CULTURE –SPECIFIC COPING AND QUALITY OF LIFE AMONG GHANIANS LIVING WITH CHRONIC ILLNESS: MENTAL ILLNESS AND CHRONIC KIDNEY DISEASE

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BY

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DECLARATION

This is to certify that this thesis is the result of research carried out by Hannah Belle Afoley Anang towards the award of Master of Philosophy degree in Clinical Psychology in the Department of Psychology, University of Ghana.

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ABSTRACT

The study examined culture-specific coping and quality of life among Ghanaians living with chronic illness such as mental illness and chronic kidney disease. A sample size of 150 was used comprising of 50 mentally ill patients, 50 Chronic Kidney Disease patients and 50 healthy controls. Participants were sampled from the Accra Psychiatric Hospitals, Pantang General Hospital and the Korle-Bu teaching Hospitals respectively. The concurrent mixed method design was used which comprised a cross-sectional survey for the quantitative and a semi-structured interview which comprised the qualitative. Patients were administered with the Africultural Coping Systems Inventory), the General Health Questionnaire WHO Quality of life Brief (WHOQOL) and a semi- structured interview also based on the Africultrual Systems Inventory was also generated).Results showed that there was a significant positive relationship between culture specific coping and quality of life generally.. Also there was a significant negative relationship between the General Health Status of Patients and the quality of life of patients. The results further revealed that, type of condition has a significant effect on Cognitive Emotional Coping and Spiritual Centred Coping. However, no significant differences were found in Collective Coping and Ritual Centered. Results showed that the type of condition has a statistically significant effect on the overall health-related quality of life. The type of condition also has statistically significant effects on the Physical Psychological and Social domains but not on Environmental.

DEDICATION

This thesis is dedicated to my Family

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LIST OF ABBREVIATIONS

ADL- Activities of Daily Life

AFSCI- Africultural Coping Systems Inventory

AMS- Aging Male Symptoms

ANOVA-One Way Analysis of Variance

CKD- Chronic Kidney Disease

COPD- Chronic Obstructive Pulmonary Disease

DSM-IV-TR- Diagnostic Statistical Manual – Text Revision

EDSS- Expanded Disability Status Scale

GHQ- General Health Questionnaire

HC- Healthy Control

HCV- Hepatitis C Virus

HIV- Human Immuno Deficiency Virus

HRQL- Health Related Quality of Life

MS- Multiple Sclerosis

PD- Psychiatric Disorder

PASAT-Paced Auditory Serial Addition

QoL- Quality of Life

SIP- Sickness Impact Profile

SGRO-St. George Respiratory Questionnaire

WHO- World Health Organization

WHQOL-BREF- WHO Quality of Life Brief

CHAPTER ONE: INTRODUCTION

Background

Asante (2009), explicitly defines Afrocentric paradigm as a revolutionary shift in thinking proposed as a *constructural* adjustment to black disorientation, decenteredness, and lack of agency. The Afrocentrist ask an important question, "What would African people do if there were no white people?" Explained differently, how would the worldview of the African be like void of any interference from other westernized world views? What natural responses would occur in the relationships, attitudes toward the environment, kinship patterns, preferences for colors, type of religion, and historical reference points for African people if there had not been any intervention of colonialism or enslavement?

Afrocentricity looks at the African within the context of African history, thereby removing Europe and other cultures from the center of the African reality. In this way, Afrocentricity becomes a revolutionary idea or an idea that hopes and seeks to bring about radical change because it studies ideas, concepts, events, personalities, and political and economic processes from a standpoint or worldview of black people as subjects and not as objects, basing all knowledge on the authentic interrogation of location. By this concept and worldview, this study seeks to know how African values affect the way people cope with chronic illness looking at it from the lens of mental and medical chronic illness.

Culture specific coping refers to the ways in which members of a particular culture heritage draw on cultural knowledge to assign meaning to a stressful event and to determine available resources for dealing with the stressor (Slavin, Rianer, McCrary & Gowda, 1991).

In some studies that reviewed issues on culture and coping, it was found that much focus has been given to the Eurocentric modes of coping while less focus has been given to the afro centric modes of coping under stressful situations (Utsey, Payne, Jackson and Jones, 2002)

(Utsey Payne, Jackson & Jones, 2002; Utsey, Brown, & Bolden 2004) identified communally and spiritually based coping to be particularly prevalent among individuals of African descent, reflecting an Afrocentric worldview. These observations find support in a recent coping study of Black Canadians patterns of coping in racial discrimination. Adopting an integrated coping frame work, the problem- focused coping and emotion- focused coping (Lazarus & Folkman, 1984) and an African centred theory (Utsey et al.,2004) were used. Joseph and Kuo (2009) reported that spiritual- and ritual-centered coping constituted the most crucial coping strategies adopted by Black Canadians in dealing with interpersonal discrimination (e.g., being looked down on as unintelligent by others). Constantine, Alleyne,Cadwell, MacRae , and Suzuki 2005) found that both acquiring from and giving support to in-group members and religious coping is an integral part of coping among African-Americans. These coping behaviors further underscored the centrality of collectivism and communalism in a way in African Americans. Participants were interviewed after the September 11 attacks on how they coped in that stressful situation. Participants reported experiencing a range of emotions such as sadness, anger and anxiety. To deal with these emotions, they dwelled on methods such as social support from significant others and the use of avoidance coping. Blacks and Latinos endorsed more religious coping such as attending church while Asians endorsed more acceptance of the situation or spiritual higher power. These studies present the importance of an African way of coping.

Although African Americans exist in different environmental, geophysical, economic, and sociopolitical conditions than their African progenitors, many of the spiritual beliefs and

practices originating in West and Central Africa have been preserved (Ani, 1990; Hollaway, 1990; Sutherland, 1993). By virtue of this, it is worth looking at certain concepts in the light of these differences to know if indeed their African progenitors do have those values. Also it will be the focus of this study to find out if Africans hold on to these values in all stressful situations such as in illness.

Though Africultural coping in this respect focuses on studies using African Americans to depict or tell how certain African values are held on to and used in times of distress, it is worth noting that African Americans and Africans though have a common descent, may have certain significant differences in relation to environmental factors as well as certain experiences. In explaining certain phenomena, it is easy to polarize certain views as African or as western. Although Africans most of the time are clustered together as one big group to include African Americans and people of a purely African ancestry, there may be significant differences on the issues that are researched into and discussed. Most studies done in the area of how Africans cope, dwell on an africentric theoretical framework using African Americans (Schulman et al., 1999; Utsey et al., 2000; Belgrave & Chipungu, 2000; Constantine et al., 2005) but very little has been done to know if people of pure African background will actually adhere to such values. There probably could be some differences as a result of certain factors such as the geographical location which could also bring about variations in African values of a specific people . This makes it necessary to do further studies to know how people in this state cope in relation to the culture of the people as well as how their quality of life is affected.

Most people at one point or another are faced with life threatening situations during the course of their lives (Bonanno, 2004). These traumatic events can either be natural such as earthquakes and tornados or man-made such as traffic accidents, murder, robbery, serious

injury, sexual assault and warfare and illness. The consequences of these traumatic events pose challenges which may be temporal or permanent, altering ones' capacity to cope and causing changes in ones' self concept. Changes in ones' self concept leads to a reduced subjective quality of life(Johansen et al., 2007). These changes do not only affect the quality of life of the victim but also that of victim's family members (Salzinger et al., 2002).

The focus of healthcare has shifted from acute, infectious diseases to chronic states (Lorig, 1993; Lorig & Holman.2003; Schlenk et al., 1998). A chronic state is an irreversible state of disease for which there is no cure (Connelly, 1987). Going by this definition, it becomes necessary for patients living in this state to cope through their circumstance. Coping has been defined as a response aimed at diminishing the physical, emotional and psychological burden that is linked to stressful life events and daily hassles (Snyder, 1999). Chronic illnesses are long term conditions which produce impairment or injury to the body (Charmaz, 2007). However, some chronic conditions may not be as serious as others and cause fewer problems. Others such as cancer, AIDS, kidney disease and heart disease may impose severe challenges for functional independence (Albert, 2004)

Mental health care is often one of the lowest health priorities for low income countries (World Health Organization [WHO], 2001) and Ghana is no exception. For this reason people living with these chronic conditions as well as their care givers go through a lot and have to deal with the stressors that come with it.

According to the World Health Organization (WHO, 2001), mental health has become a major international health concern. About 450 million people worldwide are said to be affected by mental, neurological or behavioural problems at any time. According to the WHO report, mentally ill people are often subjected to social isolation, poor quality of life, and increased mortality. The WHO world-wide estimates indicate that up to 5% of the world

population may suffer from neuropsychiatry conditions while 1% suffers from severe mental disorders during their lifetime. WHO (2007) estimated that in at least 2,816,000 people suffer from moderate to severe mental disorders. 1.17% of these people receive treatment from public hospitals. Appiah – Kubi et al. (2006) suggest that, poverty influences mental illness through its impact on the social, psychological and biological factors of mental disorders. In terms of access to treatment poverty poses the biggest challenge. Worldwide access of the poor to social services like health care, particularly developing countries, is relatively lower than the less poor.

Mental health conditions call for a very high level of coping as well as a critical look at the state of their quality of life to ensure maximum comfort in their conditions since the state is chronic and needs to be managed for a very long time, if not forever. Osei (2008) explained that mental health conditions pose a lot of challenges and consequences such as having variety of physical illness, a low quality of life, low income and low productivity which reduces the national productivity output. These challenges in mental health call for a more research in coping with mental illness.

Chronic Kidney disease is also a chronic condition which is costly and very expensive to treat. It is considered a traumatic event, with significant psychological and neurological consequences that affect patients' experience (Souza, Martino & Loops, 2007). Treatments that are made available are mostly to manage the illness and not permanent curative modes (Lucchetti, Almeida & Granero, 2010). Chronic kidney disease often makes coping with the illness very difficult and unbearable. This study hopes to compare psychiatric conditions and a medical condition to see if any differences may exist on their levels of coping and quality of life.

According to cognitive theories, cognitive coping mediated between stressful events and psychological and physical responds to stressful events (Manne, 2002). It was hypothesized that, by examining individual coping differences, a greater understanding of why people react differently to the same events would be achieved (Manne, 2002). It becomes very important to look at coping in a particular context which benefits the individual based on certain important characteristics.

Research on stress and coping exploded with the work of Lazarus and Folkman (1984), which put forth the transactional stress and coping paradigm. According to them, coping refers to cognitive and behavioural efforts to manage disruptive events that tax the person's ability to adjust (Lazarus 1981, p.2). though some research have been done in the past on coping, new researches need to focus on certain important aspects such as culture in order to suit the specific needs of the individual.

In as much as coping is an important concept to look at when it comes to chronic illness, quality of life of patient living with chronic illness also becomes important. Quality of life (QOL) concept is currently embraced by three major branches of science: Economics, Medicine, and the Social Sciences. Each discipline has fostered the development of a quite different view of how QOL should be conceptualized and measured (Cummins et al. 2004; Micholos, 2004).

QOL has been conceptualized in two ways: global QOL and health-related QOL (HRQOL). QOL is believed to be the most important outcome of care in end of life stages (Stewart, Teno, Patrick, & Lynn, 1999). Global QOL is defined as individual's subjective well-being (Cella, 1994; Cohen, Hassan, Lapointe, & Mount, 1996; Cohen & Mount, 1992; Cohen, Mount, & MacDonald, 1996), or a global evaluation of satisfaction with one's life (Cooley, 1998; Nuamah, Cooley, Fawcett, & McCorkle, 1999). HRQOL, on the other hand, is "a more

focused concept related to the impact of a medical condition or the impact of specific medical interventions on a person's physical, psychological, and social well-being' (Skeel, 1998, p. 876). Quality of life in regards to this study becomes very essential to know how the state of a patient or the quality of one's life is affected by the illness and to know which specific aspects.

Studies assessing the burden of chronic physical and mental health conditions increasingly include the negative impact on an individual's health-related quality of life (HRL), commonly defined as everyday functioning and well-being. Flanagan,(1982) and Frisch (1999) defined QOL as a global and multifaceted construct, which includes the following functional domains; (a) intrapersonal (e.g., health, perceptions of life satisfaction, feelings of well-being), (b) interpersonal (e.g., family life, social activities), and (c) extrapersonal (e.g., work activities, housing). People living with chronic conditions have their quality of life or aspects of it greatly affected as a result of the strain and stress it brings to their entire life. For this reason, it becomes necessary for critical attention to be paid to this domain of their health.

Statement of the Problem

Stress and coping research is one of the most studied areas since they give insights into wellbeing and adaptation to diverse situations (Aldwin, 2007). Lazarus and Folkman (1984) hypothesized that the way a person internalizes cultural values, beliefs and norms affect the way stress is appraised and the specific coping response they use. Culture plays an important role in all aspects of the person life. Different cultures respond to stressful situations differently considering the coping goals, coping strategies and coping outcomes (Chun, Moss & Cronkinte, 2006; Lam & Zane, 2004).

Chronic conditions present a prolonged management and care system over a long period of time (Lima et al., 2009). The demands on the life of the patient may pose a threat to the quality of life and the general coping of the patient (Chamraz, 2007). Chronic conditions pose physical challenges: experiences range between minor physical ailments to severe physical disabilities. These physical challenges have psychological implications (coping with pain and its management, dealing with disrupted lives and identities) as well as concrete impact on mobility and productivity (Agyei-Mensah, 2003). Existing work on experiences of diabetes, cancers, and sickle cell disease and childhood chronic diseases gives a skeletal picture of chronic disease in Ghana (Agyei-Mensah, 2003; Aikin, 2005; Clegg-Lamptey, 2007; Ekem, 2007; Badasu, 2007). Chronic research in Ghana has been basically dominated by a biomedical perspective (de-Graft Aikins, 2010). Though the biomedical system has come to stay, the focus now should be on more culturally and socially based methods of coping and management in stressful conditions such as chronic illness.

An individual with a chronic illness is constantly examining, interpreting, and managing his or her condition within the context of his or social and cultural system. This exchange is based on the intimate connection that often occurs between self-regulation and the culture of the individual (Baumann, 2003). It becomes important to take into consideration the culture or the way of life of a particular people in managing their general life issues.

Aims

The study is aimed at assessing the relative impact of African cultural values on coping and is impact on the quality of life in chronic illness.

Objectives

- Examine how Culture specific coping influences quality of life
- Determine if patients with mental and medical disorders differ in the choice and type of cultural coping.
- examine gender difference in the coping methods used and quality of life
- Determine if choice of specific culture coping method and also the quality of life of the patient.
- Examine how the general health of the patient influences the quality of life of the patient.

Relevance of the Study

The study becomes important and relevant in that chronic conditions are increasing day in day out. Most of these conditions have to be managed since they are incurable most of the time. For this reason, coping in this state becomes essential to help the patient through to the end. This study will help inform us of how Africans and for that matter Ghanaians cope in a chronic state since Africans have specific strategies they hold on to when they have to cope with situations and conditions. The culture of the people is indeed unique to them and by this; dealing with issues in relationship to their way of life must be an initial consideration to start with. The research will help incorporate excellent management plans in health institutions of these conditions to make managing them as easy as possible and to reduce the stress that the conditions come with specifically for people with psychiatric conditions and chronic kidney disease. This will help design and plan rigorous treatment and coping regimes since most of

the regimes we have are generalized which is not always the best It will provide a broad spectrum of knowledge and information to researchers to conduct further studies, as well as enhancing researches done in this area since very little has been done in relation to this

CHAPTER TWO: LITERATURE REVIEW

Overview of literature review

This current study seeks to examine the role of culture in the sphere of coping among patients with chronic illness (mental illness and chronic kidney disease). In other words does culture specific coping influence quality of life? This chapter therefore, presents the theoretical frameworks underlying the study with the view of elaborating on the theories that explain the various variables in the study by putting them into perspective. The reviews of the theories underpinning the study are followed by the empirical literature on the various variables in the study. These theoretical and empirical literature reviews are followed by the rationale for the present study, the hypotheses to be tested and the operational definitions of key terms.

Theoretical Framework

The Transactional Model of Stress and Coping

Stress and coping theory (Lazarus & Folkman, 1984) has been widely used to guide research into adaptation to care giving. According to this theory, stress emerges when the relationship between the person and the environment is appraised by the person as exceeding his or her resources and as threatening well-being. Lazarus and Folkman postulated that a person's internalized cultural values, beliefs, and norms affect the appraisal process of stressors and the perceived appropriateness of coping responses. Accordingly, these cultural factors delimit the coping options available to an individual in the face of stress. As follows, stress and coping are universal experiences faced by individuals regardless of culture, ethnicity, and race, but members of different cultures might consider and respond to stressors differently

with respect to coping goals, strategies, and outcomes (Chun, Moos, & Cronkite, 2006; Lam & Zane, 2004).

Even though this theory is one of the first coping frameworks to have explained coping the theory failed to look at a culturally based form of coping (Utsey et al., 2000; Kuo et al., 2009; Constantine et al., 2005).

African Philosophical Framework

An African-centered approach is of the view that the values, attitudes, and customs originating out of an African philosophical framework is necessary for understanding the behavior of people of African descent (Asante, 1998; Azibo, 1992; Nobles, 1990). An African-centered philosophy holds that everything in the universe is functionally connected, and individuals are viewed as an extension of the environment. In this regard, the collective consciousness emphasizes cooperation and group orientation; the group serves as a natural support system (Jackson & Sears, 1992; Post & Weddington, 1997).

