

**UNIVERSITY OF GHANA**



**DEPARTMENT OF PSYCHOLOGY**

**RELIGIOSITY/SPIRITUALITY, SOCIAL SUPPORT, GENERAL SELF-EFFICACY  
AND MENTAL HEALTH OF COMMUNITY DWELLING OLDER ADULTS IN  
ACCRA**

**BY**

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**DECLARATION**

This is to certify that this thesis is the result of the research undertaken by ABRAHAM KENIN towards the award of Master of Philosophy in Clinical Psychology in the Department of Psychology, University of Ghana.

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## ABSTRACT

Older adulthood is a developmental stage accompanied by a number of existential challenges. Nonetheless, a conceptual shift towards successful and positive ageing has been proposed by researchers and stakeholders of health. It was the aim of this study to find out the relationship between successful ageing variables and positive mental health. Two hundred and fifty older adults (118 males and 132 females) with the mean age of 71 were conveniently sampled from HelpAge Associations in Osu, Achimota, Abofu and Apenkwa, suburbs of Greater Accra region in Ghana. The questionnaires administered included measures of Spirituality and Religiosity, Social Support, Self-Efficacy and Mental Health. Results from the SPSS analyses indicated that Spiritual Transcendence, General Self-efficacy and Family Support were positively related to the Mental Health of older adults. Consistent with the Gerotranscendence theory, the results revealed significant differences in Spiritual Transcendence among age group categories of older adults. Further, the results indicated that education level determines the support older adults receive from friends. The results revealed a significant moderating effect of General Self-Efficacy on the relationship between Spiritual Transcendence and Mental Health meaning General Self-Efficacy strengthens the relationship between Spiritual Transcendence and Mental Health. The results from the study however indicate that Religious Sentiments and support from friends have no significant relationship with mental health. The findings from this study imply that the concept of positive ageing is largely related to mental health among community dwelling older adults in Accra hence should be promoted in psychological practice and public health interventions.

**DEDICATION**

To the glory of God, this thesis is dedicated to my aged parents; Mr. Michael Kenin and Madam Margaret Naamah and to all older adults.

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**LIST OF ABBREVIATIONS**

AMA-	ACCRA METROPOLITAN AREA
GSE-	GENERAL SELF-EFFICACY
IHD-	INSTITUTE OF HUMAN DEVELOPMENT
MHC-	MENTAL HEALTH CONTINUUM
SCT-	SOCIAL COGNITIVE THEORY
WHO-	WORLD HEALTH ORGANISATION

## CHAPTER ONE

### INTRODUCTION

#### **Background**

More people are expected to reach 60 years and over as indicated by projected estimates (World Health Organization, 2015). Ghana like many other developing countries is undergoing demographic transition with respect to the ageing population. Estimations by the World Health Organisation (WHO) indicate that 10 percent of Africa's population will be 60 years and over by 2050. The elderly population in Ghana has surged sevenfold in recent years. For instance, the 1960 population and housing census recorded a total of 213,477 older adults while 1,643,381 older adults were recorded in the 2010 census. In Ghana, people who are 60 years and over constitute 7% of the national population, one of the highest among African countries (United Nations, 2013). Mental health and well-being of older adults is important to look at as population aging continually increases over the years (Brar, Kaur & Sharma, 2013). In this regard, recent studies within the scope of gerontology have examined the challenges and prospects associated with old age. Efforts aimed at conceptualizing and engendering the positive aspects of well-being among older adults is essential given their increasing numbers in Africa and Ghana in particular.

Old age is often linked to a number of challenges including the incidence of chronic non-communicable diseases (Ayernor, 2012). It is also reported to be linked to a transformation in attitudes which encompasses the tendency to accept one's physical limitations, satisfaction with previous accomplishments, lower susceptibility to peer influence, as well as a realistic evaluation when it comes to a person's strengths and limitations (Jeste & Oswald, 2014). There are however emerging trends in gerontology which do not lose sight of the fact that these issues exist. Rather, the concept of "successful" or "positive" ageing which is against the traditional conception about

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old age has been the main focus. Positive ageing seeks to engender a focus on issues such as the transformation of beliefs, skills, lifestyle patterns and values of older adults. These ultimately help them to feel part of society by adapting to changes and not disengaging (Davey & Glasgow, 2006). The focus of healthy aging as engendered by the WHO has been on positive themes and constructs such as concepts of ‘healthy’, ‘successful’, ‘positive’, ‘active’ and ‘productive ageing’. Although the elderly has been stereotyped and viewed as being sad and lonely, it has been found that they experience better psychological well-being than younger individuals (Jeste & Oswald, 2014). Positive mental health is therefore worth studying among healthy older adults in the population. Central to the idea of positive mental health as engendered by the WHO is a state of positive affect that is defined as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004, p 12). In this regard, psychological, social and emotional well-being often form the basis for conceptualizing positive mental health (Lamers et al., 2011). Successful or positive aging usually entails the appraisal of non-biomedical concepts and theories that engenders the aging process instead of overemphasizing on biomedical concepts (Carver & Buchanan, 2016). In this regard, religiosity, spirituality, self-concepts which include general self-efficacy and social support mainly forms part of the thematic preoccupation whenever successful aging is mentioned in empirical literature (Carver and Buchanan, 2016).

### ***Religiosity, Spirituality and Mental Health***

Erikson’s (1982, 1986) psychosocial stages of development, suggest that adults who attain the age of 65 years have reached the stage of “ego integrity versus despair” in which wisdom is achieved upon successfully going through this stage. Gerotranscendence, a developmental theory

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in connection with positive ageing has however been proposed as a ninth stage. It is characterized by a shift of focus from materialism to a transcendent look at life. Swope, (2016) asserts that level of gerotranscendence does increase among older people who have gone past the eighth stage stipulated by Erikson and are in their late eighties and early nineties, meaning that these individuals continue to grow and mature across the psychological and spiritual domains while their age increases. From a critical psychological perspective however, Nsamenang, (1992) argued that the focus of Erikson's theory is more individualistic in scope therefore, not consistent with what pertains in the African sociocultural milieu. According to him the social environment could not be delineated from human development. Ngaujah and Dirks (2003) have argued that Erikson's theory is different from the West African concept of human development. Taiwo's, (1998) work from an African perspective on the other hand, corroborates largely with this perceived western concept. Central to this framework is the preoccupation of the concept of transcendence which suggests there is the existence of some reality beyond tangible experiences. This goes beyond our comprehension and scope thus, we are eventually influenced to submit our lives to transcendence in the form of supplication (Taiwo, 1998).

Although religiosity and spirituality are related, they are often conceptualized as distinct entities. Spirituality is often operationally conceptualized by focusing on an individual's subjective interpretation of experiences while religiosity has been viewed as the subjective experience of a person within the framework of formed religion (Crowther, Parker, Achenbaum, Larimore & Koenig, 2002). In contrast to religiosity, spirituality is often conceptualized as unstructured. This means that, a person can be classified as spiritual when it comes to belief and behavior, but still not have an affiliation to religious institution. Spirituality can be conceptualized as more of a phenomenon that is individually based and that can be verified in diverse ways from individual

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to individual (Musick, et al., 2000). “Religion is an organized system of beliefs designed to facilitate closeness to God whereas spirituality is the personal quest for understanding answers to ultimate questions about life and its meaning, and about how it relates to the transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community” (Koenig et al., 2000).

Gyekye, (2010) defines spirituality as “a heightened form of religiosity reached by certain individuals in the community who have, or claim to have, mystical contacts with the supernatural, the divine”. He further states that “it would be correct to assert, however, that the encounters are the results, rather than the sources, of religion in Africa in the traditional setting” leading to moral conducts which inevitably influence lifestyle and well-being. An entrenched feeling of spiritual transcendence and unity with nature is central to African cultural thought pattern and (Kwate, 2005). Spirituality is an ideal coping strategy among Africans and it reinforces the collectivism culture to a large extent (Drake-Brassfield, 2008). Wheeler, Ampadu and Wangari (2002) noted that “spirituality is deeply embedded in the healthy life-span development of people of African descent and the African diaspora. Spiritual issues do not wait to become pertinent in elderhood, as some theorists have suggested. Rather an awareness of the spirit is instilled from a very early age and reinforced through daily practices.”

When it comes to traditional forms of indigenous religion pertaining to sub-Saharan Africa, an emphasis on participatory religion and ritualistic activities are normally the case after religious knowledge has been acquired (Gore, 2002). Although western religious idea, logics and practices may differ from the African context, the underlying assumption largely remains the same. Important factors that have been found to have an effect on longevity, well-being and mental health among the elderly is religiosity and spirituality. The African cultural system is interlaced

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with religious sentiments and practices to the extent that one can hardly talk about the African culture without mentioning religion and its related activities. For instance, among individuals who are 60 years and over in Ghana, 91% of males and 95% of females were found to be affiliated to a religion by the Ghana country assessment report on ageing and health in 2014. It is therefore important to examine how religious sentiments and spiritual transcendence relates separately with mental health in the context of other psychosocial factors.

The elderly in the population are generally considered to be more religious than younger people (Piedmont, Kennedy, Sherman, Sherman, & Williams, 2008). Religious involvement has immense health benefits and of invaluable importance is the fact that religious individuals are most often motivated to adopt preventive health care measures ((Reindl Benjamins & Brown, 2004); Hill, Ellison, Burdette & Musick, 2007). Religious participation and activity at the very least, is a predictor of healthy lifestyles (Hill et al., 2007). Empirical evidence from available literature predominantly establishes a direct link among religiosity, spirituality and positive mental health variables and outcomes. Religiosity and spirituality may however, have different implications for every individual and may either be beneficial or debilitating to the health and wellbeing of individuals with chronic conditions (Arrey, Bilsen, Lacor & Deschepper, 2016).

Among elderly individuals, there are empirical studies which demonstrate the positive effects of religiosity on health. Religious sentiments in the form of faith and practice are also evidenced to have a positive influence on the mental health of older people (Al-Kandari, 2011). Studies which focus on the strengths and benefits attached to religious beliefs among the elderly mostly reveal how healthy ageing is affected by positive psychological constructs such as resilience, meaning, engagement, well-being and positive emotions.

***General Self-Efficacy and Mental Health***

The self-concept of sense of control over one's life or self-efficacy is a psychological resource that has been promoted in regard to positive ageing. This comprises the concept of positive mentality and self-esteem, personal independence, as well as effective adjustment and adaptation even when circumstances are changing (Bowling & Dieppe, 2005). Self-efficacy constitutes an essential construct when it comes to the issue of successful ageing because it is critical in self-regulating behavior. It influences individual's cognition, and determines one's motivations and behavior as well as influence how people cope with stressful situations. Self-efficacy is counter-intuitive to the spirit of African-centeredness and community, yet within the communal setting, it is imperative to develop an identity for one's own self (Drake-Brassfield, 2008). The concept of self-efficacy is an individual's appraisal of his/her ability to meet a required level of functioning that goes to have impact on events that affect life (Singh, Shukla & Singh, 2011). The focus of self-efficacy issues among older adults has mainly been on reappraisals and misappraisals of their susceptibility to perform and their abilities. As people grow older, there are accompanying functional decline in mental and physical abilities that come with challenges. Reappraisal of self-efficacy is an important factor when it comes to engendering and promoting self-esteem and healthy behaviors. Luszczynska, Gutiérrez-Doña and Schwarzer (2005) established that self-efficacy is invariably linked to a number of constructs in the field of psychology such as appraisal of stress, social relations, self-esteem, quality of life and the overall mental well-being of individuals. It may also play a foundational role in an individual's ability to adapt to changes and to maintain the necessary resources for successful ageing in the biological, psychological, and social domains and, ultimately, their self-reported quality of life. To a large extent, self-

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efficacy also influences the adaptive strategies older adults use in daily life (Slangen-DeKort et al., 1998).

