necessary community logistics were secured for a successful community entry and community stay for the Professionals.

Stage 4. Group grief/bereavement Counselling.

On Sunday, March 21, 2021, the team of professionals entered the Apam community, led by the Minister for Gender, Children and Social Protection. There was a general press/community briefing, followed by a group therapeutic session and individual therapy sessions. These meetings afforded the Professionals the opportunity to do thorough assessment, conceptualization of the situation and to develop a more specific preliminary overview of intervention models. After the professional assessment, it became necessary to identify mental health workers in the community and rope them in administering proposed intervention. This was to enable these community workers to take over occasional follow-ups as it becomes necessary after GPA completes its major interventions and follow-ups.

Stage 5. One-week Community Individual/Family therapy and follow-up.

With tailor-made interventions for specific groups and individuals, the Professionals, working in teams spent a week in the community providing psychosocial intervention to all the survivors, affected families, the security services, rescue team and other community members such as pupils, teachers and others as the need arose.

The specifics follow:

One-on- one Psychosocial Therapy with Parents and Guardians of the Deceased

The team visited thirteen *parents and guardians* of the deceased in the various communities in Apam. Prior to each visit, clients were contacted via phone to notify them of the visit and possible interactions. On arrival, the usual pleasantries were

exchanged with the entire families and clients were excused to begin the sessions. Each session explored three essential areas (discussed below) namely 'interpretation of the event, ensuing symptomatology (and its interpretations) and adopted coping strategies'. Most importantly, the interpretations of the symptoms that could lead to Post Traumatic Stress Disorder (PTSD) were further reconnoitered. Where clients' interpretations were negative or could interfere with normal functioning, the effective coping strategies (discussed at therapeutic techniques) were introduced.

Interpretation of Event

Generally, the understanding and interpretation of the cause of the drowning was noted to be culturally informed. All mothers held the belief that the god of the sea known as "Nana Apia" was behind the occurrence of the event. A tree by the sea is noted to represent the god. The common knowledge in Apam is that there is a yearly ritual performed at the sea specifically for the god. However, this ritual had not been performed for a while. The general perception was that the god pacified itself with the teenagers believed to be innocent and "virgins", in the words of three mothers. Further probing revealed that this interpretation assigned to the event is certainly a community held belief and not necessarily a view peculiar to these mothers.

There were also personal understandings revolving around the cause of event. Disobedience and the will of God were other interpretations of the event. All the mothers held the view that none of the deceased children informed them of their whereabouts that fateful day. In their opinions, the children have been disobedient, and this behaviour has eventually led to their sudden death. The mothers will usually conclude their thoughts about the cause of event by indicating that it could possibly

be the will of God quoting "God giveth and taketh." These interpretations preceded questions on the ensuing symptoms.

Ensuing Symptomatology

Experiencing the presence of the spirit of the dead, flashbacks, distress, insomnia, loss of appetite, guilt feeling (self-blame), body pains, blaming the deceased and distorted pattern of thinking were the symptoms reported.

The presence of the dead spirit was a common concern from all the mothers. They reported that the deceased present themselves in varying ways in their homes. They believed that spirit of the deceased reveals themselves to either the younger ones in the house or tampers with utensils to announce their presence. In one instance, the mother explained that the unusual barking of the dog at home at the time the boy closes from work signals the presence of his spirit. The belief, however, is that performing a specific ritual or waiting for forty days (a culturally held belief) will aid the disappearance of the spirit.

Flashbacks, distress, insomnia and loss of appetite were also common symptoms still experienced by all the mothers. Ten of the mothers expressed their worry with thinking about the event as if it is occurring for the first time. Nine complained of changes in their sleep pattern and eight reported their inability to feed well. The mothers felt guilt and consistently blamed themselves for not being able to prevent their children from stepping out on the day of the incident. In their views, they could have acted in a way to stop their children from going near the sea. Their inability to assist in this regard plays back memory that stresses them out, affect their sleep and changed their eating pattern. Body pains were concerns from three mothers indicating that the current distress could be a contributing factor. Surprisingly, one

mother consistently blamed the deceased for causing his own death. Mothers who showed severe psychiatric symptoms were referred to the appropriate professionals at the nearby Hospital.

Interpretations of Symptoms

With no hesitations, clients responded that the death of their children were the fundamental cause of their symptoms, and they hope to bounce back to normal after a period has elapsed. In the view of four mothers, the symptoms are natural expectations following a traumatic encounter. They nevertheless mentioned that there is a possibility of encountering health issues should symptoms such as flashbacks, distress, insomnia, loss of appetite and body pains persist. These views sparked the realization that there was a need for healthy coping strategies.

Mothers Adopted Coping Strategies

Questions on the strategies adopted to deal with the symptoms yielded three major responses: Performing specific cultural rites, praying to God and social support were commonly held beliefs and practices used as mechanisms to treat the ensuing symptoms.

To get rid of the spirit of the dead, one mother believed in the use of "Nayana" (i.e., Momordica fetid). The leaves are mashed in a bucket filled with seawater and used for bathing. In another instance, a couple believed in performing rites at the seashore to separate the spirit of the dead from the living. The spirit in the opinion of the clients, departs the living and from the homes after the ritual.

Praying to God as a coping strategy was an outstanding belief and practiced by all the mothers. The notion that "God giveth and taketh" in their opinion implies that constant communication

with God is key. Most women mentioned that they have committed the deceased children into the hands of God and there is they continue to engage God in prayers for protection for the remaining children and family. This is a common practice mostly in the morning and before they retire to bed in the evening.

The role of family and friends in rendering support was another means of minimizing the ensuing symptoms. The mothers expressed their profound gratitude for the extent to which their immediate and extended family members have supported them through prayers, house chores and assisting in taking care of the remaining children during this time of grief. Friends and neighbors were cited as paying regular visits or contacting via phone to strengthen them emotionally with their encouraging words.

Considering the symptoms experienced by the mothers, it was evident that the current means of coping were not exhaustive in completely ridding off the ensuing symptoms. There was, therefore, the need to introduce other therapeutic techniques, considered relevant for treating the symptoms discussed.

Therapeutic Techniques

Clients were all encouraged to implement their culturally informed practices such as using "Nyanyan", pouring libation at the seashore, praying to God and embracing support from family and friends. The rationale behind the encouragement was that knowledge of the existing belief is culturally constructed (Amineh & Davatgari, 2015) and have become the clients' worldview. To facilitate effective coping by introducing essential mechanisms in counselling requires a validation of the clients' existing practices. Merging the existing beliefs and practices

of the client, and therapeutic techniques thus, largely enhance meaning development required for healing.

Besides reinforcing clients' engagement with their cultural specificities, varying therapeutic techniques were also introduced. Wits Trauma Model (WTM), Reality therapy, Cognitive Behavioural Therapy (CBT) – cognitive restructuring, Psychoeducation, Progressive Muscle Relaxation Therapy (PMRT), empty chair approach, Systematic desensitization, Ho'oponopono (Positive self-talk), medical checkups and Family therapy, expedited clients' coping with other symptoms presented and highlighted in the DSM.

Clients who complained of body aches, insomnia and loss of appetite were referred to see a general practitioner at the St. Luke's Catholic Hospital.

Family therapy became an essential means of coping during the one-on-one sessions. It was evident from the sessions that the siblings and some family members at home were similarly traumatized. Six of these siblings and family members were visited in their homes to understand their symptoms and appropriate therapies introduced. Psychoeducation on CBT and effective communication were paramount during the group counseling. The families understood their unusual behaviour from the ABC therapy. Gaining insight into their conditions, they embraced the idea that the event does not cause the behaviour, but the interpretation of the event is the sole determinant of their behaviour. There was the need then to replace their identified negative thought patterns to a rather positive one.

One-on-one Psychosocial Therapy with Two Survivors and Their Families

In all a total of seven (7) individual sessions and three (3) group sessions were completed with the survivors. There were two initial survivors and a third discovered later during the team's school outreaches. The team also met with their families to explore the impact of the incident on them.

The three survivors shared their firsthand narration of happenings, from their motivation to visit the beach, on the faithful Sunday to the moment of surviving the drowning. The story of the third survivor was striking. According to him, he initially escaped drowning and was standing ashore and then saw that one of the girls was struggling to survive. He went back to save the girl, who held on to his leg. According to him, the idea was to gradually swim out of the sea with the girl holding on to his leg. In the process, he realized he was caught up in the whirlpool and was drowning. According to him, he realized that if he struggled, he was going to drown and so he kept calm and gently took off his shirt. He then raised it in the air with one hand, hoping that someone might see the shirt and come to his rescue. Thankfully one person who was leaving the scene turned and saw his hand in the air and came to his rescue.

The team further explored their feelings, thoughts and current behaviours in relation to their unique experiences. On observation, all three survivors looked traumatized, evidenced by their physical appearance and reluctance to respond to some questions relating to vivid account of the incident. It was discovered that the three survivors were experiencing prejudice and discrimination among their colleague students in their various schools. The team thus planned for and had school outreaches as part of the engagement process.

Extended family members of the survivors were also engaged to explore the impact of the incident on their well-being as parents and external relatives of survivors of the drowning incident. There was evidence of feelings of guilt, fear, regret and resentment. Some coping strategies were shared with the individuals and groups.

During the one-on-one sessions and school outreach, the team emphasized the importance of continued community inclusion and participation in providing support for survivors of a disaster. Furthermore, the team shared some evidence-based practices and coping strategies that both survivors, their family and friends can use to take care of themselves so they can stay well.

The Wellness Recovery Action Plan (WRAP®) practices was explored with the survivors and their families throughout the interactions. As part of efforts to assist survivors and their families to recover, the team shared five key integrative practices of recovery (Hope, Personal responsibility, Self-advocacy, Education and Support). These practices were explored to understand its implication on their recovery in relation to the incident. The team assisted survivors and their families to identify internal and external resources for living, recovery and then use these learned tools to create their own individualized plan for successful living.

In addition, using peer-led learning approach, the team facilitated a self-help transformation process. The process empowered individuals to maintain their well-being, wellness and recovery. In addition, it aided the individuals to accelerate upon joy, happiness and will power over their life-long journey. The team assisted them to put in place a simple post crisis/trauma plan.

Engagement with Rescue Team

The initial engagement with the rescue team was generally satisfactory. They expressed the challenges they are encountering after the disaster. Majority of them complained of having insomnia, hearing of voices, inability to carry out their normal daily activities. However, their major problem was risking their lives to rescue the survivors and conveying the deceased from the seashore to the morgue. In addition to the overwhelming weight of the deceased, bodily fluids from some of them also dripped on the rescuers. This was a harrowing experience for them.

Though the community recognized the devoted effort, they expected financial reward, which has not been the case. Due to this grievance, they were not concerned with the possible psychological impact and not ready for any intervention. Despite the group's challenge, few of the rescuers still realized the need for psychosocial interventions. Seven rescuers availed themselves for the counselling process.

Apart from meeting at their usual base as a means of coping with the distress, they received Psychoeducation on the current and expected symptoms. Cognitive Behavioral Therapy was employed to restructure their maladaptive cognitions and behaviours. Although the financial expectation was deemed relevant, they eventually came to the realization that the long-term psychological impact was worth responding to now.

Engagement with Representatives for NIB and Police at the Drowning Scene

The team engaged with two (2) security personnel representing the National Investigations Bureau (NIB) and the Ghana Police Service (GPS). This session was important to appreciate their (NIB and GPS) experiences in contributing to the rescue process.

As well, the team aimed at understanding the current emotions and where relevant, introduce psychosocial intervention for healing.

Interactions with the group revealed emotional reactions that mimic symptoms of PTSD. The team supported him by sharing some evidence-based practices with proven results on how to manage the stress and minimize the impact of the entire drowning incident on their well-being, especially given the role he played.

Outcomes

At the end of the interventions and follow-ups, the desired outcomes of GPA were realized.

Each of the groups and individuals attended to (survivors and family, families of deceased, rescue team and a significant section of the community) had gained insight into how their experiences in the unfortunate incident, and their evaluation of these experiences had contributed to the various symptoms they experienced. They had also gained mastery over existing coping and newly introduced interventions and had utilized these to a large extent towards recovery. Significant improvements in psychosocial problems triggered by the incident were recorded for almost all who were attended to. Those who had been referred to the General Hospital had also improved significantly.

One other significant outcome was the discovery one more survivor that was not in the official record of survivors. This person was given the appropriate psychosocial care and was officially included in the database of survivors.

Stakeholders had also gained insight into the role of psychologists in disaster management.

Discussion

This paper set out to highlight psychosocial intervention organized by the Ghana Psychological Association for the recent drowning disaster in Apam that claimed the lives of 13 adolescents. We found deeper embeddedness of local and cultural beliefs in the people's conceptualization of the disasters that found expression in the ways they interpreted the experiences, symptomology and even treatment options. The observation aligns with the view by disaster experts that disasters, their nature, patterns, and meanings are context -specific and could also be linked to wider attitudes about the local believes and meaning of misfortune, blame and social expectations and remedial measures (Furedi, 2007). From this perspective. It was therefore pertinent to adopt cultural sensitivity in achieving meaningful results.

Further, the unique experiences of particular actors of the disaster: survivors, rescue team members, and parents, in terms of their understanding of the disaster and experience accords with views observations that psychological reactions to a natural disaster or an extreme event vary across individuals depending on their age, developmental level, personality, intellectual capacity and social network. Although a whole community suffered the disaster, and the ultimate goal of the intervention was to achieve general wellness at the communal level, it was important that tailored interventions were rendered for dealing with peculiar individual needs.

Within the context of existing literature on disaster management institutions and agencies, there appears to be a deafening silence on engagement of psychologists and psychological provisions

in the management of disasters. As said earlier, the reactionary approach and materialistic oriented disaster management practices by the NADMO in the past has mainly been due to lack of trained staff generally on disasters and in particular psychosocial sequelae of such disasters. The observations found in the intervention prompt action towards scaling up training of personnel to handle general disasters and outcomes of disasters that may have psychological undertones, since all disasters leave in their trail, psychological troubles for people. While this may be a futuristic goal, Ghana's disaster management body can in the short to the medium term, collaborate with GPA as was done in the Apam incident to meet the critical needs of persons in disasters.

The collaborative role with intergovernmental agencies led by the Minister of Gender towards the success of the Apam programme should inspire efforts towards enhancing existing cooperation between and within governmental and non-governmental actors. This will not only ensure an expedited mobilization of logistics and personnel in times of disasters, but also foster a concerted effort towards preparing for and dealing with such disasters. The initiative to partner governmental agencies for Apam was based on an earlier realization that several organizations with complementing and overlapping roles exist in Ghana to manage disaster situations in the country. Although with comprehensive frameworks, enforcement of these frameworks as well as coordination had been a major problem among these organizations. Hampering such coordination had been power relations, knowledge management, institutional capacity, information sharing among several others. Moreover, the politicization of NADMO, the lead agency, was another issue identified as hampering effective collaboration among disaster management organizations and consequently effective disaster management. Since its establishment, NADMO had remained a

political appendage of ruling governments with every successive government changing and replacing the hierarchy of the organization with its own. Depoliticization of the organization will go a long way to make the organization very professional and most responsive to its core vision and mission. Effective preparedness requires close coordination among the response teams and adequate information sharing. Recommended ways of improving coordination and disaster management were identified to include facilitative and strong leadership, transparency as well as structured opportunity for information sharing (Sowah, n.d.). A wholly professional organization in NADMO can lead such coordination efforts.

Further as seen above, the attribution of disaster was socially constructed with some supernatural underpinnings. The understanding and interpretation of the cause of the drowning was thus culturally informed with mothers believing that the *god of the sea* known as "Nana Apaa" was responsible for the disaster. The families and other community members held the belief that the non-performance of the annual ritual for the sea god invited the anger of the god on the people and that the gods pacified themselves with the teenagers believed to be innocent "virgins". Apart from the belief in the supernatural cause of the drowning disaster, there was also views that the drowned had been disobedient to an order from the President and probably got their punishment in line with local axiom that "akora onnye sutsie no oko antseadze" (a disobedient child goes to the place of no return). Despite these interpretations, there were clear psychiatric and psychological symptomology among all groups such as insomnia, panic attacks, fear, and anxiety among others. Rather than discounting these local interpretations, it was important to incorporate these beliefs in the intervention in keeping with the cultural competence care model.

Again, such observations also inform the need for the Professionals to be open-minded and not to over rely on diagnostic tools. The simple reason being that, not all the symptoms can be mapped onto specific nosological categories on such formal diagnostic tools as the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Recommendation

In the light of these observations, we made key recommendations including the development of institutional framework and structures that will be capable of preventing, preparing for and responding to disasters at the beach and its surroundings in Ghana. The framework should include the establishment of a local office for disaster management agencies and related technical committees, and the strengthening of capacities of all actors: government, community, district assemblies, and district agricultural sector, organized private sectors interested in coastal activities, state institutions and development partners.