The notion of all things being connected is known as consubstantiation (Nobles, 1986) and is the axis or the bedrock of the African worldview. Consubstantiation connotes a holistic worldview in which all events, as Semmes (1996) states, "have purpose and meaning." Also within the framework of the African worldview and under the umbrella of consubstantiation is the process of maintaining cohesiveness with the elements of nature. In the African worldview, man is a force within a universal order that has the potential to harmonize and bring balance with nature (Jahn, 1961). Harmony requires the balancing of relationships between complementary opposites in accord with environmental rhythms (Nobles, 1986). Therefore, in the realm of coping behaviors, effective coping requires the ability to bring

harmony with life's events, which are spiritual manifestations that occur in a physical/ material form. In this philosophical framework (i.e., African centered), coping is viewed as an effort to maintain a sense of harmony and balance within the physical, metaphysical, collective/communal, and the spiritual/psychological realms of existence. When this balance is upset, stress and disease are the result.

Afrincentric Worldview

Africentric worldview is a set of beliefs, values, and assumptions or a way of life that is founded and purely based on African cultural traditions. This view looks at the relationship between the self, others and the evironment (e.g.,Myers, 1993; Utsey, Adams, & Bolden, 2000). Africentric principles are essentially codes of conduct for daily life that represent the minimum set of values that people of African ancestry need to build and sustain an Africentric life, family, community, and culture (Grills & Longshore, 1996; Karenga, 1988).According to Karenga (1965, 1988), the seven core principles (i.e., Nguzo Saba) of an Africentric worldview include unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith. Other African-centered scholars have noted additional primary Africentric values of spirituality, harmony with others and nature, balance, orientation to time as a social phenomenon, authenticity, and an emphasis on oral tradition (e.g., Mattis & Jagers, 2001; Mbiti, 1986; Nobles, 1976). Africentric values and behaviors can provide a reservoir from which protective factors and coping strategies are drawn (Constantine & Blackmon,2002).

Quality of Life Theory

The concept of quality of life is drawn largely from need (Maslow,1954) and role (Sarbin & Allen, 1968) theories. Quality of life as a concept stems from the social contract of

fulfillment of *needs* in exchange for meeting of *demands* which society places upon its members.

This theory provides a framework for conceptualizing people's mental health needs, describing services, and reporting program evaluations. A number of research groups have advanced the conceptualization and measurement of *quality of life* in various health fields (e.g., Guttling et al., 2006; Foster, 2009; Ahmad et al., 2010; Kaltsouda et al., 2011; Bayliss et al., 2012; Saani et al., 2013). The concept has both subjective and objective components. The subjective component is frequently referred to as "well-being," "life satisfaction," and "happiness" (e.g., Bradburn, 1969). The objective component can include aspects of social functioning such as independent living and employment (Rapp, Gowdy, Sullivan, & Wintersteen, 1988. The WHO defines six dimensions of QoL : Pysical health, psychological state, social relationships, environmental features, and spiritual concerns. Low satisfaction in ones' health care has a significant effect on ones' QoL(Glaus,1993; Wagne and Bear,2009)

Related Studies

Culture is a set of attitudes, beliefs , values and behaviours shared by a group of people , but different for each individual, communicated from one generation to the next (Matsumoto,1996). It helps us distinguish one group from another. Talking about a people's culture will include beliefs, rules of behavior, their language, rituals, art, technology, styles or ways of dressing, their way of producing and cooking food, their religion and their political and economic system. Culture in totality describes how people of a given society think and live in specific ways and this include their coping mechanisms in times of distress and stress

which includes illness. Chronic illnesses are long term conditions which produce impairment (Charmaz, 2007).

Chronic conditions have a very unfavorable prognosis which is not clear cut. These conditions i burden one to see a medical practitioner every now and then which may include hospitalization. Such illnesses usually require a strict regimen and a long term pharmacotherapy as well as other therapeutic methods where necessary (Ockene, 2001). Alhough managing chronic conditions require a strict regimen; some conditions may come up to be more fatal than others. However, the condition becomes necessary to plan appropriate measures to cope in these challenging times. This cannot be done outside the cultural scope of the individual.

Coping is defined as the individual's effort to manage external and/or internal demands that are estimated to exceed the individual's assets of behavioral and cognitive ability. The estimation of the situation and the choice of coping strategy depend on earlier experiences of similar situations, conceptions of the self and the environment and access to resources (Lazarus & Folkman, 1984) According to Lazarus and Folkman (1984), coping serves two important functions: managing or tackling the problem, and regulating the emotional distress experienced. By this it is clear that cultural selectivity of coping is strongly circumscribed by the normative values, beliefs, and orientations of a culture (Aldwin, 2007; Chun et al., 2006; Hobfoll, 1998).

The cultural syndromes of collectivism and individualism are the two most frequently enlisted cultural constructs to explain cross-cultural divergences in coping behaviors by cultural coping researchers (Chun et al., 2006). Particularly, there has been an increased empirical effort to explore and examine the collective dimension of coping among Asians (e.g.Kuo et al., 2006; Yeh & Wang, 2000) and Africans and African Americans (e.g., Utsey, Adams,& Bolden, 2000; Utsey, Brown, & Bolden, 2004).This chapter seeks to review works

done in relations to cultural influences in coping and to give concrete reasons as to why this topic should be looked into with further research.

The influence of culture on coping has been of great concern conceptually in the stress-coping literature for a great deal of time. Empirical research on cross-cultural coping has gained grounds only recently. The past two decades witnessed a significant growth in the research and the knowledge base of culture and coping, as well as an increased call by scholars for more culturally and contextually informed stress-coping paradigms (Kuo, 2010).

Scott (2003) in his study sought to find out if black culture had specific orientations that are believed to have dimensions such as communalism and spirituality. They compared this to the mainstream American culture which also looks at certain orientations such as individualism, effort optimism, and competition were related to the strategies used by African American youth to cope with perceived discrimination. 120 African American youth from two geographical regions in the United States participated in the study. Findings indicate that spirituality and effort optimism were related to greater use of self-reliance/problem solving coping strategies, whereas communalism was related to lower use of externalizing coping strategies. The implications of cultural orientation for the adjustment and psychological functioning of African American youth in the face of multiple racial contingencies are discussed. In this study it can be deduced that there can be more research to this effect. In their sample, they used African Americans and mainstream Americans. The question one would ask is that if people of pure African progeny are used in a similar research will there be any exceptional differences as found in this study? This makes it worth researching and exploring.

Greer (2011) looked at the moderating effect of culture-specific coping strategies to understand the relationships between race- and gender-based discrimination and

psychological symptoms for African American racism. in his study, it was hypothesized that coping strategies would influence the severity of discrimination-related psychological consequences, such that frequent use of coping efforts would be related to less severe psychological symptoms. Moderated structural equation modeling was used to test the study hypothesis. Results revealed that race and gender discrimination were associated with increased psychological symptoms. No moderating effect of coping strategies was found (Greer, 2011)

The purpose of Greer's study was to determine whether culture-specific strategies would moderate the relationships between race and gender discrimination and psychological symptoms for African American women. Internalization of Africentric values or the belief people have in these African centred values, has been associated with improvement in psychological outcomes for African Americans (Nasim, Belgrave, Jagers, Wilson, & Owens, 2007). For the purposes of this study, it was hypothesized that Africentric strategies (i.e., culture-specific efforts to address discrimination) would be a moderator between race- and gender-based discrimination and psychological symptoms (e.g., anxiety, depression) such that frequent use of coping efforts would be associated with less severe symptoms. Results revealed moderate correlations between the racism and sexism variables.

Africentric coping strategies were also significantly and positively associated with racism and sexism. Moderate, positive correlations were observed between the majority of the psychological symptom variables, and between the variables for racism, sexism, and Africentric coping. Contrary to the study hypotheses, coping strategies were not significant moderators. These results seemingly contradict those of previous studies in which culture-specific strategies were found to improve the psychological health of African Americans in coping with discrimination and other stressful situations (e.g., Nasim et al., 2007). For this reason, further research needs to be done to ascertain if culturally related values tend to

improve the life of Africans in all situations or rather presents a negative effect in specific situations.

Dadgeid and Duckert (2008) looked at how people living with HIV/AIDS cope as well as the support interventions they use. The researchers examined how such interventions should take people's reported needs, coping strategies, and context into account. They used in-depth interviews to find out how South African women cope. In many studies active problem-focused coping strategies have been encouraged because they are considered to be more beneficial than passive emotion-focused strategies. The overriding aim of coping was to solve the tasks of physical, psychological, and social survival. They found that strategies involving avoidance of, escaping from, or minimizing HIV/AIDS and its accompanying emotional distress were predominant. Such strategies could be adaptive in a society with scarce resources and marked by gender inequalities. Their findings suggest that care and support interventions should be sensitive to culture and context, should be holistic and participatory, and should include income generation and child care services. Though this study sought to bring a change in the coping researches it could have been done using a mixed method design. Where people still give in- depth interviews of how they cope and the reasons they use those methods as well as look at how they interpret these strategies using active problem focused coping strategies as well as passive methods of coping. Though these are thought to be non- African methods of coping it would have been better to compare and find out to what degree they are used or not used. In this regard this particular study seeks to use both quantitative method and qualitative to find out how people cope. Another focus of the above research was on the issue of researching in a cultural context.

Banerjee et al. (2011) in their study describe how cultural beliefs and coping strategies are related in dealing with childhood cancer through a qualitative study. In this

study their sample was specifically based on care giving experiences of first-generation South Asian immigrant parents of children with cancer. Using constructivist grounded theory approach, a post-diagnosis of children from oncology centres were recruited into the research. In-depth semi-structured interviews were conducted in diverse languages such as English, Hindi, Punjabi, or Urdu with a sample of 25 South Asian parents. Results from the interviews generated two central themes in relation to culture and coping. The first was that cultural beliefs about childhood cancers were believed to be incurable, rare, unspeakable, and understood through religion. Also parental coping strategies included gaining information about the child's cancer, practicing religious rituals and prayers, trusting the health care professionals, and obtaining mutual support from other South Asian parents. From this study it was learned that cultural beliefs and coping strategies have important implications for health care providers to understand the variations in the perceptions of childhood cancer and coping in order to implement culturally sensitive health care services. This study lays emphasis on the fact that the culture of a specific people influences their choice of coping which may be entrenched in their beliefs. As we know cultures vary significantly even if found in the same country as we see this evident in the various ethnic groups that exist. Therefore it is worth focusing on a particular culture of a people when the issue of coping is addressed.

Lam and Zane (2004) tested the mediating role of self-construals on ethnicity and preference for *primary* versus *secondary* control coping approaches in dealing with interpersonal stress among Asian American and White American college students. In this study, it was found that significant differences existed amongst the groups that they looked at. Amongst the Asian Americans, in managing stress interpersonally, they cope by adjusting themselves to contain the external stressor. On the other hand white Americans also cope by trying to adjust the environment or the stressful situation they find themselves the environment or the stressor so

that they can be in congruence with the person's will. These results reflected an indigenous Asian normative value on how people depend on things socially and communally while that of the Americans implies a culture which focuses on independence and environmental autonomy. The outcome of this study explicitly brings out differences in the ways people cope and how this is specifically influenced by the mother or native cultures. This explains that indeed no two cultures are the same and that the culture of a people permeates their entire life even the way they cope with stresses. in line with the above study, two other studies examined internally and externally targeted control strategies in response to life stressors in European Canadians, East Asian Canadians, and Japanese.(Tweed, White & Lehman, 2004).

In the initial study, European Canadian, East Asian Canadian, and sojourning Japanese university students in Canada were made to recall any stressful life event or situation they had experienced and say which coping strategies they used. in the second study, East Asian Canadian and European Canadian university students in Canada and Japanese university students in Japan. Both studies discovered that in relation to specific targeted control strategies, the various groups that took part in both studies took to a particular type of strategy to control a stressful event or situation.eg East Asian participants used more internally control strategies whiles self- enhancing interpretive control strategy was more prevalent among people with Western English-speaking backgrounds. Both Study 1, which was conducted entirely in the West, and Study 2, which also included Japanese in Japan, supported the hypothesis that people from collectivist, high-power distance, Buddhism-influenced, and Taoism-influenced countries tend to engage in more internally targeted control strategies in stress and coping contexts. Self-enhancing interpretive control, however, which could be considered a type of internal control, were more common among Western English speakers. This result concurs with the growing body of literature suggesting

that self-enhancement is particularly characteristic of individuals influenced by Western English-speaking cultures (Heine & Lehman, 1999).

This points to a cultural typology of self as a valuable cultural framework through which cultural variability in coping can be comprehensively conceptualized and measured. In this particular study as well, emphasis has been made once again on the fact that cultural differences play a role in the way people cope and also this influence a specific coping method they fall on in a stressful event. In this case an argument can be made on the fact that if there are differences in cultures and these can be made evident in copings strategies there is a possibility that Africans may also have specific coping mechanisms they use and to what extent and degree do they use these coping mechanisms, or do they even use them at all? This is worth answering through this study.

Coon et al. (2004) also found that Latina family caregivers reported less perceived stress and more perceived benefits and used more religious coping in providing care to family members with dementia than did female Caucasian caregivers. Similarly, (Haley et al., 1996) in a different study also found that African American family caregivers of patients suffering from Alzheimer's reported less perceived stress, manifested lower depression, and adopted less of both approach and avoidance coping in care giving in comparison to their Caucasian counterparts. Specifically, for Caucasians, approach type coping helped reduce depression and increase life satisfaction, but avoidance-type coping led to adverse psychological effects. However, such effects were not found among African American caregivers.

On the other hand, in a large-scale study by Knight, Silverstein, McCallum, and Fox (2000), African American family caregivers of dementia patients perceived care giving to be less burdensome but tended to adopt more emotion-focused coping than did a group of non-Hispanic White, Hispanic, and Asian/Pacific Islander caregivers. The authors concluded that the culture-specific appraisal and coping behaviors of African American caregivers were

indicative of "culturally transmitted" values and behaviors of this group. Emotion-focused coping has been shown to be beneficial (e.g., reducing distress)for Asian Americans and Asian Canadians in dealing with various stressors, including family conflicts and racial discrimination (Lee & Liu, 2001; Lee et al., 2005; Noh et al., 1999; Noh & Kaspar,2003; Sue et al., 2005).

Problem-focused coping also has been found to be effective for Asian Americans and Asian Canadians in responding to male gender conflicts, racial discrimination, and cross-cultural adjustment (Cross, 1995; Noh & Kaspar, 2003; Wester et al., 2006; Yoo & Lee, 2005). For non-Asians, emotion-focused coping was shown to be negative in increasing stress for African American adult caregivers (Knight et al., 2000), but problem-focused coping was shown to be negative in exacerbating stress for Hispanic American college students in facing family conflict (Lee & Liu, 2001). As evident, the existing knowledge on the adaptive quality of different coping strategies is currently incomplete and inconclusive and necessitates further research and that is what this study seeks to find. Also in most of the studies the focus has been people of other cultures rather than those with African progeny. This makes this study worth researching into.

Yeh and Inose (2002) studied coping with cultural adjustment among Chinese, Korean, and Japanese immigrant youth in the United States. Korean youth used religious coping more than did the Chinese and Japanese; Japanese youth used social support as compared to the other two groups in the study. On the other hand, both Koreans and Japanese were similar in their use of creative activities as coping. In a study by Yeh and Wang (2000), it was found that while Chinese, Korean, Indian, and Filipino American university students reported similar coping resources and methods in resolving mental health problems, they differed dramatically in the relative importance assigned to the various coping options.

These studies also raise the need to research into the cultural basis for how people cope since from all indications there are major differences observed.

In a qualitative study by Yoshihama (2002), Japanese-born Japanese American women who had experienced domestic violence reported the use of more passive coping strategies, such as minimizing the problem or focusing on the positives of the abuser than did their U.S.-born Japanese American counterparts. Yoshihama reasoned that active, problem-oriented coping inherently contravenes traditional Japanese cultural values of forbearance and endurance, particularly for the Japanese-born women. In a unique qualitative study, Constantine, Alleyne, Caldwell, McRae, and Suzuki (2005) interviewed Asian, Black, and Latino/Latina Americans living in New York to explore how they coped with the aftermath of the September 11 terrorist attacks. All participants enlisted acquiring additional information about the attacks; expressing a range of emotions (i.e., sadness, anger, anxiety); seeking support from or giving to family, friends, colleagues, and peers; and avoidance behaviors as their typical coping methods. However, Blacks and Latinos/Latinas endorsed more religious coping (e.g., attending church), while Asians endorsed more acceptance of the event as a result of fate or spiritual higher power as their coping with the posttraumatic stress. It was noteworthy that the idiosyncratic cultural characteristics on coping based on ethnicity were observable even in the face of momentous events.

In a study by Chiang, Hunter, and Yeh (2004), both African American and Latino American college students identified family and religion to be highly important sources of help and coping for them in dealing with personal, interpersonal, and academic stressors. However, turning to parents was more important for Latino Americans while engaging in religious activities was more important for African Americans. The authors explained that the coping preference of African Americans reflected the centrality of spiritualism and religion in

Afrocentric values. In a study by Lee and Liu (2001), the authors found Asian, Hispanic, and European American college students to share a similar coping preference for direct actions over indirect actions in managing conflicts with their parents. However, for Hispanic Americans, the use of direct coping actually heightened family conflict, but not for the other two groups.

Frydenberg, Lewis, Ardila, Cairns, and Kennedy (2001) found that when compared to youth in Colombia and Australia facing serious stress over social issues (e.g., pollution, discrimination, fear of global war, and community violence), youth in North Ireland used not only more nonproductive coping, including self-blame, tension reduction, and not coping, but also more socially oriented coping, including seeking friends and social support. Colombian youth, on the other hand, used problem solving, spiritual support, social action, seeking professional help, and worrying more than did their Ireland and Australian counterparts. In a different study, Frydenberg et al. (2003) found in comparison to Australia, Colombia, and Germany youth, Palestinian youth are more likely to cope with seeking to belong, investing in close friends, ignoring the problem, not coping at all, seeking professional help, social action, social support, solving the problem, spiritual support, and working hard, but less in physical recreations to cope. Meanwhile, coping through engaging in relaxing diversion and tension reduction (e.g., physical recreation) were more common among Australian youth.