### ***Social Support and Mental Health***

Another essential psychosocial resource that is instrumental in the concept of successful aging is social support. Social support is an important multidimensional factor that contributes to the well-being and quality of life of older adults. Among the elderly, social support is often linked to high levels of positive affect (Jones, 2003). To this end, Lyyra and Heikkinen (2006) argued for the need to identify, develop and promote new social innovations and interventions. This they assert will go a long way to engender a sense of emotional social support among the elderly, hence promoting their welfare and health status. Ghana as a developing country has been identified to be undergoing rapid urbanization due to socioeconomic reasons. This phenomenon invariably has contributed to the change in the traditional support systems the family provided in the past for the elderly (Apt, 2012). Ample evidence points to the fact that material family support for older individuals has waned in recent years (Aboderin, 2004). Consequently, "... modern institutions have created cultural obstacles on the aged where the aged are abandoned socially and psychologically, making them unnecessary, marginalized and alien to the society..." (Egwu, 2013, p. 116). Social support is therefore an important factor when it comes to studying topics related to gerontology in contemporary times.

### **Problem Statement**

With the unprecedented surge in the elderly population the world over and Ghana in particular, empirical research concerning them has mostly focused on studying issues that are linked in one way or the other to health, longevity, generic influences, general life style and demographic variations. Although the concept of successful ageing that has been widely reported in literature, it is based on the biomedical framework to a large extent because it is mostly labeled as “physical and mental health” (Bowling & Iliffe, 2011). Individual psychological factors such as self-efficacy are also studied among the elderly population but it is mainly in relation to biomedical factors such as dimensions of functional limitation and disability problems (Rejeski, Miler & Foy, 2001; Paluska & Schwenk, 2000). Social support and network have also been identified to be essential in preserving the mental well-being and health among the elderly (Fiori, Toni, Antonucci & Cortina, 2006; Litwin & Shiovitz-Ezra, 2010), but its relationship with other successful aging concepts remain largely underexplored. Although spirituality and self-efficacy have been reported to enhance psychological wellbeing (e.g. Bisschop et al., 2004; Elliott & Hayward, 2007), it is understudied among the healthy elderly population. More empirical studies in this direction are however needed in order to identify, promote and engender potential positive constructs that are linked to the well-being of older adults. Most Ghanaian studies concerning the subjective well-being of the older adults focus mainly on constructs such as disease symptoms and psychopathological manifestations, functional limitations and treatment as well as socio demographic profiles including age, sex, educational level, income and ethnic background (Calys-Tagoe et al., 2014; Gildner et al., 2016; Oppong Asante, 2012; Hewlett et al., 2015; and Domfe & Aryeetey, 2016).

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Psychology however, is not only about the study of disease, weakness, and pathology. It also entails the study and exploration of strength and virtue among individuals (Seligman, 2002). Of central importance to the whole concept of 'positive psychology' is also how preventive measures can effectively be championed to engender well-being among individuals. Given this background and the possible benefits associated with religiosity and spirituality among the elderly population in other jurisdictions, finding out the relationship between the non-biomedical constructs of religious sentiments, spiritual transcendence, social support, self-efficacy and positive mental health among older adults within communities in the Ghanaian context is worthwhile.

### **Relevance of the Study**

The findings from this study will help inform practicing clinicians and counselors about the separate roles of religious sentiments and spiritual transcendence in the promotion of the positive construal of mental health among older adults. This will invariably help in planning appropriate intervention programs taking into consideration the level of religiosity and spirituality of the elderly. The outcome of this study will also help in determining the extent to which the self-efficacy of community dwelling older adults contributes to their mental health aside religiosity and spirituality. This area has been under studied in the Ghanaian context so an understanding of these factors will contribute to public health interventions at the local Ghanaian level. An understanding of how social support types affect the well-being and mental health of community dwelling older adults will not only inform individualized care, but also contribute immensely to policies which are oriented towards improving the lives of older adults. The study will also make an empirical contribution to existing literature on religiosity/spirituality and mental health among

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older adults in relation to other personal psychosocial factors. Finally, the study will propel more studies in the field of positive mental health among community dwelling older adults.

### **Aims and Objective**

The study's broad objective was to investigate the relationship among religious sentiments, spiritual transcendence, social support, self-efficacy and mental health of community-dwelling older adults within the Accra metropolitan area.

Specific objectives were to:

1. Investigate the relationship among older adults' Religious Sentiments, Spiritual Transcendence and their Mental Health within the Ghanaian context.
2. Find out which of the Social Support dimensions (family or friends) is significantly related to Mental Health among older adults.
3. Examine whether the General Self-Efficacy of older adults significantly relates to their Mental Health.
4. Investigate the moderating role of General Self-Efficacy in the relationship between Spiritual Transcendence and Mental Health.

### **Research Questions**

The following research questions were formed and answered based on the specific objective and aims of the study:

1. What relationship exists among Religious Sentiments, Spiritual Transcendence and Mental Health among older adults in Accra?
2. Which dimension of Social Support is significantly related to Mental Health among older adults in Accra?

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3. What relationship exists between General Self-Efficacy and Mental Health of older adults in Accra?
4. Will General Self-efficacy moderate the relationship between Spiritual Transcendence and Mental Health?

## CHAPTER TWO

### LITERATURE REVIEW

#### **Introduction**

The present study examined whether religious sentiments and spiritual transcendence among community dwelling older adults are significantly related to their mental health. In addition, the predictability of mental health by the dimensions of social support (family and friends) was assessed. How older adults' self-efficacy are related to their spirituality was also investigated by this study. The literature review captures the theoretical frameworks underlying the study. The theories of interest in this study include the theory of religious effects (Smith, 2003), the Social Cognitive theory (Bandura, 2001) and the Gerotranscendence theory (Tornstam 1989; 2005). This is followed by the empirical review of literature on the various variables in the study. The theoretical and empirical review is subsequently followed by the limitations and gaps in the studies reviewed, rationale for the study, and the hypotheses tested. The conceptual framework of the study and the specification of the study variables then follow.

#### **Theoretical Framework**

Three main theories that guided the study are listed and discussed below.

The general concept of well-being is very essential when it comes to matters pertaining to individuals' health. Religiosity and spirituality has been said to be correlated positively with well-being in other jurisdictions (Western and Asia). For this reason, it is imperative to find out whether this link does exist within the Ghanaian context as well, focusing on the elderly living in communities.

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***Theory of Religious Effects***

Smith (2003) argued that the theory of Religious Effects is an explanation of how religiosity and spirituality have an impact on general well-being. The theory argues that the benefits of religiosity to individuals happen within the context of nine constructs which are distinct, but connected and may be mutually reinforcing. These nine constructs are categorized under three main factors, namely social and organisational ties, learned competencies and moral order (Smith, 2003). Chokkanathan (2013) has used this model in a study involving the elderly although Smith (2003) used it primarily among the youth.

The factors that fall under moral order has to do more with acculturation into religious belief systems and providing an avenue that makes it normal to express those traditional beliefs (Smith, 2003). Chokkanathan's (2013) framework also elaborates learned competencies and social ties as underlying concepts.

Learned competencies refer to skills that are gained when one participates in religious programs that build confidence and also give access to a plethora of diverse coping skills on both cognitive and behavioural levels (Smith, 2003). Social and organisational ties highlight the relationships that give opportunities for interaction. This interaction can eventually go beyond the walls of churches and religious organisations. These factors are at the same time perceived as constructs which may be present or not in same quantity or quality among various religious organisations (Smith, 2003).

Although other organisations often render services that improve the well-being of individuals, religious institutions are common and pervasive in society. Other empirical findings have demonstrated that positive well-being which is often attributed to higher levels of religiosity is also noted to go beyond the benefits of other resources, including access to social network and

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support, marital status and income alone (Koenig & Larson, 2001). This positive effect probably happens as a direct result of religious sentiments and practices which are connected to optimism, thereby promoting hope in adherents. Through religious practices, individuals learn to concentrate on caring for others' needs, forgiving others, demonstrating kindness and generosity towards others. These may lead to distracting people from their personal problems thereby promoting positive psychological outcomes. Religion also engenders social ties and connections which goes beyond family relationships to a large extent and plays a supporting role in times of stress and hardship (Chokkanathan, 2013; Koenig & Larson, 2001).

Although this theory provides a conceptual basis for understanding how religion relates to human behavior, it does not emphasize on how individual psychological factors could possibly have an influence on this relationship.

### *Social Cognitive Theory (SCT)*

Individuals are viewed as agents of experiences rather than just undergoers of experiences. The various sensory, motor, and cerebral systems are recognized as tools which individuals use to accomplish diverse tasks and goals which eventually give meaning, direction, and satisfaction to their lives and it is seen as central and basic to existence (Bandura 2001). Self-efficacy constitutes one aspect of the social cognitive theory and it has underlying relevance towards the subject matter of well-being and quality of life. The relationship between social structures and personal influences is adequately expounded by the social cognitive theory. In essence, human behavior is determined by individual belief systems within the broader social milieu.

General self-efficacy is universal, trait-like and inherent in all individuals and it is cross-cultural in scope. It has however emerged that persons with individualistic cultural orientations have a greater sense of efficacy and perform optimally under individually oriented systems, whereas

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individuals from collectivistic cultural backgrounds deem themselves most efficacious under group-oriented systems (Drake-Brassfield, 2008). Although the concept of self-efficacy is applicable across various cultural contexts, the role of context specific culture and tradition cannot be underestimated when it comes to characteristics of positive human experiences (Keyes et al., 2008). The SCT and its construct, self-efficacy has often been reported in studies involving physical and functional activities (e.g. Rejeski et al., 2001; Paluska & Schwenk, 2000). Self-efficacy beliefs form part of the determinants of how people behave, think and motivate themselves (Bandura, 2011). Studying the relationship between general self-efficacy beliefs and positive mental health of older adults is therefore important. Additionally, religious and spiritual commitments can culminate in the development of self-efficacy. Religious and spiritual practices to a large extent, could build individuals' aspiration, competencies and motivation through social and extensive modeling.