The next is the development of institutional facilities and resources capable of preventing, preparing for and responding to disasters at the beach and its surroundings. This includes providing local rescue team with incentives like life jackets, outboard motors, and sea defense around the coastal area.

Further, we recommend the integration of disaster risk reduction into sustainable policies and plans. The interventions in this area will focus on mainstreaming disaster management and risk reduction into local, regional and national policies with key emphasis on psychosocial interventions. This can be done through the development of national platform for disaster management, sensitization, and awareness creation on disaster management, capacity building and introduction of disaster risk reduction

into the school system, family and community. This priority area should also involve establishing the necessary linkages and capacity building at all levels, as well as development and implementation of an effective resource mobilization mechanism and necessary follow-ups possibly on monthly basis in the coastal areas.

Another recommendation concerns the generation of a body of knowledge that will be useful to know needs of persons in disaster to aid the delivery of tailored support for families, coastal workers and traditional rulers, NADMO, local rescue team and other partners; to anticipate, plan for and manage disasters effectively. Interventions in this area will aim at developing and improving on effective early warning systems, development of a comprehensive database, system development, conduct surveys and develop communication channels and provide psychoeducation on disaster and its management.

The creation of broad and effective partnership among family, community, local agencies, district assemblies and humanitarian organizations and other partners to engage in disaster risk reduction activities and addressing the underlying factors in disasters is paramount. The local disaster management office's intervention (if established) will focus on ensuring that the necessary platform or structures and processes exist for genuine partnership and concerted efforts in disaster risk reduction and management. The interventions will focus on sensitization programs, psychoeducation of psychosocial interventions for individuals and groups that are exposed to loss, bereavement and other forms of trauma.

We also recommended the development of an efficient response system to disaster management and equipping of disaster management agencies with the requisite resources. Interventions

in this area will aim at building capacities at all levels and within all working committees or agencies; develop strategies for resource mobilization and for monitoring and evaluation. These resources should be focused on providing support for rescue team more especially in the discharge of their duties.

Finally, a strong recommendation is made for the depoliticization of NADMO and training and retraining of its staff to be abreast with regional and international best practices in disaster and risk reduction management. The National Office should also establish links with external institutions for best practices and sharing of experiences in disaster and risk reduction issues.

Conclusion

Disasters leave grave consequences in all dimensions in the lives of people. Effective response measures should therefore target not only the material losses but also the psychological losses that people suffer. The intervention of the Ghana Psychological Association (GPA) in the recent Apam Disaster aimed primarily at addressing the missing links in disaster management in Ghana by incorporating interventions to deal with the psychosocial impact. However, the GPA interventions has also thrown up key areas that need swift attention for effective disaster prevention and management in Ghana. These areas include the critical role intergovernmental and non-governmental collaboration plays, as well as the importance of cultural beliefs in understanding and designing effective treatment and intervention options for disaster victims.

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Socio-demographic Predictors of Quality of Life among Breast Cancer Patients

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Abstract

This study examined the link between socio-demographic variables and quality of life among breast cancer patients at various stages of the disease. Two hundred (200) breast cancer patients at the Korle-bu Teaching Hospital were the sample of this study. The age range of the patients was between 18 and 80 years. A number of the patients in the study had at least basic education and were employed. The cross-sectional survey design was employed for this study. Furthermore, quantitative research approach was employed to examine the responses of the patients. Statistical tests used to analyze the hypotheses were the Pearson Moment correlation and the Multiple Regression statistics. The results indicated that duration of illness had a significant relationship with quality of life of breast cancer patients. Age of patients, religious status, management plan and age of onset of the illness significantly predicted quality of life. Implications of the findings are discussed below.

Key words: Socio-demographic factors, Breast cancer, Quality of life, Ghana

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Introduction

Based on worldwide research, breast cancer is the most common malignancy among women, with an estimated 715,000 new cases for the year 2008 diagnosed in the more developed regions (26.5% of the total) and 577,000 (18.8%) in less developed countries (WHO-IARC, 2008). Breast cancer is the leading cause of neoplastic deaths among women; the estimated number of deaths in 2002 was 410,000 worldwide (WHO-IARC, 2008). In developed countries, survival from breast cancer has slowly increased to the current rate of 85%, following improvements in screening practices and treatments. On the other hand, the survival rate in developing countries remains around 50-60% (WHO-IARC, 2008).

A diagnosis of cancer regardless of stage is a stressful event impacting on all facets of the patient's life and that of her family caregivers. To minimize the impact, adaptive coping mechanisms are required (Mukwato, Mweemba & Makula, 2010). The time of diagnosis, initial stages of treatment course and the months following the end of the treatment are hard times for patients both physically and emotionally. During these periods, poor adjustment and decreased quality of life in patients can easily occur. It is known that decreased quality of life as a result of chemotherapy side effects may predict early treatment discontinuation in patients (Richardson, Wang, Hartzema-Pharm & Wagner, 2007). Patients diagnosed in the early stages experience the stress of coming to terms with the diagnosis, the experience of complex and usually long treatments, and the side effects of the different treatment modalities. Those diagnosed in the late stages, have to come to terms with their diagnosis, the fact that they will have to receive palliative as opposed to curative care and the fears and uncertainty about end of life (Mukwato et al., 2010).

More often than not, quality of life is considered as an existing phenomenon relative to an individual or cultural expectations and goals hence the literature reports no single agreed definition of health-related quality of life. Health related quality of life (HRQOL) refers to the domains of health which include physical, psychological, and social. These domains are seen as distinct areas that are influenced by a person's experiences, beliefs, expectations, and perceptions (Testa & Simonson, 1996). According to Carr and Higginson (2001), determining quality of life (QOL) is dependent on many factors including; the extent to which hopes and ambitions are matched by experience; individual's perceptions of their position in life taken within the context of the culture and value systems where they live and in relation to their goals, expectations, standards, and concerns; appraisal of one's current state against some ideal; and the things people regard as important in their lives.

Moreover, additional factors that have been found to be high risk factors for poor quality of life of breast cancer patients are age, duration of illness and types of treatment (Kwan, Ergas & Somkin, 2010). Previous studies suggested that younger women have greater psychological morbidity and poorer QoL after breast cancer than older women (Kwan et al., 2010).

Some studies have demonstrated the quality of life among breast cancer patients and how this is influenced by socio-demographic variables. According to research by Dehkordi, Heydarnejad and Fatehi (2009), no significant correlations were found between quality of life and variables such as age, sex, and marital status, duration of disease, economic conditions and occupational function. Contrary to this study, Shen, Liu, Zhang, Feng, Zhou and Chen (2012) revealed that younger age, lower stage of cancer, higher education and income significantly influence the quality of life of cancer patients A study by Ho, So, Leung, Lai

and Chan (2013) revealed that the treatment plan of patients had a significant influence on quality of life of patients. Thus, the ongoing therapy group showed higher levels of anxiety and depression and lower levels of all quality-of-life dimensions than the post-therapy group.

Despite the relative importance of quality of life in prognosis of breast cancer patients, most studies conducted have focused on the quality of life of other conditions other than breast cancer. In Ghana the few studies available are prevalence studies interested in estimating the number of people suffering from the disease and the medical complications (Clegg-Lamptey, 2012) without paying attention to how socio-demographic variables influence quality of life of the patients. Owing to this dearth of literature it is important to explore the relationship that exists between socio-demographic variables and the quality of life of breast cancer patients. Based on the reviewed studies above, the following hypotheses were examined: 'there will be a significant positive relationship between duration of illness and quality of life of breast cancer patients'; 'demographic variables will significantly predict the quality of life of breast cancer patients.'

Method

The population of the study was breast cancer patients receiving treatment at the Korle Bu teaching hospital. Out of this population a sample size of 200 breast cancer patients was chosen. This sample comprised 34(17%) single, married 104(52%), divorced 29(14.5%) and widowed 33(16.5%). Employed participants were 111(55.5%), whilst unemployed and retired participants were 57(28.5%) and 32(16.0%) respectfully. In terms of religious status, Christians constituted 154(77%) whilst Muslims constituted 46(23%). Another demographic variable is highest level of

education, and its dimensions and respective constituents are basic 66(33%), secondary 55(27.5%) and tertiary 79(39.5%).

Participants with primary education were 44(22%) whilst participants with JHS education were 26(13%). Participants with secondary education were 34(17%) whilst participants with vocational education were 39(19.5%). On the other hand, participants with polytechnic education were 11(5.5%) whilst participants with training college education were 19(9.5%). The total number of patients with university education was 27(13.5%). Furthermore, patients treated by surgery, chemotherapy and radiotherapy made up 38(19%), surgery and radiotherapy 19(9.5%), surgery and chemotherapy 81(40.5%) surgery alone 17(8.5%) and chemotherapy alone 45(22.5%). Patients with stage 1 breast cancer were 15(7.5), stage 2 = 38(19%), stage 3 = 47(23.5%) and stage 4 = 100(50%). Finally, 80(40%) patients had other health conditions whilst 120(60%) did not have other health conditions.

Procedure

Prior to the data collection process, a proposal was sent to the ethics committee for the humanities for clearance. The clearance letter and an introductory letter were sent to the Korle Bu teaching hospital requesting to use their patients for the study. After permission was granted, data collection dates were fixed. Through convenience sampling techniques participants who were willing to partake in the study were sampled and the questionnaire was administered to them on a one-on-one basis.

Measures

A questionnaire was used to collect data for the study. Specific information relating to the quality of life of breast cancer patients

was asked. Demographic variables gathered include age, marital status, employment status, religious status, educational level, management plan, age of onset and duration of illness. Age as well as age of onset was measured on an interval scale. On the other hand, the other demographic variables were measured on a categorical scale.

WHQOL-BREF

The WHOQOL-BREF is a 26- item Likert scale that assesses four domains of quality of life: physical health, psychological health, social relationships and environmental well-being. Some items on the scale in line with the above stated domains are; "to what extent do you feel physical pain prevents you from doing what you need to do?", "how often do you have negative feelings such as blue mood, despair, anxiety, or depression?", "how often do you have negative feelings such as blue mood, despair, anxiety, or depression?" and "how healthy is your environment?" respectively. The WHOQOL Group (1998) assessed Cronbach alpha for the four domains: physical health, .86; psychological health, 0.76; social relationships, 0.66; and environmental well-being, 0.80. Test-retest reliabilities for the four domains were .66 for physical health, .72 for psychological health, .76 for social relationships and .87 for environmental well-being. The WHOQOL-BREF was found to correlate .90 with the longer version of the instrument - WHOQOL-100.

Data Analysis

Hypothesis 1 was analyzed using simple correlation analysis. This statistical test was carried out to find out the relationship that existed between duration of illness and quality of life of breast cancer patients. Hypothesis 2 was analyzed using the

multiple regression analysis because the demographic variables were used to predict the quality of life of the patients.

Results

Relationship between Duration of Illness and Quality of Life among Breast Cancer Patients

Results in Table 1 show that duration of illness was significantly and positively related to the quality of life of breast cancer patients (r=, -0.47p < 0.01). There was significantw negative relationship between duration of illness and all the specific quality of life measures: physical quality of life, *r* (198) = -.40 ϱ <. 01; psychological quality of life, *r* (198) = -.45, ϱ < .01; social quality of life, *r* (198) = -.34, ϱ < .01 and environmental quality of life, *r* (198) = -.34, ϱ < .01.

Table: 1: Pearson Correlation matrix of duration of illness and quality of life among breast cancer patients

	Variable	1	2	3	4	5	6
1	Duration						
2	QOL	-.47**					
3	Physical	-.40**	.83**				
4	Psychological	-.45**	.92**	.74**			
5	Social	-.34**	.64**	.45**	.53**		
6	Environmental	-.34**	.86**	.56**	.72**	.38**	

***= Significant at .01 alpha level*

The results of the multiple regression shown on table 2 below indicate that all the demographic variables significantly explained 40% variance in quality of life of the patients, [$R^2 = .40$, $F_{(6, 194)} = 11.26$, $p < .01$]. The Age of onset significantly predicted quality of life of breast cancer patients; [$\beta = 1.62$, $t = 2.50$ $p < .05$]. Additionally, management plan negatively and significantly explained quality of life of the breast cancer patients, [$\beta = -.17$, $t = - 2.79$, $p < .05$]. Also, religious status significantly and negatively accounted for quality of life of the breast cancer patients, [$\beta = -0.24$, $t = -4.08$, $p < .01$]. Finally, age accounted significantly and negatively for quality of life of breast cancer patients, [$\beta = -1.81$, $t = -2.65$, $p < .05$].

Table 2: Multiple regression of demographic variables on quality of life.

PREDICTORS	B	SEB	B	*T*	*P*
Age	-2.67	1.01	-1.81	-2.65	0.01
Marital status	0.65	1.51	0.03	0.43	0.67
Employment status	-3.75	1.92	-0.14	-1.95	0.05
Religious status	11.31	2.77	-0.24	-4.08	0.00
Educational level	-1.27	1.27	-0.13	-1.00	0.32
Management plan	-2.48	0.89	-0.17	-2.79	0.01
Age of onset	2.49	0.99	1.62	2.50	0.01
Duration	-0.10	0.11	-0.11	-0.93	0.35

$R^2 = 0.40$

Discussion and Recommendations

The study aimed at examining socio-demographic factors as predictors of quality of life among breast cancer patients in Ghana. Interesting findings were gathered from the analyzed data. A significant negative relationship was found between

duration of illness and quality of life among the patients. The time of initial diagnosis, initial stages of treatment course and months following the end of treatment are hard times for patients both physically and emotionally since they are characterised by decreased quality of life. In a simple correlation analysis, the results interestingly showed a significant negative relationship between duration of illness and all dimensions of the quality of life of the patients. This means that the longer a patient had been diagnosed with breast cancer the lower the quality of life of the patient. On the other hand, the shorter a patient had been diagnosed with the disease the higher the quality of life. In essence, one would think that patients diagnosed with breast cancer over the years would have gotten used to living with the condition and found ways of coping in such a way that improves their quality of life. The study speculates that those with longer duration of the condition had become frustrated with having to live with the condition for long if not for their whole life thereby having deleterious effects on their quality of life. This finding is contrary to previous results by Ho et al. (2013) who compared psychological health and quality of life of women with breast cancer as well as the relationship between anxiety, depression and quality of life during treatment and afterwards. Their results showed that ongoing therapy group or those who had not been diagnosed with the condition for long showed higher levels of anxiety and depression and lower levels of all quality-of-life dimensions than the post-therapy group or those who had a longer duration of the condition. Finally, the finding again contradicts the earlier account of Safaee et al. (2008) who reported among other factors that grade of tumor and duration of illness have significant influence on quality of life, with patients of lower duration of illness significantly reporting lesser global quality of life.

The other demographic variables which predicted quality of life of breast cancer patients include age of patients, religious status, management plan and age of onset. Thus, younger patients were found to have lower quality of life than older patients. Also, patients who were religious experienced a better quality of life as well as those who were receiving full management for their breast cancer. Finally, patients diagnosed whilst older experienced better quality of life than young patients who had been diagnosed with breast cancer. This finding was similar to that of Jordan et al., (1999) who found young age to predict presence of anxiety and depression as well as lower quality of life among patients. Similarly, Ardebil, Bouzari, Shenas, Zeinalzadeh, and Barat (2011) found management plan to significantly predict the quality of life of patients.

Limitations

The study employed the quantitative research approach. Adapting the mixed method would have provided additional understanding of the reasons why breast cancer patients' experienced lowered quality of life. The limited clinic day(s) for breast cancer patients at both the radiotherapy and the surgical departments of the hospital per week/month markedly delayed the data gathering.

Practical recommendations

The above findings have important implications for the health sector. The findings indicate that multidisciplinary bio-psychosocial approach which emphasizes involvement of professionals from medical, psychiatric and psychological fields be involved in the management of breast cancer so that this holistic care can have better and improved impact on the patient's

life. This study has found most patients to report low quality of life, it is thus recommended that it is replicated to ascertain the culturally specific coping and adjustment strategies that are used by patients to find out whether they rely on maladaptive ones or not. It may also be important to research into the psychopathological distress that most patients experience after being diagnosed with this condition.