In an exceptional descriptive exploratory study Baldacchino, Borg, Muscat and Sturgeon (2012) explored illness appraisal and spiritual coping of three groups of individuals with life-threatening illness. These were hospice clients with cancer (Ca; n = 10), clients with first myocardial infarction (MI; n = 6), and parents of children with cystic fibrosis (CF; n =16). Qualitative data were collected by audio taped face-to-face interviews (parents) and focus groups (MI and Ca). Similarities in illness appraisal and spiritual coping were found

across the three groups except appreciation of crafts, which was found only in clients with Ca and causal meaning of parents (CF). Overall, illness was appraised negatively and positively, whereas spiritual coping incorporated existential and religious coping. These findings confirm the psychological theory (Lazarus & Folkman, 1984) and theological theory (Otto, 1950), which guided this study. Recommendations were proposed to integrate spirituality and religiosity in the curricula, clinical practice and to conduct cross-cultural comparative longitudinal research.

Kuo et al (2006) examined acculturation and coping among three cohorts of Chinese adolescents in Canada: Chinese Canadians, late-entry Chinese immigrants, and Chinese sojourners. The study adopted a unilinear model of acculturation, measuring the participants' acculturation using the Minority-Majority Relations Scale (Sodowsky, Lai, & Plake, 1991); it assessed Chinese adolescents' relative degree of cultural orientation toward Canadian culture and value. Consistent with the prediction of the study, significant cohort differences in acculturation levels as well as coping behaviors were found. Less acculturated cohorts (e.g., Chinese sojourners) adopted more collective coping and avoidance coping methods in managing acculturative stresses than did those in more acculturated cohorts (e.g., Chinese Canadians).Less acculturated adolescents were found to adhere more strongly to traditional Asian values of collectivism and interpersonal harmony, which in turn prompted a greater use of collective and avoidance (e.g., not rocking the boat) coping.

Kuo (2010) also the systematically reviewed and took stock of the theoretical and empirical knowledge that emerged from the cumulative cultural coping research. Specifically, this corpus of literature was summarized and analyzed in terms of (a) theoretical propositions, (b) empirical studies on cross-cultural coping variations, (c) cultural dimensions of coping, and (d) implications for future research. The results evidenced culture's consequences on coping with respect to the identification of conceptual pathways through which culture affects

stress coping; cultural differences and specificities in coping patterns across national, ethnic, and racial groups; and the differential effects of acculturation, self-construal, and individualism-collectivism on coping. Conceptual and methodological recommendations are offered for future research.

Culture-Specific Coping

Culture specific coping refers to the ways in which members of a particular culture heritage draw on cultural knowledge to assign meaning to a stressful event and to determine available resources for dealing with the stressor (Slavin, Rianer, McCrary & Gowda, 1991).

Utsey, Adams and Bolden (2000) define africultural coping "as an effort to maintain a sense of harmony and balance within the physical, metaphysical, collective/communal, and the spiritual/psychological realms of existence"

Africultural coping has four primary components (Utsey et al., 2000):

a. Cognitive-emotional debriefing
b. Spiritual-centred coping
c. Collective coping
d. Ritual-centred coping

Utsey et al. (2007) examined the role of culture-specific coping in relation to resilient outcomes in African Americans from high-risk urban communities. Results showed that spiritual and collective coping were statistically significant predictors of quality of life outcomes compared to traditional predictive factors. This study examines the antecedent factors affecting the quality of life of African Americans. Both culture specific coping and spiritual well-being were significant predictors of quality of life. Spiritual well-being partially

mediated the effects of culture-specific coping on quality of life. Though this study is one of the enlightening studies on the concept of culture and coping, the question here will be " in all other situations will Africans or people of African descent rate high on the use of spirituality and collective coping ?" this study seeks to find out if any differences may occur and why.

Constantine, Donnelly, and Myers (2002) studied the relationship between collective self-esteem and Africultural coping. In this related study, they found that African American adolescents who believed their cultural group was an important part of their self-concept reported greater use of collective and spiritual –centered Africultural coping to deal with stressful situations than those without such beliefs. African Americans also use different types of coping methods to deal with different types of racism stressors. This study clearly points to the fact that Africans indeed have a way of coping but this is influenced by their belief in that culture. Therefore if one does not believe in the African values and culture the source of coping or mechanism used to cope may be different. Also, depending on what the stressor is a particular type of coping mechanism is used. For these differences, the current study seeks to find out how people who have chronic illness may cope and what type of coping styles they will adapt.

In related study to the above, Lewis-Coles and Constantine (2006) examined whether a particular africultural coping style was used to cope with a specific type of racism stress. The race-related stress involved stress arising from individual racism (such as a racist remark), stress arising from institutional discrimination in the employment or housing market, and stress arising from cultural racism such as a negative portrayal of African Americans, the researchers were also interested in whether there were differences between men and women in methods for coping with different stressors.

The authors found that men and women differed in the relationships between race-related stressors and africultural coping styles. African American women, who perceived greater institutional racism stressors may be less likely to use their own personal control for addressing stress and rely upon collective and spiritual resources (such as talking to each other). On the other hand, higher levels of cultural racism-related stress among African American men were associated with greater use of collective coping strategies (and not the other cultural coping styles).

Spirituality, Social Support and Coping

Historically speaking, spirituality has been used to encourage, comfort, and aid African Americans, allowing them to survive years of slavery, segregation, and discrimination (Lewis, 2008). Mayerstein (2005), in his study explained that Illness is a universal experience that evokes a range of difficult emotions and tough spiritual questions, often without satisfying answers. Illness affects the body and the spirit, presenting a challenge on physical, emotional, social, and spiritual levels.

Gall (2000), in a cross- sectional study explored the role of religious resources and how they are used in the adjustment of long term breast cancer. In their study, a sample of 52 women, notably breast cancer survivors participated in the study. They were assessed on different dimensions of religious resources. (e.g., image of God), nonreligious resources (e.g.cognitive appraisal) and emotional and spiritual well-being. Results indicated that both relationship with God/God image and religious coping behaviour were related to the nonreligious mediator variables of cognitive appraisal and coping in response to the current cancer situation. Various experiences of relationship with God (e.g., Presence) were related to more positive appraisals of the current cancer situation as well as to the greater use of the

nonreligious coping behaviour of focusing on the positive. In contrast, religious coping behaviours demonstrated more complex associations with cognitive appraisal and nonreligious coping factors. The same coping behaviour, for example religious avoidance, could be related to both positive and negative appraisals of the cancer situation. Finally, religious resources, but not nonreligious resources predicted emotional and spiritual well-being for these long-term breast cancer survivors. In general the study showed that most women held religion in high esteem and this formed part of their lives especially in the time of their illness. Majority of the women attended church frequently than not at all. Also all the women to some degree acknowledged the fact that spirituality could not be disregarded at all cost.

Ferraro and Kelly- Moore (2001) in a review of religious research, studied how people who identified themselves as having no religious preferences (non- affiliates) and those who have a kind of preference when it comes to religion(affiliates) spur religious seeking in physical and mental health problems. In other words, are there any significant differences in the way these groups hold on to religious forms of coping given the situation to be a physical or mental health issue? In this study data was collected from a national longitudinal survey. The data used in this study are from Americans' Changing Lives (ACL). This was a multi-stagea rea probability sample of non-institutionalized adults 25 years or older with-in the continental United States (House 1990; Umberson & Chen 1994). Baseline data were collected in 1986, referred to as wave 1 (W1), on 3,617 persons, 2,869 of whom were successfully followed up in 1989, referred to as wave 2 (W2). ACL included over-samples of African-American and elderly persons Results indicate that generally, non-affiliates were less likely to seek religious consultation or counsel than affiliates. Despite this, non-affiliates who had a stronger religious identity increased their religious seeking behaviours over-time.

Taste (2011) in another study identified how African American women often use spirituality to overcome the physical, psychological, and emotional burdens that accompany a breast cancer diagnosis. Spirituality has been used over the years by African American women to bring hope when dealing with hardships. This integrative study explored the importance of spirituality to African American women throughout the breast cancer experience. Thirteen qualitative and quantitative studies that discussed how spirituality was used to cope with breast cancer from initial diagnosis to survivorship were reviewed. Spirituality was found to be the main coping mechanism used during all phases of the cancer experience. To provide holistic nursing care, nurses must understand that spirituality is an important coping strategy used by most African American women with breast cancer. The implications for nursing that were identified include the incorporation of spiritual interventions and the utilization of culturally appropriate assessment tools.

Pargament et al. (2004) in their study used a total of 268 medically ill, elderly, hospitalized patients responded to measures of religious coping and spiritual, psychological and physical functioning at baseline and follow-up two years later. After controlling for relevant variables, religious coping was significantly predictive of spiritual outcome and changes in mental and physical health. Generally, positive methods of religious coping (e.g. seeking spiritual support, benevolent religious reappraisals) were associated with improvements in health. Negative methods of religious coping (e.g. punishing God reappraisal, interpersonal religious discontent) were predictive of declines in health. Patients who continue to struggle with religious issues over time may be particularly at risk for health-related problems.

Casarez (2008) describe how spirituality affected the lives of African American mothers with Human Immunodeficiency Virus (HIV) in the context of coping. This qualitative descriptive

study used secondary data of interviews from a larger longitudinal study of parental caregiving of infants seropositive for HIV. Participants were 38 African American mothers with HIV. Data from longitudinal semi-structured interviews were analyzed using content analysis. The women dealt with the stresses of HIV through a relationship with God. Two domains explain this relationship: God in control and God require participation. The benefits of their relationship with God were a decrease in stress and worry about their own health and that of their infants. It is important for nurses working with mothers with HIV to acknowledge their spirituality and assess how spirituality helps them cope with and manage their illness.

Walton et al. (2004) investigated how Spirituality plays a powerful role in cancer treatment and recovery; it has been identified by hospitalized patients as one of their top priorities of care. However, health care providers struggle to find ways to address the spirituality of their patients. The purposes of this study were to discover what spirituality means for men with prostate cancer and how it influences their treatment. Eleven men, ages 54 to 71, with prostate cancer were interviewed within several days following radical prostatectomy with bilateral lymph node staging. This grounded theory methodology generated three categories of spirituality: (a) praying, (b) receiving support, and (c) coping with cancer. The basic social process, coping with cancer, occurred in four phases: facing cancer, choosing treatment, trusting, and living day by day. These results were validated by four of the participants for truthfulness. The findings of this study provide holistic nurses with knowledge and a midrange theory of spirituality that can be used in building a research-based practice.

Loeb (2006) also researched African American elders to cope with their chronic health conditions. A focus group study of 28 African American elders with multiple chronic conditions was conducted. Data collection occurred during the last 4 months of 2003.The five

focus groups were audiotaped and transcribed verbatim. Content analysis was performed on the data to ascertain coping strategies employed to manage daily life with chronic conditions. Categories of coping strategies identified are (a) dealing with it, (b) engaging in life, (c) exercising, (d)seeking information, (e) relying on God, (f) changing dietary patterns, (g) medicating, (h) self-monitoring, and (i) selfadvocacy. This study expands nurses'knowledge of the repertoire of coping strategies used by African American elders to ameliorate the effects of their chronic health conditions. Study findings will be valuable for planning intervention studies aimed at promoting successful coping. This study brought to light interesting line of strategies people dwell on when they are medically ill or have to cope with a condition.

Chronic Illness and Quality of Life

A chronic illness is a long- lasting or recurrent disease. Its name denotes or describes the course of the disease, its onset as well as development. A Chronic state can be referred to as a long lasting medical condition. Chronicity is plied to a condition that last more than 3 months usually (Zerarekh & Clabon, 2007). For this reason quality of life amongst such people will be will be necessary to look at.

Quality of life (QoL) is a multidimensional construct that communicates an individual's overall sense of well-being and life satisfaction. Health care practitioner and patient/family agreement on primary contributors to QoL are key to the provision of effective health care. This is particularly important in guiding treatment choices and measuring outcomes in individuals with chronic health conditions. The concept of QoL has changed over time. It encompasses social, cultural, and political factors that affect people's decisions regarding QoL. Youssef and Wong (2002) in their study explained that culture is a way of life that

shapes the way people make meaning out of illness and suffering. Home care practitioners should strive to be aware of the cultural influences on a client's health care decision making. The purposes of their article was to describe the dimensions of QoL as well as to discuss cultural influences on QoL and explain common measurement tools used to assess health-related QoL, and provide suggestions to home health practitioners for implementing strategies to foster patient-centered care and outcome assessment that emphasizes QoL.

Low and Gutman (2003) also compare perceptual differences between chronic obstructive pulmonary disease (COPD) patients and their non-COPD spouses regarding the patients' health-related quality of life (HRQOL). Sixty-seven community-dwelling COPD patients and their non-COPD spouses participated. Participants completed the Sickness Impact Profile (SIP) and the St. George's Respiratory Questionnaire (SGRQ). On both questionnaires, spouses' perceptions of patients' HRQOL were lower than those of the patients themselves. At the bivariate level, statistically significant differences were found on the sickness impact profile in the physical domain and on the SGRQ in the psychosocial domain. At the multivariate level, the age and gender of both the patients and spouses accounted for 22% of score differences in the psychosocial domain of HRQOL for the SGRQ. Discordance was greatest among the oldest couples with female non- COPD spouses. Domain-specific HRQOL differences provide direction for supportive nursing interventions to enhance coping among COPD couples. From this study it is clear that the quality of life of patients can be influenced by many factors such as age, as well as differences being observed in a specific domain. This shows that more research needs to be done to determine other possible factors which could bring about variations in quality of life and this will help structure interventions to suit patients.

Earnshaw, Quinn and Park (2011) in a similar study examined the process by which anticipated stigma relates to quality of life among people living with chronic illnesses. They hypothesized that stress; social support and patient satisfaction mediate the relationships between three sources of anticipated stigma and quality of life. Data were collected from adults living with chronic illnesses recruited from support groups and online communities, and were analyzed with path analysis. Results showed that stress mediated the relationships between anticipated stigma from friends and family, and work colleagues with quality of life; social support mediated the relationships between anticipated stigma from friends and family, and work colleagues with quality of life; and patient satisfaction mediated the relationship between anticipated stigmas from healthcare providers with quality of life. This work highlights potential points of intervention to improve quality of life. It calls attention to the importance of differentiating between sources of anticipated stigma in clinical settings, interventions and research involving people living with chronic illnesses. In this related study, stigma influences quality of life in a number of ways. The question one may ask is " can other factors such as choice of coping also have a significant effect on the quality of life of patients with chronic illness?" if so, which methods will they dwell on most.

Tang, Aaronson and Forbes (2004) in a cross-sectional correlational design conducted a study based on Stewart, Teno, Patrick, and Lynn's conceptual model of factors affecting QOL of dying patients and their families. Sixty participants were recruited from two local hospice programs in the midwestern region of the United States. Data were collected at the participants' homes. The participants had an above average QOL. Living with the caregiver, spirituality, pain intensity, physical performance status, and social support as a set explained 38% of the variance in their QOL. Among these five predictors, living with the caregiver, spirituality, and social support statistically were significant predictors of the QOL

of these participants. Participants, who did not live with their caregivers experienced less pain intensity, perceived higher spirituality, had more social support, and had a significantly better QOL. Like the studies that have been reviewed above, the search is on for more factors that influence quality of life and how best the patient and caregiver living with the condition can be well taken care of. This study in a different angle, seeks to explore how a cultural coping significant to a people influencing their quality of life and if there will be differences that may exist comparing with other studies that have been done. Also will geographical location also bring about any of these differences anticipated.

Saarni et al. (2006) investigated the impact of major chronic conditions on HRQoL using 15D and EQ-5D in a representative sample of Finns.Information on chronic somatic conditions was obtained by interviews. Psychiatric disorders were diagnosed using a structured interview (M-CIDI). Tobit and CLAD regression analysis was used to estimate the impact of conditions on HRQoL at the individual and population level. Adjusted for other conditions and socio-demographic variables, Parkinson's disease had the largest negative impact on HRQoL at the individual level, followed by anxiety disorders, depressive disorders and arthrosis of the hip and knee. Based on prevalence, arthrosis of the hip or knee, depression, back problems and urinary incontinence caused the greatest loss of HRQoL at the population level. The results obtained with the two HRQoL measures differed markedly for some conditions and the EQ-5D results also varied with the regression method used. Musculoskeletal disorders are associated with largest losses of HRQoL in the Finnish population, followed by psychiatric conditions. Different HRQoL measures may systematically emphasize different conditions. Analyzing this study, it can be observed that various chronic conditions affect quality of life in diverse ways. Some have a great toll or impact on the quality of life of the patient while others do not.

Foster (2009), observed that chronic infection with the hepatitis C virus (HCV) has a profound effect on health-related quality of life (HRQoL) – with fatigue, depression and neurocognitive deficits among the most common complaints. Neuropsychiatric symptoms have prompted research to determine whether the HCV acts within the central nervous system. Replicating virus has been found in central nervous tissues, and changes in neurotransmitter levels in the frontal white matter of patients with chronic hepatitis C are correlated with impaired attention and concentration. Other symptoms of chronic hepatitis C that decrease HRQoL include associated sexual dysfunction and depression. Treatment of chronic HCV infection may temporarily worsen HRQoL, and common adverse effects of currently available agents include fatigue, muscle aches, depression and cognitive deficits. The relationship between sustained viral response and improvement in HRQoL is nonetheless well accepted. Although treatment-related adverse effects may dissuade people from starting therapy and reduce compliance with associated reductions in sustained viral response, for the majority of patients viral clearance produces improvements in both HRQoL and long-term prognosis. Novel agents, with improved adverse effect profiles, may afford more patients the opportunity to achieve a sustained viral response.