This social construct has however been criticized by Kwate (2005) as Eurocentric in scope within the wider African setting. Despite the lingering debate about the appropriateness and applicability of the social cognitive theory in the African sociocultural milieu, Drake-Brassfield (2008) contends that empirical evidence of its strengths far exceeds its negative outcomes. As a result, its adoption and use within the African context is in the right direction.

### ***Gerotranscendence Theory***

Gerotranscendence theory is a developmental theory that centers on positive aging propounded by Tornstam (1989, 2005) to address the limitations of other foremost and leading developmental theories of aging. This theory asserts that older adults maintain relationships that are meaningful and relevant to their existence. It is "a shift in meta-perspective from a material and rational vision to a more cosmic and transcendent one, usually followed by an increase in life

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satisfaction” Tornstam (1989, p.60). Contrary to the widely held assumption that older adults are generally lonely and disengaged, the theory of gerotranscendence argues that old age is a period where older adults tend to experience high levels of life satisfaction. Tornstam argued that even though the aging process is normally characterized by loss of social relationships and networks, it does not necessarily result in loneliness and disengagement.

Erikson’s (1982, 1986) psychosocial stages of development serves as the main empirical basis for the theory of gerotranscendence. It elaborates that there exists another stage in the human developmental lifespan which is characterized by a shift in perspective from materialism and pragmatism to a more transcendent and cosmic view of life. According to Tornstam (2005, p. 144), “... gerotranscendence implies a transcendental shift in metaperspective. This shift seems to be gradual, starting in early adulthood and normally reaching its peak in old age.” White (2015) asserted that the theory of gerotranscendence is embedded with the potential to have a positive influence on the ageing experience as well as care structures for older adults. In this regard, it has been proven to be a viable and coherent developmental framework of ageing that invariably correlates with satisfaction with life and positive construal of mental health.

A study by Buchanan, Lai and Ebel (2015), lent credence to the notion that a subset of gerotranscendent behaviors are likely to be perceived and interpreted differently by younger people and older people who engage in it. Consequently, its fundamental principles of positive attitude and pragmatism do not only influence behaviour, but also engender care structures.

In Ghana and other African societies, old age and periods of gerotranscendence is often conceptualized as wisdom and maturity. To this end, the elderly are normally assigned special roles in social functions and are often consulted for ideas in difficult moments. These duties and

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responsibilities invariably enable them to be actively engaged with society and family thereby providing them with support for successful aging (Apt, 2002; Dosu, 2014).

This theory has served as an instrumental framework for nursing care for the elderly since its inception and has also promoted positive ageing to a large extent. It helps in understanding behavior that comes along with the normal ageing process, viewing it from the right perspective and not from a pathological viewpoint. This theory has been studied and extensively applied across cultures. The focus of this theory is more at the micro or individual level rather than the broader macro level which includes socio-demographic factors. This however contradicts the assertion by Rajani and Jawaid (2015) that older adults often get involved in altruistic activities which eventually contributes to their healing and increased self-worth. These altruistic activities also serve as relevant pathways in transcending their worries and concerns which come along with ageing, consequently leading to life satisfaction.

### **Review of Related Studies**

In search of empirical evidence to establish the relationships among the various variables in this study, several studies were found with varying outcomes. Depending on the objective of this study as well as the methodological approach that was adopted in the various studies, those that are relevant have been selected and reviewed. Review of related studies is divided into sections as follows;

#### ***Religiosity, Spirituality and Mental Health***

Ellison and Fan (2008) conducted a study among adults in the United States to determine the link between daily spiritual experiences and mental health. In the process, multiple dimensions

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of psychological well-being which included happiness, excitement with life, satisfaction with life and optimism about the future were measured. The results indicated that daily spiritual experiences had a robust positive relationship with the variables that captured psychological well-being. In contrast, daily spiritual experience was detected to have a little bearing on negative affect and psychological distress.

In a related study, Lawler-Row and Elliot (2009) investigated the role of religious activity and spirituality in the health and well-being of U.S older adults. Participants completed religiosity, spirituality and health questionnaires aside measures of social support and healthy behaviors which were considered as mediator variables. Regression analyses revealed that spiritual wellbeing and prayer predicted variables of psychological wellbeing and subjective well-being. Additionally, spiritual wellbeing and prayers had significant negative relationship with physical symptoms and depressive symptoms. Although social support and healthy behaviors served as mediators in the existential-health effects, it did so only partially.

In a similar study, Greenfield, Vaillant, and Marks (2009) adopted a multidimensional approach that systematically delineated how religion and spirituality contribute to different aspects of psychological well-being. Personal growth, purpose in life, self-acceptance, positive relations with other, environmental mastery and autonomy constituted the different dimensions of psychological well-being in the study. They emphasized that although religiosity and spirituality are related, they are distinct concepts. The emerging findings indicated that organized religiosity and spirituality had different effects on all the measures of psychological well-being in the study. Spirituality however predicted psychological well-being better than religiosity per the outcome of the study (Greenfield, Vaillant & Marks, 2009).

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Leondari and Gialamas (2009) carried out a quantitative cross-sectional survey on Greek orthodox Christians to find out the relationship between religiosity and psychological well-being. The participants comprised of 83 men and 280 women who were between the ages of 18 and 48. Religiosity was conceptualized as church attendance, frequency of prayer and belief salience. Additionally, one item was used to tap the dimension of beliefs about God. Depression, anxiety, loneliness, and general life satisfaction served as dependent variables in the study because they were thought to represent important dimensions of psychological well-being. The preliminary findings established that women were more religious than men. In line with what Ellison & Fan, 2008; Lawler-Row & Elliot, 2009 established, the study also established that church attendance and belief salience were associated with better life satisfaction. A positive association between anxiety and frequency of personal prayer was also detected through hierarchical regression in the study although no significant relationship was observed between faith in God and psychological well-being dimensions. Overall, the study revealed that, the hypothesis that religiosity and psychological well-being are positively related was not fully supported.

Harvey and Silverman (2007) conducted an in-depth interview among a sample of 88 older adults in Allegheny County in Pennsylvania. The aim of the study was to find out how older adults employ the use of spirituality in coping with chronic health conditions as well as the racial disparities in the use of spirituality. The study was longitudinal that lasted for four years. In-depth interviews and thematic content analysis were done in the process. The results revealed that racial disparities existed in the use of spirituality when it comes to self-management of chronic health conditions. For instance, White American older adults were identified to be more likely to adopt healthy eating habits as a result of spirituality and develop faith in God than African American older adults. On the other hand, African American older adults indicated more

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readily than their White counterparts that God is their healer and enabler in addition to the greater combined use of spiritual practices and medicine. The findings indicate that spirituality is very integral in chronic disease self-management among older adults.

In order to explore potential pathways that lead to meaning in life among adults who are seeking treatment, Bamonti, Lombardi, Duberstein, King, and Van Orden (2016) ascertained whether spirituality moderates the relationship between depression symptom severity and meaning in life. The study which was cross-sectional recruited 55 older adults who were 60 years or older. Self-report questionnaires assessed depression symptom severity through the Patient Health Questionnaire-9. Spirituality was measured with the Spirituality Transcendence Index, and meaning in life was assessed using the Meaning in Life subscale of the Geriatric Suicide Ideation Scale. The study revealed a significant negative association between depression symptom severity and meaning in life at lower levels of spirituality. This was however not the case for higher levels of spirituality. The findings of the study implied that in the presence of elevated depressive symptomatology, older adults who reported high levels of spirituality also had higher levels of meaning in life. The findings also indicated that the assessment of older adult's spirituality has the potential of unveiling ways that spiritual beliefs and practices can be incorporated into therapeutic frameworks in order to enhance meaning in life.

A study by Chokkanathan (2013) among older adults in Chennai, India examined the relationship that is inherent among religiosity, social support, mastery and psychological distress. In the process, 321 older adults who were predominantly Hindus were sampled and interviewed individually. The study was centered on Smith's theory of religious effects. The results indicated that the relationship between religiosity and psychological well-being is mediated by psychosocial resources (social support and mastery).

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In a multidimensional study to investigate religious involvement and psychological well-being among urban elderly African Americans, Frazier, Mintz and Mobley (2005) sampled eighty-six participants who completed multidimensional measures of religious involvement and psychological wellbeing. After a correlation analysis was done, the results pointed out that the various dimensions of religious involvement which include organizational, nonorganizational, and subjective were linked with the dimensions of psychological well-being. The dimensions of psychological well-being included positive relations with others, self-acceptance, environmental mastery, purpose in life and personal growth. This study outlined the saliency of religious involvement and commitment among the older adult population with African background and recommended that counselors should refine their knowledge base about religion and health.

A study by Wallace and Bergeman (2002) examined older African Americans' religiosity and spirituality. It adopted the life story approach in which the participants aged between 58 and 88 years. They narrated their personal experiences to the researchers in tape recorded interviews. This approach was used with the aim of identifying individual factors that promoted positive outcomes in the face of adversity. A thematic analysis revealed that the major thematic preoccupation of the study was religiosity and spirituality. They served as important buffer mechanisms for the participants (older adults) in moments of distress and adversity thereby fostering positive outcomes. Religiosity and spirituality were observed to be strong indicators that fostered a sense of self, community belongingness and feeling of social support. The study argued that, among people with African origin, religiosity and spirituality serve as an essential coping mechanism throughout the lifespan.

Similarly, Skarupski, Fitchett, Evans and Mendes de Leon (2013) conducted a study among 6864 older American adults aged 65 years and above who were participants in the Chicago health and

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aging project. They examined the disparities between the African and White race in spiritual experiences and satisfaction with life. The results revealed that African American elderly reported lower life satisfaction than the White American elderly. However, spiritual experiences were associated more positively with life satisfaction among African American older adults than their White counterparts. This study indicates that aside worship experience in the context of religion, spiritual experiences are important resources which contribute to life satisfaction especially among African Americans. It also implies that older adults who report low on life satisfaction and well-being may be struggling with their religious and spiritual commitments.

Cohen and Koenig (2004) have however reported that although religiosity might be related to health outcomes, this relationship could either be negative or positive. This they argued is contingent on the forms of religion. The empirical review highlighted that religion could be linked to a number of positive emotions but on the other hand, it has the tendency of causing neurotic and adverse mental health behaviors among its adherents. These behaviors may present in either clinical or non-clinical symptoms. For instance delusions, obsessive compulsive disorder (OCD) and rigid fundamentalism in thought patterns are some of the possible negative consequences of religiosity (Cohen & Koenig, 2004). Invariably, the presence of any of these mental disorders does not promote positive mental health since anxiety has been found to be inversely related to psychological well-being and life satisfaction (Bamonti et al., 2016).

In an African related study, Hamren, Chungkham and Hyde (2014) examined the factors that predicted quality of life among Ethiopian older adults. Two hundred and fourteen adult participants aged 55 years and over were sampled and assessed on measures of religiosity/spirituality, quality of life and social support. The analyses indicated that quality of life is positively related to both social support and religiosity/spirituality. In conceptualizing the

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quality of life and well-being of the African elderly, little attention has been given to it by researchers. The outcome of this study however posits that religiosity and spirituality as well as social support could serve as important buffers against loneliness and deprivation which are quite prevalent among older Africans on the continent. To this end, relief organizations in Africa who are set out to help the elderly must adopt a strategy of working with religious bodies and informal social networks in order to engender holistic interventions.