Conclusion

The study found most patients to report marked lowered quality of life as predicted by demographic variables. Indeed, majority of the patients especially those with advanced diagnosis were observed to have lowered quality of life. It also came to light that patient who lived long with breast cancer exhibited poorer quality of life. It is possible that these patients may not have been coping with diagnosis of the disease well. In summary, the findings may serve as the basis of future research since there are only few studies in the Ghanaian and African context with regard to socio-demographic variables and quality of life among breast cancer patients.

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The Relationships between Hope, Perceived Social Support and Life Satisfaction: Relation to Emotional Well-being and Distress

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Abstract

There is increasing evidence emphasising the importance of positive experiences in the promotion of mental health, however such evidence has not been replicated in the Ghanaian context. The current study, therefore, sought to investigate the relationship between positive experiences of hope, perceived social support, life satisfaction and mental health. Using the method of structural equation modelling, we determined whether these positive would be predictive of both emotional well-being components of mental health as well as distress among the randomly selected sample of 717 adolescents from seven schools in the Northern region of Ghana. We found that positive experiences were both directly and indirectly related to emotional well-being, but not emotional distress. Our findings also indicated that the presence of emotional well-being did not preclude the absence of distress.

Keywords: Mental health; emotional well-being; distress; Ghanaian adolescents

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Introduction

There has been a resurgence of interest in positive psychological research (Seligman & Csikszentmihalyi, 2014; Seligman, Steen, Park, & Peterson, 2005) and theoretical positioning of mental health as a positive state of being (e.g. feeling cheerful, interested in life, enjoyment of life; Huppert & So, 2013; Keyes, 2014) rather than absence of illness or emotional distress. Hope, perceived social support and life satisfaction are constructs that feature prominently in positive psychology research, with emphasis being made regarding their positive relationship with adolescent mental health (Danielsen, Samdal, Hetland, & Wold, 2009; Guse & Vermaak, 2011; Yarcheski & Mahon, 2014). Notably, the bulk of this research is found in the Western countries, with scholarly work on this subject in the Ghanaian context being minimal (see Salifu Yendork & Somhlaba, 2015). Against this background, the present study sought to investigate, firstly, the positive relationships between hope, perceived social support, life satisfaction and emotional well-being components of mental health and, secondly, whether these constructs and emotional well-being itself would be negatively related to emotional distress in school-going adolescents in the Northern region of Ghana.

Hope has been defined as a combination of pathway thought and agency directed towards future goals and aspirations (Snyder et al., 1991), and as a key character strength that not only attenuates the negative impact of adverse circumstances but also fosters psychological well-being among adolescents (Esteves, Scoloveno, Mahat, Yarcheski, & Scoloveno., 2013; Proyer, Ruch, & Buschor, 2013; H. M., 1989). Snyder (2002) also added that the successful attainment of goals through the setting of pathways and feelings of agency was crucial for the experience of life satisfaction. Hopeful thinking has been found to correlate positively with life satisfaction and psychosocial well-being and, also serves as a buffer against future stressors (Guse & Vermaak, 2011; Snyder, Lopez, Shorey, Rand, & Feldman, 2003).

With hope closely related to life satisfaction (Satici, 2016; Marques, Pais-Ribeiro, & Lopez, 2011), there is also evidence illustrating that life satisfaction increases positive emotions (Gruber, Kogan, Quoidbach, & Mauss, 2013) and adaptive behaviour in adolescence (Sun & Shek, 2010). It stands to reason that there is the possibility of a mediated relationship between hope and emotional well-being component of mental health, via life satisfaction. It is worth noting that most studies have focussed on life satisfaction as a consequent variable, limiting the evidence on the possible mediating role of this construct in the relationship between hope and the emotional well-being component of mental health. The mediating role of life satisfaction is possible because success during the goal-pursuit process could lead to positive cognitive appraisals, which could in turn protect the individual from environmental circumstances that could have resulted in negative emotional states and disruptive behavioural reactions (Lazarus, 1991).

In the consideration of the mental health outcomes, emotional well-being has also been closely tied to the perceptions individuals

have of social support received from significant others within their social context. Defined as the evaluation of an individual's social support system as being adequate (Cohen & Wills, 1985), perceptions of social support are deemed to have a buffering effect against stressful experiences (Stewart & Suldo, 2011). Extant international research conducted on the role of perceived social support on child and adolescent mental health (Amoah & Jørgensen, 2014; Danielsen et al., 2009) as well as life satisfaction (Kong & You, 2013). This study examined both the mediation effects of loneliness and self-esteem for the relationship between social support and life satisfaction. Three hundred and eighty nine Chinese college students, ranging in age from 17 to 25 (M = 20.39; Kong & Zhao, 2015) has revealed a positive relationship between perceived social support and mental health. In Ghana, a micro-level study using the world values survey has shown that social capital was positively related to the experience of life satisfaction (Addai, Agyeman, & Amafu, 2014). Also in the Ghanaian context, Annor (2016) found that support from supervisors and family increased subjective well-being among university employees. The buffering functions of social support are seen as both protecting the individuals from stress and enabling them to judge their lives as satisfactory. Given the evidence on the direct positive relationships between perceived social support and both life satisfaction and mental health as well as evidence of the mediating role of self-evaluation (Song, Kong, & Jin, 2013) in the relationships between positive psychology variables and well-being, we hypothesized that perceived social support would be partially positively related to emotional well-being component of mental health via life satisfaction.

Apart from the positive relationship between perceived social support and mental health, the direct positive relationship between perceived social support and hope has also been established in previous research (e.g. Cheng et al., 2014; Mahon

& Yarcheski, 2015). Snyder (2002) opined that an environment without support could be detrimental for the development of hope, and that hopeful thinking is likely to be fostered in an environment in which the individual perceives the presence of adequate social relationships and support.

In mental health research, there have been few studies (Yadav, 2010; Yarcheski, Mahon, & Yarcheski, 2001) exploring the interaction between internal- and external resources in enhancing well-being. For example, Yarcheski et al. (2001) highlighted hope as an important mediator of the positive relationship between perceived social support and general well-being. Perceptions of support and hope have also been identified to account for a large amount of variance in life satisfaction among individuals with chronic illness (Yadav, 2010). A recent study by Ng, Chan and Lai (2014) among a sample of underprivileged children in Hong Kong indicated a mediated positive relationship between hope and life satisfaction via perceived community support. The observed inconsistency between the study by Yarcheski et al. (2001) and Ng et al. (2014) on the role of perceived support as either an antecedent or mediator, necessitates further research into the mediated relationship between perceived social support and life satisfaction. Against the background of the perceived support being a crucial antecedent, we hypothesised that perceived social support would be related to life satisfaction and emotional well-being component of mental health and distress via hope.

Life satisfaction refers to the cognitive appraisal of the overall quality of an individual's life compared to laid-down standards (Diener, Suh, & Lucas, 1999). The authors review current evidence for Wilson's conclusions and discuss modern theories of SWB that stress dispositional influences, adaptation, goals, and coping strategies. The next steps in the evolution of the

field are to comprehend the interaction of psychological factors with life circumstances in producing SWB, to understand the causal pathways leading to happiness, understand the processes underlying adaptation to events, and develop theories that explain why certain variables differentially influence the different components of SWB (life satisfaction, pleasant affect, and unpleasant affect; Diener, 2009). It is important to note that, although most previous studies have used life satisfaction as a measure of mental health (Keyes, 2014), there is support for a need to differentiate between life satisfaction and positive mental health (Marques et al., 2011). Moreover, previous research has shown that, while domain-specific satisfaction was similar to global life satisfaction, these constructs are different – with domain-specific satisfaction predicting global life satisfaction (Pavot & Diener, 2008). We therefore differentiated between domain-specific life satisfaction and global life satisfaction (as a component of mental health) and included both in the analysis because of evidence showing that these constructs are distinct and could be predictive of each other. Given that most studies have focused on the antecedents of life satisfaction, Gilman and Huebner (2006) have argued for a need to understand the consequences, and not merely the antecedents of life satisfaction. We hypothesized that life satisfaction is not only a consequent of hope and perceived social support, but also a positive antecedent of emotional well-being component of mental health including positive affect and emotional ties. Given that life satisfaction is a key indicator of mental health and a likely important negative correlate of distress, we posit a model with life satisfaction serving as the major mediator, which connects other variables to mental health.

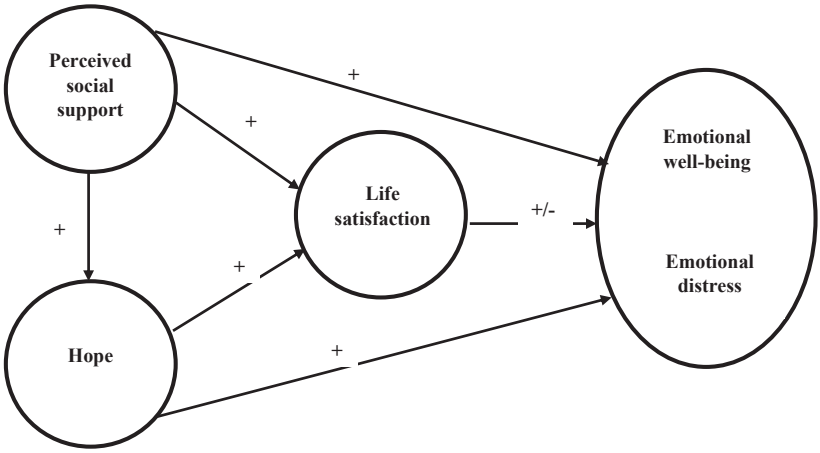


Figure 1: Hypothesized model of relationships between hope, perceptions of support, life satisfaction, emotional well-being and distress.

To our knowledge, there have been no studies that have tested the hypothesized model (see Figure 1) to be explored in the present study. In addition, given that there has been limited research exploring hope, perceived social support and life satisfaction in the Ghanaian context (notably, Amoah & Jørgensen, 2014). The interest in the relationship between social connections and health related wellbeing of a given population has received a major boost in public health recently. This relationship either produces or prevents health risks and health problems. This paper qualitatively explores this relationship using the case of a unique group (street children, we sought to explore the pathways to mental health. We used the method of structural equation modelling (SEM) to determine whether the hypothesized model would fit the observed data. We hope that the present study would provide evidence for the importance of enhancing positive experiences among adolescents in Ghana. The results of this study could also demonstrate the extent to which the emotional

well-being components of mental health and emotional distress could be separate factors in the Ghanaian context.

Although we did not measure any indicator of poverty, previous research in the Northern region of Ghana has shown that only 6.1% of the population is gainfully employed, while 68% of the population is economically active, albeit self-employed. Approximately, 22.9% of the population of the Northern region comprises unpaid family workers ("Ghana Northern Region," n.d.). This region was chosen for research because previous studies on mental health in this context has focused on negative predictors of psychological distress with the absence of research on positive mental health. Given the economic deprivation of the Northern region, adolescents in this context are faced with a number of challenges that could have a negative impact on their well-being. However, there are purely positive experiences such as hope, perceptions of support and life satisfaction that could enhance their well-being but has been poorly researched. Hence the current sought to explore the experience of these indicators in relation to mental health among this population.

The aim of this study was to test the overall model fit of the relationships between hope, perceived social support, life satisfaction and mental health (emotional well-being and distress) in school-going adolescents in the Northern region of Ghana.

The hypothesised effects of the main study variables are that firstly, there would be direct relationships between hope, perceived social support-, life satisfaction- and outcome variables of emotional well-being and distress. Secondly, there would also be direct positive relationships between independent variables of hope and perceived social support and the outcome variable of life satisfaction. Thirdly, there would be a partially

mediated relationship between independent variables of hope and perceived social support and outcome variables of emotional well-being and distress, via life satisfaction. Fourthly, there would be a significant direct positive relationship between perceived social support and the dependent variable of hope as well as a partially mediated relationship with life satisfaction via hope. Fifthly, there would be a partially mediated relationship between perceived social support and mental health via hope.

Methods

Sample and Participant Selection

The sample consisted of 717 participants (429 males and 286 females), all of whom were school-going learners in the Northern region of Ghana. These participants were chosen from seven schools, which were randomly sampled from a population school across the local government divisions (metropolitan, municipality and district divisions) in the Northern region of Ghana. Regarding school grade, 360 participants (50.2%) were in Grade 11 and 357 (49.8%) in Grade 12. Eight of the learners (1.1%) were below 15years of age, 210 were aged between 16 and 18 years (29.3%), and 498 learners (69.6%) were in the age ranging between 18 years and above. Given that the data were collected in the predominantly Islamic Northern region of Ghana, 508 learners (70.9%) self-ascribed to the Islamic religion, while 205 learners (28.6%) self-described as Christian. For the remaining 4 participants, two (0.3 %) indicated following an 'unspecified' religion, while the other two were instances of missing data.

Procedures and Ethical issues

Data collection commenced after ethics clearance had been obtained from the research ethics committee (REC) for human research at Stellenbosch University, South Africa, and following the first author obtaining institutional permission from the Ghana Education Service and the respective administrators of the participating schools in the Northern region of Ghana. Prior to the field work, consent forms for learners aged above 18 years and parental consent forms from the legal guardians and parents (in respect of participants younger than 18 years), as well as the assent forms for participants aged below 18 years were used as part of the recruitment strategy. There was a 100% return rate of consent and assent forms. Using a modified multi-stage cluster sampling technique, 100 learners from each of the seven schools were included in the study. In compliance with ethical responsibility of anonymity, no personal identifiers were recorded but rather interviewer-assigned numbers were used. Data was gathered individually using a paper-pencil format. The average response time was approximately 60 minutes. Questionnaires were administered in English because this was the major of language of instruction across secondary schools in Ghana.

Assessments and Measures

Hope. Hope was measured using the Integrative Hope Scale (IHS; Schrank, Woppmann, Sibitz, & Lauber, 2011). The IHS consists of 23 items that assess individuals' level of confidence in the future – in other words, the general outlook in life, including the subjective determination of the future prospects. The items are on a 6-point Likert scale, ranging from 1 (strongly disagree) to 6 (strongly disagree). Examples of the items on the scale

include 'I have deep inner strength' and 'I see possibilities in the midst of difficulties' (Schrank et al., 2011). The IHS comprises four subscales, namely 'trust and confidence', 'positive future orientation', 'social relations and personal value' and 'lack of perspective'. The internal consistency estimate for the IHS was 0.92 (Schrank et al., 2011, 2012), with factor analysis and discriminant validity providing for the scales construct validity. In our present data, we obtained a Cronbach alpha value of .71 for the IHS scale.

Perceived Social Support. Perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS consists of 12 items designed to measure the participants' perceptions of the available social support (Zimet et al. 1988). The items are rated on a 7-point scale ranging from 1 to 7, with higher scores indicating higher perceptions of social support. Items on this scale include: 'My family really tries to help me' and 'I can talk about my problems with my friends'. The MSPSS has a reliability score (Cronbach's alpha coefficient) of .88 (Zimet et al. 1988). The test-retest reliability for MSPSS was .85, indicating a good internal reliability and stability over time (Zimet et al., 1988). Construct validity was determined by showing its correlation with depression. Each of the subscales (family, friends and significant others) were significantly inversely related with depression as was the whole scale (r= -.25) (Zimet et al. 1988). The use of the MSPSS in Ghanaian research to date shows the Cronbach alpha value of .87 (Salifu Yendork, 2014). In our present data, we obtained a Cronbach alpha value of .81 for the MSPSS scale.

Life Satisfaction. Life satisfaction was measured using the Multidimensional Student Life Satisfaction Scale (MSLSS; Huebner, 1994). The MSLSS consists of 40 items that provide

a multidimensional profile on children's evaluation of many aspects of their life (Pavot, Diener, Colvin, & Sandvik, 1991). The items are rated on a 4-point scale that ranges from 1 (never) to 4 (always). Items on the scale include: 'I like where I live' and 'I am a nice person'. The reliability co-efficient for the MSLSS ranged from .70 to .90 (Huebner, 1994). Convergent and discriminant validity have been demonstrated through correlations with other self-report well-being indexes (Gilman & Huebner, 1997; Huebner, 1994). Two studies investigated the properties of a children's subjective well-being measure, the Student's Life Satisfaction Scale (SLSS. The scale provides information on important domains for children's life satisfaction such as school, family, friends, living environment and self and can be used across wide range of ages including grades 3-12. For the present study, internal reliability was a Cronbach alpha of .77.