Kaplan ,Criqui, Denenberg, Bergan and Fronek (2003) in their study found that Chronic venous disease in the lower extremities may have a substantial effect on functioning and quality of life. They reported quality of life data for an ethnically diverse population that had been systematically evaluated for venous disease. Current and retired employees from a large public university were randomly selected within strata of age, sex, and ethnicity. The sample included 2404 men and women ages 40 to 79 years. The quality of life was measured with the Medical Outcomes Study 36-Item Short Form (SF-36). Venous disease of the lower extremities was evaluated with two methods. Visual inspection was used to place participants into four categories: normal, telangiectasias and spider veins, varicose veins, and trophic

changes. Duplex ultrasound scanning was used to place participants into three categories: normal, superficial venous disease, and deep vein disease .There were significant associations between quality of life and venous disease severity as assessed with both visual and ultrasound methods. These differences were observed for both men and women for functional scales of the SF-36.The relationships were significant, and were graded with degree of disease severity. Differences categories were not statistically significant for the mental health scales of the SF-36. Chronic venous disease in the lower extremities has a substantial effect on physical health aspects of quality of life but not on mental health components.

Walker (2007) assessed the importance of multiple chronic diseases (co-morbidities) to how people feel about their lives generally. To do this, they studied the associations between co-morbidities and indicators of quality of life and/or psychological distress. Analysis of unit record cross-sectional data from Australian national surveys for the population aged 20 years or more. Identification of an appropriate indicator of multiple chronic diseases (i.e. co-morbidities). Logistic regression techniques to study associations between: (1) co-morbidities and demographic, socio-economic and risk factor variables was used. Quality of life (general and psychological distress) and demographic, socio-economic and health status indicators were also investigated. Older people, obese persons, women, persons with low socio-economic status and those living alone had significantly greater probability of having three or more chronic illnesses than did other people aged 20 years .Also, people with co-morbidities and/or with poor self-rated general health, those living alone, people with low educational qualifications and persons with low socio-economic status were more likely to feel dissatisfied, unhappy or terrible about their lives and to have moderate, high or very high psychological distress scores than the rest of the 20-year-old population . Multiple chronic diseases were found to have a considerable negative impact on

quality of life, not only in terms of how people felt about their lives generally, but also in terms of the extent of their psychological distress.

The relationship between the cognitive and physical aspects of multiple sclerosis (MS) and health-related quality of life (HRQL) was examined with particular focus on illness intrusiveness as a mediator of this relationship. Disease severity, cognitive functioning, HRQL, depression, and illness intrusiveness were assessed in 90 patients with MS. Disease severity predicted physical aspects of HRQL. Information-processing speed predicted mental and emotional aspects of HRQL. However, both the EDSS and the PASAT predicted depression. Illness intrusiveness was significantly correlated with all indicators of HRQL. Illness intrusiveness also mediated the manner in which disease severity predicted: physical health, fatigue, and depression. Results underscore the need to assess MS and its impact more broadly rather than relying on traditional mobility-centered assessments. While in most cases physical indices of disease predict physical quality of life and cognitive assessments predict mental and emotional quality of life, the individual's perception of MS is also a major factor contributing to quality of life. MS clearly affects multiple aspects of life and activity, as illustrated by the broad and powerful network of relationships between illness intrusiveness and all aspects of HRQL. Perceptions of illness intrusiveness appear to be a central and essential measure of the impact of MS on HRQL.

Serrano et al. (2009) in their study assessed mental health and quality of life in a general population, as well as to mapping the GHQ-12 as a screening test for population psychological distress to a generic health state measure (EQ-5D. this was done to estimate the health state values and to allow deriving quality adjusted life years of people in the general population. Participant in the study were categorized as probable psychiatric cases according to the GHQ-12. Using a multiple Regression Analysis to examine the possible relationship between the GHQ and the EQ-5D, Results showed that index scores decreased as the GHQ

scores increased. Meaning the quality of life of patients decreased as the general health scores increased. The health states of people were determined and this showed in their quality of life. Though this study added much to the body of knowledge the population used was a general population. In most cases after one has been diagnosed of an illness, it is not a usual routine to follow up on the general health or mental health of patient and for that matter their quality of life. This study will look at the relationship between the general health of patients with chronic illness and its effect on their quality of life.

Gender Differences and Choice of Coping

One may wonder if in coping there are gender differences for selecting a specific coping method. Much controversy has gone on with this issue and this makes it worth reviewing. Clyman *et al.* (1980) in their study found that in times of grieving and coping men were more likely to move on in life while women on the other hand were still depressed with thoughts of the dead child. Mandell *et al.* (1980) have asserted that fathers utilize activity-based coping styles after the loss of a child, while Littlewood *et al.* (1990) reported that many of the fathers they interviewed noted the buffering effect of the social support they received from their employment activities. Littlewood *et al.* (1991) found that fathers reverted more quickly to normal patterns of coping than did mothers. Not only did fathers suffer less general reduction in coping capabilities than mothers, they also showed a tendency to keep busy and take on additional workloads in order to cope with their loss.

In relation to , gender and coping Ebata and Moss (1994) in a consistent gender difference study in the adolescent and adult coping literature has it that females are likely to seek social support as a way to cope than males.

In another related study, Finkelstein et al. (2007) reported that female adolescents tended to use more engagement coping than adolescent males. In this study, the findings were obtained in samples of primarily White participants, and this led to the process of a research investigation to answer some interesting questions that are if coping strategies may differ by gender for African Americans. For example, Utsey and Hook (2007) reported that African American men and women differ in their experiences of race-related stress.

Greer, Laseter, and Asiamah (2009) investigated gender differences in race-related stress and found that African American men and women appraise race-related incidences in different ways; although there were no gender differences in cultural and individual racism, African American men reported significantly higher levels of institutional racism than did African American women. Although we are unaware of any studies that have directly compared African American men and women in their coping strategies, these findings suggest that it is possible that if African American men and women differ in their experience and appraisal of racism, there may also be gender differences in the coping strategies they use. From the above feedback, it is worth noting that further studies or researches need to be done in regards to gender differences.

Kathleen and Rafique (2012) documented gender differences in psychological well being, quality of life and coping strategies employed by cardiac patients. However, there is limited research in this area for developing countries, including Pakistan as stipulated by the researchers. The aim of this study was to investigate gender differences in Psychological well-being, Quality of life and Coping strategies in patients with cardiac diseases. It was hypothesized that in cardiac patients there is a difference in psychological well being as well as quality of life between men and women. Moreover, it was proposed that men compared to women cardiac patients employ different coping strategies (avoidant coping strategies, emotional coping strategies, religious coping strategies, reflective coping strategies and

strategic planning coping strategies). The patient sample consisted of cardiac patients (n=50); 25 male and 25 female from the cardiac wards of various hospitals in Pakistan, through the use of a purposive sampling technique. The age range of these patients was 50-70 years. Three measures were used to assess the study variables; General Health Questionnaire 12, the Mac New Health Related Quality of Life Questionnaire and a self-constructed coping scale whose indicators were drawn from the Proactive Coping Inventory. Significant gender differences between men and women cardiac patients in psychological well-being, quality of life and coping strategies were observed. Female compared to male cardiac patients reported better psychological well being as well as quality of life. However female cardiac patients employed strategies of avoidance and emotional support seeking coping whereas male cardiac patients used more of reflective and strategic planning coping. From this study it can be seen that both men and women have various ways of coping in cardiac condition. This raises further questions for research such as the possibility of other differences in other chronic conditions such as mental illness.

Akinyemi and Aransiola (2010) examined gender variations in self reported quality of life among randomly selected elderly populations in selected Yoruba communities in three local government areas of Osun State Nigeria. A cross sectional survey was used of which 947 elderly populations aged 60 years and above participated. Activities of Daily Life (with 14 items scales) (ADL) and Aging Male Symptoms (AMS) (with 17 items scales and adapted for both males and females). Findings showed that elderly female fared better than the male counterparts on some of the measures. Also, females were more likely than their spouse to be able to cope without any assistance. Results from males with a living spouse showed that majority of the spouse (females) were more likely to need assistance for usual daily activities compared with the male (husband). This trend was also confirmed among female respondents

as a fewer proportion of spouse (male) can cope without any help compared with females. The AMS showed that male reported a better health status in the domains of sexual, psychosocial and somatic measures. The study concluded that measures of quality of life were likely to favors elderly females than males because of many challenges and responsibilities of males. This study though brought about significant changes in the scope of quality of life did little on the scope of culture and coping. Though most men and women may cope differently and dwell on diverse coping resources could more studies being done attest to the fact that in all situations gender differences exist when measuring quality of life? Especially amongst people living with a chronic condition.

Summary and Analysis of Literature

A critical analysis and review of the literature given above on how culture influences coping has given a new look and perspective to look at when it comes to the issue of coping. Despite this, there are certain aspects of these researches done which needs a further assessment. Some of the studies done are focused on African Americans or people from a specific or designated culture. (Scott, 2003;Frydenberg et al.,2001;Lee & Liu ,2001 Yeh & Inose, 2002; Yeh &Wang ,2000;Constantine et al. , 2005)

The prevailing stress-coping theories and research have been characterized by a monoculture perspective that is entrenched in the Western, individualistic values of North America, where most of the research is developed and conducted (Hobfoll, 2001).

For this reason this study will like to focus on Ghana and Africa for that matter to know how culture influences coping and how they interpret these. Another important thing this study is going to incorporate and look at is the use of both qualitative and quantitative analysis. In other words the use of a mixed method design will help get a holistic picture and understanding into how people cope. Most of the literature reviewed either used qualitative

method or quantitative. In-depth interviews give more insight into issues and make understanding of a concept better. Another important focus of the study I will be to find out how the patient copes as well as the significant other in times of chronic illness. With the focus not only on physical illness but looking at it holistically this includes spirituality. In the reviewed studies, some focus only on coping on the part of the family or solely on a significant other but not much on the one suffering from the illness.

Another focus of this research will also be to zero down of a specific stressor which is the illness and how this affects their quality of life. From the reviewed studies, it was observed that different factors influence quality of life in different ways. Most of the reviewed studies looked at stress in general and how people cope with stressors. The danger here is that though stressors can be generally categorized as such, the way people may cope with each stressor will be different. This study will want to focus specifically on End Stage Renal Disease and Mental illness to specifically know how these stressors are coped with. It is interesting to even note that even with the various illnesses we have there are diverse ways and degrees of coping and this research will want to zero down to make it easy to identify the coping needs of these specific disorders.

Reviews done on coping measures (i.e., Ways of Coping Questionnaire [Folkman & Lazarus, 1988], Coping Strategy Indicator [Amirkhan, 1990], COPE [Carver, Scheier, & Weintraub, 1989], and the Coping Strategy Inventory [Tobin, Holroyd, Reynolds, & Wigal, 1989]) observed an absence of the coping behaviors unique to people of African descent. (e.g., collective coping, spiritual centered coping, ritual-centered coping). This study is geared towards enhancing studies done in the field of culture and coping.

Rationale of the study

Consequently, several criticisms have been leveled against the extant stress and coping literature. First, the prevailing stress-coping theories and research have been characterized by a monocultural perspective that is entrenched in the Western, individualistic values of North America, where most of the research is developed and conducted (Hobfoll, 2001)

This is seen in the compelling emphasis placed on personal control, agency, and direct action among the major stress-coping theories (Folkmaan & Moskowitz, 2004). Second, this highly individual and intrapersonal stance of the stress-coping literature has led some to criticize the overly "a contextual" nature of the extant stress and coping literature (Folkman & Moskowitz, 2004) and its neglect of culture as a fundamental context of coping (Chun et al, 2006). Consequently, culture has not been examined within the present stress-coping literature, and empirical coping research based on non-White samples within or outside of North America remains relatively scarce (Heppner et al., 2006). These coping strategies are not exclusive to African Americans but represent common cultural framework shared by many persons of African descent (Utsey, Adams, et al., 2000).

Utsey, Bolden, Lanier, and Williams (2007) examined culture-specific coping among African Americans. Their findings indicate that African American stress-coping strategies are result of experiences with racism and oppression and the need to rely on family and community resources such as extended family networks, deep spiritual bonds through black churches, a strong sense of communal orientation, and emotional sharing (Utsey, Adams, & Bolden, 2000; Utsey et al., 2007). The interdependence of African American families has shaped cultural responses in the form of collective coping, spiritual-centered coping, and ritual-centered coping (Utsey et al., 2000). The concept of collective coping reflects the reliance on

family members and the larger extended kin networks that are well established among African Americans both for economic resources and social support (Gallant, 2003; Jarrett & Burton, 1999; Jet 2002; Mosley-Howard & Burgan Evans, 2000; Warren-Findlow & Prohaska, 2000). Similarly, the use of spirituality as a self-care practice in relation to chronic disease is also consistent in research on African Americans (Abrums, 2000; Harvey, 2006; Harvey & Silverman, 2007; Holt & McClure, 2006). Ritual-centered coping is apparent in the reverence toward ancestors that is manifest in funeral rituals and family reunions.

Africentric psychological theory provides a culturally relevant lens through which coping behaviours of African Americans and for that matter people of African progeny can be investigated. A primary tenet of Africentric theory is that African descended persons are the developers and interpreters of their own realities and cultural experiences, as opposed to being objects of inquiry and interpretation based on European conceptual frameworks (Asante, 1987).

This premise represents the foundation of an Africentric worldview in which values, attitude, and behaviours are characterized by a sense of unity with other African descended persons, in addition to a reliance on spiritual and religious faith, practices, and rituals such as prayer (e.g., Myers, 1988; Nobles, 1986). An Africentric worldview further emphasizes interdependence and collective responsibility of all African descended persons, and therefore individuality is not espoused (Kambon, 1992; Nobles, 1986).

Although the writings of many Africentric theorists and researchers attest to shared perspectives on the cosmological foundations of Africentrism (Asante, 1987; Belgrave, Brome & Hampton, 2000), some theorist suggest that Africa descended persons are biogenetically predisposed to adopt Africentric values, attitudes, and behaviours (e.g.,

Kambon, 1992).Others are inclusive in considering the influences of environmental and societal contexts in the development of Africentric values and behaviours (e.g., Myers, 1988).

Africentric values and behaviours are indeed biogenetically conceived and are naturally predisposed to adapt to these African values, then this perspective would hold that coping behaviours as well other forms of behaviour are also biogenetically derived and employed by African descended persons. However, a biogenetic premise to coping behaviours cannot be empirically tested, thus, an Africentric perspective in which environmental and societal contexts are considered appears to be much more viable to the stud of coping behaviours for African American population and for that matter African descended people.

In religious cultures, coping by prayer may be legitimate and even encouraged (Bardi & Guerra,2010) unlike secular cultures, coping by praying may be legitimate only in certain situations, in which there are no active ways to solve the problem (e.g., coping with the death of a loved one). Throughout socialization, individuals learn the coping strategies that are legitimate and encouraged in their culture (Olah, 1995).

Similar to norms, it has also been suggested that culture influences behaviour through internalized cultural values (e.g., Matsumoto, Yoo & Nakagawa, 2008). Hence, culture may also affect coping responses through personal values.

Statement of Hypotheses

1. There will be a significant positive relationship between culture specific coping and quality of life
2. There will be a significant negative relationship between general health status of the patient and their quality of life.
3. Significant differences will exist in culture specific coping among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls such that;

a. Persons with psychiatric illnesses are more likely to use culture specific coping than Healthy controls

b. Persons with chronic kidney disease are more likely to use culture specific coping than Healthy controls

4. Significant differences will exist in quality of life among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls such that

a. Healthy controls are more likely to report better quality of life than persons with psychiatric illnesses

b. Healthy controls are more likely to report better quality of life than persons with chronic kidney disease

5. All the Africultural Coping Domains are likely to predict Quality of Life significantly.

6. There will be significant gender differences in quality of life among persons with psychiatric, physical illnesses and healthy controls

7. There will be significant gender differences in culture specific coping among persons with psychiatric, physical illnesses and healthy controls

Proposed Conceptual Framework

Figure 1 shows the proposed conceptual Framework of the current study's hypothesized findings. The figure depicts the expected significant relationships between the variables under study. Culture specific coping is expected to affect the quality of life of patients living with chronic illness. Gender is also expected to influence the choice of coping and quality of life. Last but not the least, the general health of patient is will affect the quality of life of the patient with chronic mental or medical illness.