Aukst-Margetic and Margetic (2005) conducted an empirical review of existing literature on the link between religiosity outcomes related to health and the results do not unanimously indicate a significant relationship between the two. Whiles majority of the studies conducted in this field indicate a significant positive relationship between religiosity and health outcomes, others also reveal no relationship at all or a significant negative relationship. They therefore concluded that studies that are targeted at exploring religion and health related variables ought to control for factors that has to do with health, socio-demography and socio-cultural issues.

Findings from a study conducted by Waite (2017) among Kenyans in Minnesota however indicate contrary outcomes. The study was aimed at examining whether a significant relationship does exist between self-reported measures of religiosity and depression among 63 participants. The results depicted that there was no significant correlation between religiosity and depression among the marginalized population.

Pokimica, Addai and Takyi, (2017) in Ghana used data from the 2008 Afro barometer survey of Ghana to examine the relationship between religion and mental health. They examined how different religious groups experience subjective well-being. Using a nationally representative

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sample of 1200 adult population, the results of the study indicated that religious affiliation has a significant association to both absolute subjective well-being and relative subjective well-being. The results revealed that the None/Traditional religious group had less favorable subjective well-being as compared to other Christians. Also, Evangelical/Pentecostal, and Muslim groups were found to have more absolute subjective well-being while the None/Traditional group were found to have significantly less favorable relative subjective well-being than Protestant groups.

The study underscored the important role religion and religiosity plays in the experience of subjective well-being among a Ghanaian population. The final outcome indicated that religious groups that viewed religion as very essential had more favorable experiences of the two types of subjective well-being than the group that did not consider religion as important at all or not very important.

### *Age related differences in Spiritual Transcendence.*

An empirical review of existing literature between 1985 and 2003 was carried out by Dalby (2006) to ascertain whether the ageing process is characterized by spiritual change and development. In the process 13 studies were subjected to critical review within the framework of Tornstam's theory of gerotranscendence. Whiles the review depicted that certain components of spirituality do not change in old age, it also underscored the occurrence of certain identifiable changes in relation to spirituality and old age. For instance, a number of studies in this review indicate that ageing related changes come along with particular spiritual needs and tasks. The study also highlights the point that spiritual and gerotranscendental experiences cannot be effectively examined outside the context of culture and individual psychological variables.

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A longitudinal study carried out by Wink and Dillon (2002) examined spiritual development across the adult lifespan. Participants in this study comprised of 130 people (67 females and 63 males) who were part of intergenerational studies, an initiative of the Institute of Human Development (IHD) of the University of California. The participants in the study had undergone four different interviews and assessments at the early adulthood, middle adulthood, late middle adulthood and older adulthood stages in relation to spirituality, religiosity and personality indicators. The outcome of the analysis indicated that there was a significant increase in spirituality especially from middle late to older adulthood. Scores on the measure of religiosity in early adulthood were found to predict spirituality in older adulthood. This indicates the dynamic relationship between ageing and spirituality.

Gupta and Chadha (2013) conducted a study to investigate the impact of gender and age differences on spirituality among three different age-cohorts in India. This study was an attempt to understand the demographic factors that underpin spirituality throughout the human developmental milestone. One hundred and seventy one participants who were involved in the study were classified based on middle age (40-45 years), young old (60-65 years) and oldest old (80 years and above). Subsequently, the participants' spirituality was assessed using the Daily Spiritual Experience Scale. A consistent increase in spirituality was observed with increasing age as revealed by the results. This gives an indication that as individuals grow older their spiritual experiences also increases alongside. Gender difference was also observed in spirituality with females experiencing higher levels.

Levin and Taylor (1997) have earlier established similar findings in a study that was aimed at determining the frequency of prayer with regard to age differences. The participants were drawn from the U.S General Social Survey and subsequently categorized according to the following

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four different age cohorts; 18-30 years, 31-40years, 41-60years and  $\geq 61$  years. The ensuing results from the analyses indicated that although prayer is a routine practice among all the age cohorts, the successively older cohorts reported more frequency in prayer.

### ***General Self-Efficacy and Mental Health***

According to Fry and Debats (2002), previous studies had investigated how socio-demographic factors including social support, and physical health serve as predictor models of loneliness and adverse psychological outcomes among older adults who have varying health conditions. Their study was conducted among 141 women and 101 men between the ages of 65 and 86 living in Southern Alberta. The study was however, based on the main hypothesis that self-efficacy beliefs of older adults significantly predicts loneliness and psychological distress more than the previously studied demographics, social support, and physical health variables. Eight different domains of perceived self-efficacy were assessed using standardized self-report measures. It emerged from the results that the superiority of the self-efficacy variables over other variables when it comes to predicting loneliness and psychological distress was indeed the case. Although gender-specific variations were observed in the various domains of self-efficacy, spiritual self-efficacy was seen to be the most potent predictor, contributing to the biggest percentage of explained variance in loneliness and psychological distress. This study has obvious implications for clinicians and geriatric practitioners across disciplines in the sense that targeted interventions must be put in place to boost the self-efficacy .of older adults in order to realize optimum health outcomes.

Bowling and Iliffe (2011) carried out a longitudinal study on the approach to successful ageing among British adults. The study was anchored by the factors and approaches that underpin successful ageing which include the biological, psychological or social factors. The study was to

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ascertain which of the approaches to successful ageing assessed at baseline predicted quality of life after 7 years. The results indicated that only perceived self-efficacy and optimism which constituted the psychological factor was significantly associated to successful ageing. The ensuing results underscore the need not to only focus on the biomedical approach when it comes to conceptualizing successful ageing. This makes the institution of intervention programs that will focus on developing the individual psychological resources of older adults throughout the life course very important.

Informed by converging evidence that depressive symptoms in older adulthood is predicted by personality traits, Shea., Dotson and Fieo (2016) explored perceptions of aging and self-efficacy as potential individual differences that could mediate such a relationship. As predicted, all the five personality traits were observed to be significant indicators of depressive symptomatology in varying degrees. Aging perceptions and self-efficacy both mediated the relationship between personality traits and depressive symptoms. Aging perception and self-efficacy are therefore important constructs that must be taken into consideration when explaining depression among older adults aside personality traits.

In a similar study, Ferguson and Goodwin (2010) explored how social support and perceived control could serve as mediating factors in the relationship between optimism and well-being among community dwelling older adults. The study determined whether promoting positive constructs are related to well-being in older adults. They reported that optimism emerged as a significant predictor of both subjective and psychological well-being. Social support was identified as a mediator of this relationship but perceived control was not. On the other hand, having support from significant others be it family or friends has been identified as a potential pathway to improved self-efficacy and perceived control. This study broadly underscores the

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opinion that varied psychosocial factors determine both subjective and psychological well-being among older adults.

Cheung and Sun, (2000) examined the separate influence of self-efficacy and social support on the mental health and well-being of members of a mutual-aid organization in Hong Kong. Sixty five (65) people who had adverse mental health problems and had accessed cognitive-behavioral treatment participated in the study and it was revealed that residual forms of self-efficacy were the strongest indicator of mental health.

Singh, Shukla and Singh (2011) carried out a similar study that corroborates the findings of Cheung and Sun, (2000). The study examined the relationship between perceived self-efficacy and mental health of 160 elderly Indians. Perceived self-efficacy was identified as an important predictor of mental health. Older adults who perceive themselves self-efficacious tend to have control over their environment and report better mental health. The results of the study indicated that the problems faced by the elderly population are emerging not only as a result of their increasing proportion of age but also as a result of their own faulty cognitions, perception and interpretation of ageing.

Based on the concept that the sense of mastery could serve as buffer against psychological distress in older adulthood, Morin and Midlarsky (2016) carried out a cross-sectional study of 311 White American and African American older adults between the ages of 65 and 94 years. For both racial groups, it was detected that high sense of mastery has a significant relationship with lower psychological distress. This indicates the beneficial and guarding effect of high mastery or efficacy against psychological distress in older adulthood.

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Schönfeld, Preusser and Margraf (2017) have however examined the costs and benefits of self-efficacy in the context of different stress responses. The study was a systematic review of existing literature on how self-efficacy influences mental health and performance. Individual differences in the perception of one's self-efficacy was deemed important and influential in terms of peripheral physiological reactions, effective performance, and mental health. It was however noted that self-efficacy is not uniformly beneficial but rather, higher levels of self-efficacy can sometimes result in a phenomenon of increased neuroendocrine and psychological stress responses and decreased performance. This finding has not been extensively explored in empirical literature. The implication of the study is that high levels self-efficacy is not always beneficial to mental health. As such, therapeutic interventions do not always have to focus on enhancing self-efficacy since it might result in detrimental and disadvantageous health outcomes.

In order to explore whether general self-efficacy would moderate the relationship between stress and positive mental health, Setswana participants from a South African context were used by Redelinghuys (2010) in a cross-sectional study with the background that, the African socio-cultural milieu is most often said to be more collectivistic and also accompanied by social harmony and interdependence. It was observed after the final analysis that, higher levels of self-efficacy are of important benefits to the well-being of people within the African context. General self-efficacy also moderated the relationship between stress and mental well-being among the study participants.

Similarly, Melato, Eeden, Rothmann and Bothma (2017) studied the relationship between coping self-efficacy and psychosocial well-being among marginalized youths of South Africa. Seven hundred and ninety four (794) black South Africans who had no access to education and decent livelihood were the participants in the study. They completed questionnaires comprising coping

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self-efficacy and measures of well-being. The ensuing results indicated that apart from their social well-being, their psychological and emotional well-being was positively and significantly predicted by coping self-efficacy.

A study conducted by Onuoha and Bada (2016) in Nigeria however report contrary findings. They examined how the psychological well-being of flood survivors in Nigeria could be predicted by psychosocial and demographic variables including gender, age, spirituality and self-efficacy. Three hundred and forty nine participants between the ages of 20 and 54 years were sampled from Southwestern Nigeria for the study. All the independent variables were found to have an influence on the psychological well-being of the participants. It was however realized that unlike spirituality, self-efficacy, gender and age did not significantly predict psychological well-being. Although this finding does not corroborate with studies regarding self-efficacy and mental health, it provides insights into understanding how disaster victims appraise their capabilities in domains relating to their mental health.

### ***Social Support and Mental Health***

A study by Adams and Blieszner (1995) revealed that as people grow older, their relational ties with respect to friendship and family relationships enhances significantly. This heterogeneity in social relationships help older adults to easily benefit from support be it emotional, financial or instrumental. Having a lot of friendship and family ties in older adulthood has been identified as a healthy pathway for psychological and social adjustment. Highlighting the dimensions of personal relationships, the study indicated that older adults may find a particular relationship as either detrimental or beneficial depending on the exigencies and situational demands hence the importance of diverse types of relationships. The study highlights the need for interventions that are aimed at developing the interpersonal skills of older adults to be initiated and engendered so

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as to promote positive ageing in different contexts. This study was purely an empirical review and did not directly sample the views and perceptions of older adults in any form.