Mental Health. To measure participants' state of mental health, the Mental Health Inventory (MHI-38; Veit & Ware, 1983) was used. This is a 38-item scale that has been used to assess the individual's level of psychological distress and well-being (Veit & Ware, 1983). The scale also assesses several aspects of mental health including anxiety, depression, loss of behavioural and emotional control, emotional ties, positive affect, and life satisfaction and has a Cronbach alpha coefficient of .93 (Veit & Ware, 1983). All of the items, except two (items 9 and 28), are scored on a six-point scale (1-6) with items 9 and 28 scored on a five-point scale (1 – 5). Items on this scale include questions such as: 'Did you feel depressed during the past month?' and 'how much of the time, during the past month, have you been a happy person?' While the MHI-38 can be aggregated into a global mental health index, it may also be aggregated into two global scales, namely, psychological distress and psychological well-being. The raw scores of the MHI-38 range from 38 to 226, with higher scores indicating greater psychological well-being and

hence, relatively attenuated psychological distress. Cronbach alphas for both global scales ranged from .92 and .96, and test-retest reliabilities went from .56 to .64 (Veit & Ware, 1983). The items on the psychological distress global scale were reverse scored and higher scores on this global scale indicated increased psychological distress. The same rule applied to scoring some items measuring psychological well-being. In the present study, the items on the psychological well-being scales are described as the emotional well-being component of mental health, while items on the psychological distress were referred to as emotional distress. Mental health in the present study was measured using the two global subscales and their Cronbach alphas were .73 and .70 for emotional well-being and distress, respectively.

Data Analyses

The analyses of data were conducted using both the Statistical Package for Social Science researchers (IBM SPSS 23.0) and Mplus (Muthén & Muthén, 1998-2006). The method of SEM was used to test if the hypothesized model fit the observed data. Confirmatory factor analyses (CFA) were run on all the instruments individually in order to estimate their factorial validity before proceeding with the testing of the measurement model. A summary of modification fit indices of each for each instrument is presented in Table 1.

Table 1: *Correlation Matrix for the Latent Variables*

	Hope	Life Satisfaction	Social Support	Emotional Well-being	Emotional Distress
Hope	1				
Life Satisfaction	.38***	1			
Social Support	.42***	.44***	1		
Emotional Well-being	.32***	.34***	.32***	1	
Emotional Distress	-.25**	-.22**	-.17***	-.22***	1

*$p < .05$, **$p < .01$, ***$p < .001$

We further used the two-step SEM approach as recommended by Anderson and Gerbing (1988). As proposed by Weston and Gore (2006), the first step of the analysis involved testing the measurement model to determine if indicators loaded on to specific latent variables. The measurement model was tested using the method of confirmatory factor analysis (CFA) with robust maximum likelihood (MLR). The second step of the analysis involved estimating the structural paths in the relationship among the latent variables. A bootstrap mediation test (see also Shrout & Bolger, 2002) was also performed to determine whether the hypothesized mediation effects were significant. We generated 1000 bootstrapping sampling from the original data set (717) by random sampling with replacement. This method provides a more reliable estimate of partially mediated effects because it does not impose distributional assumptions. Several comparative fit indices were reported to determine whether the measurement model had a good fit (Hu & Bentler, 1999). These were chi-square statistics; Comparative Fit Index (CFI); Root Mean Square Error of Approximation (RMSEA); and the Standardised Root Mean Square Residual (SRMR).

Results

The total scores for hope ranged from 44.00 to 127.00 (M = 98.41 and SD = 12.18). Total scores for life satisfaction ranged from 69.00 to 132.00 (M = 104.06, SD = 10.89), while those of perceived social support ranged from 13.00 to 84.00 (M = 62.09, SD = 11.90). The descriptive statistics for emotional well-being included a range of 23.00 to 77.00 (M = 48.87, SD = 8.78), and the total scores for distress ranged from 25.00 to 99.00 (M = 62.71, SD = 11.22). Table 2 shows the inter-item correlations, strong correlations at significant levels of p < .001 were found among the indicators of hope, perceived social support, life satisfaction and emotional well-being.

Table 2: *Summary of modification indices for latent variables and measurement model*

Variable	χ^2/df	CFI	RMSEA	SRMR
Hope	1.57	0.91	0.03	0.045
Social Support	2.66	0.937	0.048	0.042
Life Satisfaction	2.24	0.746	0.044	0.058
Emotional Well-being	0.977	1	0	0.037
Emotional Distress	1.22	0.955	0.019	0.035
Overall measurement model	1.76	.502	.039	.059

Measurement and Structural Models

The fit indices were as follows: χ^2 (4939) = 8690.13, p < .001, χ^2/df = 1.76; Comparative Fit Index (CFI) = .502; Root Mean Square Error of Approximation (RMSEA) = .039 [90% CI: .037, .040]; Standardised Root Mean Square Residual (SRMR) = .059.

We tested a structural model showing the hypothesised relationships between the latent constructs of hope, perceived social support, life satisfaction, emotional well-being and distress. The hypothesised model had a partially good fit shown by the following fit indices: The fit indices were as follows: $\chi 2$ (4939) = 8690.13, $p < .001$, $\chi 2/df = 1.76$; Comparative Fit Index (CFI) = .502; Root Mean Square Error of Approximation (RMSEA) = .039 [90% CI: .037, .040]; Standardised Root Mean Square Residual (SRMR) = .059. The percentage of variance explained by the hypothesised model was 18%, 25%, 23% and 8% for hope, life satisfaction, emotional well-being and distress, respectively.

We hypothesised that there would be a significant positive relationship between hope and emotional well-being, hope and life satisfaction as well as between life satisfaction and emotional well-being. Contrary to the hypothesised relationships, the relationship between hope and emotional well-being was not significant. However, hope was found to have a significant positive relationship with life satisfaction (b = .18, [95% CI: .00, .33], $p < .05$). There was also a significant positive relationship between life satisfaction and emotional well-being (b = .32, [95% CI: .15, .46], $p < .001$). We also had hypothesised that perceived social support would have a significant positive relationship with emotional well-being. This hypothesis was not confirmed. The hypothesised relationship between perceived social support and life satisfaction was significant (b = .46, [95% CI: .24, .64], $p < .001$), as well as that between perceived social support and hope (b = .49, [95% CI: .32, .63], $p < .001$).

With the exception hope (b = -.14, [95% CI: -.28, -.02], $p < .05$), all of the hypothesised direct negative relationships between emotional distress and perceived social support and life satisfaction were not confirmed. Also noteworthy was the lack of a statistically significant relationship between emotional well-being and distress (see Figure 2).

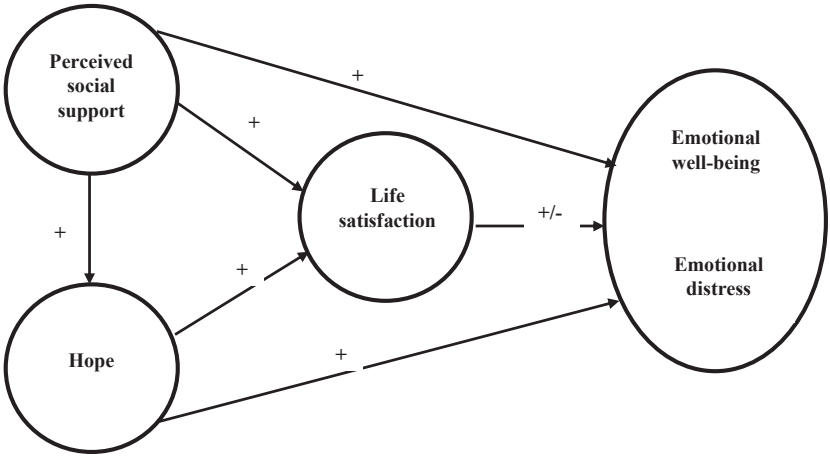
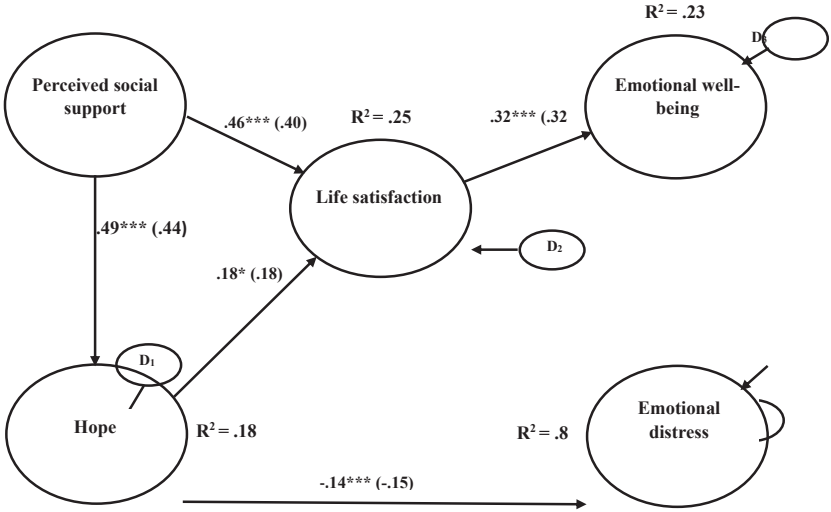


Figure 1: Hypothesized model of relationships between hope, perceptions of support, life satisfaction, emotional well-being and distress.



**p < .05, **p < .01, ***p < .001, Standardized estimates in parenthesis*

Figure 2: Model showing relationships between hope, perceptions of support, life satisfaction, emotional well-being and distress.

An indirect positive relationship between perceived social support and emotional well-being mediated by either life satisfaction or hope was hypothesised. The result of the analyses showed that there was a significant total sum of indirect effects of perceived social support on emotional well-being (b = .21, [95% CI: .08, .33], $p < .01$). Life satisfaction was a stronger mediator of the relationship between perceived social support and emotional well-being (b = .14, [95% CI: .04, .23], $p < .01$) compared to hope, which had a statistically non-significant mediating effect on the relationship between perceived social support and emotional well-being.

Hope was also hypothesised to be indirectly positively related to emotional well-being via life satisfaction. This hypothesis was not confirmed.

The hypothesised partially mediated relationship between perceived social support and life satisfaction via hope was confirmed (b = .09, [95% CI: .00, .17], $p < .05$). Fourthly, supporting our hypothesis, there was a significant sum of indirect effect of perceived social support on emotional distress, (b =.-12, [95% CI: -.23,-.04], $p < .05$), however, none of the mediated relationship via hope or life satisfaction were significant. Fifthly, hope (in the same way as perceived social support) was hypothesised to be inversely related to emotional distress when mediated by life satisfaction, however, this hypothesis was not confirmed.

Discussion

The results of the study revealed that each of the latent variables was well represented by their indicators; however, the hypothesized measurement model demonstrated only a partial fit with the data. The structural model aimed at showing

relationships among latent variables was also found to have only a partial fit with the observed data.

In line with the hypothesis, the present findings showed adolescents' experience of hope to be significantly related to life satisfaction. The relationship between these two variables has been found in a number of studies to date (e.g. Esteves et al., 2013; Ng et al., 2014; Valle et al., 2006; H. M., 1989).This relationship was probably due to the fact that the present sample of adolescents believed they had the necessary capacity and strategies (markers of hopeful thinking) to achieve their goals. Against the backdrop of stressors such as poverty, which was pervasive among this Ghanaian sample of adolescents, it would seem that finding the means to achieve goals in academic and economic domains and the ability to envisage a successful future, was instrumental in enabling adolescents to judge the current state of their lives as satisfactory.

In addition to hope, the findings of the present study revealed that adolescents were satisfied with their lives, as a result of the perception of the availability of social support. Perceived social support has been identified as important correlate of life satisfaction (Danielsen et al., 2009; Sidall, Huebner, & Jiang, 2013). Adolescents in the present sample could have evaluated their lives as satisfactory and experienced emotional well-being because the presence of quality and reliable relationships among friends and family served as a buffer against life challenges and provided an assurance that practical support and companionship would be available when needed. In line with the present finding, evidence from research in impoverished communities in Ghana has determined that social relations and the support coming from social networks were important for the well-being of adolescents (Wilson & Mittelmark, 2013). Additionally, these

studies demonstrated that irrespective of material deprivation, social support was an important predictor of life satisfaction.

Apart from the direct relationships between perceived social support and life satisfaction as well as emotional well-being, we had also hypothesized a significant direct relationship between perceived social support and hope, as well as a mediated relationship between perceptions of support and life satisfaction via hope. Our finding on the positive relationship between perceptions of support and hope has been confirmed in previous studies (Esteves et al., 2013; Yarcheski & Mahon, 2014) H. M. (1989). A possibility exists that the presence of supportive relationships could have served to instil hopeful thinking about many aspects of the livelihoods for this sample of school-going Ghanaian adolescents.

Furthermore, our data confirmed the hypothesized partially mediated relationship between perceived social support and life satisfaction via hope. With hope as a personal factor and social support presenting itself as a situational factor (Yarcheski et al., 2001), the interaction of the feelings of agency (hopeful thinking), with the perceptions of adequate support, could have provided the platform for adolescents to judge their lives as satisfactory (Lu & Hsu, 2013). It is possible that adolescents' perceptions of support had enabled them to manage the anxieties of the future. Should this be the case, the perceptions of available support could in turn have enabled them to evaluate the challenges associated with different domains of their life as manageable, consequently promoting a sense of satisfaction with life.

Another important finding from the present study, which was in line with previous research (Gilman et al., 2006), was the relationship between life satisfaction and emotional well-being. Related to this finding, Huppert and So (2013) noted that most

well-being indicators tend to be positively correlated. However, we were unable to find studies showing the relationship between life satisfaction and the latent variable of emotional well-being comprising the exact indicators of general positive affect, emotional ties and life satisfaction, which we used in the present study. A possibility exists that the adolescents' experience of emotional well-being was due to having had a positive appraisal of the different domains of their lives, which included family, friends, living environment and the self. Consistent with this interpretation, Pavot and Diener (2008), in their review of SWB research, noted that domain satisfaction could be predictive of overall life satisfaction with life, which we measured as a component of emotional well-being. These authors also stated that the additive effect of satisfaction in different domains could influence the changes in global life satisfaction. In addition, domain-specific satisfaction has also been found to result in stronger emotional ties (Diener & Seligman, 2002), providing further support for the relationship between life satisfaction and emotional well-being.

In relation to the finding of the lack of a significant relationship between emotional well-being and distress, Suldo, Savage, and Mercer (2014) indicated similar results in an intervention program for adolescents that resulted in increased psychological well-being but had no impact on psychopathology. The fact that emotional well-being and distress were not significantly related in the present study provided preliminary evidence for the claim made by some (notably, Kern, Walter, Adler, & White, 2015; Suldo, Thalji, & Ferron, 2011) that well-being is not simply the absence of ill-health. Moreover, although some indicators of emotional well-being in the present sample were correlated with some indicators of emotional distress, the two constructs (well-being and distress) were not directly related to each other. This finding suggests the likely existence of a dual-factor model of

mental health in the Ghanaian context. However, given that only emotional well-being was explored in the present study, further research is needed to understand the structure of mental health in Ghana and whether the hypothesis of a dual-continuum of mental health and mental-illness (Keyes, 2007) would be applicable in this context.

Implications for Research and Interventions

The overall model fit implied that in order to promote mental health among adolescents in impoverished communities such as those found in the Northern region of Ghana, some attention needs to be given to their positive experiences and not just the reduction of negative symptoms. The findings of our study indicate that mental well-being among black populations is hinged on the experience of hope and evaluation of the presence of support when needed. Another implication of our findings is that the Ghanaian context provides positive experiences that are instrumental in enhancing psychological well-being. Within psychological research in black populations, there is a need for further exploration of these constructs in a cultural context.

Mental health promotion programmes in schools could encompass interventions targeted at building hope, creating supportive environments and fostering factors necessary for adolescents' life satisfaction. For enhancing perceptions of support, it would be useful to develop community programmes targeted at improving the quality of caregivers, while creating effective and supportive school and home environments. Home environments found to be characterised by generally unsupportive conditions could be improved through, for example, parent counselling sessions (see Yarcheski et al., 2001), directed at encouraging parents to be more supportive of adolescents' school-related needs. In order to instil

hope, psychosocial support from teachers could include enabling adolescents identify their areas of strengths and assisting them to develop appropriate goals and pathways for achieving these goals.

Limitations

The cross-sectional nature of the research design made it difficult to draw causal inferences regarding the relationship among variables. In addition, the absence of scales that had been previously validated in a Ghanaian sample, necessitated that we employed western scales that might not be properly suited for the context of the study. However, the given the acceptable Cronbach alphas that were obtained, our results could be said to representative of the sample of the study. We also used self-report scales without corroborating our findings with reports from perhaps parents and teachers of the adolescents. Findings were also limited to school-going adolescents, and this restricted the conclusions that could be made about adolescents in Ghana in general.