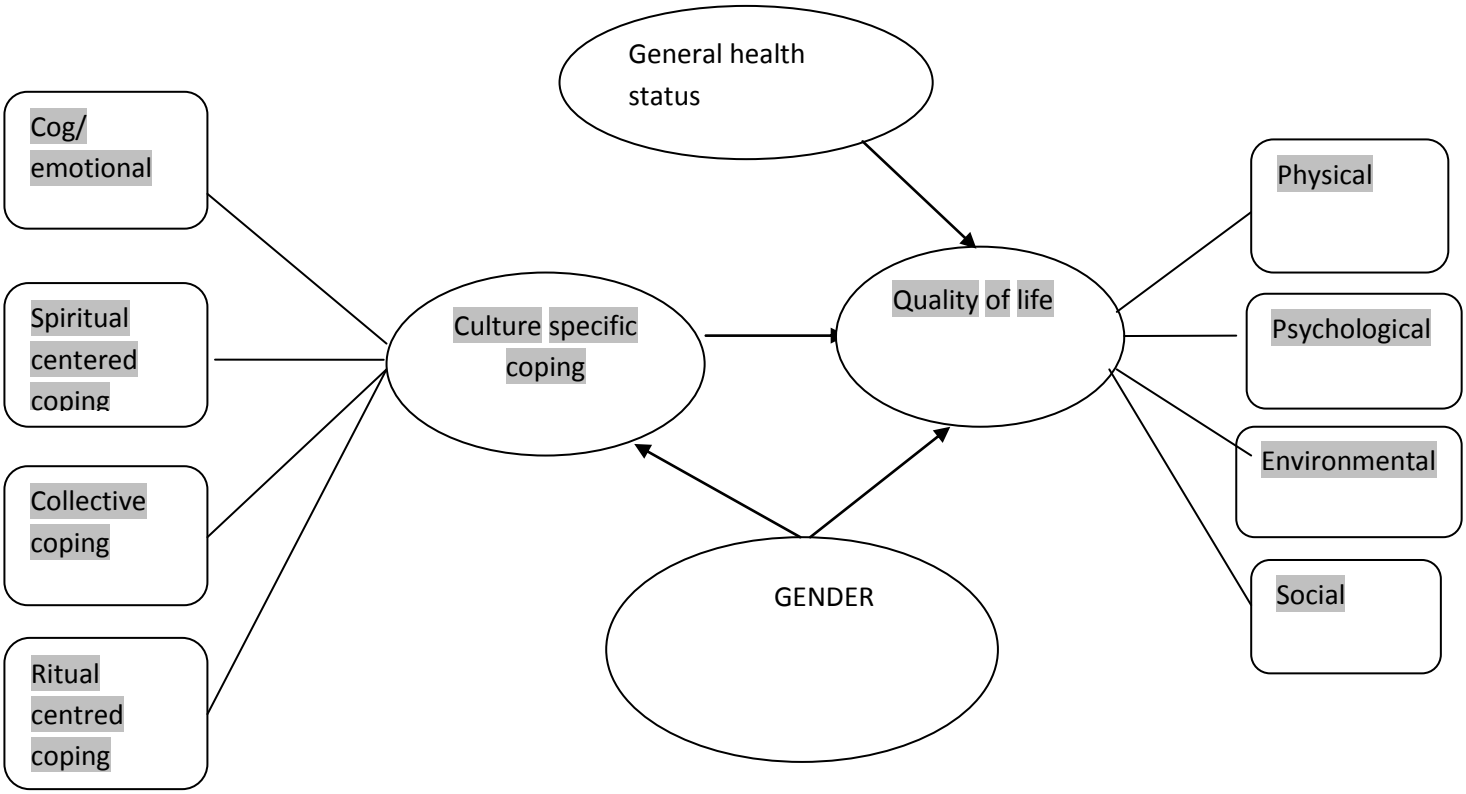


Figure 1. Proposed Conceptual Framework

Operational Definition

Adult- A person above 18 years

Culture specific coping- coping method related to people of African descent (cognitive debriefing, spiritual centred coping, collective coping, ritual centred coping)

Quality of life- general views a person has about how good or bad their life is

Chronic illness- A condition that has not cure and involves a life time management (mental illness and chronic kidney disease)

CHAPTER 3: METHODOLOGY

Introduction

This chapter presents the procedures for conducting the study in terms of the research setting/population, sample and sampling technique, the design, measures as well as the procedures involved in the data collection process. This section details the steps that were taken in gathering evidence to test the stated hypotheses.

Population

The primary population comprised of patients with mental disorders (mood disorders, schizophrenia and substance related disorders) and medical disorders (chronic Kidney disease). This population was chosen because they fall in the category of chronic illnesses which need further research and investigation especially in the field of culture also, because the Greater Accra region is the capital of Ghana and comprises of people from all parts of the country. As a result, the various sections of the population cut across in terms of health and illness. Patients with chronic kidney disease were sampled from the Renal Unit of the Korle-Bu teaching hospital. Both out-patients and in-patients were used for the study. Patients with mental condition were also sampled from the Accra Psychiatric Hospital and The Pantang General Hospital which are the two main mental health facilities in the country aside Ankafol Psychiatric Hospital which is in cape- coast.

Sample size determination

. The sample size was 150 comprising of 50 mental health cases, 50 medical cases and 50 healthy controls. This sample size selection was based on the minimum sample size determination offered by Field (2009) taking into consideration the effect size as well as the statistical power at which the effects would be 50 detected. This applies to performance of multiple regression analysis and the minimum sample sizes are listed below; for a medium effect size and high level of statistical power (.80) with 10 predictors, a minimum of 150 sample size is required. For a medium effect size and high level of statistical power (.80) with 20 predictors, a minimum of 200 sample size is required. From the sample size determination therefore, the sample size of 150 is sufficient for multiple regression analysis to be performed in order to obtain a medium effect size and a high statistical power .80

Sampling technique

. The purposive sampling was used to select participants for the psychiatric disorders and the Chronic Kidney Disease disorders respectively. This was because of the peculiar characteristics the groups under study. With the healthy controls the convenience sampling was used to select them from the general population.

Participants

The study sample was made up of Psychiatric patients, Chronic Kidney Disease patients and healthy controls .The inclusion criteria for participation in this study incorporated participants aged above 18 years who were willing to participate. Some potential participants were

excluded on grounds of cognitive contra-indications like dementia, and unstable medical illness.

Participants' selection criteria were based on the following criteria;

Mental disorders

Inclusion Criteria

The subjects with chronic illness were selected according to the following criteria

1. Clinical diagnosis of the specific mental condition by medical practitioner (based on the DSM-1V-TR)
2. Should be in a lucid state
3. Should have been diagnosed with the disorder for at least 6 months
4. Should be above the aged of 18
5. Volunteer participation and signed consent form

Mental disorders

Exclusion Criteria

1. Patients with a history of dementia were excluded from the study.
2. Patients who had neurological abnormalities were also excluded from the study.
3. Decline to voluntarily participate in the study

Chronic Kidney Disease

Inclusion Criteria

1. Diagnosis of ESRD by a qualified medical practioner
2. No evidence of other neurological condition except secondary to ESRD
3. Must be 18years and above

4. Must not be in crisis at the time of testing

Chronic Kidney Disease

Exclusion Criteria

1. Patients with a history of dementia were excluded from the study.
2. Patients who had neurological abnormalities were also excluded from the study.
3. Decline to voluntarily participate in the study

Healthy Controls

Inclusion Criteria

1. Should not be Diagnosed of ESRD and any mental condition by a qualified medical practitioner.
2. No evidence of other neurological condition
3. Must be 18years and above

Healthy Controls

Exclusion Criteria

1. Had suffered from a renal failure
2. Had a history of mental disorder
3. Had a history of neurological condition
4. Refusal to willfully participate or offer consent

Design

The concurrent mixed method design was used which involves both a quantitative research and qualitative research. This involved a cross-sectional survey which is one of the simplest survey designs and involves approaching a sample of respondents only once. The sample size is usually a cross-section of the population under study. A semi-structured interview was also used to explore and probe further into the issue of culture and coping than relying solely on the quantitative information and analysis. It is important to know the reasons behind the actions and choices people make to draw better inferences from the information given.

Procedure

Ethical clearance was sought from Noguchi Memorial Institute for Medical Research Ethics Review Board. A letter of introduction was obtained from the Department Of Psychology, University of Ghana to introduce the researcher to the Korle bu teaching Hospital, Pantang General Hospital and Accra Psychiatric Hospital. After permission was given, a date and time of convenience was agreed upon to inform and interact with patients and their families to select willing persons as participants. Healthy controls were selected from the University of Ghana Campus comprising both workers and students. The General Health Questionnaire served as a screening tool to determine their health status before they continued with the research. An appropriate setting was located within the hospital environment for the collection of data. Participants were briefed on how to answer the structured and semi-structured questionnaires. All participants answered both questionnaires but the structured questions were answered first before the semi-structured interviews. The interviews took approximately 15-20 minutes. For participants who could not write as a result of their

condition, the questions were read to them and the responses written down. Consent was sought form participants before administering the test.

Data Analysis

Data was analyzed using regression analysis which involves predicting outcomes using one or more predictor variables and in this study since we are looking at culture specific coping and quality of life on people living with chronic illness. Also multiple regressions was also used to find out how much each of the sub-scales under the various independent variables influence the general choice of coping and quality of life.(hypothesis 5). The peason Moment Correlation was also used to analyse hypothesis 1 and 2.The One Way Analysis of Variance was also used to examine differences between the three groups (psychiatric patients, chronic kidney patients and healthy controls) on the independent and dependent variables respectively.(hypothesis 3 and 4) The independent t test was also used in comparing two distinct groups male and female to find out if there are any differences between the two.(hypothesis 6 and 7)

Measures/ Instruments

Demographic Questionnaire

The demographic questionnaire is describtion of personal information about participants and their condition. This included ones' name, age, sex, highest level of education obtained, marital status, religion and the number of times they visit their place of worship, occupation and amount of money they earn every month as well as their diagnosis and the length of illness.

Table 1. Summary of Demographic Characteristics of the Respondents in the Study

Variables	Psychiatric Cases	Physical Cases (CKD)	Healthy Controls
Sex			
Male	36	27	29
Female	14	23	21
Age Range			
18-29years	18	14	34
30-49years	21	19	8
50-64years	11	17	8
Education Level			
Primary	9	1	2
JHS	3	1	3
Secondary/Tech/Voc.	24	30	19
Tertiary	14	15	24
Postgraduate	0	3	2
Marital Status			
Single	38	16	45
Married	7	21	3
Divorced	4	9	0
Separated	1	2	1
Co-habitation	0	1	1
Widowed	0	1	0
Number of Children			
None	33	20	45
One	4	7	2
Two	6	9	0
Three	6	8	2
Four and above	1	6	1
Religion			
Christianity	49	45	46
Islam	1	4	4
Traditional	0	1	0
Employment Status			
Fulltime	23	23	6
Part-time	0	6	8
Not employed	25	10	36
Retired	2	2	0
Monthly Income (GHC)			
Below 500	31	17	34
500-2000	12	20	6
2000-3000	1	1	0
Above 3000	6	12	10

Africultural Coping Systems Inventory

The Africultural Coping Systems Invetory (ACSI; Utsey, Adams, et al, 2000). The ACSI is a 30-item multidimensional measure of the culture-specific coping strategies inventory used by African Americans during stressful situations. The ACSI was conceptualized by an African-centered philosophical framework; and it was developed in response to Eurocentric coping measures that did not adequately represent the unique life experiences and history of African Americans and their culture-specific coping strategies. Instead, the ACSI was based only on the general ideas of problem-focused coping in which the individual aims to manage or regulate the stressful situation, or emotion-focused coping in which the individual regulates his/her emotional response to a stressor (Utsey, Adams, et al., 2000). To complete the ACSI, respondents are asked to vriefly describe a stressful event in their lives in the past few weeks or more. On a 4 point Likert type scale Likert scale (0 = *does not apply or did not use*, 1 = *used a little*, 2 = *used a lot*, and 3 = *used a great deal*). Participants are asked to indicate the degree to which they used specific strategies to cope with the adversity. The ACSI is composed of the following subscales:

The Africultural Coping Systems Inventory (ACSI) is also a thirty-item, self-report, likert scale measure of the culture-specific coping strategies used by African Americans in stressful, day-to-day situations which has also been successfully tested for validity and reliability (Utsey, 75 The ACSI is comprised of four subscales: Cognitive/Emotional Debriefing (11 items, 5,8,12,14,15,17,18,19,20,26,29); Spiritual-Centered Coping (8 items,1,6,10,13,16,21,27,30); Collective-Centered Coping (8 items, 2,3,4,7,9,11,22,24); and Ritual-Centered Coping (3 items,23,25,28) (Utsey, Brown, et al., 2004). In completing the ACSI, participants are asked to recall a stressful event that occurred over the past week, briefly describe the situation, and then, using a 4-point likert scale measure, (0=did not use,

1=used a little, 2 =used a lot, 3=used a great deal) rate the coping techniques they used during that stressful situation (Utsey, Brown, et al., 2004). Cronbach's alpha coefficients for the ACSI subscales have been found to range from .71 to .82 (Utsey, Adams, et al, 2000) and from .83 to .87 (Constantine, Wilton, Gainor & Lewis, 2003, as cited by Utsey, Brown, et al., 2004). Through an exploratory analysis and CFA, the model was found to be most efficient for representing the unique coping factors of African Americans (Utsey, Brown, et al., 2004).

The General Health Questionnaire

The GHQ12 is an extensively used screening instrument for common mental disorders. It is a measure of current mental health. It focuses on two major areas which are the inability to carry out normal functions and the appearance of new and distressing experiences. It was originally developed as a 60- item instrument but now has a range of shortened versions available such as the (GHQ-30, GHQ-28,GHQ-20 and GHQ-12). The questionnaire asks whether the respondent has experienced a particular symptom or behavior recently. Each item is rated on a four-point likert (0-3) scale the 12 item version has been shown to be as effective as the 30 item version(Goldberg et al.,1988)

It is intended for use with adults aged sixteen years and above. The GHQ has been shown to be valid and useful in clinical settings, as well in settings in which patients need help to complete the questionnaire (Goldberg et al., 1997); its psychometric properties have been studied in various countries (Werneke, Goldberg, Yalcin, & Üstün, 2000) and with various types of population, for example, elderly people (Costa, Barreto, Uchoa, Firma, Lima-Costa, & Prince, 2006), and urological patients (Quek, Low, Razack, & Loh, 2001). Internal consistency has been reported in a range of studies using cronbach alpha with correlations ranging from 0.77 to-0.93. Sample of items in the GHQ are " have you been able to face up to your problems?, have you been feeling unhappy or depressed?." There is good evidence that

clinical assessments of the severity of psychiatric illness are directly proportional to the number of symptoms reported on the GHQ12 (Goldberg& Huxley,1980). The predictive validity of the GHQ in comparison with other scaling tests of depression is also good (Goldber 1985).

WHO QUALITY OF LIFE BRIEF

The WHOQOL-BREF is a 26- item likert type scale that assesses four domains of quality of life: physical health (e.g. "to what extent do you feed psychical pain prevents you from doing what you need to do?"; psychological health (e.g. " how often do you have negative feelings such as blue mood, despair, anxiety, or depression?"; social relationships (e.g. how satisfied are you with the support you get form your friends?"; and environmental well-being(e.g. " how healthy is your environment?")

The WHOQOL Group (1998) assessed Crombach alpha for the four domains: physical health, .86; psychological health,.76; social relationships,66; and environmental well-being,.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, the WHOQOL-100.

Semi- Structured Interview

Interview guide

This is a short semi- structured interview which was based on the africultural coping systems inventory (Utsey, 2000). This was administered to get in-depth information in relation to how people cope, dwelling of the African centred values. This basically threw more light on the responses that had already been given in the quantitative data. Some of the questions asked were "Does spirituality serve as a major covering or protection in times of your illness? And

why?", "Do you think your condition needs a greater spiritual solution than any other solution and why?", "Do you perform any spiritual activities or use some objects or items which in your opinion help you through your condition? E.g. anointing oils, candles, etc", and "Does support from your family and friends and social group mean anything to you in these times of your illness? Why?

CHAPTER FOUR: RESULTS

Introduction

This chapter presents the results from the analyses of the data by summarizing the key findings in appropriate tables. The SPSS 16.00 was used in analyzing the data and series of statistical tests were used including descriptive statistics to summarize the data.

4.1 Data Analyses

Hypothesis one which states that there will be a significant positive relationship between culture specific coping and quality of life was tested using the Pearson Correlation because the two variables are assumed to be linearly related and measured on an interval scale. Hypothesis two which states that there will be a significant negative relationship between general health status of the patient and their quality of life of the patient was tested using the Pearson Correlation because the two variables are assumed to be linearly related and measured on an interval scale.

Hypothesis Three which states that significant differences will exist in culture specific coping among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls was tested with the One-Way ANOVA as three independent groups of respondents were compared on their use of culture specific coping strategies. Hypothesis four which states that significant differences will exist in quality of life among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls was tested with the One-Way ANOVA as three independent groups of respondents were compared on their use of culture specific coping strategies.

Hypothesis five which states that all the Africultural Coping Domains are likely to predict Quality of Life significantly was tested with the use of multiple regression analysis since the

components Africultural Coping served as the predictors with quality of life as the criterion. Hypotheses Six and Seven which state that there will be significant gender differences in quality of life and culture specific coping among persons with psychiatric, physical illnesses and healthy controls were tested with the independent t-test as two groups of males and females were compared on the dependent variables.