A meta-analysis was conducted by Wrzus, Hanel, Wagner and Neyer (2013) to examine the changes in social networks throughout the human lifespan. The study was an empirical review of existing literature between 2008 and 2009 and subsequently updated in 2012. Consistent findings from the study revealed that although social network increases until the stage of young adulthood, it declines steadily going into older adulthood. Friendship network and personal network were also found to decline steadily throughout older adulthood although the size of family network remains relatively stable from adolescence till old age. Family ties were observed to be the same among countries with variations in collectivistic values. Global and personal network typologies were also observed to be more prevalent among countries with individualistic values. Network changes were also observed as a recurring trend not only within the context of age, but also in instances of life events such as job entry, widowhood and transition to parenthood.

A recent study by Stokes and Moorman (2017) corroborates the evidence that social network ties of older adults grow narrower with increasing age as a result of intentional selection and involuntary loss. As a result, they sought to investigate the influence social network had on older adults' mental health. Specifically, how depressive symptomatology is caused by the relational network with family and friends. Participants in the study were community dwelling older adults in the United States who participated in the National Social Life, Health, and Aging Project. A total of 3,377 were sampled for the study. It emerged from the findings that being in a married relationship is a protective factor against depressive symptoms. Perceived friend and family support were also observed to have significant negative relationship with depressive

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symptomatology. Aside quality marital relationships, family and friends social support network were identified as critically essential buffers against depressive symptoms.

Litwin and Shiovitz-Ezra (2010) studied a sample of older Americans to ascertain how social network types are linked to different indicators of their subjective well-being. Five types of social networks which has been identified to be; “restricted”, “family”, “congregant”, “diverse” and “friend” were systematically explored. These social network typologies were found to be associated with the various indicators of well-being after demographic variables and health confounders were controlled. This study presents an overarching concept for professionals in the field gerontology in the sense that the interpersonal issues of older adults in relation to their well-being are multifaceted. Social network assessment is therefore a potential pathway towards engendering improved mental health among older adults. Similar findings also emerged from a study by Fiori, Antonucci and Cortina (2006).

In a related study, Cheng, Lee, Chan, Leung and Lee (2009) examined the types of social networks that existed among a cohort of Chinese older adults in Hong Kong numbering 1,005. This was studied in relation to their subjective well-being. Empirical evidence suggests that the extended family constitutes the basic social unit in most traditional societies in China as a result; family relations serve as a very important support system for Chinese irrespective of age. In this regard, the study also aimed at examining the contributions of extended family members to social support among the participants. Participants in the study comprised of older adults who were married, divorce, separated or widowed and they were interviewed either at a social center or at home individually. The results indicated that five network types comprising of distant family, friend focused, family focused, diverse and restricted were present. It was also observed that family-focused network and diverse network contributed more to well-being than the rest.

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The importance of the extended family in support provision for the elderly is evident from the findings of this study and the contribution of such support to well-being and mental health cannot be underestimated. This study has a collectivistic orientation, making it relevant to the Ghanaian context. However, it did not highlight the agency of the individual and how individual psychosocial factors could also contribute to mental health and well-being within the context of the available support systems.

Schwartz and Litwin (2017) also conducted a study among older European adults with the aim of establishing whether or not a reciprocal relationship between social network and mental health does exist. The study was also to determine whether changes in social connectedness are predicted by mental health. Data for the study was drawn from an analytic sample of the Survey of Health, Aging and Retirement in Europe (SHARE). A total of 14, 706 older adults aged 65 years and above from 14 countries constituted the sample for this cross-national study. The analysis confirmed that a reciprocal association existed between social connectedness and mental health. Baseline social connectedness contributed positively to mental health just as initial mental status contributed to social network ties. Although no gender difference was found in regard to this reciprocal association, the findings from this study indicated that relatively, mental health contributed to observed changes in social network ties more than how corresponding social network ties contributed to mental health. The results of this study indicate that there exists a dynamic interrelationship between social support and mental health, highlighting the importance of understanding the nature of this relationship in any given context.

A study by Fuller-Iglesias (2015) was towards getting more insights into this dynamic relationship. The study examined the mediating role of relationship satisfaction on social ties and psychological well-being in late life. The finding indicated that relationship satisfaction has a full

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mediation effect on this relationship. This study highlights the point that although the social network ties of older adults is an essential determinant of psychological well-being; relationship satisfaction and other psychosocial constructs is important pathway that cannot be overlooked in the association.

Another study by Thomas (2010) underscores the effects of different network types on the well-being of older adults in relation to different dimensions of either giving or receiving social support. The study was conducted on the premise of secondary data set gathered from the Social Networks in Adult life (SNAI) survey in the United States which consisted of 718 adults aged 50 years and above. The size, impact and types of social support networks on well-being were assessed among the sample of older adults. The results indicated that older adults' well-being is positively influenced when they provide support to others. It was also observed that apart from support received from spouses and siblings, support received from other sources did not have significant positive influence on well-being. The study which was based on the identity theory established that when older adults offer social support, it is better for their well-being than when they receive same from others.

A study by Chatters, Taylor and Nicklett (2018) to determine the factors that account for older adults' social isolation from friends and family, sociodemographic variables including the educational level of the participants did not relate significantly with social isolation from friends or family. The study which involved 1321 ethnically and racially diverse older Americans had objective social isolation as the main dependent variable and sociodemographic variables (age, gender, education, family income, household status, ethnicity and marital status) as the independent variables. It was observed that unlike family income, educational level is not significantly associated with reported isolation either from friends or family.

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Similarly, Cornwell, Laumann and Schumm (2008) came out with findings that suggest that social connectedness among older adults is largely contingent on life course-factors and contrary to the widely held view that old age leads to social isolation; they established that old age has positive influences on social connectedness. Data from the National Social Life, Health, and Aging Project (NSHAP) entailing American older adults between 57 and 88 years was used. They found out from the analysis that age is negatively related to the size of support and network but is positively related to the tendency to socialize and connect. According to the study, the difference in various forms of connectedness could be explained by the divergent effects of life-course factors. A significant finding in this study is that social connectedness is greater among non-retirees, women, the Black and Hispanic race as well as individuals with less education.

In a similar study among U.S older adults between the ages of 40 and 93 years, Ajrouch, Blandon, and Antonucci (2005) hypothesized that higher level of education would have a greater association with personal social networks, higher proportion of friends as well as frequent contacts. The results indicated that respondents who reported higher levels of education also reported larger social connections and networks. Those with lower levels of education however reported more closeness and proximity to their social connections. Frequency of network connections and proportion of companions in the network was however not tied to education level.

### *Social Support in Ghanaian context*

A study by Aboderin (2004) was to unfold the reasons underpinning the decline in material family support among older adults dwelling in urban Ghana. The decline in material support invariably affects all aspects of well-being and existential happiness. This study was necessitated by increasing incidence of poverty and destitution among the elderly in Ghana at the time. With

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specific focus on older adults living in a socioeconomically diverse area of Accra, the study was based on an interpretive grounded approach using 51 participants. The findings from this study reveal that the basis for the dwindling material support to the elderly is as a result of changing material circumstances and ideas. This is because the younger generation lacks adequate resources to cater for the needs of relating older adults and this has been entrenched by modern technological and lifestyle demands. The idea of reciprocating same treatment meted out by parents was also found to be ingrained in the mentality of younger generation hence the consequence. This indicates that, it is no longer a definite norm that older adults are being supported by their family relations who are younger rather, the popular notion of self-reliance persists in this generation.

Another study by Dosu (2014) within the Ghanaian context had the aim of defining the scope of support received by older adults. This qualitative enquiry was also examined the perception of younger people in regard to aging related issues. It was identified that support from family ties constitute the major form of social support received by older adults in Ghana. The findings from the study indicated that although older adults face psychological and functional limitations, they are often engaged by their immediate family and society as advisors. Additional findings revealed that they have supportive relationships in church and religious settings which enhance their spirituality. On the other hand, they do not have the sense that there is support and respect in the social milieu they find themselves in. This study underscores the importance of family support for the elderly in the Ghanaian sociocultural milieu. Nukunya (2003) established a point in this regard that, the Ghanaian family system engenders economic co-operation, socialization and procreation.

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Apt (2002) have also reviewed how social support and security systems function in developing countries. She contends that rapid modernization, migration and poverty has contributed to the precarious situation most elderly Africans find themselves in because normal family support and care structures has been weakened. This situation has left many older adults in developing countries to face social and communal exclusion. More women than men have been identified to be vulnerable in this regard. In light of this glaring evidence, an advocate for a reorientation of social support intervention programs has been proposed. This is to inure to the benefit of the elderly who are marginalized in our societies.

Atefoe and Kugbey (2014) conducted a study to examine the relationship between social relationships and psychological well-being among Ghanaian women. Two hundred (200) women in Accra with diverse socio-economic orientations were the participants in this study. The results revealed that, perceived social support and psychological well-being had no significant relationship. On the other hand, social negativity and psychological well-being were found to be negatively related.

### ***Spirituality and General Self-Efficacy***

Although extensive studies have not been conducted on the relationship between spiritual transcendence and self-efficacy, the little available empirical evidence in relation to similar studies consistently indicates that there exists a relationship between them. Although religiosity and spirituality reduces distress, it does not enhance sense of mastery or individual psychological potency (Ellison, 2001). The thaumaturgical components that come along with religious practices including spiritual transcendence and beliefs have however been suggested to be helpful in resolving the challenges of daily life (Schieman, Nguyen and Elliott, 2003).

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Schieman, Nguyen and Elliott (2003) studied how the self-concept of sense of mastery is related to religiosity/spirituality among adults in Toronto. The study which was a cross-sectional survey revealed that respondents who reported high on religiosity and spiritual outcomes had lower sense of mastery. High income and educational levels were found to influence this relationship positively.

Similarly, Schieman (2008) carried out a study with data on a nationally representative sample of U.S based adults. They ascertained the role of religion in sense of personal control. The outcome of the study supports the relinquished control theory over the personal empowerment theory in the sense that, high levels of religious related activities contributed significantly to lower levels of self-efficacy or personal control.

McCullough and Willoughby (2009) adopted Carver and Scheier's (1998) self-regulation theory in an empirical review to explain the association between religious activity and the self-concepts of self-control and self-regulation. Most of the studies reviewed were carried out in North America. The authors contend that religious activities have a positive relationship with self-control and other self-concepts that relate to social behavior. This empirical review highlights 6 main thematic areas in literature that goes to support the idea that religious involvement is invariably related to self-concepts and social behavior. These thematic outcomes include: (a) that religious activities have an influence on how goals are selected, followed and organized; (b) that religious beliefs have the ability to engender self-control; (c) that religious oriented behavior promotes the development and strengthening of self-regulation among individuals; (d) that religious beliefs enhances self-monitoring; (e) that religious participation recommends and promotes proficiency when it comes to the pursuit of behaviors in relation to self-regulation; and (f) that the influences religious activities have on social behavior, well-being and health may be

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due to its influence on self-regulation and self-control. Although more empirical scrutiny is essentially lacking in this direction of spiritual activity and self-regulation, this study presents with a theoretical foundations that warrants further studies.