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Social Anxiety and Self-Compassion in Persons with Alcohol Dependence

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Abstract

The study examined the relationship between social anxiety and self-compassion among alcohol dependents in a clinic setting in Ghana. It was a correlational study that employed purposive sampling in obtaining its participants. Sixty participants were involved in the study. Frequencies and Pearson's product-moment correlation coefficient were used to analyze the data. The findings revealed that social anxiety was highly prevalent among participants. Moderate level of self-compassion was observed. A highly significant inverse relationship between social anxiety and self-compassion was also found. The small sample size and the use of an adapted version of the self-compassion scale are considered as limitations for the study.

Key words: Social anxiety, self-compassion, alcohol dependence

Introduction

Alcohol is a legal substance whose benefits cannot be overemphasized. Its use cuts across gender, culture and globe. Its use for medicinal purposes is well-known (Stolberg, 2006). In Africa and especially Ghana alcohol was used as a sign of masculinity and by people who had status in society (Akyeampong, 1995). However, the World Health Organisation (2006) report indicated that alcohol consumption is a growing

problem in Ghana. This was consistent with the finding of Adu-Mireku (2003) who found that more youth are being implicated.

Social anxiety is a common condition among people with alcohol dependence disorder (Clarke & Sayette, 1993) and it is characterized by excessive fear of social scrutiny and negative evaluation (Kushner, Abrams & Borchardt, 2000). In a study conducted by Randall (2000) alcohol addicted social anxiety disorder sufferers unanimously confirmed the use of alcohol to cope with anticipatory anxiety regarding social situations.

Alcohol dependence has become an issue of concern and a menace not only in Ghana but globally (Fisher, Bang & Kapiga, 2007). For instance, 12.4% men and 4.9% women have an alcohol use disorder in the United States (APA, 2013). In Europe one in seven deaths among men and one in thirteen deaths in women has been attributed to alcohol (WHO, 2013) while it is the leading cause of death in Australia.

In Ghana however, commercials in the media portray alcohol as a need. Variety of alcoholic beverages now exists with each portraying its potency without disclosing the long-term effects and problems that come with it. In the absence of a national policy on alcohol, advertisement of these beverages in the media is on the increase (WHO, 2011), with celebrities and high-profile personalities playing major roles. The upsurge of numerous bars and spots and the low cost of alcoholic drinks attract a lot of patronage. World Health Organisation (2004) ranked Ghana as 132nd out of 185 countries based on per capita pure alcohol consumption. In Ghana, alcohol dependence is viewed as a moral problem and so labelling, and stigmatization of these people are very common.

The cognitive theory proposed by Beck (1976) explains that there are deep cognitive structures or schemas that enable us to process incoming information and interpret our experiences in a meaningful way. Any symptom of psychopathology results when pathological schemas are activated by stressful events. How we behave or react to any event or situation is based primarily on how that event or situation is appraised. The meaning we make of situations is what informs our reaction. This implies that socially anxious persons experience this form of anxiety because they think people hold a negative view of them. It is this thought pattern that generates their psychopathology (Ledley, Huppert, Foa, Davidson, Keefe & Potts, 2005). However, Conger (1951) developed the tension reduction hypothesis and explained that alcohol is used as a panacea for the symptoms that develop as a result of anxiety. This assertion explains why social anxiety and alcohol dependence have been reported as comorbid disorders (Thomas, Randall & Carrigan, 2003: Kaufman & Charney 2000).

Neff (2009a) reported a link between self-compassion and psychological health including happiness, conscientiousness, optimism, decreased anxiety, depressive symptomology and rumination. According to Neff self-compassion is the ability to treat oneself with kindness, recognizing one's shared humanity and being mindful when considering one's negative aspects and it acts as a buffer against anxiety (Neff, Kirkpatrick & Rude, 2007) and are therefore less likely to use alcohol for coping (Neff, 2003a; 2003b). Neely, Schallert, Mohammed, Roberts and Chen (2009) also describe self-compassion as healthy self-acceptance in the light of realistic understanding of one's inadequacies.

Rendon (2007) found that among a sample of college students, self-compassion correlated negatively with alcohol use. Social anxiety and self-compassion among people who use alcohol has not been investigated in Ghana. We investigated prevalence of

social anxiety and self-compassion in alcohol dependents. It was also hypothesized that social anxiety would negatively correlate with self-compassion at a significant level.

Methods

Participants and Inclusion Criteria: A correlational research design was used to investigate the strength and direction of relationship that existed among variables. Descriptive statistics was used for the prevalence of the social anxiety and self-compassion among participants. A sample of 60 participants met the inclusion criteria. These were alcohol dependent persons receiving professional attention for their condition. This sample met the criteria of being in treatment for at least two weeks, understanding basic English language and being psychologically stable at the time of data collection with none of the participants experiencing any form of psychosis.

Instruments: To measure social anxiety, the Social Interaction Anxiety Scale (SIAS) by Mattick and Clarke (1998) was adopted. The instrument is a 20-item questionnaire on a 5-point Likert scale ranging from 'not at all' to 'extremely'. The Social Interaction Anxiety Scale was found to be highly correlated with Social Phobia and Anxiety Inventory (SPAI) with correlation coefficient of $\alpha = 0.86$. Mattick and Clark found a strong internal consistency of $\alpha = 0.84$ in both clinical and undergraduate samples; and the test-retest correlation in a sample of patients with social anxiety disorder (SAD) at 4 and 12 weeks was also strong at r α 0.91. The Cronbach alpha for the scale in the sample for this study was $\alpha = 0.92$ which reflected a high reliability. The scale has three categorizations based on the scores obtained. The first category involved people with normal level of anxiety with a score of below 34, the second category involved persons who obtained a

score ranging from 34 to 42 and they were categorized as social phobic while a score of 43 and above indicated social anxiety.

In measuring self-compassion, the Self-Compassion Scale developed by Neff (2003) was adapted. The original instrument consists of 26 items on a 5- point Likert scale ranging from 'almost never' to 'almost always. It has six facets that determine the presence or absence of self-compassion. The facets are self-kindness, self-judgement, common humanity, isolation, mindfulness and over identification. Research by Neff (2003a) has indicated strong convergent and discriminant validity with no correlation with social desirability, as well as good test-retest reliability. Werner, Jazaieri, Goldin, Ziv, Hermberg & Gross (2011) found that Cronbach alphas for the subscales of the instrument were as follows: Self-kindness, 0.81; Self-judgment 0.90; Common humanity, 0.81; Isolation, 0.93; Mindfulness, 0.78; and Over-Identification, 0.86 and Cronbach alpha for the full scale was $\alpha = 0.96$. The Self-Compassion scale was adapted after deleting 3 items from the original instrument and scaling items down to 23, the Cronbach alpha obtained for this study was $\alpha = 0.74$. The items 'When times are really difficult, I tend to be tough on myself', 'when I'm feeling down, I tend to feel like other people are probably happier than I am' and 'when I fail at something that is important to me, I tend to feel alone in my failure' were deleted. However, the instrument had both positively and negatively worded items which meant some items were reverse scored. For the purpose of this work, the scale had three categorizations, scores that were one standard deviation below the mean were indicative of a low self-compassion. Those that were one standard deviation above the mean were also indicative of a high self-compassion, any score that lied within the low or high self-compassion values were indicative of a moderate self-compassion.

Procedures: The study received approval from the University's Institutional Review Board. Sixty participants principally diagnosed of alcohol dependence were obtained through purposive sampling from the three main Mental Hospitals in Ghana and one rehabilitation home in Accra. Only participants who consented to be part of the study were used in this research

Results

In table 1, we describe the demographic factors of the participants.

Table 1: ***Demographic Factors***

Variable	Frequency	Percent (%)
Sex		
Male	56	93.3
Female	4	6.4
Age		
Below 30 years	23	38.3
31-40 years	24	40.0
41-50 years	7	11.7
51 years and above	6	10.0
Marital Status		
Single	42	70.0
Married	12	20.0
Divorced	2	3.3
Separated	4	6.7

Variable	Frequency	Percent (%)
Duration in Treatment		
Below 4 weeks	4	6.7
5-6 weeks	5	8.3
7-8 weeks	2	3.3
9-10 weeks	2	3.3
11-12 weeks	15	25.0
13 weeks and above	32	53.3
Religion		
Christian	55	91.7
Muslim	4	6.6
Traditional	1	1.7

Majority of alcohol dependents in this research were males with about 78% of them under the age of 41. Majority of the participants were single and most of them had been in therapy for more than 10 weeks. In terms of religion, they were mostly Christians.

The means and standard deviations of the variables are described in table 2.

Table 2: *Mean and Standard Deviations of Variables n = 60*

	Mean	SD
Social Anxiety	43.77	11.39
Self-Compassion	74.05	11.15

The mean score of the participants on the social anxiety scale indicated that majority of them experienced social anxiety, while the mean and standard deviation of self-compassion suggested moderate self-compassion. The percentage distributions for the social anxiety and self-compassion are represented on figures I and II respectively.

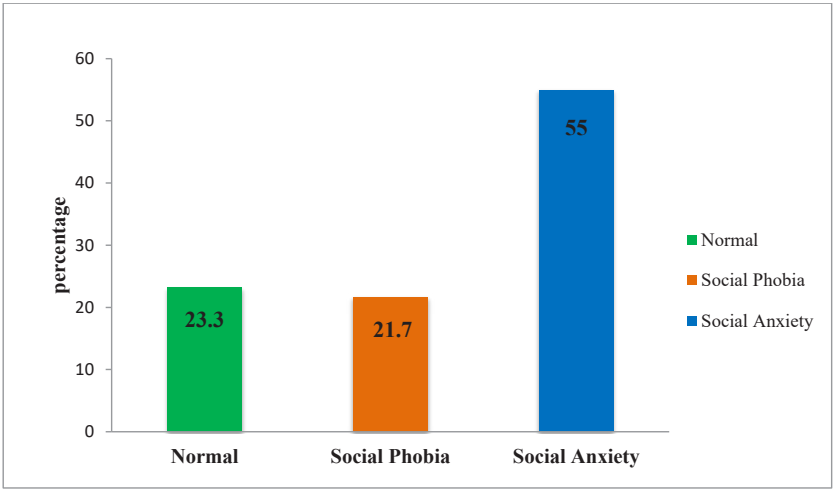

Figure I. Percentage Distribution of Social Anxiety

Figure I shows that 55 % of the participants had social anxiety.

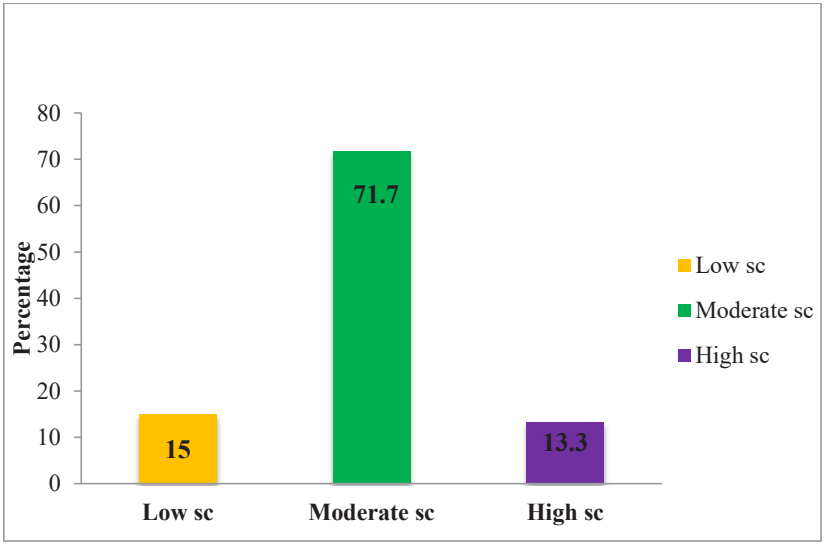

Figure II. Percentage Distribution of Self Compassion

As figure II depicts, only few of the respondents had a high or low self-compassion. The percentage difference between persons with low and high self-compassion was 1.7% as compared to the percentage difference between low and moderate self-compassion of 56.7%. The relationship between social anxiety and self-compassion as examined by Pearson product-moment correlation produced a moderate and significant correlation (r = -.41, and p = 0.01).

Discussion

That majority of the participants were males and this consistent with the assertion of APA (2013) that alcohol dependence is a male dominated condition. Akyeampong (1995) had argued that alcohol use expresses power especially for Ghanaian men. Again,

men are expected to play major roles in their various families, societies and communities compared to their female counterparts. Magazine (2004) found that men are more likely to drink heavily because drinking helps them to ignore responsibilities especially domestic roles or demonstrate their immunity to obligations. Women have also been found to be less likely to drink because they have greater domestic responsibilities to get things done (Ahlstrom, Bloomfield & Knibbe, 2001). Drinking may therefore hamper their efficiency in carrying out these responsibilities. The less domestic roles account for the male dominance in alcohol dependence reported by this study as Ghanaian culture subjects women to enormous roles both in the home and society that drinking could negatively affect performance. Also, alcohol dependence in our Ghanaian culture has been noted as a male affair and women who engage in it are subjected to various forms of shaming and ridicule.

In this study it was found that younger persons were more implicated in alcohol dependence than the elderly. Over 78 % of the respondents were less than 41 years. This meant that more young people are involved in alcohol dependence than older persons. This finding was similar to that found by Adu-Mireku (2003) when he called the condition a growing concern in Ghana and said concerted effort was needed to curb the situation.

It was also a wakeup call because the World Health Organisation had reported in 2011 that Ghanaian college students ranked third in Africa for problematic alcohol use. The WHO report was more disturbing as it implicated persons in college who are expected to know the devastating effects of alcohol and lead the campaign to educate the uneducated in Ghana.

It was observed again that most of the respondents in this study were single compared to the married, divorced and separated

respondents. The distribution was a reflection of a finding by Schonbrun, Zach, Stuart and Strong (2011). They asserted that marriage was a buffer against alcohol dependence so less married people are likely to be implicated in the condition. Being single was a state that could render one vulnerable to alcohol use as the support married people may obtain from their spouses would be absent for these individuals. This could account for the high frequency of single persons being implicated in the condition. A larger proportion of the respondents had been in treatment for three months and more. Others had spent two months, one month or less. Since being in treatment for at least a week was part of the inclusion criteria, no participant was less than a week old in treatment. The demographic data also provided information on participants' religion. Most of the respondents were Christians. This could be. due to the fact that a greater proportion of the Ghanaian population are Christians and secondly Islamic religion strongly forbids the use of alcohol comparing it to the Christian religion.

The presence of social anxiety among the participants finds support in studies on alcohol dependence and social anxiety which indicated that alcohol dependence and social anxiety are usually comorbid disorders (Kushner, Abrams & Borchardt, 2000; Clarke & Sayette, 1993). Akyeampong (1996) also reported that most people with social anxiety are highly likely to use alcohol especially for the relaxing effects that alcohol provides. This distribution further indicated that alcohol dependents in this study were sensitive to society's evaluation of them and this could be culture specific considering the Ghanaian society's outlook on alcohol dependence especially with the moral definition of the condition.

With regard to self-compassion, findings from the study indicated that majority of respondents scored within the

moderate range. The prominence of moderate self-compassion among respondents could also be explained based on respondents' possible thoughts about their condition. In Ghana, chronic medical and psychological conditions including alcohol dependence have been given definitions such as the supernatural which places the individual at the mercy of the 'gods' or disease. With such an explanation for alcohol dependence it becomes easier to empathize with oneself and treat oneself with more care and concern as the alcohol dependent is rather a victim of the condition.

This result supported the hypothesis that there would be a negative correlation between social anxiety and self-compassion. People diagnosed as suffering from anxiety often are cushioned against these feelings of anxiety when they tend to be self-compassionate even though they may keep the anxiety provoking situations in perspective (Leary, Adams, Allen & Hancock, 2007). However, Werner et al. (2011) explained the cushioning that people with anxiety obtain from self-compassion was not applicable to people with social anxiety disorder. Although majority of the participants reported social anxiety, a similar number indicated moderate self-compassion.

Self-compassion has been found to involve how an individual think of himself considering his human nature and making allowances to err. These thoughts are regarded to be positive and enhancing; however, the socially anxious person may be too preoccupied with his self-defeating thoughts to have any positive thought. However, when the individual manages to give room for more positive thoughts, his negative thoughts would on the other hand diminish. The finding for this hypothesis suggests that self-compassion could be a cushion for people with social anxiety as well. It may well be that the participants of this study

are people who are prepared to give up alcohol use and may benefit from strategies based on compassion.