4.2 Presentation of Results

4.2.1 Preliminary Analysis

Table 2: Summary of Means, Standard Deviations and Internal Consistencies of the Variables

VARIABLES	**N**	**Mean**	**SD**	Min	Max	**α**	Skew	Kurt
General Health Status	150	10.96	6.82	0.00	33.00	.88	.93	.60
Quality of Life (WHQOL)	150	52.26	7.16	32.00	67.00	.87	-.53	.05
Physical QOL	150	13.43	2.07	8.00	18.00	.61	-.15	-.44
Psychological QOL	150	13.07	2.29	5.00	18.00	.78	-.40	.16
Social QOL	150	12.29	2.74	4.00	20.00	.41	.02	.16
Environmental QOL	150	13.47	2.44	8.00	19.00	.81	-.25	-.51
Africultural Coping (AFCSI)	150	41.23	10.04	14.00	65.00	.79	-.23	-.32
Cognitive Emotional Coping	150	16.72	5.48	3.00	28.00	.72	-.44	-.57
Spiritual Centred Coping	150	12.77	3.90	3.00	21.00	.68	-.17	-.49
Collective Coping	150	10.68	3.50	3.00	17.00	.52	.21	-.30
Ritual Centred Coping	150	1.05	1.86	0.00	8.00	.65	2.01	3.71

4.3 Testing of Hypotheses

Table 3: Summary of Correlation Matrices of the Relationships among the Variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Age														
Sex	.03													
Mar Sta.	.47**	.17*												
Educ.	-.05	-.03	.05											
GHQ12	.05	.07	.11	.07										
WHQOL	-.09	-.06	-29**	-.03	-.51**									
QOL1	-.23**	-04	-.30**	-.11	-.30**	.72**								
QOL2	-.01	-.13	-.22**	.06	-.48**	.83**	.50**							
QOL3	.00	-01	-.22**	.11	-.33**	.71**	.23**	.54**						
QOL4	-.06	-01	-.13	-.16*	-.41**	.75**	.52**	.48**	.26**					
AFCSI	.08	.00	.01	-.21**	-.24**	.24**	.30**	.17*	.04	.25**				
C E C	.03	.14	-.01	-.22**	-.22**	.24**	.37**	.12	.04	.21**	.81**			
SCC	.07	-.0	.03	-.12	-.14	.15	.16*	.12	.03	.15	.68**	.33**		
CC	.07	-.13	.02	-.14	-.22**	.20*	.18**	.18*	.05	.23**	.73**	.36**	.39**	
RCC	.09	-.11	.00	.06	.04	-.08	-.13	-.03	-.09	-.01	.22**	.04	-.10	.16

(*= significant at the .05 alpha level, ** = Significant at the .01 alpha level.*Age-1, Sex-2, Marital Status-3, Education-4, GHQ12-5, WHQOL-6, QOL1-7, QOL2-8, QOL3-9, QOL4-10, AFCSI-11, C E C-12, SCC-13, CC-14, and RCC-15*) NB: GHQ12-General health status, WHQOL-World health quality of life, QOL1=physical quality of life, QOL2=Psychological quality of life, QOL3=Social quality of life, QOL4=Environmental quality of life, AFCSI-Culture specific coping scale, CEC-cognitive emotional coping, SCC-spiritual centered coping, CC-collective coping, RCC-Ritual centred coping

Hypothesis One

Hypothesis one states that *there will be a significant positive relationship between culture specific coping and quality of life*

This hypothesis was tested using the Pearson Correlation because the two variables are assumed to be linearly related and measured on an interval scale. The results from the correlation matrix above indicate that a significant positive relationship exists between culture specific coping (AFCSI) and overall quality of life (WHOQL), [$r(148) = .24$, $\rho < .01$]. Therefore, the first hypothesis that there will be a significant positive relationship between culture specific coping (AFCSI) and quality of life (WHQOL) is supported. Additionally, the culture specific coping (AFCSI) correlated significantly and positively with three domains of quality of life [Physical (QOL1) -$r(148) = .30$, $\rho < .01$],[Psychological (QOL2)-$r(148) = .17$, $\rho < .05$], and [Environmental (QOL4) -$r\ (148) = .25$, $\rho < .01$]. However, no significant relationship was found between culture specific coping and Social quality of life (QOL3), [$r(148) = .04$, $\rho > .05$].

Hypothesis Two

Hypothesis two states that, *there will be a significant negative relationship between general health status of the patient and their quality of life of the patient*.

From the correlation Matrix in table 4.2 above, it was observed that a statistically significant negative relationship exists between respondents' general health status (GHQ12) and quality of life (WHQOL), [$r(148) = -.51$, $\rho < .01$]. Therefore, the second hypothesis that there will be a significant negative relationship between general health status of the patient and their quality of life of the patient is supported.

Hypothesis Three

Hypothesis Three states that, significant differences will exist in culture specific coping among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls such that;

c. *Persons with psychiatric illnesses are more likely to use culture specific coping than Healthy controls*

d. *Persons with chronic kidney disease are more likely to use culture specific coping than Healthy controls*

To examine whether significant differences exist among Persons with Psychiatric, Physical Cases and Healthy Controls in the use of Africultural coping, the One-Way ANOVA was used and the results are presented in the table 4.3

Table 4: One-way ANOVA and Post-hoc analysis of Afrocultural Coping among Persons with Psychiatric, Physical Cases and Healthy Controls

VARIABLES	Psychiatric (PD)	Physical (CKD)	Healthy Controls (HC)	F-ratio	Post-Hoc
Africutural Coping	45.22 (SD=9.57)	41.04 (SD=9.18)	37.42 (SD=9.97)	8.30*	HC<PD
Cognitive Emotional	19.04 (SD=5.01)	16.06 (SD=4.64)	15.06 (SD=5.99)	7.78*	CKD<PD, HC<PD
Spiritual Centred	13.76 (SD=5.48)	13.54 (SD=3.55)	11.02 (SD=4.03)	8.37*	HC<PD, HC<CKD
Collective Coping	11.40 (SD=3.57)	10.78 (SD=3.22)	9.86 (SD=3.81)	2.50	-
Ritual Centred	1.02 (SD=1.73)	.66 (SD=1.55)	1.48 (SD=2.20)	2.48	-

*= significant at the .05 alpha level.

The table 4.3 above shows that the type of condition has a statistically significant effect on the level of Africultural coping method at the .05 level of significance, [$F(2,147) = 8.30$, $\rho <$

.05]. Post-hoc analysis results showed that persons with psychiatric illnesses had significantly higher mean scores (Mean= 45.22, SD=9.57) than healthy controls (Mean=37.42, SD=9.97) and therefore, the hypothesis 3a that persons with psychiatric illnesses are more likely to use culture specific coping than Healthy controls is supported. However, no significant mean difference exists between persons with CKD and healthy controls and therefore, the hypothesis 3b that persons with chronic kidney disease are more likely to use culture specific coping than Healthy controls is not supported. For the specific Africultural coping domains, the results revealed that, type of condition has a significant effect on Cognitive Emotional Coping, [$F(2,147) = 7.78$, $\rho < .05$], and Spiritual Centred Coping [$F(2,147) = 8.37$, $\rho < .05$]. The post-hoc results are summarised in the table above. However, no significant differences were found in Collective Coping, [$F(2,147) = 2.50$, $\rho > .05$] and Ritual Centred coping, [$F(2,147) = 2.48$, $\rho > .05$] among the three groups of participants. The Bonferroni results for the overall culture specific coping among the groups are summarised in the table 4.4 below;

Table 5: Multiple Comparisons of the Three Groups of Participants on Culture Specific Coping using Bonferroni Test

Variables	Psychiatric Illnesses	Chronic Kidney Disease	Healthy Controls
Psychiatric Illnesses	-	4.18	7.80*
Chronic Kidney Disease	-	-	3.62
Healthy Controls	-	-	-

**= significant at the .05 level of significance*

Hypothesis Four

Hypothesis four states that *significant differences will exist in quality of life among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls such that*

c. Healthy controls are more likely to report better quality of life than persons with psychiatric illnesses

d. Healthy controls are more likely to report better quality of life than persons with chronic kidney disease

To determine whether significant differences exist in the quality of life among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls, the One-Way ANOVA was used and the results are summarised in the Table 4.5 below;

Table 6: One-way ANOVA and Post-hoc analysis of Quality of Life among Persons with Psychiatric, Physical Cases and Healthy Controls

VARIABLES	Psychiatric (PD)	Physical (CKD)	Healthy Controls (HC)	F-ratio	Post-Hoc
WHQOL	52.78 (SD=6.09)	49.56 (SD=7.86)	54.44 (SD=6.66)	6.45*	CKD<HC
Physical	14.44 (SD=1.79)	12.36 (SD=2.00)	13.48 (SD=1.91)	15.02*	CKD<HC<PD
Psychological	12.86 (SD=2.22)	12.22 (SD=2.20)	14.12 (SD=2.01)	9.96*	PD<HC, CKD<HC
Social	11.46 (SD=2.86)	11.86 (SD=2.36)	13.56 (SD=2.55)	9.21*	PD<HC, CKD<HC
Environmental	14.02 (SD=1.96)	13.12 (SD=2.75)	13.28 (SD=2.51)	1.96	-

**= significant at the .05 alpha level.*

An examination of the ANOVA Table 4.5 above shows that type of condition has a statistically significant effect on the overall health-related quality of life at the .05 alpha level, [$F(2,147) = 6.45$, $\rho < .05$]. Post-hoc analysis revealed that no significant mean difference exits between persons with psychiatric illnesses and healthy controls in their quality of life and therefore, the hypothesis 4a that healthy controls are more likely to report better quality of life than persons with psychiatric illnesses is not supported. However, a significant difference exists between healthy controls and person with chronic kidney disease with healthy controls reporting better quality of life and therefore, the hypothesis 5b that healthy controls are more likely to report better quality of life than persons with chronic kidney disease is supported. The multiple comparisons for the overall quality of life are summarised in table 4.7 below. Further analyses of the domains of quality of life showed that the type of condition has statistically significant effects on the Physical, [$F(2,147) = 15.02$, $\rho < .05$], Psychological, [$F(2,147) = 9.96$, $\rho < .05$]and Social domains, [$F(2,147) = 9.21$, $\rho < .05$], but not on Environmental, [$F(2,147) = 1.96$, $\rho > .05$]. The post-hoc results are summarised in the ANOVA table above.

Table 7: Multiple Comparisons of the Three Groups of Participants on Overall Quality of Life using Bonferroni Test

Variables	Psychiatric Illnesses	Chronic Kidney Disease	Healthy Controls
Psychiatric Illnesses	-	3.22	1.66
Chronic Kidney Disease	-	-	4.85*
Healthy Controls	-	-	-

**= significant at the .05 level of significance*

Hypothesis Five

Hypothesis five states that *all the Africultural Coping Domains are likely to predict Quality of Life significantly.*

Table 8: Multiple Regression Analysis of the Predictive Abilities of the Africultural Coping Subscales in Quality of Life

Variables	B	SEB	β	t	ρ-value
Cognitive Emotional Coping	.235	.114	.180	2.056*	.042
Spiritual Centred Coping	.033	.165	.018	.200	.841
Collective Coping	.306	.187	.149	1.635	.104
Ritual Centred Coping	-.430	.314	-.112	-1.368	.173

R^2 = .085, Adjusted R^2 =.060, F(4,145) = 3.364, ρ =.011.

The results multiple regression analysis have shown that Cognitive Emotional Coping was the only significant predictor of quality of life at the .05 alpha level, β = .180, t = 2.056, ρ < .05. Thus, Cognitive Emotional Coping explained 18% of variance respondents' overall quality of life. The other three (Spiritual Centred Coping, β = .018, Collective Coping, β = .149, and Ritual Centred Coping, β = -.112) did not account for any statistically significant variance in the quality of life as shown in the table 4.8 above. Therefore, the hypothesis that all the Africultural Coping Domains are likely to predict quality of life significantly is not supported.

Hypothesis Six

Hypothesis Six states there will be significant gender differences in quality of life among persons with psychiatric, physical illnesses and healthy controls

To test this hypothesis, the independent t-test which is used to compare differences between two groups of respondents was used and the results are presented in the table 4.8 below:

Table 9: Summary of Independent t-test of Sex Differences in Quality of Life among Respondents

VARIABLES	Male (n=92)	Female (n=58)	t(df=148)	ρ
Quality of life	52.58(*SD=7.57*)	51.76(*SD=6.48*)	.68	.50
Physical	13.49(*SD=2.21*)	13.33(*SD=1.84*)	.46	.64
Psychological	13.29(*SD=2.36*)	12.71(*SD=2.16*)	1.53	.13
Social	12.30(*SD=2.85*)	12.28(*SD=2.57*)	.06	.95
Environmental	13.49(*SD=2.56*)	13.45(*SD=2.26*)	.10	.92

An examination of the table 4.9 above shows the sex of the respondents did not have any statistically significant effect on respondents' quality of life at the .05 level of significance, t(148) =.68, ρ > .05 as males had a mean of 52.58 with a standard deviation of 7.57 while females had a mean of 51.76 with a standard deviation of 6.48 . Similarly, sex did not have any statistically significant effect on the specific domains of quality of life, Physical-t(148) = .46, ρ > .05, Psychological-t(148) = 1.53, ρ > .05, Social-t(148) = .06, ρ > .05 and Environmental-t(148) = .10, ρ > .05. Thus, the ninth hypothesis that there will be significant gender differences in quality of life among persons with psychiatric, physical illnesses and healthy controls is not supported.

Hypothesis Seven

Hypothesis Seven states that *there will be significant gender differences in culture specific coping among persons with psychiatric, physical illnesses and healthy controls*

To test this hypothesis, the independent t-test which is used to compare differences between two groups of respondents was used and the results are presented in the table 4.9 below:

Table 10: Summary of Independent t-test of Sex Differences in Culture Specific Coping among Respondents

VARIABLES	Male (92)	Female (58)	t(df=148)	P
Africultural Coping	41.20(*SD=9.95*)	41.28(*SD=10.27*)	.05	.96
Cognitive Emotional Coping	16.11(*SD=5.53*)	17.69(*SD=5.31*)	1.73	.09
Spiritual Centred Coping	12.83(*SD=3.72*)	12.69(*SD=4.21*)	.21	.84
Collective Coping	11.04(*SD=3.61*)	10.10(*SD=3.27*)	1.61	.11
Ritual Centred Coping	1.22(*SD=2.08*)	.79(*SD=1.44*)	1.36	.18

Analysis of the independent t-table 4.9 above shows that sex of respondents did not have any statistically significant effect on their culture specific coping at the .05 level of significance, $t(148) = .05$, $\rho > .05$ with male respondents reporting a mean coping score of 41.20 with a standard deviation of 9.95 while female respondents reported a mean coping score of 41.21 with a standard deviation of 10.27. Similarly, sex of respondents did not have any statistically significant effect on the specific domains of the culture specific coping, Cognitive Emotional Coping-$t(148)= 1.73$, $\rho > .05$, Spiritual Centred Coping-$t(148) = .21$, $\rho > .05$, Collective Coping-$t(148) = 1.61$, $\rho > .05$ and Ritual Centred Coping-$t(148) = 1.36$, $\rho > .05$. Thus, the

hypothesis seven which states that there will be significant gender differences in culture specific coping among persons with psychiatric, physical illnesses and healthy controls is not supported.

SUMMARY OF QUALITATIVE RESPONSES

ID NUMBER	SPIRITUALITY AS A COVERING OR PROTECTION	SPIRITUALITY AS THE MAIN SOLUTION TO ONES PROBLEM	RITUAL ACTIVITIES	MEANINGFULNESS OF SOCIAL SUPPORT
1	" 50-50" sometimes because I went to a prayer camp and I was treated badly and beaten. I think sometimes spirituality is evil" male 32	NO- " for now I believe in this therapy now"	NO-"Now I do not believe in any of them. Sometimes I kill an animal as a ritual since I come from a stool home"	YES-"it means much because my mum supports me and my friends I chat with make me feel happy. They give me money and support"
2	"it is ultimate protection when others fail because the for I believe in is omniscient and omnipotent" male 53	YES-" I think I need a greater deal of the spiritual because we have had enough of the physical. We did not create ourselves and some things are unknown"	YES- " I wash my hands ceremonially because people of my religion practice it"	YES-"now it helps but in a small way. It is not enough"
4	"because only jesus can solve my problems" male 27	YES-"because solves my problems"	-	YES-"because it will show that they love me and care about me
6	"Because I don't know how my condition comes about. God does not need anything from us except for our praise. I believe that in His own time he will heal me" male 34	YES /NO " I believe that both spiritual aspects and medical aspects are needed. This is because God created us and he will take care of the spiritual while the doctors will take care of the physical. Initially I did not use to take my medication but now I do both"	NO- " it was before that I used to use these things when I was part of charismatic churches but since I moved to orthodox I do not use those again"	NO-" In my case not really because my siblings do not call me, they always want me to call them. I take care of myself, I work and earn enough and since I do not have children I'm okay"

7	" sometimes because I see God as the supreme being and all knowing" male 24	YES-"because anytime I reduce my communication with God, I tend to experience much stress"	NO-" because I solely believe that Christ died for my problems and hence do not need any medium between God and I"	YES-" because they sometimes take my mind off my stressors and provide me with some financial support when I am not capable "
8	Because human beings have spiritual and physical sides. God is the one who protects in times of adversity. When people go through situations , God comes first"	NO-Spirituality counts but does not necessarily come first. Physical responsibility also dwells on you. So God does his and we also have to do ours"	NO-" because I do not believe in objects but prayer since it is an effective weapon"	YES-"very necessary because family encourages and anything you go through they support. They are a source of pride for me"
10	YES-" there are a lot of forces that come and this leads to illness"	YES-"because there are a lot of breakthroughs one can get spiritually rather than going to the hospital an seeking other means"	NO	YES-" but now I feel they do not care only my mum and sister understand me and not the others.
11	YES-" because He is the creator of the universe and by that we are covered and protected by Him in all circumstances" male 53	YES-because even if you will be cured medically, God gives the doctor insights to prescribe your medications"	YES-I believe that T.B Joshua has given a strong power to heal people. I use his holy water. Anything from him can b regarded as power from God Himself"	YES-" because since this illness started family members support me financially, spiritually and socially"
13	YES-" because no matter what the problem is, its in God's full control" male 25	YES-"because when you have the sickness you have to get prayer group for prayers and visitation"	NO-" its only prayers I believe in"	YES-"Maximum support from everywhere. I have a singing group and people who love the way we sing. I get much love from these people"

14	YES-" we all know the bible. It's a helmet of salvation. I find spirituality covering me against the negative opinions and stigmatizations of my situation. And I find spirituality strengthening my positives this helps me resolve to move on despite the odds	NO- "it does not need a greater spiritual solution but I believe it doesn't but rather compensates for other solutions. I think both spiritual and non-spiritual solutions must go hand in hand. Both are important. Though sometimes I think the medical stuff is not needed"	YES-I sometimes apply oils on my head to signify wholeness of mind. It makes me know that God is in my case and hasn't abandoned me. This helps me think positively through my issues. Helps me focus positively forward and not backwards	YES-their support means a lot to me and I'm so grateful that for their support. It helps me know that I'm loved and not abandoned. Helps me to think positively too.
16	YES- "God created the whole universe and has the power to protect people who have gone through worse situations than mine and have been healed. Therefore I believe that God can deliver me. God never sleeps and I believe that as I am alive things will be good.	YES-I believe that spirituality comes first before medication. This is because God comes first than other solutions but medications are also important.	YES- I use anointing oils and holy water sometimes because through these things God heals	YES- because in this condition, they have supported me through it. I'm hoping that they will do more like getting me a job because I do not want to be dependent.
17	YES- it does because with this kind of illness I believe the only source of hope and protection is in God people do not understand but I believe that only God understands.	NO-I do not really believe in just one solution but I also believe that spirituality is the first followed others such as the hospital and medications.	YES-I use anointing oils very much. Bible says the anointing breaks the yolk so when my pastor blesses it I use it very much and believe in it as an instrument to heal.	YES- very much. In this time my family cares for me very much and without them im sure I will be like those on the street.
18	YES-I believe it. I know of someone who has experienced this situation and a direction was given and they prayed for her and she was delivered. Therefore I believe that God protects us.	YES- I believe	NO- in church I was never told to use those things and my spirit too has never been moved to use those things.	YES-because I love them and they love me.