Schieman, Pudrovska and Milkie (2005) carried out a similar study among older adults who were 65 years and above in the United States. The aim of the study was to ascertain the relationship between the self-concept and perceived divine control among both African Americans and White Americans. Whereas perceived divine control was negatively associated with mastery among the White participants, it was positively associated with mastery and self-esteem among Blacks especially women. This indicates that spiritual transcendence or sense of divine control is of greater benefit to self-concepts among Africans more than Whites. Socio-economic status was controlled in these analyses.

Following Mbiti's (1969) framework that health and well-being in Africa is viewed and interpreted with supernatural and religious lens, van Dyk and van Dyk (2015) conducted a study among Black South Africans. The aim was to investigate the religious coping strategies adopted by South Africans and the extent to which they attribute health conditions to the supernatural and spiritual factors instead of other factors. Five hundred and seventy five ethnically diverse South Africans participated in this study by answering structured questionnaires. The outcome of the study indicates that Mbiti's framework is still relevant to the African race in every respect. It emerged that, over 80% of the respondents in the study had the mindset that supernatural and magical forces play a significant role in their disease, health and well-being. About only 16% who were mainly city dwellers and highly educated attributed same to natural causes and individual reasons. This might eventually lead to diminished self-mastery or self-efficacy.

### **Limitations and Gaps in the Studies Reviewed**

Rigorous methodological and procedural approaches including large sample size (e.g. Skarupski et al., 2013; Schwartz & Litwin, 2017; Pokimica et al., 2017) and longitudinal methods (e.g. Bowling & Iliffe, 2011) informed most of the studies reviewed. Most of these empirical studies however do not reflect contextual happenings within the African and Ghanaian socio-cultural milieu although a good number of them are cross-culturally oriented (e.g. Morin & Midlarsky, 2016; Wallace & Bergeman, 2002; Frazier et al., 2005).

Although Religious Sentiments and Spiritual Transcendence are two distinct conceptual variables, their independent relationship with mental health has not been determined by most of the studies reviewed except for the study conducted by Greenfield et al., (2009).

With regards to Social Support, converging evidence from the literature review gives an indication that support from friends and family have different effects on mental health and well-being (e.g. Apt, 2002; Litwin & Shiovitz-Ezra, 2010; Dosu, 2014; Cheng et al., 2009). However, the difference in both Social Support domains in respect to demographic characteristics such as the educational level and gender of older adults remains largely unknown.

Whereas most of the studies reviewed above indicate that a positive relationship exists between the independent variables of: Religious Sentiments, Spiritual Transcendence, General Self-Efficacy, Social Support and Mental Health, some of the studies including Cohen & Koenig, 2004; Schönfeld et al., 2017; Onuoha & Bada, 2016; and Thomas, 2010 report divergent findings. This indicates a probable limitation of these findings when it comes to generalizing it to all older adults and community dwelling older adults within the Ghanaian context in particular.

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The relationship between Spiritual Transcendence and General Self-Efficacy has been reported to be either positive or negative depending on cultural orientation but most of these cross-cultural studies are Western in nature. More studies are however needed within the African context to either corroborate or contest what van Dyk and van Dyk, (2015) found in South Africa. Their study indicates that religious and supernatural coping feature prominently among Black South Africans which in effect leads to a sense of diminished self-responsibility.

There exist some limitations with regards to the studies reviewed which leave an existing gap in literature. This is to the extent that although the population used in most of the studies was healthy older adults, some were also patients or older adults who were chronically ill (e.g. Cheung & Sun, 2000; Harvey & Silverman, 2013). As a result, findings and conclusions from such unhealthy samples does not enhance the understanding of factors that influence the mental health and well-being of community dwelling older adults who are not ill.

### **Rationale for the Study**

Religious Sentiments and Spiritual Transcendence have separately demonstrated to have different effects on Mental Health among older adults in community settings. Most studies reviewed have often focused on religiosity or spirituality and its relationship with mental health outcomes and well-being. Few studies have so far considered how both religiosity and spirituality relates to mental health simultaneously among older adults. The study conducted by Greenfield et al. (2009) addresses this gap to some extent but it was conducted in the United States. The role of context specific culture and tradition can however not be underestimated when it comes to characteristics of positive human experiences (Keyes et al., 2008). Hence a study within the Ghanaian context is imperative.

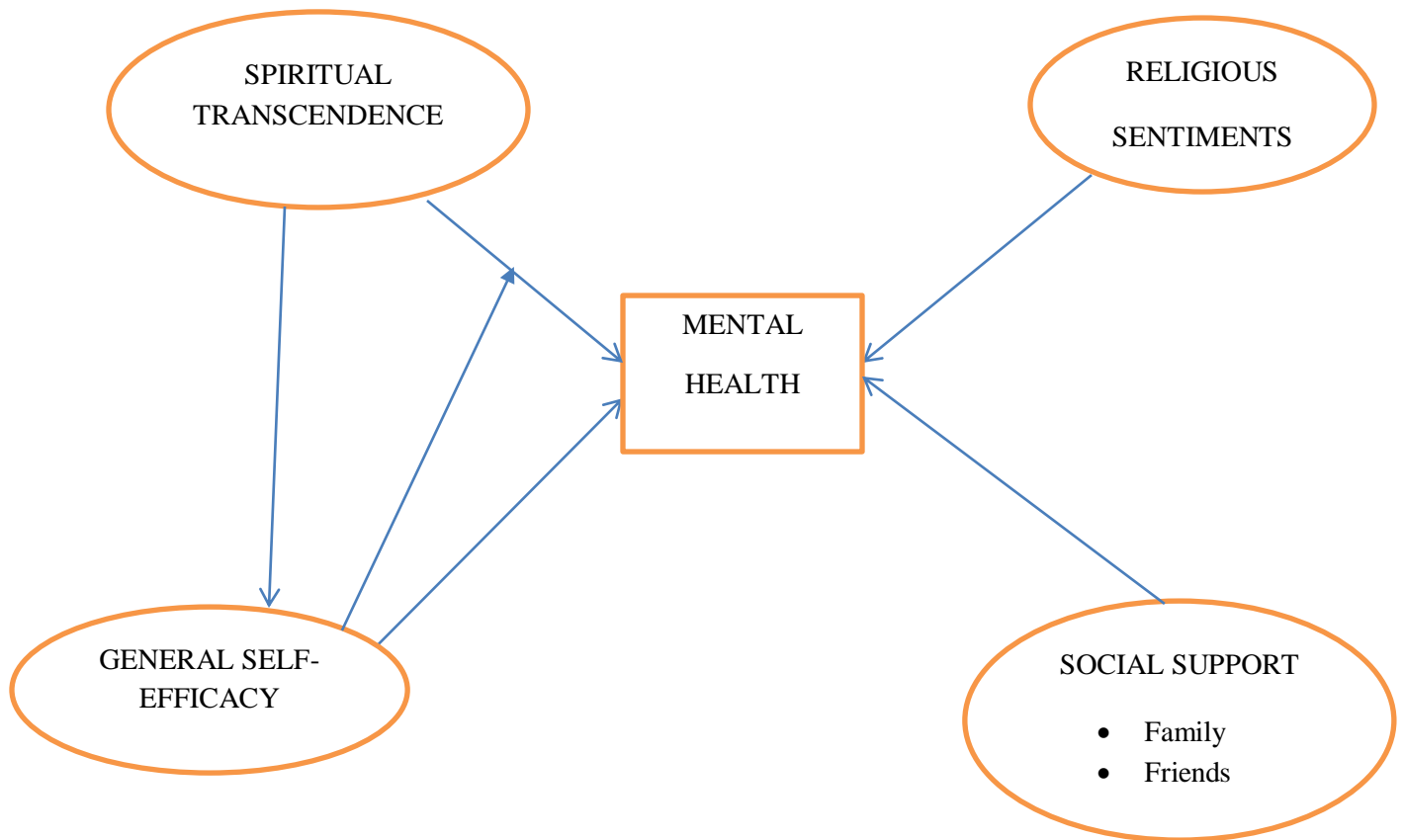
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Additionally, the sample used in Greenfield et al's. (2009) study was not exclusively older adults. Religiosity and Spirituality however has different implications for young individuals and older adults alike (Smith, 2003; Chokkanathan, 2013; Buchanan et al., 2015) hence this study adopts the use of only older adult participants in order to come out with findings that can easily be generalized to older adult populations.

Based on evidence from studies conducted by Apt, (2002) and Dosu, (2014) which points to dwindling psychosocial resources among Ghanaian older adults, how Social Support relates to their Mental Health is worth investigating. More so, the difference in support types based on older adults' socio-demographic characteristics is important to study. This is because Bandura's (2001) social cognitive theory posits that a relationship (positive or negative) exists between social structures and personal individual factors when it comes to behavioral outcomes.

### **Statement of Hypotheses**

1. a.) There will be a significant positive relationship between religious sentiments and mental health.  
b.) There will be a significant positive relationship between spiritual transcendence and mental health.
2. There will be a significant positive relationship between social support domains (family and friends') and mental health.
3. General self-efficacy will positively and significantly be associated with mental health.
4. There will be a significant positive relationship between spiritual transcendence and general self-efficacy.
5. There will be a statistically significant difference in spiritual transcendence between older adults who are in their early 60s and those who are 80 years and above.
6. There will be a statistically significant difference in the dimensions of social support among older adults based on education level and gender differences.
7. General self-efficacy will significantly moderate the relationship between spiritual transcendence and mental health of older adults.



**Figure 1: Proposed Conceptual Framework of the Study**

Figure 1 above depicts the possible influence of Religious Sentiments, Spiritual Transcendence and psychosocial factors (General Self-Efficacy and Social Support) on Mental Health. The aforementioned variables have been proposed to predict Mental Health of community dwelling older adults. The relative effectiveness of two main forms of Social Support in predicting Mental Health was also examined. Additionally, the moderating role of General Self-Efficacy on the relationship between Spiritual Transcendence and Mental Health was tested.

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**Operational Definition:**

**Religious sentiments:** The views and practices in relation to organized religion.

**Spiritual transcendence:** The perceived experience of the sacred and supernatural that affects one's current perspective about life.

**General self-efficacy:** The belief that one can reach his or her goals successfully and solve most problems.

**Mental health:** This entails positive aspects of well-being focusing mainly on the emotional, social and psychological well-being of individuals. This concept has been the main focus of the W.H.O with regard to positive mental health. It has also been engendered to a large extent by Lamers et al. (2011) in the South African context.