Conclusions

The study examined the relationship between social anxiety and self-compassion among alcohol dependents. It was a correlational study that employed purposive sampling in obtaining its participants. Frequencies and Pearson product correlation coefficient were used to analyze data. The univariate analyses conducted revealed that the participants in the study were predominantly male, single, below forty years, Christians and had been in treatment for at least three months. The findings also revealed that social anxiety was highly prevalent among participants with predominantly moderate level of self-compassion. Pearson product moment correlation coefficient was also used to examine the relationship between social anxiety and self-compassion. It was found that there was a highly significant inverse relationship between social anxiety and self-compassion.

It is therefore imperative that alcohol dependents receiving treatment at various health facilities primarily for their alcohol use disorder also obtain professional attention for their anxiety-related conditions. It is especially the case as social anxiety was found to be a comorbid condition and need to be addressed as such even in the face of their moderate levels of self-compassion which happened to have not much effect as social anxiety was still highly prevalent among participants.

It is noted that the small sample size limits the extent to which generalization could be made. Secondly, the use of an adapted version of the self-compassion may inhibit comparisons that may be desired.

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How Else Can I Survive: Reflections on Ageing in Rural Ghana

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Abstract

Globally, there is now a growing concern for the elderly. In the developing world especially, this concern has grown significantly due to increase in life span, the structural difficulties caused by globalization, rural-urban migration and the breakdown in the capacity of the extended family to perform its traditional roles. The net result is that in Ghana as in many developing countries, in the absence of government support, the elderly is compelled to fend for themselves. How the elderly in rural Ghana negotiates the means of livelihood is the focus of this paper. The aims and objectives of the study were:

- To understand the dynamics of day-to-day life of the elderly in rural communities.
- To examine the challenges faced by the elderly in their day-to-day life
- To examine the causes of these challenges as well as factors affecting elderly survival
- To find out the survival strategies of the rural elderly in the face the challenges
- To find out how society (social networks) impacts on the survival challenges
- Examine the welfare implications of the problems of the elderly care in rural Ghana

Given the orientation of the paper, data were collected from 300 participants in the three geographical zones of the country, central, forest and savannah. Both qualitative and quantitative data were collected using questionnaire, in-depth interview and focus group discussion.

Key Words: Ageing, Rural, Survival, Family

INTRODUCTION

Setting the Scene

This article is about how elderly people in rural Ghana negotiate their survival strategies in the face of economic difficulties and changes in the traditional Ghanaian care of the elderly. To situate my concern, this article begins with an event that occurred a few years ago in the Northern region of Ghana in Tamale the regional capital around the Central Market.

A blind elderly man assisted by a young boy was begging for alms. One generous woman wanted to give him some coins but had none. The woman asked the beggar to change her paper money from the coins he had in his sack. As he was about to do this, suddenly, the adhesive that held his eyelids together gave way exposing the beggar as one with clear vision. Consequently, the astonished onlookers subjected him to a severe beating. When asked why he had deceived the public, his response was '***wula ka n nyen'.*** Literary meaning, ***'How else can I survive?***

Having witnessed this unfolding drama, I was confronted with a deluge of unanswered questions:

- Why should this old man go through this ordeal just to survive?
- Where are members of his family?

- Has he no children?
- Does the state have any meaningful policies and programmes for persons in their later years?

There were many more questions, but this sufficed as part of the curtain raiser for my PhD study undertaken years later. In this article, elderly and aged are used intermittently.

The Issues

In Ghana, about 72 percent of elderly Ghanaians (elderly persons 60 years and over) live in the rural areas of the country, although there has been a large increase in the number of mostly young people who have migrated to the urban areas for education and employment opportunities (Nabila, 1986). Given this migration trend, it may be expected that rural populations will age more rapidly than urban populations. Despite the rapid increase of the number of the elderly population globally, it has been shown that not enough institutional measures have been put in place to monitor and ensure favourable social and economic conditions for them in Ghana (Brown, 1999). Family and social networks have continued to provide appreciable living conditions and support systems for the well-being of the elderly in rural areas (Apt, 1997). Rural-urban migration affects the care of the elderly at three levels. Firstly, the departure of the young and able-bodied whose services are needed in the processing of daily needs by the elderly poses a problem. The departure of the caregivers, mostly women, through education and employment as providers within the family and household presents another problem for the elderly. Thirdly, the inability of the able-bodied to earn income as providers due to increasing unemployment, affects elderly welfare (Apt, 1992)

Profiling the elderly in Ghana shows that about two-thirds live in rural areas (Stucki, 1992). With regard to income levels, there is no reliable estimate on the average monthly or yearly earnings of the elderly Ghanaian. The large and growing informal sector, the sporadic work force of most Ghanaians, and the lack of adequate documentation on income sources, create a problem in compiling reliable data on earnings. Generally, it can be said that most Ghanaians work in the informal sector, as peasant farmers, artisans, masons, craftsmen and traders (Apt, 1992). They are more likely to experience instability in the source and magnitude of their income.

The life situations of older adults in rural areas have been further affected by individual level social and economic changes during the last decade. For example, the elderly residing in rural areas have become more diverse. This increased diversity has complicated the creation of viable service models. Rowles and Johansson (1993) described four types of rural elderly residents in terms of their community integration:

a. Lifelong community residents who have maintained large kinship and informal networks

b. Lifelong community residents whose informal support resources have been reduced as family members have moved from the area

c. Return migrant elders who, because of their limited recent history in the area, have minimal access to informal support networks and

d. Retirees who have moved from urban areas with little or no previous social history in the area and, as a result, have limited informal social support.

The concept of survival has gained wide acceptance as a valuable means of understanding the factors that influence people's lives and well-being, particularly those of poor rural communities in the developing world. Elderly people living in low-income rural households in developing economies face greater challenges and difficulties in generating income than those in urban communities. According to Help Age International (2003:6), the increasing percentage of our total population living 65 years and beyond has made the problems of ageing more widespread, more visible and ultimately more widely known.

In earlier days, survival of the elderly was ensured by the combined efforts of the extended family, children, churches, charitable organizations, local village communities and, in some cases, the individuals own efforts. However, with time, resources dwindled, and people overstretched their capacity for philanthropy. The elderly had to intensify their efforts to sustain themselves. This is certainly the case in Ghana. According to Gorman (2002), reduced economic opportunities and deteriorating health frequently increase vulnerability to poverty as people age. Barrientos & Lloyd-Sherlock (2003) argue that the strong decline in economic opportunity with age is a key factor in explaining the high incidence of poverty and vulnerability among elderly people and their households. In order to assess the desirability of implementing policies to cushion old age poverty and the adverse shocks and risks the elderly face, it is crucial to understand what elderly people do to sustain a living. It is, therefore, a key concern of the study from which this paper has emerged to investigate the survival strategies of elderly people in some selected rural communities in Ghana who live in conditions of threatening poverty. In the light of the above statement, we need to ask a few questions.

How do these elderlies manage to provide for their needs? How do they manage to put food on the table, provide their grandchildren with resources as is the custom in Ghana, and provide for their own health needs? In other words, what are the survival strategies that elderly men and women adopt to ensure their own well-being as well as that of their dependents? What are the opportunities available to them and what dilemmas do they face? These are the issues explored in this article.

Observation indicates that the survival of the elderly in Ghana, especially rural areas has not been given much attention and as a result, there is not much information on this population. The lack of data means that ageing is poorly understood and as such, not much resource is allocated to meet the needs of this population (Biritwum et al., 2013). Additionally, despite the fact that the elderly makes substantial contributions to families and communities, they are often viewed as a drain on resources and dependent on others for survival (Tonah, 2009). Reduced economic opportunities and deteriorating health frequently increase vulnerability to poverty as people age and can no longer care for themselves properly (Gorman, 2002). There is a need to consider and manage issues concerning the elderly in rural Ghana as a sub population of interest (UN, 2007b). The need to consider and manage issues concerning the Ghanaian elderly as a key resource for development has become more paramount.

To answer questions raised above, this article's discussion is based on a study of three selected districts of Ghana, namely Sekyere South of Ashanti Region, Nanumba in the north and Agona East in the Central region.

Methodology

The mixed method, a combination of both quantitative and qualitative methods, was used.

The specific mixed method strategies employed were the concurrent triangulation strategy and exploratory sequential design. These provided the opportunity for triangulation, interpretation and generalization. Thus, it provided confirmation, cross-validation, convergence and corroboration of results from both methods (qualitative and quantitative) to complement each other. According to Creswell, et al., (2009) and Teddie & Yu, (2007), the mixed method technique enables the study to obtain a balanced information that has breadth and depth. Realizing that no method is devoid of limitations, it is believed that the use of the mixed method helped in the sense that "biases inherent in any single method could neutralize or cancel the biases of the other methods" (Creswell, 2009). Alternatively, combining methods will provide insight into different levels or units of analysis (Tashakkori & Teddie, 1998).

Geographical and situational contexts were principal reasons for the choice of a mixed method, which is both qualitative and quantitative research method. One thing that needs to be understood here is that the subjects of the research are elderly people who have different capacities and literacy levels. Although Ghana is one of the African countries with high literacy levels, this cannot be generalized for all the people.

Zoning of the Country and Selection of Regions, Districts and Rural Communities

The researcher stratified the nation into three zones or strata, namely the Northern Zone, Middle Zone and the Southern Zone, so as to give a national character to the study. The Northern Zone comprised three regions, namely Northern, Upper East and Upper West Regions. The Middle Zone comprised Brong-Ahafo, Ashanti and Eastern Regions. The Southern Zone comprised Central, Volta, Western and Greater Accra Regions. Within each zone or stratum, the researcher used the simple random sampling to pick one region. Obviously, the regions in each of the zones have a lot of things in common. They have similar cultural backgrounds and social characteristics. In view of this, it was deemed appropriate to select one region to represent each of the zones. The following regions were therefore selected accordingly: Northern, Ashanti and Central. The Northern region has 26 districts, Ashanti 30 districts and Central, 20 districts.

In each region, simple random sampling was used to select one district and two rural communities in each district for the study. In each of these districts, the simple random sampling was used to select two villages.

Table 2: Selected Regions and Districts

Region	Districts	Corresponding Rural Communities
Central	Agona East	Kookosu Seth Okai
Ashanti	Sekyere West	Beposo Brengo
Northern	Nanumba	Taali Lepusi

Source: Field data, 2013

The Elderly

In each village, the houses were serialized (numbered) and simple random sampling was used to select a number of houses based upon the size of the village. The use of the simple random sampling was because it afforded every member of the larger population an equal opportunity of being selected. In the selected houses, the number of households in each house was identified and one elderly person was selected from each household (where available). Consequently, the number of elderly persons selected in various villages was as shown in the table below:

Number of Elderly Selected in each Study Area

District	Village Communities	Selected Number of Elderly
Agona East	Kookosu	49
	SethOkai	48
Sekyere West Nanumba	Beposo	55
	Brengo	37
	Taali	25
	Lepusi	39
Total	**6**	**253**

Source: Field data, 2013

Sampling of Participants

The study population consists of elderly persons, (60 years and above) within households and the caregivers of the elderly persons within various households, some selected traditional rulers, health officials and governmental and non-governmental organizations within the study areas. In each village, one Assemblyman was selected purposively. In the village where there was more than one Assemblyman, the simple random sampling was used to select one of them. In each household,

the caregiver of the elderly was purposively selected. Where the caregivers were more than one, the principal caregiver was selected. The following persons were also purposively selected.

- The village chief
- Family head of the elderly
- Head of NGO and governmental Organization

Altogether, 300 participants were selected for the study using both quantitative and qualitative methodology to collect primary data. Out of the 300 participants selected, 50 of them were involved in the qualitative data collection.

Non-participant Observation

As part of the data collection methods, the interviews were supplemented with non-participant observation. With this method of data collection, the research team observed the home environment of respondents for facilities and amenities that enhance the activity of daily living conditions of the elderly such as electricity supply, barrels for storing water, toilet facilities and bathhouses. The availability or otherwise as well as accessibility suggested to the research team the nature of the living conditions of the elderly respondents and the extent of family support in the area of activities of daily living. In addition, the state of the living quarters or buildings was observed focusing on how the elderly move around their environment, the physical conditions of the houses, and their preparation of meals, eating times, visitation by friends and relatives and above all, the physical state of the elderly respondents.

The interviews were conducted in the participants' homes. The interview settings were very comfortable to the participants, and there was a high sense of privacy. Each elderly person and

a family or household caregiver was interviewed separately. The interviews were similar in nature to a conversation, where participants were allowed to respond freely to questions.

Since many elderly persons in the community do not have formal education, the interviews were conducted in the local dialects of the participants. The use of local dialects encouraged participants to talk to the research team as they normally talk to other people in their cultural setting. On the average, the interview with each participant lasted for approximately twenty-five (30) minutes. All the interviews were recorded by a research assistant while the principal researcher took written notes alongside. Six focus group discussions were conducted. Two in each study location. The groups were stratified by sex. The groups were made up of 10 members with a moderator from the research team. A group of this size was manageable and helped to get in-depth discussion on the subject matter. In all, members were first identified by the opinion leaders. Then, with the list of names and contact numbers, we made contacts with the selected persons willing to commit to a minimum of 2 hours on a weekend for the focus group discussion. Ten (10) persons were selected for each group. Although the same number of men and women were selected, more women than men showed up at the appointed time. The discussions involved the same five themes. The focus group sessions ran for two (2) hours.

Socio-Demographic Data

Age		Sex		Marital Status		Occupation		Educational Background	
Years	**%**	**Sex**	**%**	**Status**	**%**	**Sector**	**%**		%
60-69	56.4	Male	41.5%	Married	62.6	Informal	78.5	M/E	21.3
70-79	23.6	Female	58.5	Single	37.4	Formal	21.5	Secondary/ Commercial	11.9
80-90	13.7		**100.0**		**100.0**		**100.0**	Skill/Trade Training	14.2
90-100	6.3							Tertiary	2.4
	100.0							No Education	50.2 **100.0**

Daily Living Conditions of the Elderly

About 8.4% and 10.4% of the elderly indicated that their conditions were quite good. About two fifths (2/5) or 38.8% of participants had a somehow favourable life at the time of the data collection. Approximately 30% of the participants indicated that their socio-economic condition was difficult/poor. Approximately 18.5% of the participants indicated that their conditions were not stable whiles 14.6% of participants indicated low socio-economic conditions.

Socio-Economic Conditions of the Elderly

It was found that many of the elderly experienced economic challenges since they were still the breadwinners of their families. This finding confirms Case and Deaton's (1998) assertion that if the aged had income through reliable means like employment or social security, the entire family benefits in one way or the other from such earnings. One male discussant of the FGDs had this to say:

> *. . . Because my husband is far older than I, he does not earn much. I am more or less the breadwinner of the household. . .*

Also, a female participant said:

> *My husband brings resources to take care of the family . . . we all contribute to take care of the family.*

Health Conditions of the Elderly

During an in-depth interview, one aged person recounted:

> *Growing old is not only associated with the outward appearance . . . the whole-body system fades off. Internally, the organs degenerate and therefore the system cannot function well. I have lost my vision, cannot hear very well and there are the periodic bodily pains, malaria, and anaemia The Health Insurance Scheme is not functioning well so accessing health care at the hospitals does not help much. Mostly, I depend on chemical shops for prescription which is not the best. Sometimes you are referred to the specialist and it becomes difficult to see him/her because the money for transportation is even not there, how much more, pay for the services to be rendered . . . it is only God who has kept me . . . (Grandpa, Seth Okai, 85)*

Some of the health challenges mentioned by the participants confirm the works of Aboderin and Ogwumike (2005), Apt (1995), and Mujahid (2006) that, some sicknesses are related to lifelong lifestyles and/or old age. In view of the fact that good health is a vital asset (Apt 1995), its contribution to the livelihood of the elderly cannot be over emphasized. The sustainable livelihood framework suggests that good health reduces a person's vulnerability and thus improve his or her capabilities and assets.

Resources and Assets of the Elderly

The quantitative data showed that about 38% of the elderly included in the study had assets that provided them capacity to survive. Some owned lands, inheritance of family properties, cars for commercial purposes, rooms for rent, children/family and were members of local/community groups:

> *The only resource I own is this piece of land on which I have built. There is nothing again to count on . . . Initially, when I retired from active service, I had some savings and investments in the form of treasury bills, but I have depleted all the reserves. There is nothing in the accounts again. Hmm eye asem oo!' (90-year-old man).*

Other elderly persons shared their experiences:

> *Before the enactment of the Interstate Succession Law (PNDCL. 111), we of the matrilineal inheritance custom-the Akans, used to deny spouses any share of the properties left behind by their late spouses. I inherited family properties (lands, cocoa farms, houses etc) from my late uncles and brothers which I depend on but now the family has setup a management committee which handles the affairs of the family properties so I cannot easily access any funds from those assets. (In-depth interview, 73-year-old man).*

> *I still have my cocoa farm, which is being taken care of by my last son, who is also my caretaker . . . (In-depth interview, 80-year-old woman).*

Survival Challenges of the Elderly

According to the participants, in their daily survival, many elderly persons faced challenges which were related to their age, deteriorating health, poor finances, loss of respect and allegations of witchcraft. The quantitative showed that age, sickness, loneliness and lack of appropriate health facilities were the major challenges of the elderly in the selected rural communities.