19	YES- God has a hand in healing in the church and could heal me.	I think it is alright	NO	-
20	YES- because God looks at that to heal you.	A combination of the two is fine. God will do his side and the medications do their sides	NO- because the church I attend Pentecost does not use those things.	YES- family has helped me a lot in my illness.
21	YES- because if you do not pray you will be disgraced. I was almost dead but I fasted and prayed and this is how far I have come.	YES- because what happened to me happened suddenly. It has never happened to me and it is purely spiritual.	YES- it serves as a source of protection that any evil spirit that targets me will not get me	YES- because relatives here are those who cared for me. They are very important. They give me money each time they visit me
22	YES- because one has to pray 3 times a day. For things to move on for you. Everything starts from spiritual before it manifests spiritually	YES- so far as im going through what I am facing, if it does not come physically then it is spiritual	YES- sometimes I read my bibles and use anointing oils. Sometimes you need it to deal with the things that happen.	YES- because the way things are , I seek advice from them and this makes me be at peace with them.
23	YES- it is good to pray with my condition to make my illness go away.	YES- because this as well as other methods will make me better.	NO	YES- because I think so much in the state I find myself but when they are around it helps me feel better.
26	YES-because I believe that with this condition only God can help me. I have some family members with this illness and the way it is, only God can help. On my father's side when we are	NOT REALLY- spiritual solutions are very important to me but I also think that medical solutions should be considered also. Each time I take my medications I'm okay.	NO- I do not believe in those things, they are physical things. I just believe in God and pray to Him.	YES-because of my age I do not get enough financial support but help me all the same in these times.

	pushing forward, they bring as down.			
28	YES- because if it had not been for God, I don't know where I will be no matter how much I take drugs and the madness does not go but with spirituality it gets much better	YES- because initially I relied on so much medication but now doctor says I'm fine. I do not need so much medication to function so I need more prayer.	YES- I use anointing oils. It gives rapid results. It helps things work faster than they will.	YES- because financially advice and the company they give are very important.
31	YES-because when I pray to God I believe that God can heal me.	NO- my condition is not all that spiritual too so I believe there should be a balance.	YES- it helps me know God and through this my prayers are answered	YES- because they are the ones who bring me to the hospital in times of crisis and help me take my drugs.
32	YES- because if we pray God helps us. God will show us and guide us as to what to do	YES- because prayer leads to so many things that other thing cannot give us.	NO- I believe in praying to God directly.	YES- they help me a lot in this condition.
33	Yes- all Christians believe God heals. And he does. I am expecting Him to heal me soon	Yes- I believe when I become more committed to God he would show me mercy and heal me.	Not really	Yes. Family and friends support mean a lot to me. It shows they are always there for me.

34	Yes-because God is first and gives the doctor knowledge to cure. Therefore it becomes important to rely on only him.	Yes- because initially I was told I would be going on dialysis but did not have money. I'm looking better now and feeling fine.	Yes- there are specific prayers I do in my condition	Yes-because through God they have helped me especially my wife
35	Yes-my faith tells me so	No- I need normal medical treatment	No	Yes- my sister means a lot to me. she is caring for me now.
36	Yes. I believe it is one of my strong pillars. It is something I hold on to and I believe it has seen me through this far.	No-for now it needs both medical and spiritual attention	Yes- I use anointing oils very much given to me by my pastor	Yes- I do not know what I will do without my family. Though sometimes we have issues they are there for me.
37	Yes- it does but should go a long with medication	No- I do not think so because the medication should come before the spiritual aspect. Unless you are sick and you cannot be diagnosed	Yes- I use anointing oils because I believe that God can work through it	Yes- it makes me strong and they support me financially
38	Yes- I believe that my illness has a spiritual dimension and for this reason I will need a spiritual covering	Yes- I think my condition is first and foremost spiritual and if I also come to the hospital I will get better	Yes- I use anointing oils because my brother is a pastor and said I should use it in these times	Yes. My uncle and aunt are those who sponsor me in times of my illness. They really support me.
39	Yes- I believe God can do anything	Yes- because the doctors have told me that I will be on dialysis for life until a get a kidney transplant	Yes- I pray because God can help me through prayer	Yes- their support encourages me that I can get better

40	Yes- now that im sick if I don't get a covering, what will I do. My dad always prays for me and I believe anything can happen	Yes- as for me my only hope is GOD	Yes-I use anointing oil. That is what I know from the bible and it is biblical	Yes-because had it not been for their financial support and help I would have been dead. Emotionally they have supported me.
41	Yes, I believe God can help me	No- I believe both God and the medications I take can help me	Yes- I use anointing oil. I believe it can help me get well quickly.	Yes
42	Yes because I believe diseases have a spiritual cause	Yes- the doctor have not been able to cure my condition	Yes, because I am a Muslim	Yes, it makes me feel stronger
43	Yes-because I believe all things have a spiritual and a physical dimension	Yes- because doctors have told me there is no cure for my condition except I get a kidney transplant.	Yes- I pour libation to my ancestors because that is what I was taught	Yes
44	yes- it does. As a Christian and in this condition. The covering of God is very important.	No- I think it needs both spiritual and other forms of care.	Yes- I use anointing oil because the priest has blessed it and I believe in it.	Yes though they do not know much about my condition, with the little they know I get maximum support.
45	Yes –because sometimes when prayer is given by the priest, or pastor you feel relieved. When we pray and believe that God will come through for us he will.	Yes- I believe that prayers can solve everything	No- I don't use any of these things but when it happened the first time I used anointing oil.	Yes- because when I'm coming to the hospital they bring me and take me back and pay for my bills. Friends also bring me fruits and advice me on my diets.

THEMES GENERATED FROM RESPONSES

1. SPIRITUALITY AS A COVERING
    - When all others fail
    - The ultimate solution (superiority of God)
    - Mystery of the illness
    - Spiritual and physical explanations to life events
2. Spirituality as the main solution to the problem
    - Merging solutions (spiritual and medical)
    - Spirituality at all cost when there is no cure
    - Tenatic believes
    - Current state of patient
3. Ritual Activities
    - Religious beliefs
    - Religious symbolism
    - Religious affiliation
    - Spiritual authority
4. Meaningfulness of social support
    Type of support (financial, social, emotional, spiritual and physical)
    Specific support

Table 11 explains the themes generated from the semi-structured interview using a thematic analysis. Under spirituality as a covering, people view spirituality as a covering when all other methods of healing have proved futile. Also when people see God as superior in their lives spirituality is used as a covering. The mystery of one's' illness makes people hold on to spirituality as a covering. If one cannot find the main cause of his or her illness, spirituality becomes the only option as a covering. Last but not the least, people view occurrences in life as having two extreme sides; spiritual and physical. Therefore if the explanation for the occurrence is not physical then it must be spiritual.

Spirituality as the only solution to ones' problem generated four themes. Most people believe that spirituality should be merged with other solutions such as medical solutions. They believed that a merger of the two gave better results. Others also believed that spiritual

solution should be the only source coping. Tenatic beliefs or holding on to a certain line of thoughts also made people see spirituality as the only solution. The current state of the patient either made one to solely rely on spiritual solutions or merge it with others forms of coping.

With ritual activities most people engage in them or did not engage in them based on four main themes. If a ritual was part of one's' religious beliefs and had a symbolic meaning to their belief they engaged in it. People engaged in ritual solution depending on their religious affiliations or the kind of church they attend, whether orthodox, charismatic or Pentecostal. Also the performance of a ritual activity was based on whether it was coming from a spiritual authority or not. Most people will perform a ritual only if they have been mandated by their priest or spiritual head to do so.

Social support was also another important coping mechanism for most people. The type of support people found to help them most in their situation was financial, emotional, social, spiritual and physical support. Also specific support was also another theme under social support. Most patients always had a specific person who gave them support in times of their illness. Not all family members gave them support even though they wish they had that.

4.4 Summary of Findings

1. There was a significant positive relationship between Africultural Coping and Quality of Life
2. A significant negative relationship exists between general health status of the patient and their quality of life
3. Significant differences exist in culture specific coping among persons with psychiatric illnesses, Physical Illnesses and Healthy Controls with psychiatric patients using more culture-specific coping than healthy controls.

4. Significant differences exist in quality of life among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls with chronic kidney patients reporting less overall quality of life than healthy controls.
5. Not all the domain of Africultural Coping significantly predicted quality of life. Only cognitive emotional coping domain predicted quality of life significantly.
6. No significant gender differences exist in the quality of life and culture specific coping among the respondents in the study.

Additional findings

1. Level of education did not have any significant effect on the overall quality of life , general health status and culture specific coping among all the three groups
2. Age did not have significant effect on quality of life, general health status and culture specific coping among the three

CHAPTER FIVE: DISCUSSION

Finding from hypothesis 1 supported the claim that there will be a significant positive relationship between Africultural coping and quality of life. Nasim et al. (2007) explained that the internalization of African values determines the improvements it has with their psychological outcomes. From the results of the study the patients' belief in the coping mechanisms influences their quality of life. Also cultural values about illness influences the coping strategies people use and dwell on (Banjeree et al., 2011). In their study, they point out the fact that beliefs people hold influences how fit they become in their time of illness. Utsey, Adams and Bolden (2000) define africultural coping "as an effort to maintain a sense of harmony and balance within the physical, metaphysical, collective/communal, and the spiritual/psychological realms of existence".

Daly et al. (1995) found that African Americans prefer coping strategies that were group centered (e.g., family, community, and social support net-works) and/or relied on religious or spiritual approaches to dealing with adversity (e.g., prayer,meditation). Other researches in relation to social support have found that African Americans appreciate coping strategies that include forming affiliations with others, seeking guidance from elders in the community, prayer, and the use of rituals (Jackson & Sears, 1992; Mattis, 2002; Utsey, Adams, et al., 2000).

Cultural values offer blueprints by which behaviors, thoughts, and feelings are deemed normal or abnormal (Banerjee & Banerjee, 1995; Constantine, Myers, Kindaichi, &Moore, 2004). By virtue of the African culture, there is an influence of the values of this culture on diverse aspects of the life of people of African descent. The qualitative responses given by participants also goes a long way to show that African values are very important and

help improve the quality of life of people to some extent. Most people find spirituality to be a covering under four major headings which are: when other methods fail, the ultimate solution (superiority of God), mystery of the illness, spiritual and physical explanations to life events. Spirituality is frequently characterized as an individual phenomenon identified with a belief in some form of higher creational force or Supreme Being (Jagers & Smith, 1996).

People suffering from chronic conditions depending on the mystery of the illness or how it started believe they have no option but to hold on to spiritual things since it may have a bearing on their condition. *"Male 34- i don't know how my condition came about."* For this reason he believes that spirituality serves as a major covering in illness. *"There are a lot of forces that come and this leads to illness female-32"* most people are also of the view that as human beings, there is a spiritual and physical explanation to life events and anything that happens and for a chronic condition which will not go away and starts suddenly, one must definitely hold on to spirituality.

Secondly, though people see spirituality to be a necessary covering in times of their illness, they do not solely believe it is the only way they can cope or deal with the condition. Also social support is held in very high esteem by people living with chronic mental illness and chronic Kidney Disease Social support refers to support received (e.g.informative, emotional, or instrumental) or the sources of the support (e.g. family or friends) that enhance recipients' self-esteem or provide stress-related interpersonal aid (Dumont & Provost, 1999) Social support reduces the impact of stress caused by illness (e.g. Aro, Hanninen, & Paronene, 1989)

Some of the themes generated as to the importance of social support in these times were Type of support, Specific support. In relation to the type of support, patients view this in five different ways (financial, emotional, social, spiritual and physical *support).* These forms of support on the other hand are given by specific people in times of their illness.*Male-24*

social support from family is very important and sometimes helps take my mind off my stressors and provide me with some financial support when I'm not capable". "Female 45- my family cares for me very much in time of my illness. Without them I will be like those on the street." From these response there is no doubt that social support is very important. Last but not the least, ritual centred coping, is also another means of coping by people of African origin. The themes generated from the use of rituals in times of chronic illness were; rituals being used as a result of one's religious beliefs, religious symbolism, religious affiliation and spiritual authority. *"I pour libation to my ancestors because that is what I was taught" "I use anointing oil because the priest has blessed it and I believe in it". "I believe in T.B Joshua has been given a strong power to heal people. I use his holy water. Anything from him can be regarded as power from God Himself"* Generally Africans hold on to these values which see them through very stressful situations.

Hypothesis 2 which states that there will be a significant negative relationship between general health status of patient and quality of life was supported. Semane et al. (2009) in their study found a similar relationship between health and health related quality of life. The results showed that as HRQL scores decreased, the general health of patients also increased. This becomes a necessary measure in chronic illness to serve as a follow up in how patients are faring in their general mental health and their overall quality of life.

The third hypothesis states that Significant differences will exist in culture specific coping among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls such that;

a. Persons with psychiatric illnesses are more likely to use culture specific coping than Healthy controls

b. Persons with chronic kidney disease are more likely to use culture specific coping than Healthy controls.

From the results, it was observed that the various groups differed significantly in culture specific coping. Post-hoc analysis results showed that persons with psychiatric illnesses had significantly higher mean scores than healthy controls and therefore, the hypothesis 3a that persons with psychiatric illnesses are more likely to use culture specific coping than Healthy controls is supported. However, no significant mean difference exists between persons with CKD and healthy controls and therefore, the hypothesis 3b that persons with chronic kidney disease are more likely to use culture specific coping than Healthy controls is not supported. For the specific Africultural coping domains, the results revealed that, type of condition has a significant effect on Cognitive Emotional Coping.Mayer and Latu, (2008) in their study speculate that the uniqueness of a stressor may bring about differences in the coping methods people use. Cater, 1991 also raised the issue of within group differences which may exist in the use of cultural values. These explanations may be the reason for which not all the groups dwell on africultual coping significantly. In collective coping and ritual coping, no differences within the groups were observed. An individual's choice of coping modality is dependent on the situation, with usually more than one strategy being applied over time (Kafanelis,Kostanski, Komesaroff, & Stojanovska, 2009). In the semi-structured interview in this study, patients

Hypothesis four which states that Significant differences will exist in quality of life among persons with Psychiatric Illnesses, Physical Illnesses and Healthy Controls such that

a. Healthy controls are more likely to report better quality of life than persons with psychiatric illnesses

b. Healthy controls are more likely to report better quality of life than persons with chronic kidney disease was supported.

Saarni et al. (2006) investigated the impact of major chronic conditions on HRQoL using 15D and EQ-5D in a representative sample of Finns. The results obtained with the two HRQoL measures differed markedly for some conditions and the EQ-5D results also varied with the regression method used. Musculoskeletal disorders are associated with largest losses of HRQoL in the Finnish population, followed by psychiatric conditions. Different HRQoL measures may systematically emphasize different conditions. Analyzing this study, it can be observed that various chronic conditions affect quality of life in diverse ways. Some have a great toll or impact on the quality of life of the patient while others do not. From this related study on quality of life and coping, it can be observed that the type of condition influenced a specific domain of quality of life that was affected. Consistent with (Saarni et al,2006) , there is a possibility that the type of disorder or condition can influence the choice of coping and quality of life. Post-hoc analysis revealed that no significant mean difference exits between persons with psychiatric illnesses and healthy controls in their quality of life and therefore, the hypothesis 4a that healthy controls are more likely to report better quality of life than persons with psychiatric illnesses is not supported. However, a significant difference exists between healthy controls and person with chronic kidney disease with healthy controls reporting better quality of life and therefore, the hypothesis 4b that healthy controls are more likely to report better quality of life than persons with chronic kidney disease is supported. Some studies have demonstrated deteriorated HRQoL also in early stages of CKD, especially in physical health but also in mental health (Chin et al., 2008; Mujas et al., 2009; Perlman et al.,2005).Under the domain of social quality of life, patients with chronic disease scored lower compared to healthy controls. Patients with psychiatric disorder also scored lower as

compared to healthy controls on social quality of life. On environmental quality of life they did not differ.

Hypothesis five which states that all the domains of africultural coping styles predicted quality of life was not supported. The results multiple regression analysis have shown that the Cognitive Emotional Coping was the only significant predictor of quality of life. The other three (Spiritual Centred Coping, Collective Coping, and Ritual Centred Coping, did not account for any statistically significant variance in the quality of life. Therefore, the hypothesis that all the Africultural Coping Domains are likely to predict quality of life significantly is not supported.

The expectation was that all the domains of africultural coping will significantly influence quality of life but the hypothesis was not significant. In some studies reviewed (Utsey et al., 2007) not all the domains predicted quality of life. Rather spirituality and collective coping were the main predictors. In this study only cognitive emotional coping predicted quality of life. In a cognitive/emotional regulation response to adversity, the individual evaluates (cognitive) the level of risk and adversity in an effort to regulate emotional response to the situation (Utsey, 2000).