**Study Variables:**

**Independent Variables:** Religious sentiments, Spiritual transcendence, Social Support and General Self-Efficacy.

**Dependent Variable:** Mental Health (emotional well-being, social well-being and psychological well-being).

**Demographic Variables:** Gender, Age, Marital Status, Religious background, Level of Education.

## CHAPTER THREE

### METHODOLOGY

#### **Introduction**

This chapter is made up of the research design, setting of the research, the population involved, sample and sampling technique employed the criteria for inclusion and exclusion, research instruments/measures, pilot study of the instruments, and the data collection procedure adopted. Ethical issues, concerns and approval are also addressed as well as the procedure involved in data entry and cleaning. The strategy for the data analysis is also outlined.

#### **Research design**

The study adopted a quantitative research design, using the survey method. Studies involving quantitative methods utilize standardized instruments so as to capture the different views and lived experiences of research participants. This could be fit into standardized response categories to which numbers have been assigned. This then results in numerical data. To this end, Creswell (2014) asserts that “quantitative research is an approach for testing objective theories by examining the relationship among variables. These variables in turn can be measured typically on instruments so that numbered data can be analyzed using statistical procedures”. Ensuing findings of quantitative research designs can therefore be generalized to wider populations. It can also be easily replicated by other researchers. The cross-sectional survey design was regarded appropriate for this study because the research objectives and hypothesis tested in the study explored the relationship between independent variables (religion/spirituality, general self-efficacy and social support) and a dependent variable (mental health). This design made it possible for the researcher to elicit information from community dwelling older adults about their level of religious sentiments/spiritual transcendence, social support, general self-efficacy

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and mental health. This was achieved by making use of appropriately designed questionnaires to collect data from the respondents only once. Purposive and convenient sampling techniques were deemed appropriate, hence adopted for this study. The purposive sampling technique was adopted mainly because the study's objective is premised on a specific subgroup within the population; healthy older adults who were 60 years and older. Participants were also recruited into the study on the basis of their willingness and availability to participate.

### **Research Setting**

HelpAge Ghana zonal centers within the Greater Accra Metropolitan Area constituted the sites of the study. The communities are Osu, James town, Achimota, Abofu and Apenkwa. These communities were chosen because they have a number of resident older adults who come together often to discuss issues pertaining to their well-being. This provided an avenue to get adequate research participants within the available time.

### **Population**

Community dwelling older adults who are aged 60 years and above and are part of HelpAge associations in Osu, James town, Achimota, Abofu and Apenkwa, suburbs of Accra were the target population of interest for this study. This population was chosen because it comprises of people with diverse backgrounds making it more nationally representative than other cities and towns. Accra is highly populated and made up of diverse ethnic groups.

### **Sample size**

A sample size of two hundred and fifty (250) was considered suitable for the study because according to Field (2009), a sample size of 200 is adequate in multiple regression analyses

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involving 20 predictors in order to obtain a medium effect size of .8 while a sample size of 100 is adequate when the predictors are 6 or less.

**Sampling Procedure**

The sample size of two hundred and fifty older adults were drawn mainly from HelpAge Ghana zones within the Accra Metropolitan Assembly (AMA) using convenient sampling technique and purposive sampling technique. Convenient sampling was used to select the communities as well as older adults who were available and willing to participate in the study while the purposive sampling was used in selecting older adults who met the inclusion criteria to participate in the study. This helped in meeting the research objectives and also testing the hypothesis appropriately

**Table 1:**

*Demographic Characteristics of the Older Adults in the Study (N=250)*

Variables		Frequency	Percentage
Gender	Male	118	47.2
	Female	132	52.8
Age	<i>M = 71.12, SD=8.23</i>		
Marital Status	Married	113	45.2
	Divorced	30	12.0
	Widowed	107	42.8
Religion	Christianity	214	85.6
	Islam	30	12.0
	Other	6	2.4
Education Background	No Education	61	24.4
	Primary	126	50.4
	Secondary	39	15.6
	Tertiary	24	9.6

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### **Inclusion Criteria:**

1. Any older adult in the research setting who is 60 years and older.
2. Willingness to participate.
3. No signs of mental illness or cognitive dysfunction.

### **Exclusion Criteria:**

1. Adults below the age of 60 years.
2. Older adults who were 60 years and older but cannot participate in the study because they were too sick to be interviewed.
3. Older adults who declined to participate.

### **Measures**

The variables in the study were measured by using the following questionnaires:

#### **Demographic Questionnaire**

This was used to capture demographic information about the respondents such as age, gender, educational level, religious affiliation, ethnic group and marital status.

#### **Assessment of Spirituality and Religious Sentiments - Short Form (ASPIRES – SF)**

This was also used to measure religiosity/spirituality among the study participants. This instrument was developed by Piedmont (2012). Research has shown that spiritual transcendence and religious sentiments differentially predict outcomes as a result, the instrument is designed to measure two main domains. These are the religious sentiments domain and the spiritual transcendence domain (Piedmont, 2012). It is utilized across faiths and denominations and has acceptable psychometric properties. It is rated high when it comes to its level of internal consistency. The spiritual transcendence domain and the religious sentiments domain of the self-

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report measure is reported to have an alpha coefficient of 0.89. Examples of items that fall under the religious sentiments domain include: “how frequent do you attend church services?”, “how often do you pray?” The spiritual transcendence domain also has items such as “In the quiet time of my prayers/meditation, I find sense of wholeness.”, “I do not have any strong emotional ties to someone who has died.” All the items are responded to on a likert scale.

### **The Lubben Social Network Scale**

This scale was used to measure social support. This scale is a self-report questionnaire that captures domains of social engagement including friends and family. It was developed by Lubben (1988) and is made up of 12 items but has a short form which comprises of 6 items. Both scales have internal consistencies of .70 and .83 respectively. The family domain of the scale has items such as “How many relatives do you see or hear from at least once a month?” and “How often is one of your relatives available for you to talk to when you have an important decision to make?” while the friendship domain has items such as “how many of your friends see or hear from at least once a month?” and “How often is one of your friends available for you to talk to when you have an important decision to make?”. All the items are responded to on a 6-point likert scale in the format of 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often and 5 = Always.

### **The Mental Health Continuum-Short Form (MHC-SF)**

This measure was adopted and used to assess the mental health of the respondents in the study. It is an instrument for measuring positive aspects of mental health among individuals. It was developed by Keyes et al., 2008. It emerged out of the concept that mental health entails more than just the nonexistence of mental illness. As a result, this instrument captures the domains of social well-being, emotional well-being and psychological well-being. The MHC-SF contains 14

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items and has been validated among Setswana-Speaking South Africans (Keyes et al., 2008). The internal reliability of the overall scale was 0.74.

### **The General Self-Efficacy Scale (GSE)**

This scale was designed by Schwarzer & Jerusalem, (1995). The purpose for developing this self-report measure was to assess the general sense of perceived self-efficacy among the general adult population. The scale is made up of 10 items and they are all unidimensional. All the items are rated on a 4-point likert scale in the format of 1 = Not at all true, 2 = Hardly true, 3 = Moderately true, and 4 = Exactly true. Each item refers to successful coping and implies an internal-stable attribution of success. The total possible score ranges from 10 to 40. With regards to the internal reliability of the scale, it is reported to range from .76 to .90. Validity studies carried out on the scale indicates that it is positively correlated with emotion, work satisfaction and optimism whiles it is negatively correlated with constructs such as stress, anxiety, burnout, depression and health complaints.

### **Pilot Study**

In order to ascertain the reliability of the various instruments for this study, a pilot study was conducted. This is expedient before actual data collection was done in order to establish whether or not the research participants understand the items on the questionnaire. Reliability analysis was also conducted to ensure that the various scales have high Cronbach alpha reliability appropriate for any empirical study. Forty community dwelling older adults in Accra were conveniently sampled and interviewed for the purpose of the pilot study. The consent of the participants were sought after the purpose of the research has been explained to them. After each interview, the views of the participants were sought regarding how easy it was to understand the various items of the questionnaire. In general, the pilot study indicated that most of the

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participants understood the various items on the questionnaire. The study was conducted in English, Ga and Twi depending on the dialect of each participant. The Cronbach alpha run for the various scales is presented as follows

**Table 2:**

*Summary of Cronbach's Alpha for the Study Instruments in the Pilot study (N=40)*

<b>SCALE</b>	<b>Cronbach Alpha</b>
<b>ASPIRES-SF Sub-Scales</b>	
Religious Sentiments (RS)	.74
Spiritual Transcendence (ST)	.77
Social Network Scale (SNS)	.83
<b>Social Network Scale (SNS) Sub-Scales</b>	
Family	.82
Friends	.84
General Self-Efficacy Scale (GSE)	.80
Mental Health Continuum (MHC)	.73
<b>Mental Health Continuum Sub-Scales</b>	
Emotional well-being	.61
Social well-being	.67
Psychological well-being	.54

### **Data Collection Procedure**

After ethical clearance with reference number: ECH 058/17-18, was sought from the Ethics Committee for the Humanities (ECH), an introduction letter from the department of Psychology was also obtained and sent to the director of HelpAge Ghana. This was part of the bid to seek permission to reach HelpAge zonal centers within the Accra Metropolitan Area to carry out the study. Upon getting approval from the Helpage secretariat, preliminary visits were made to selected communities to get first-hand information on their meeting days and schedule of activities.

Subsequently, weekly visits were paid to the elderly population in the HelpAge zones at Osu, James Town, Achimota, Abofu and Apenkwa from January to March, 2018. The aims and objective of the study was explained to them as a group during their meetings before reaching them individually. Follow-up visits were also made to homes of older adults who could not be interviewed at the meeting due to time constraints. At the individual level, each potential respondent was asked some questions in order to be sure that they met the inclusion criteria stipulated for the study. Consent was then sought from older adults who qualified to participate in the study. Participants were made aware that participation in the study is on a voluntary basis. Also, the possible risks and benefits were clearly spelt out to each participant and an assurance of confidentiality was also made to each participant.

After consent had been sought from each participant, the researcher went ahead to administer the questionnaire in the form of a one on one interview. This procedure was adopted in order to boost response rate and to also ensure that the questionnaires are completed properly although it does not allow privacy. In the process, the items on the questionnaire were read out to the participants and their responses were indicated with a thick of a pen. Questions and clarifications

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that came up during the process were adequately addressed by the researcher. In order to ensure the cultural adaptability of the various measures, the questionnaire was translated into two main Ghanaian languages, namely Akan and Ga which are the dominant local languages in the research setting. Participants in this study who understood English language were interviewed in English and those who do not understand English language were interviewed in either Ga or Akan with the aid of the translation guide. The interview process and completion of the questionnaire took between 25 to 40 minutes for each participant. After interviewing each participant, the opportunity was given to ask questions or seek clarifications after which they were addressed. After thanking them, the contact information of the researcher was given to participants so as to enable them to contact in case they have any question in the future regarding the study.