> *…. People brand me as a wizard and say that I have exchanged my children for long life . . .*

> *I attribute my poor financial position to lack of planning . . . I did not invest for my future . . .*

Other elderly participants explained:

> *I wrongly believed the Akan idea that my children belonged to my spouse's family and did not take care of them to support me during my old age . . . it is difficult to straighten a crooked tree that had taken years to bend . . .*
>
> *. . . Loss of control over family properties was associated with loss of respect in my family and community . . . exerts psychological stress on me . . . don't belong anymore.*

Commenting on lack of job opportunities leading to poverty, a participant said:

> *I do not have any work and that is why my financial situation is tough . . . my children are not in any good financial position to help me . . . they are also struggling to make ends meet.*

Survival Strategies of the Elderly

The study found that almost all the elderly persons in this study had different ways of coping with life. Some of which are highlighted below.

Formal and Informal Support

The data showed that over 35% of the elderly did not have any source of formal support, especially from the government. For those who received support, they had formal (35.1%) and informal (29.1%). Many of the elderly relied on their children and relatives for survival and this shows how the family assisted the elderly to

cope with challenges and survive in rural communities. Some of the focus group discussants had these to say:

> *As for money matters, one of my children, when he gets money he gives me, if that does not come, I suffer before I eat . . .*
>
> *I used to have financial difficulties, but presently I don't have any such difficulty due to the assistance I receive from my children.*

In addition, during the in-depth interviews, a female elderly person shared her experience:

> *As for me, I don't have an uncle; my father is dead, my mother is also dead, and I do not have male siblings or sons. . . . I look up to my daughters and nieces for my daily needs.*

In terms of government support, almost all the participants did not give any credit to state sponsored interventions. A focus group discussant said:

> *There is no free medication for the aged in this country. If you are sick and you do not have money you will die. The little that the insurance scheme and the government's policy proposed for the aged, are not functional . . . it is now cash and carry.*

Also, an in-depth interview participant explained:

> *For now, I do not think any help comes from the government. If it is now that the government is going to think of a package for the elderly, then it has not materialized . . . the nation should consider this as a matter of urgency. The NHIS has collapsed . . . the nation must think of the aged and provide for their needs.*

Variations in the support system available to the aged confirms Scoones' (1998) assertion regarding financial, human, social, physical and natural assets and these could enhance a person's capability for survival, whilst the contrary leads to vulnerability. The findings of this study confirm Hutchison (2011) assertion daughters tend to provide most of the care giving support to the elderly.

In Ghana, mostly, the family constitutes social assets during old age as Atim et al. (2001) suggest that children are the most secured social security for the elderly in rural communities, given that many of the elderly may be single. Barrientos (2002) noted that the transfer of money from children to parents has prevented many elderly persons from falling into destitution and this confirms the notion that caring for one's children and other relatives is a social investment against future eventualities. Apt (1992) emphasized 'that the hand of the child cannot reach the shelf and also the hand of the elder cannot get through the neck of the gourd on the shelf (Akan proverb). This according to her explains the fact that the old and the young support each other with economic and social activities.

Conclusion

In conclusion, the majority of elderly in the study areas experienced some challenges meeting their daily needs. The challenges faced by the elderly included in this study related mainly to lack of finances, health, lack of respect and accusations of witchcraft and these affected their survival. However, some of the elderly had assets and resources in the form of land, houses and commercial vehicles. More importantly, children of the elderly were the most reliable source of support (social capital) for the elderly. Close relatives and membership in community

associations were also helpful for the survival of the Elderly. This study found that the majority of elderly in the study areas experienced some challenges meeting their daily needs.

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The findings of study confirmed findings of other scholars like Atim et al. (2001), Apt, (1992) and Barrientos (2002). Also, for their survival, the aged relied on assets, such as natural, human, physical and financial resources as emphasized by Scoones' (1998, 200) Sustainable Livelihood Framework. For a sustainable livelihood, the assets and resources acquired by the aged during their active years could greatly assist them in their old age by reducing their vulnerabilities and enhancing their capabilities. Furthermore, it can be concluded that amid their challenges, the aged in the study areas, found ways and means to survive. Moreover, for the aged who still engaged actively in farming and other activities, they defy the assertions by some scholars that elderly persons withdraw from all their roles and activities to make way for the young and able-bodied.

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ABSTRACTS

Development of a Model for the Care of the Aged in the Cape Coast Metropolitan Area, Ghana

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Background

Old age is a period during which people need help from others. Formal and informal care for the aged shows the dynamisms between home support workers and family care givers.

Aim To build a culturally accepted model for the care of the aged in the Cape Coast Metropolis.

Methods This was mixed method study conducted with four different target populations to develop a model for care of the aged in the Cape Coast Metropolis. The research sought to answer the following questions: How did the aged prepare for their ageing? What services constitute the traditional model for care? How would the community feel if the present care was replaced with assisted care? The information was collected through individual in-depth interviews, focus group discussions and questionnaires over a period of five months and analyzed.

Results Preparation for ageing is an individual and private affair but to a large extent not given conscious attention for both the formal and informal sectors of the population. The idea of assisted care was received well with a lot of enthusiasm, but on condition that care provided is culturally and spiritually sensitive. About 98% of caregivers and 78% of nurses thought establishment of an assisted living facility would be a great idea.

Conclusion The model for care would be appreciated in caring for the aged in an era where there are lack resources and employment. Caregivers and nurses could be trained specifically to care for the aged.

Keywords: Aged, Cape Coast metropolis, caregivers, nurses, model for care,

Psychological Health Quality of Life among the Aged with Disability in Selected Districts in the Upper West Region of Ghana

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Abstract

Globally, people with disability are considered as disadvantaged groups in society with poor psychological health quality of life (QOL). Accordingly, this study examines the psychological health QOL among the aged with disability in selected Districts in the Upper West Region of Ghana (Wa Municipality, Nadowli-Kaleo, Jirapa and Wa East Districts). Through a census survey, quantitative data were obtained from 810 respondents using interviewer administered questionnaires. Means, independent-samples t-test and one-way Analysis of Variance (ANOVA) statistical tools were used to analyse the data in SPSS. The results revealed that mean scores in psychological health QOL were generally low for both males and females. However, mean scores in psychological health QOL was highest among those

aged 60-69 years and lowest for those aged 80 years and older. It was also discovered that the mean score in psychological health QOL was higher for those with physical disability than those with visual disability. The study recommends for the Department of Social Welfare and Community Development of the Metropolitan, Municipal and District Assemblies in Ghana, benevolent organizations and individuals to organize free educative, counselling and geriatric interventions for the aged who are aged 80 years and older and those with visual disability in order to improve upon their psychological health QOL.

Key concepts: Ageing, disability, aged with disability, quality of life, psychological health quality of life

A Blessing or a Curse? The Dilemma of Aging and the Quality of Life of Older Persons in Contemporary Ghana.

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Abstract

Even though the increasing number of ageing populations is considered as a global public health success, it comes with national effects on the economic and health systems. Unlike developed countries, the existing formal social protection systems in lower-income countries cover only a small proportion of older persons. Hence, the ability of the developing countries to ensure that older persons are living a fulfilling life with secure social security system, care and support remains a question of concern. Through a review of various literatures, this study sought to

identify gaps in both informal and formal support systems for older persons and make recommendations for improvement, since elderly care in contemporary Ghana is in crisis. Findings indicated that in Ghana, families still act as a safety net and social support system for older persons. However, a growing literature also notes that this family-based support is no longer effective as before. This results from children's immigration, modernization with emphasis on nuclear family, family members' poverty, and abandonment due to myths of witchcraft. Also, the ageing population policies that Ghana implements unveil some gaps. Hence, their impact on the health and well-being of all older persons across the country is less felt. There is the need for policy reviews/reforms in Ghana to help improve targeting, implementation, and monitoring of existing social protection programs for older persons. Also, age criteria for intervention programs need to be put downward from 60 years to benefit all older persons. These will help improve the wellbeing and living standards of older persons amidst the crisis of limited family support.

Somatic Dance Movement Practice as Tool for Regulating Blood Pressure Level of the Elderly

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Abstract

Most deaths in the elderly population are caused by non-communicable diseases like heart, cancer, diabetes and hemorrhagic stroke with high blood pressure as the highest

health risk factor leading to hemorrhagic stroke in older people. Treating these health challenges of the elderly is often a huge financial burden, hence, need for an alternative management tool for these health challenges. Somatic Dance movement practice involves the holistic use of movements from various Ghanaian dances, walks, games, storytelling, laughter, and relaxation in bringing about a complete cognitive, social, emotional and physical wellbeing of older people. Twenty (20) elderly people from the Dance for Fitness Program of the Center for Aging Studies, University of Ghana were sampled as a case study. They were taken through a three (3) months dance movement practice session where their blood pressure was measured before and after each session. The goal was to ascertain the impact of dance movement practice on the blood pressure level of the elderly. Guided by the concept of successful ageing, method triangulation and instruments like focus group discussion, interviews, questionnaires and participant observation were applied to collect data. After evaluating and analyzing the data gathered, the findings proved that Dance Movement Practice had a significant impact on the diastolic and systolic blood pressure levels of the elderly.

Keywords: Elderly, Somatic, Dance, Wellness, Health, Blood Pressure

Regional Adiposity and Testosterone Levels in Postmenopausal Females

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Abstract

Objective: Research findings on the relationship between serum androgens and adipose tissue in older females are inconsistent. We aimed to clarify the relationship using state-of-the art techniques to evaluate associations between body fat distribution and plasma testosterone (T) levels in older postmenopausal women.

Design: Observational, cross-sectional study of healthy, community dwelling postmenopausal women

Patients and Measurements: Postmenopausal women, (60-80 years old) were included in this study. Overall body composition was evaluated by dual-energy x-ray absorptiometry. Abdominal and thigh fat depots were measured by magnetic resonance imaging. Circulating T concentrations by liquid chromatography-tandem mass spectrometry.

Results: Thirty-five women (66.6 ± 0.8 years) participated in this study. T levels were positively associated with clinical proxy measure of adiposity (weight, BMI and waist circumference, r=0.38, 0.35 and 0.38 respectively, $p<0.05$). Fat mass and percent body fat were correlated with T levels (r=0.39 and 0.36 respectively, both $p<0.05$). T increased with greater abdominal and thigh fat (r=0.35 and 0.43 respectively, $p<0.05$) in both deep and superficial depots.

Conclusion: Our results suggest that postmenopausal women with higher circulating T levels have both higher regional and overall body adiposity. These findings underscore the sexual dimorphism in the relationship between serum androgen levels and adiposity.

Assessment of Social Support among Mentally Challenged Patients in the Three Psychiatric Hospitals in Ghana.

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USAID Partnership for Education; Ghana Health Service; Ghana Education Service

Abstract

In the available literature, social support has been widely acknowledged as one of the key constituents for mental health and well-being. Nevertheless, other scholars are of the view that social support in some instances could be perceived as a source of conflict, insensitivity, and interference among some mentally challenged patients. Through a census survey, this study therefore strives to understand the perspectives of mentally challenged inpatients in the three psychiatric hospitals in Ghana (Accra,

Pantang and Ankaful). Through a census survey, 409 inmates who were in 'lucid Interval' were recruited and interviewed using the Demographic and Social Relationship Index Questionnaire. Chi-square and binary logistic regression model were used as the main analytical techniques. The results indicated that Patients aged 30-39 years were less likely to be dissatisfied, conflicted with social support from parents, significant other and the family. However, it was discovered that patients aged 40 years and above considered social support from parents and family to be negative. Patients who were employed prior to their admission were more likely to be dissatisfied or conflicted. Male patients were more likely to receive negative social support from parents, family members and significant others. Female patients reported less negative support and received more positive social support especially from parents and significant others than males. Verbal communication between mentally challenged patients and family members as well as parents could help in securing the actual type of support at a particular time when providing social support to patients especially those above 40 years to prevent conflicts and dissatisfaction.

Key words: Conflict, Lucid interval, Negative social support, Relationship, Stress.

Does Church-Related Social Support Influence the Health and Wellbeing of Elderly People in the Accra Metropolitan Assembly?

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Abstract

Background

Many sub-Saharan African societies often use religion as an important resource or conduit through which they address issues concerning their health and wellbeing. However, not much is known in terms of how Christianity, especially church-related social support, influence the health and well-being of elderly people in Ghana. The aim of this study was to explore how church-related social support influences the health and well-being of elderly people in Accra, Ghana.

Methodology: Three major churches within the Accra Metropolitan Assembly were purposively selected for the study. The elderly (60 years and above) was selected to participate in Focus Group Discussions and In-depth Interviews seeking to elicit information about how various kinds of church-related social support received influence their general health and wellbeing. The data were analyzed using Thematic Analysis in NVivo 11.

Results

The results showed that the church provides the elderly with spiritual support, financial support, health support, visitation,

material support, and socialization support. Also, support received made the elderly feel better about themselves, comforted, and accepted. In addition, support received brought them happiness, hope, and helped them to recover early from illness. Finally, the elderly desired for more frequent visitation, more financial assistance and material support from the church as an institution, individual members of the church as well as church leaders.

Conclusion

The church provides the elderly with social support which results in positive emotions such as joy, happiness, hope, and relief. Church-related social support is relevant to the elderly in solving problems related to financial constraint, hunger, and loneliness.

Role of Support Services System on Psychosocial Well-Being of Elderly in Nigeria

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Abstract

Aging is not entirely a negative process, but old age is undoubtedly a difficult period, worsened by the inadequacy of social institutions to care for the aged people especially in a country like Nigeria. This prompted this study to examine the influence of support services system on psychosocial well-being of elderly within Ibadan metropolis.

The study adopted a descriptive survey research design. A structured and validated questionnaire was used to collect data. A total of three hundred questionnaires were prepared but two hundred and ninety-one questionnaires were retrieved using purposive sampling technique procedure.

The finding revealed that there was there was a significant positive relationship between family support and Psychosocial wellbeing (r=752; df =289; P<0.05). Community social support and Psychosocial support (r=258; df=289; P<0.05). Sex, Age, Ethnicity, Marital status, Number of children and Family type jointly predicted Psychosocial Wellbeing (R2 = 0.42, F (0.22), p<.05).

The study concluded that there was significant relationship of family support and community social support among elderly. The study therefore recommends that psychologists and social workers should identify the elderly who are in need or who have different psychosocial problems, such that intervention programmes that can improve their psychosocial wellbeing be provided for them.

Social Support Variations and Mental Health among Older Adults in Accra

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Abstract

Evidence from empirical literature indicates that support from friends and family has different effects on mental health and

well-being for older adults. Social support dimensions may be influenced by factors such as the educational level of older adults. There is limited knowledge on how friends and family support dimensions interact with other social factors to influence the mental health of older adults within the Ghanaian setting. The current study investigated the relationship between dimensions of social support and mental health among older adults, and the potential interaction effect of education level. Two hundred and fifty older adults (118 males and 132 females; with the mean age of 71) were conveniently sampled from HelpAge Associations in the Greater Accra region of Ghana. Questionnaires assessed dimensions of support, social networks, mental health, as well as other socio-demographic variables. Data analysis revealed that among the older adults, family support was significantly related to their mental health but not friends' support. This implies that the support older adults receive from their family, rather than friends, contributes positively to their mental well-being. Further, multivariate analysis of variance indicated that the education level of older adults determined their friendship network suggesting that those who had higher education were likely to have more friends and also report receiving friendship support. The findings have important implications for gerontological care and support structures in Ghana.

‘The Good Old Days’: Music, Generation and the Ageing Process

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Abstract

The phrase ‘The good old days’ has become a cliché among ageing folks. The phrase simultaneously evokes a sense of nostalgia, articulates generational boundaries and symbolizes the passage of time and loss of power. In terms of music, generational boundaries and sense of exclusion and loss are further accentuated by the term ‘old school music’. This term has been coined by younger generations as a way to separate music of their generations from those of their parents and grandparents. Perhaps to bridge this generational gap and ameliorate the ageing process, some radio stations in Ghana have devoted a large chunk of music programmes to playing ‘old school music’. However, while the idea of ‘the good old days’ spans a broad spectrum of life in different contexts and historical periods for different folks, this paper asks: To what extent is music an important aspect of what constitutes ‘the good old days’ among ageing folks in contemporary times? How do ageing folks engage with music as a socio-cultural and psychological survival strategy? What is the impact of deliberate radio programming of ‘old school music’ on the wellbeing of ageing folk? My paper draws its essential data from fieldwork in Nigeria and in Ghana using mixed methods of inquiry.