The reason for this being that, depending on the stressor in question or the situation, the type of coping method that is used differs. Also the culture of a people is peculiar to them and this determines and influences their choice of coping (chiang et al., 2004; Lee & Luu, 2004; Frydenberg et al., 2001; and Baldacchino et al., 2004). From the qualitative responses that were given, most patients on some level did not believe that spirituality should be the main solution to their problem. Most of them went through a form of cognitive appraisal and did not only dwell on spirituality, rituals and support as a means of coping. They believed in medical and other means to give them support through their stressful situation. (*"spirituality counts but does not necessarily come first, physical responsibility also dwells on me. God does His and we also have to do ours*") another also said "I *do not believe in just one solution*

but I also believe that spirituality is the first followed by other means too" under the use of rituals too, people of African descent for that matter Ghanaians do not use primitive indigenous rituals. The rituals used are based on their religious beliefs and faith and these have symbolic meanings to them. Also they only use these rituals depending on who it is coming from. Meaning whether it is coming from a spiritual authority or their priest or whether their religious affiliation (church) believes in that. Though these beliefs are still held on to, they are done in very subtle and completely different ways " *no do not use rituals, in church I was never told to use those things and my spirit too has never been moved to use those things".*

Hypothesis six and seven which states that there will be significant gender differences in quality of life and culture specific coping was not supported. Though it was expected that there will be gender differences in the ways people cope and their quality of life, The results drifted away from the literature that was reviewed where most saw gender differences in coping and quality of life (Clyman et al, 2008; Ebata & Moss, 1994; Finkelstein et al, 2007; Utsey & Hook, 2007; Greer et al, 2009 and Kathleen & Rafique, 2012). Gender of the respondents did not have any statistically significant effect on respondents' quality of life. Similarly gender did not have any statistically significant effect on the specific domains of quality of life. Meaning even in all the specific domains of quality of life did not see male and female perform differently. The turn in this study as discussed earlier may be as a result of the type of condition or stressor involved (Saarni et al., 2006). In this study both males and females did not differ on their choice of coping and quality of life. Also the bridging of the gap in gender roles could also account for these changes. In some cultures, men are taught to internalize their emotions and the way they feel while women are allowed to express themselves. Looking at the qualitative responses given by participants since the illness is

chronic and needs to be managed for a long time, both male and female patients express themselves freely and openly and state how much they need the support.

Observed Conceptual Framework

Figure 2 shows the observed conceptual Framework presenting the significant relationships between the variables measured in this study. The figure depicts a significant relationship between culture specific coping and quality of life in general. Cognitive emotional coping was the only predictor of quality of life taking into consideration the other sub scales of culture specific coping. Last but not the least, the general health of patient had a significant negative relationship with quality of life of the patient with chronic mental or medical illness.

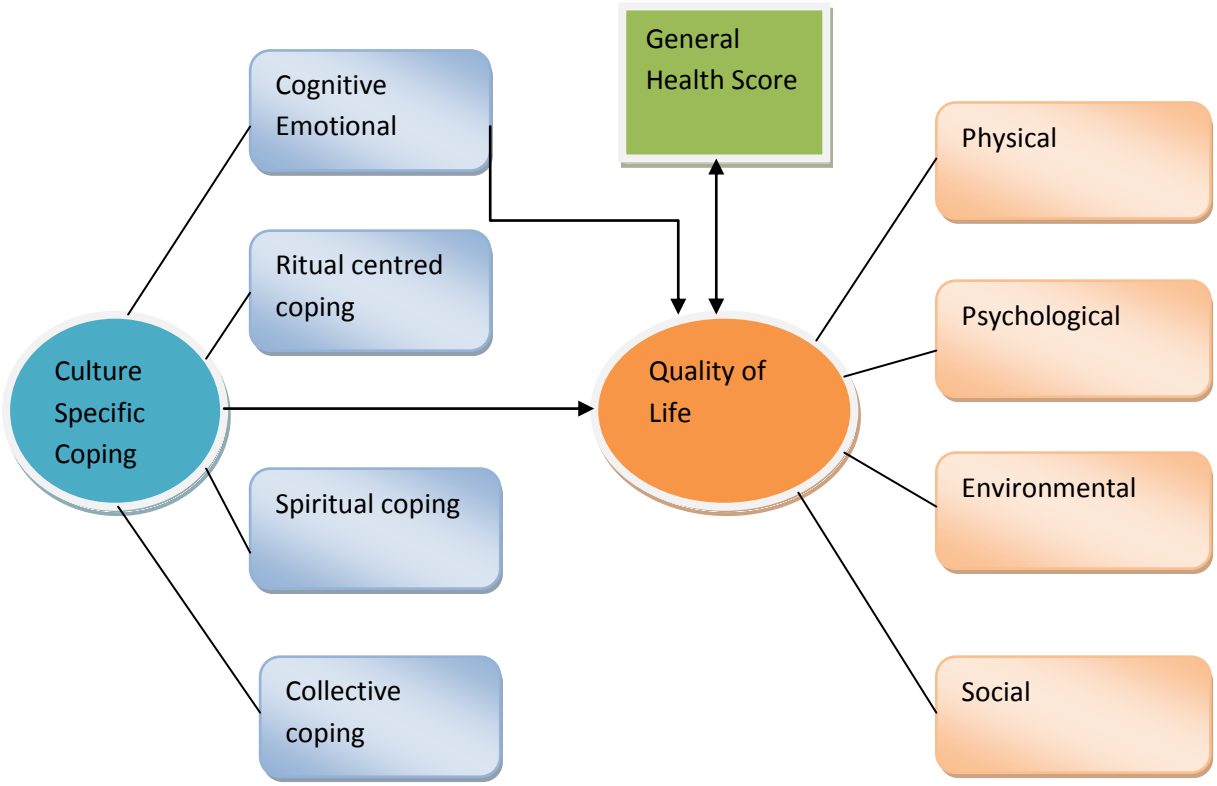
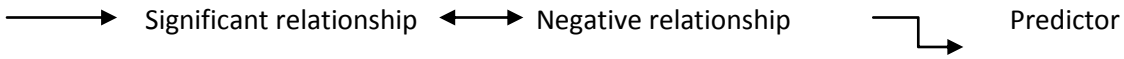


Figure 2



Recommendation/ Implication for further clinical practice

The main findings from this study confirms that indeed in chronic mental and chronic kidney disease people dwell on cultural values to cope in times of their illness. Though in general these afrocentric values are used, there are differences in literature as to the particular type of domain which influences quality of life. From this study patients really dwell on cognitive emotional debriefing where patients dwell more on other activities which take their minds off focusing on the illness. In clinical practice a holistic form of treatment and counseling system should be incorporated in the management of both chronic mental illness and chronic kidney disease. Also the general health of patients has a significant relationship with quality of life. The general health status of patients from the study can be of great importance in determining the quality of life of a patient. General health of patients should be followed up periodically to determine how their state of illness is from time to time. Another important recommendation is to take into consideration the type of illness when looking at coping and quality of life. There were significant differences observed in how the various conditions coped as well as in their quality of life. This helps focus on peculiar treatment plans for specific conditions and not generalize treatment and management plans since differences do exist.

Limitations

The study was the specialized nature of the sample. Using a clinical sample especially people with chronic conditions makes it very difficult and involving. This is because

sometimes patients could not answer the questions continuously and this made it take quite some time in acquiring the needed information. For patients with psychiatric conditions patients in their lucid states had to be used and if there were none the researcher needed to wait till those who could answer the questions flawlessly were got.

Another limitation in the study was that though the sample used a mixed method design it will be much better to undergo a rigorous interview analysis to draw more information on and not a semi- structured interview. This is because the semi-structured interview focused more on culture and coping on a very low profile as a result of time factor. A rigorous focus group discussion on how these conditions affect their general health and quality of life would have give much information than what was done initially.

Other areas such as tribal affiliation and primary givers were not looked up. These areas are interesting areas which can also bring up new directions in coping.

Healthy control selection was not done on matching basis and this could also affect the outcome of the study.

In relation to the cultural models that explain culture, only the Africultural coping system was looked which was okay but there are other cultural models which could have been looked at and compared.

Notwithstanding the various limitations encountered, this study has raised more questions to be answered in the sphere of culture and coping especially in relation to African progeny (Ghana).

Though Ghanaians and Africans for that matter are believed to hold on to certain values they really practice these or issues such as westernization, acculturation, and gender equality affect the issues on coping and quality of life? Do these Africans believe in this

African world view? All forms of chronic illness and conditions should be researched into to know exactly how they specifically cope since there are sure to be differences. This will aid in planning a dependent management and care system for the various chronic conditions.

Direction for future research

- In-depth studies into beliefs held by people of African progeny especially in relation to African centred values.
- Factors that may be influencing African values such as westernization, acculturation and issues in gender equality and gender based studies.
- Research into other chronic conditions to tell if there may be differences in their ways of coping
- In-depth qualitative ways of research such as focus group discussions into African centred coping, values and quality of life.

Conclusion

Cultural values offer blueprints or skeletal framework by which behaviors, thoughts, and feelings are deemed normal or abnormal around which people live their lives, (Banerjee & Banerjee, 1995; Constantine, Myers, Kindaichi, &Moore, 2004). This makes the culture of a people an integral part of their lives in every field. This study sought to find out how cultural methods of coping influence the quality of life of people and also found out how much people of African progeny hold on to these modes of coping. If they do use them, why do they use them or why do they not use them. Most literature surrounding culture has been

done mostly with African Americans. Chronic illness brings about a lot of pressure and discomfort to those who have to manage which such conditions. In this case the study looked at chronic mental illness and chronic kidney disease. These conditions require maximum coping and management... Using a systematic thematic review and analysis of theoretical frameworks and related literature, this was achieved.

Results from the study showed that generally, cultural specific coping influences quality of life of patients living with chronic illness. There was a significant positive relationship between Africultural Coping and Quality of Life. Also when the general health status of a patient is known, it helps predict the quality of life of a patient. Considering the type of diagnosis there were differences in choice of coping methods with psychiatric illnesses, Physical Illnesses and Healthy Controls as well as with their quality of life. No Gender differences were observed in the choice of coping and quality of life of patients living with chronic illness.

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APPENDICES

Appendix I Ethical Clearance by Noguchi

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979
A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

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Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

14th March, 2013

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 075/12-13 **IORG 0000908**

On 14th March 2013, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **The culture-specific coping and quality of life among Ghanaians living with chronic illness**

PRINCIPAL INVESTIGATOR : **Hannah Belle Afoley Anang, MPhil Cand**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 13th March, 2014. You are to submit annual reports for continuing review.

Signature of Chairman:.....
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

Appendix II Ethical Clearance by Hospital

Pantang Psychiatric Hospital

4rd June 2013

To: In-charges –Psycho OPD, Wards, etc.

Dear Sir/Madam,

Letter of Introduction

RE: Hannah Belle A. Anang

The above is an M.Phil student of the Department of Psychology, University of Ghana undertaking a research entitled: *"Culture-Specific Coping and Quality of Life Amongst Ghanaians Living with Chronic Illness"*.

She has chosen Pantang Hospital as the focus of her study. Ethical clearance has been acquired from the Ethics Committee of Pantang Psychiatric Hospital.

We will be very grateful if you could let her have access to outpatients and inpatients for her data collection. The location for the interviews will be negotiated between the researcher and the participants. Please ensure that the participants sign or thumbprint the consent forms. Copies of each consent form should be given to Dr. Wozuame by the researcher as evidence.

Attached are copies of her application and ethical clearance from the appropriate agencies.

Thanks for your cooperation.

Yours sincerely,

Dr. Benedictus Wozuame

Chairman, Ethics Committee.

Appendix III Summary of Frequencies of Demographic Variables

Summary of Demographic Characteristics of the Respondents in the Study

Variables	Psychiatric Cases	Physical Cases (CKD)	Healthy Controls
Sex			
Male	36	27	29
Female	14	23	21
Age Range			
18-29years	18	14	34
30-49years	21	19	8
50-64years	11	17	8
Education Level			
Primary	9	1	2
JHS	3	1	3
Secondary/Tech/Voc.	24	30	19
Tertiary	14	15	24
Postgraduate	0	3	2
Marital Status			
Single	38	16	45
Married	7	21	3
Divorced	4	9	0
Separated	1	2	1
Co-habitation	0	1	1
Widowed	0	1	0
Number of Children			
None	33	20	45
One	4	7	2
Two	6	9	0
Three	6	8	2
Four and above	1	6	1
Religion			
Christianity	49	45	46
Islam	1	4	4
Traditional	0	1	0
Employment Status			
Fulltime	23	23	6
Part-time	0	6	8
Not employed	25	10	36
Retired	2	2	0
Monthly Income (GHC)			
Below 500	31	17	34
500-2000	12	20	6
2000-3000	1	1	0
Above 3000	6	12	10

Appendix IV Semi structured Interview

Interview Guide

1. **Does spirituality serve as a major covering or protection in times of your illness? And why?.....**

   .....

2. **Do you think your condition needs a greater spiritual solution than any other solution and why**

   .....

   .....

3. **Do you perform any spiritual activities or use some objects or items which in your opinion help you through your condition? E.g. anointing oils, candles, etc**

.....

.....

4. **Does support from your family and friends and social group mean anything to you in these times of your illness? Why?**

.....

.....

Appendix V AFCI

Instructions: Please consider the strategies you use in coping with stressful lsituations. Recall a stressful situation(s) that occurred. Rate each coping strategy by indicating whether you used it to cope with the stressful situation.

0 = Did not use 1 = Used a little 2 = Used a lot 3 = Used a great deal.

_____ 1. I prayed that things would work themselves out.

_____ 2. I got a group of family or friends together to help with the problem.

_____ 3. I shared my feelings with a friend or family member.

_____ 4. I remembered what a parent (or other relative) once said about dealing with these kinds

of situations.

_____ 5. I tried to forget about the situation.

_____ 6. I went to church (or other religious meeting) to get help or support from the group.

_____ 7. I thought of all the struggles Black people have had to endure and it gave me strength

to deal with the situation.

_____ 8. To keep from dealing with the situation, I found other things to keep me busy.

_____ 9. I sought advice about how to handle the situation from an older person in my family or

community.

_____ 10. I read a scripture from the bible (or similar book) for comfort and/or guidance.

_____ 11. I asked for suggestions on how to deal with the situation during a meeting of my

organization or club.

_____ 12. I tried to convince myself that it was not that bad.

_____ 13. I asked someone to pray for me.

_____ 14. I spent more time than usual doing group activities.

____ 15. I hoped that things would get better with time.

_____ 16. I read a passage from a daily meditation book.

_____ 17. I spent more time than usual doing more things with friends and family.

0 = Did not use, 1 = Used a little, 2 = Used a lot, 3 = Used a great deal.

_____ 18. I tried to remove myself from the situation.

_____ 19. I sought out people I thought would make me laugh.

_____ 20. I got dressed up in my best clothing.

_____ 21. I asked for blessings from a spiritual or religious person.

_____ 22. I helped others with their problems.

_____ 23. I lit a candle for strength or guidance in dealing with the problem.

_____ 24. I sought emotional support from family and friends.

_____ 25. I burned incense for strength or guidance in dealing with the problem.

_____ 26. I attended a social event (dance, party, movie) to reduce stress caused by the situation.

_____ 27. I sang a song to myself to help reduce the stress.

_____ 28. I used a cross or other object for its special powers in dealing with the problem.

_____ 29. I found myself watching more comedy shows on television.

_____ 30. I left matter in God's hands.

Appendix VI: WHOQOL-BREF

WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last four weeks.**

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Do you have any comments about the assessment?

_____

_____

[The following table should be completed after the interview is finished]

		Equations for computing domain scores	Raw score	Transformed scores*	
				4-20	0-100
27.	**Domain 1**	(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:
28.	**Domain 2**	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:
29.	**Domain 3**	Q20 + Q21 + Q22 ☐ + ☐ + ☐	a. =	b:	c:
30.	**Domain 4**	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:

* See Procedures Manual, pages 13-15

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5

20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Do you have any comments about the assessment?

_____

_____

[The following table should be completed after the interview is finished]

		Equations for computing domain scores	Raw score	Transformed scores*	
				4-20	0-100
27.	**Domain 1**	(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:
28.	**Domain 2**	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:
29.	**Domain 3**	Q20 + Q21 + Q22 ☐ + ☐ + ☐	a. =	b:	c:
30.	**Domain 4**	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	a. =	b:	c:

* See Procedures Manual, pages 13-15

Appendix VII: General Health Questionnaire

We want to know how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Have you recently:

1. been able to concentrate on what you're doing?

better than usual same as usual less than usual much less than usual

(0) (1) (2) (3)

2. lost much sleep over worry?

Not at all no more than usual rather more than usual much more than usual

(0) (1) (2) (3)

3. felt that you are playing a useful part in things?

more so than usual same as usual less so than usual much less than usual

(0) (1) (2) (3)

4. felt capable of making decisions about things?

more so than usual same as usual less than usual much less than usual

(0) (1) (2) (3)

5. felt constantly under strain?

Not at all no more than usual rather more than usual much more than usual

(0) (1) (2) (3)

6. felt you couldn't overcome your difficulties?

Not at all no more than usual rather more than usual much more than usual

(0) (1) (2) (3)

7. been able to enjoy your normal day to day activities?

more so than usual same as usual less so than usual much less than usual

(0) (1) (2) (3)

8. been able to face up to your problems?

more so than usual same as usual less than usual much less than usual

(0) (1) (2) (3)

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9. been feeling unhappy or depressed?

not at all no more than usual rather more than usual much more than usual

(0) (1) (2) (3)

10. been losing confidence in yourself?

not at all no more than usual rather more than usual much more than usual

(0) (1) (2) (3)

11. been thinking of yourself as a worthless person?

not at all no more than usual rather more than usual much more than usual

(0) (1) (2) (3)

12. been feeling reasonably happy, all things considered?

more so than usual same as usual less so than usual much less than usual

(0) (1) (2) (3)