Can I Still Afford to Go to the Hospital? Factors Predicting Use of Formal Healthcare among the Aged in Ghana.

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Abstract

The elderly population is gradually expanding globally and in Ghana. Ghana has a National Health Insurance Scheme which makes limited provisions for the elderly. In addition, the scheme has not gained wide coverage. The essence of this study was to explore the various sources of finance for the elderly besides the National Health Insurance Scheme and investigate the implications it had on their healthcare consumption. This study was conducted based on data from the World Health Organization's Study on Adult Health and Ageing (SAGE), Wave 2 from Ghana. A quantitative research design was employed in carrying out this study. Findings indicated that age and other factors such as job sector employer, current working status, payment types, community and government support, current income of household members, insurance, borrowing from other financial institutions and additional benefits influence use of formal healthcare by the elderly. Based on the analysis of a representative individual and household survey, it is recommended that, post-retirement labour arrangements are implemented to keep the elderly engaged in work in order to still earn income and a savings culture specifically for health is emphasized and promoted widely.

Factors Militating Against Care and Support for the Aged in Contemporary Rural Nigeria

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Abstract

In traditional African society, children and members of the extended family to provide care and support for their relatives especially when they are too old to cater to themselves, engage in domestic and agricultural work. The major responsibilities of these caregivers include but not limited to running errands, washing their clothes, providing shelter, food, helping hands in the farms and medical support while the elderly ones stayed at home to look after their grandchildren left behind while adult children are away in the farm in form of reciprocal relationships. However, recent events have shown that care and support for the aged are declining among family members. The study analyzed the dynamics that shaped the decline in care and support for the aged among rural dwellers in selected communities in Ile-Ife of southwestern Nigeria. Four rural communities namely: Abiri-Ogudu, Owena. Tokere and Akile were selected for the study. Primary data was collected using qualitative data. In all, 20 in-depth interviews and 8 focus group discussions were conducted with men and women aged 70 years or older. The results show that rural-urban or international migration, quest for formal education, women involvement of paid employment, children's inability to provide both financial and material support due to unemployment as well as western influence on our culture were found to have been responsible for the decline in care and support for aged relatives. Pragmatic policy options aimed at

addressing this emerging social problem in the rural areas in Nigeria were provided.

Keywords: Factors, Care, Support Older Persons, Rural, Nigeria

Promoting Specialized Care for the Elderly Population in Ghana. The Role of Geriatric Education

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Background: Ghana has one of the highest growing elderly populations in West Africa. However, the number of practicing geriatric specialized health care providers, especially physicians, is limited. Very little is also known about medical students' levels of interest and consideration for geriatric medicine. This paper discusses (1) medical students' current levels of interest and consideration of geriatric medicine and (2) impact of an educational intervention on levels of interest and consideration of geriatric medicine.

Methodology: An exploratory qualitative study of 12 clinical medical students from the Kwame Nkrumah University of Science and Technology - School of Medical Sciences. Face to face interviews were conducted using a semi-structured questionnaire.

Results: Before the intervention, only 2 out of the 12 participants expressed some interest in geriatric medicine. However, none had the intention to pursue the specialty in the future. After the intervention which involved an overview of geriatric medicine

and its potential impact on the health and wellbeing of the aging population, interest in the specialty increased. Consideration of the specialty for future practice also increased. The underlying reasons for the favorable and unfavorable specialty decisions as well as suggestions to improve the interest of future medical students are discussed.

Conclusion: To secure specialized care for the aging population, it is critical that geriatric education is prioritized in medical schools in order to increase students' interest and consideration of the specialty for future practice. This will help improve the long-term health and wellbeing of the elderly in Ghana.

Psychological Effects of Unplanned Return (Deportation): Case of Ghanaian Deportees

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Abstract

Deportation is a system of expulsion regulating human mobility (Walters, 2002). It is an exercise of state power that reinforces its own sovereignty, restoring concepts such as citizenship and aliens. This establishes the boundaries between those who are included and those excluded as well as attributing certain benefits to citizens which are denied the aliens (Allegro, 2006).

Forcibly returning or exiling persons who have lived in a foreign country for a number of months and most at times years comes with psychological distress. The reasons for this deportation are most at times legal as a result of lack of documentation or crimes committed on the part of the immigrants. In recent time, western

countries such as United States, United Kingdom, and Germany have tightened their immigration laws returning persons seeking asylum or seeking greener pastures to their home countries. This has been influenced by the increasing levels of migration secondary to conflict, climate change and economic challenges.

This paper reports on the distress levels and challenges deportees go through during arrest, detention, and transportation to Ghana. The paper covers a cross-sectional report of distress amongst adult returnees from United States of America, United Kingdom and Germany over the Period of March 2018 to March 2019 who were screened on depression, anxiety, stress and mental state. Reported distress included, anger, disappointment, suicidal thoughts, loss of hope, vengeance, low self-esteem and reintegration anxiety. This points to the importance of considering psychosocial interventions and structural arrangements for immigrants prior to deportation especially those within retirement age.

Spousal Violence in Middle and Later Life: Implications for Psychological Wellbeing and Positive Aging in Osun, Nigeria.

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Abstract

In Nigeria, the prevalence of spousal violence (SV) is on the increase and strongly associated with physical and mental health problems which negatively affect aging process. This study set out to determine the prevalence of SV, identified the types

of and factors responsible for the act among married women; assessed the influence of spousal violence on the physical and psychological health of the abused women and examined the joint influence of type of marriage and spousal violence on the psychological well-being (PWB) of the respondents.

Data was obtained from 300 married women who were randomly selected with 100 participants from each of the three selected cities. Data was collected through questionnaire and in-depth interview. The severity of Violence Against Women Scale (SVAWS) was used to measure spousal violence; Brief Symptom Inventory (BSI) was used to measure psychological well-being.

The results of the findings revealed that physical violence was the most prevalent with 16%, followed by controlling behaviour-11.3%, and psychological abuse was 9.0%. The factors responsible for the violence revealed to be prolonged arguments, jealousy, nagging, polygamy, low income and unemployment with 12.7% respectively. The results of the findings also revealed that physical and psychological abuse did not directly influence PWB of women but interacted with the other types of spousal abuse, polygamous marriages encouraged influence of spousal on the PWB of the women. The results of the in-depth interview also revealed that spousal violence has a significant influence on the psychological well-being of married women.

The study concluded that SV is prevalent among married women in Osun State, Nigeria and it contributes to physical and psychological health problems for the victims. Therefore, it is suggested that scholars and gerontologists together need to focus more attention on spousal abuse and its impact on successful aging.

Keywords: Spousal Violence, Women, Nigeria, Aging, Well-being

Pension Reforms and Retirement Income Security for Ghanaian Workers: Implication for Including the Informal Sector

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Abstract

This study was conducted to examine pension reforms and retirement income security in Ghana and the extent to which the informal sector workforces are covered under the third tier of the three-tier pension scheme. Using a qualitative research method, the research sampled views from 83 informal sector workers from selected markets and 3 officials from the regulator, regulated and informal sector foundation using a combination of elite interviews and focus group discussions. The study also reviewed relevant laws on pensions. Respondents were selected using the purposive, convenience and stratified sampling techniques. The descriptive and thematic analyses were used to analyze the data. To meet the retirement income security needs of Ghanaian workers, efforts have been made to enhance the system through the current pension reform. The system has made it possible for all informal sector workers to be fully covered under the third tier of the three-tier pension scheme. There is low patronage by informal sector workers due to lack of trust in the trustees and their long-term pension products. Investment in the education of children, investment into business ventures and continuous reliance on current business proceeds are the well-known retirement plans for informal sector workers. Informal sector workers perceive the third-tier pension scheme as an effective way to secure their future. Finding also indicates awareness creation and public education, marketing campaigns

and engagement of trade unions as ways used to extend pension coverage to the informal sector. Efforts have been made by stakeholders to educate informal sector workers.

Attitudes towards Ageing in Ghana

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Abstract

Although Ghana remains a youthful population, the proportion of elderly persons have increased over the last four decades. The aging process constitutes physical, biological and social psychological changes in elderly persons. These changes are mostly due to debilitating health conditions faced by the elderly and the burden of caregivers. A systematic review of the literature shows that studies on aging in Ghana have focused extensively on the patterns of ageing, health challenges of the aged, forms of support, roles of the elderly and social representations of the elderly. Although the elderly population in most Ghanaian societies experience different forms of discrimination (ageism) on daily basis leading to stigmatization, research on the attitudes towards ageing is absent in the current literature. The aim of this conceptual paper is to utilize the theory of Planned Behavior by Fishbein and Ajzen (1975) to help society understand and form positive perceptions towards the process of aging and the elderly. The idea is that Ajzen (1991) accentuated behaviours are displayed through the availability of resources and prospects to carry out a particular behavior. Therefore, the opportunities (socialization) provided in society have the potential to either positively or negatively affect the development of and changes in attitudes toward aging. Hence, the theory of Planned Behavior

will be used as a framework in studying, understanding and improving the attitudes towards of aging in the Ghanaian context, as part of the Sustainable Development Goals in ensuring good health and wellbeing for all persons including the elderly.

The Currency of Age

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Abstract

The article titled "The Currency of Age" defines aging as the quality of growth with infinitesimal potentials but attempts to Highlight a few of the potentials of the growing individual/ institutions including nations, emphasizing the need to sensitize professionals, leaders, Governing Boards and Councils to take advantage of the invaluable skills, knowledge and experiences of the aged while they may because " the night cometh when no man can work"

Allusion is made to the Ghanaian culture of storytelling as a means of transmitting its values and distinctive which had been the backbone of its consistent growth and development. A well informed and very discipline generation can only emerge when young people are trained and made to understand the currency of age and the need to closely associate with the aged which insures to the mutual benefit of existing young and old/aged population.

The Autumn of Life: Gerotranscendence and Religio-Cultural Impact on Successful Aging in Africa.

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Abstract

Medical progress and improved overall living conditions make people live well into old age more than in previous generations. However, the discussion on aging today is not merely about the longevity of life but what makes for successful and happy aging. This paper analyzes Lars Tornstam's theory of gerotranscendence and how its three dimensions namely – the cosmic dimension, the self-determination, and the social and personal dimensions relate with the African concept of successful aging. The paper engages with how to shift our concept of materialism, superfluous way of life, and a rational view of the world into a more cosmic and transcendental view of aging. The research also focuses on the path of successful aging from a religio-cultural point of view emphasizing in this case on some cherished African values such as maturity and wisdom, life review, forgiveness, reconciliation, spirituality, and life satisfaction in old age.

Cognitive Aging: A Review of Challenges, Opportunities, and Individual Risk Profiles in Ghana.

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Abstract

Cognitive aging is a global problem characterized by a decline in cognitive functioning during adulthood. Although this age-related dysfunction has serious socio-economic and public health implications, it has received little attention in Ghana. The purpose of this review is to analyze existing gaps and opportunities in Ghana regarding cognitive aging. Additionally, the authors aim at suggesting recommendations based on existing evidence on institutions, policies, and interventions to delay cognitive aging and dementia. This paper has implications for specialist training, research and policy.

The Social Organization of Retirement Planning in Ghana: The Case of Social Institutions

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Abstract

Using qualitative explorative approach, data was obtained from pension planning institutions/organizations [n=12]. Employing the in-depth interview, the scope of the research

is to examine opportunities that focus on the roles that social institutions perform to enhance retirement planning. Through direct engagement with pension service providing institutions, the study elicited new insights and negotiated meanings with participants. Crucially the paper finds that retirement planning is facilitated and enhanced diversely by social institutions. Variously designated social institutions create avenues that are used to leverage retirement preparation and ensure the extensive access to quality and holistic retirement planning services. The social institutions play significant functionally imperative roles in the process of retirement planning. These are performed by the political, religious, economic, marriage and family, educational and health institutions respectively. The roles cut across the formulation of laws and regulations to ensure compliance to pension contribution, dissemination of retirement planning information, the earning of income through employment, custodians of retirement planning schemes and portfolios. The roles in turn go to facilitate fluidity in the process of planning. Yet, these notwithstanding only 20% of Ghanaian workers plan towards their retirement especially those in the formal sector of the economy. This is attributable to systemic challenges such as reaching out to the dearth of informal sector workers, which contains a greater proportion of Ghana's labour force. This is worrying due to longevity, weakened extended family support system, inadequate formal support infrastructure. Therefore, extensive retirement planning information dissemination is recommended while individual workers are also encouraged to plan.

Exploring the Nexus between Family Planning and Retirement Planning in Ghana

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Abstract

The study articulates the perspectives and attitudes of workers in an attempt to uncover thoughts and ideas in relation to the phenomena of family planning and retirement planning. Use was made of both quantitative and qualitative datasets. The sample for the study consisted of 442 respondents using a multi-stage sampling technique. The paper finds that there is a link between family planning and retirement planning. The reasons for this nexus encompass the fact that family sizes may inhibit saving abilities, dictates the planning mode, determines the need to increase savings, traditional belief. Family size determines the extent of living expenditure, kind of work, financial status or income among others. Further, large family size hinders the ability to save. Family size determines the retirement planning nexus in the context of extended family preferences. The ideal family size in this context ranges between 1 and 5. The findings show that family planning positively correlated with (0.605) with retirement planning. Whilst large family size inhibits retirement planning, small family size facilitates less expenditure and the better the saving and ensures the availability of financial resources to be channeled into retirement plans. Family size correlates with planning towards retirement to a greater extent. These findings reflect a change in thoughts regarding large family size as opposed to small family size. Yet, the former was in vogue in the immediate past, where large families served economic purpose of 'labour force'. However, in contemporary

times, a gradual shift pertains to smaller families with retirement planning in focus.

Performance-Related Pay and Well-Being: The Case of Ghanaian Financial Services Employees

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To motivate superior employee performance and drive aggressive deposit mobilization in order to maximize profit, several financial institutions are reported to be making extensive use of individual performance-related pay (IPRP) schemes as a reward strategy. This research therefore assessed the impact of performance pay on employee wellbeing on a sample of 112 employees across three Ghanaian financial services institutions. Using a multi-method qualitative approach, data was drawn from corporate policy statements, and multi-level semi-structured interviews conducted with human resource managers, line managers and lower-level employees. Thematic analysis of data highlighted that performance pay tends to impact negatively on employees' psychological, emotional and physical wellbeing. This finding was attributed to the shortfalls in organizational IPRP policies as well as the high level of uncertainty within the Ghanaian socio-economic context

Some Relationships among Socio-Economic Conditions and the Nutritional Status of Pensioners in Greater Accra Region of Ghana.

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Abstract

PREAMBLE: Pensioners are elderly people who constitute a remarkable proportion of our national population. They are vulnerable, particularly from the perspectives of their nutrition, psychology, social life, economics, and politics. Compared to the vast amount of focus and research-based data available on other vulnerable groups such as infants and young children, adolescents, pregnant and lactating women, there is relatively little information on these issues on elderly people.

OBJECTIVE: This study therefore sought to assess the socio-economic status of a group of pensioners and its statistical association with their nutritional wellbeing. It was cross-sectional in design and involved the administration of pre-tested structured questionnaires to over 300 consenting eligible respondents who were 60 (sixty) years of age and above. Details of the sampling technique, the mode of background data collection, quality assurance, project logistics, anthropometric measurements, data analysis and conclusions will be presented. The prospects for further studies and collaboration will also be discussed.

The COEL Project (Ghana) – A Concept Proposal

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PREAMBLE: The number of people 60+ years of age and above in Ghana was estimated at over 1.6 million in the 2010 census report by the country's Statistical Service. This represented approximately 6.5% of the population at the time. It is very significant and should be of prior interest to stakeholders such as finance and economic planners, nutritionists, public health practitioners, healthcare providers, social scientists, politicians, media outlets, among others. Undoubtedly, policies on this segment of the population would be more effective if they are carefully guided by reliable data.

OBJECTIVE: The prime objective of COEL is to establish a routine system for collecting relevant data on the health, social, medical, nutritional, and psychological conditions of samples of the Ghanaian population above 60+ years of age. This would form the crucial basis for functional statistical analysis for advocacy to support local and national policy direction. The proposed COEL project activities would be presented for discussion and interested individuals would be cordially invited to be members.

Nyansapo
(n-yahn-sah-poh)
Symbol of wisdom, ingenuity,
intelligence and patience.

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