### **Ethical Consideration**

Approval in the form of ethical clearance was sought from the University of Ghana ethics committee for Humanities. A letter of introduction from the Department of Psychology together with the ethical clearance certificate was sent to the head office of HelpAge Ghana for permission to reach older adults in the various HelpAge zones in Accra. Consequently, the strict guidelines of the committee on the use of human subjects were adhered to. According to the APA's Ethics Code (2002), "when obtaining informed consent as required in Standard 3.10, Psychologists should inform participants about: (1) The purpose of the research, expected duration, and procedures; (2) Their right to decline to participate and to withdraw from the research once participation has begun. Research participants were duly informed before they were allowed to take part in the study."

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When it comes to assuring confidentiality as required in Standard 4 that Psychologist should assure a participant about: (1) His or her ability of ensuring that confidentiality of keeping of participant information; (2) Discuss limits of confidentiality with participants; (3) Must minimize intrusions on participant privacy; (4) Before recording the voices or images of participant, the researcher must obtain permission from the person; (5) Must not disclose the information to anyone without the participant consent; (6) Should maintain, disseminate and disposal of confidential records properly. These privacy and confidentiality guidelines were also adhered to in the process of data collection and analysis.

In order to address the issue of risk and benefits regarding participation in research, the APA ethics code which states the following was strictly applied by spelling out to the research participants the following:

(1) The foreseeable consequences of refusing to participate; (2) Reasonably possible consequences that may come along with participation such as potential risks or discomfort; (3) Any prospective benefit from the study; (4) Participation incentives; and (5) The person to contact for questions about the study and questions in relation to participants' rights. It was explained to the study participants that there is no foreseeable risk, discomfort or adverse effect should they decline to participate in the study and that their participation was completely voluntary.

### **Data Entry and Cleaning**

The data that was collected from the study participants were coded and entered into the Statistical package for Social Sciences (SPSS). A cross-check of the entries was done to ensure that the right entries were done. Ensuing errors were corrected after referring to the respective

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questionnaires that has been appropriately numbered. Additionally, descriptive analysis was carried out to ascertain the distribution and skewness of the data.

### **Data Analysis Strategy**

In analyzing the data for this study, SPSS version 23.0 for windows was used. The resulting outcomes are presented in the fourth chapter of this study. All the inferential statistical analyses in the study were two-tailed. The level of significance was also set at 95% ( $p < 0.05$ ). For the descriptive statistics mean, percentages, standard deviations and frequencies for the study variables were conducted. In order to understand the relationship between religious sentiments, spiritual transcendence and mental health, Pearson Product-Moment Correlation was carried out. Analysis of variance (ANOVA) was used in assessing the variance in spiritual transcendence among the various age categories whiles multivariate analysis of variance (MANOVA) was used to ascertain the variability of education level and gender on the social support dimensions. Finally, hierarchical multiple regression was employed in testing the moderating role of general self-efficacy on spiritual transcendence and mental health.

## CHAPTER FOUR

### RESULTS

#### **Introduction**

The findings from this study are summarized in this chapter with the use of appropriate tables. The version 23.00 of SPSS was used for the data analyses. With regard to specific statistical tests, descriptive statistics was employed in summarizing the data collected from respondents. Subsequently, Pearson moment correlation coefficient, analysis of variance (ANOVA), multivariate analysis of variance (MANOVA) and hierarchical multiple regression analysis are the key statistical tests that were used in testing the stated hypotheses. Following this, statements about whether each hypothesis was accepted or rejected is outlined. A detailed presentation of tables alongside their interpretation is then provided. A summary of the key findings are presented as well with the final observed model.

#### **Descriptive Statistics**

Table 3 is the summary of the means and standard deviations of scores on religiosity, spirituality, social support dimensions (family and friends), general self-efficacy and mental health dimensions (emotional well-being, social well-being and psychological well-being). Table 3 below also presents with the internal consistencies of the various scales in addition to the degree of skewness and kurtosis.

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**Table 3:***Means, Standard Deviation and Cronbach Alpha of Variables*

Variables	<i>M</i>	SD	$\alpha$	Skewness	Kurtosis
RS	18.92	6.17	.79	-.32	-1.46
ST	40.30	3.35	.72	-.55	.33
SS	15.96	5.66	.75	.32	.02
FaS	10.48	2.89	.71	-.55	.18
FrS	5.48	4.13	.84	-.46	-.60
GSE	35.67	4.76	.81	-1.46	2.74
MH	60.51	6.23	.78	-.98	.99
EWB	13.08	2.15	.74	-1.53	2.62
SWB	20.07	3.67	.75	-1.28	2.32
PWB	27.35	2.49	.61	-1.39	2.66

*1. RS=Religious Sentiments Scale, 2. ST=Spiritual Transcendence Scale, 3. SS=Social Support Scale, 4. FaS=Family Support Scale, 5. FrS =Friends Support Scale, 6. GSE=General Self-Efficacy, 7. MH=Mental Health Continuum, 8. EWB=Emotional Well-Being Scale, 9. SWB=Social Well-Being Scale, 10. PWB=Psychological Well-Being Scale.*

From table 3 above it can be observed that with the exception of the PWB scale, all the other scales were reliable since they were above .70. The skewness and kurtosis ranges between +/- 2.

This is an acceptable range of normal distribution according to Field (2013).

### **Data Analyses**

Pearson Product-Moment Correlation was used in testing hypotheses 1a, 1b, 2, 3 and 4. This is because the variables were measured on at least an interval scale, and also assumed to be linearly related. Hypothesis 6 was tested by using one way analysis of variance (ANOVA). This was deemed an appropriate test because the independent variable (age) had several levels and the dependent variable (spiritual transcendence) was measured on at least an interval scale. Hypothesis 7 was also tested using multivariate analysis of variance (MANOVA). This was appropriate because the independent variables (education level and gender) had more than one level and the dependent variables (family support and social support) were measured on at least an interval scale. Finally, hypothesis 8 was tested by using hierarchical multiple regression. This test was used to investigate the moderating role of general self-efficacy on the relationship between spiritual transcendence and mental health

### **Hypotheses Testing**

Pearson Product Moment Correlation Coefficient (Pearson  $r$ ) was carried out to test hypotheses 1a, 1b, 2, 3 and 4 as stated in chapter two of this study. A summary of the results are presented in Table 4 and 5 below:

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**Table 4:**

*Correlation Matrix of Scales and Subscales in the study*

VAR	1	2	3	4	5	6	7	8	9	10
1. MH	-									
2. EWB	.69**	-								
3. SWB	.81**	.31**	-							
4. PWB	.71**	.40**	.29**	-						
5. RS	.03	-.04	.00	.09	-					
6. ST	.32**	.26**	.25**	.22**	-.08	-				
7. GSE	.36**	.27**	.16*	.42**	-.00	.26**	-			
8. SS	.02	-.04	.03	.05	.20**	.01	.16*	-		
9. FaS	.14*	.07	.09	.15*	.08	.24**	.26**	.71**	-	
10.FrS	-.07	-.11	-.02	.04	.22**	-.15*	.04	.87**	.28**	-

*\*\*Correlation is significant at .01 alpha level, \*Correlation is significant at .05 alpha level.*

*MH=Mental Health, EWB= Emotional Well-Being, SWB= Social Well-Being, PWB= Psychological Well-Being, RS= Religious Sentiments, ST= Spiritual Transcendence, GSE= General Self-Efficacy, SS= Social Support, FaS= Family Support, FrS= Friends' Support.*

**Hypothesis 1a**

*There will be a significant positive relationship between religious sentiments and mental health.*

This hypothesis was tested by using the Pearson Product-Moment Correlation. This was to find out whether a relationship exists between one independent variable (religious sentiments) and the dependent variable (mental health) among community dwelling older adults. Both variables were continuous and also measured on an interval scale at least. Observing from table 4 above, the correlation matrix indicates that there was no significant relationship between religious

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sentiments and mental health [ $r = .03, n = 250, \rho = .66$ ]. Therefore the hypothesis that was stated as “*There will be a significant positive relationship between religious sentiments and mental health*” was not supported.

### ***Hypothesis 1b***

*There will be a significant positive relationship between spiritual transcendence and mental health.* This hypothesis was tested by using the Pearson Product-Moment Correlation. The independent variable (spiritual transcendence) and the dependent variable (mental health) are both considered to meet the assumption of being continuous variables and measured on at least an interval scale hence the use of the Pearson Product-Moment Correlation to test the relationship between both variables. The results as shown in the correlation matrix in table 4 above indicates that a significant positive relationship existed between spiritual transcendence and mental health [ $r = .32, n = 250, \rho < .01$ ]. Therefore the hypothesis that “*There will be a significant positive relationship between spiritual transcendence and mental health.*” was supported.

### ***Hypothesis 2***

*There will be a significant positive relationship between social support domains (family and friends’) and mental health.* In testing this hypothesis, the Pearson Product-Moment Correlation was used. The independent variables (family support and friends support) and the dependent variable (mental health) are continuous variables and also measured on at least an interval scale thus the use of the Pearson Product-Moment Correlation in testing the relationship between the two variables. The results as captured in the correlation matrix in table 4 above indicates that there was a significant positive relationship between family support and mental health [ $r = .14, n = 250, \rho < .05$ ]. There was however no significant relationship between friends

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support and mental health [ $r = -.07, n = 250, \rho = .27$ ]. Therefore the hypothesis that “*There will be a significant positive relationship between social support domains (family and friends’) and mental health*” was partially supported.

### ***Hypothesis 3***

*General self-efficacy will positively and significantly be associated with mental health.* This hypothesis was also tested by using the Pearson Product-Moment Correlation because both the independent variable (general self-efficacy) and the dependent variable (mental health) are continuous variables and are measured at least on an interval scale. Observing the results from the correlation matrix in table 4 above gives an indication that there was a significant positive relationship between general self-efficacy and mental health [ $r = .36, n = 250, \rho < .01$ ]. Therefore the hypothesis that was stated as “*General self-efficacy will positively and significantly be associated with mental health.*” was supported.

### ***Hypothesis 4***

*There will be a significant positive relationship between spiritual transcendence and general self-efficacy.* In order to test this hypothesis, the Pearson Product-Moment Correlation was used. Both variables (spiritual transcendence and general self-efficacy) were considered to have met the assumption of being continuous variables and measured on at least an interval scale. For this reason, the Pearson Product-Moment Correlation was used in testing the relationship between both variables. The results as shown in the correlation matrix in table 4 above indicates that a significant positive relationship does exist between spiritual transcendence and general self-efficacy [ $r = .26, n = 250, \rho < .01$ ]. As a result the hypothesis that “*There will be a significant positive relationship between spiritual transcendence and general self-efficacy.*” was supported.

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**Hypothesis 5**

*There will be a statistically significant difference in spiritual transcendence between older adults who are in their early 60s and those who are 80 years and above.*

**Table 5:**

*Summary of ANOVA results on Spiritual Transcendence among older adult age groups*

Source	SS	df	MS	F	Sig	Partial Eta Squared
Between groups	124.365	4	31.091	2.857	.024*	.045
Within groups	2666.531	245	10.884			
Total	2790.896	249				

*\*Statistically significant difference:  $p < .05$*

A one-way analysis of variance was carried out to compare the means of the various age groups on the experience of spiritual transcendence. The results in Table 6 above indicates that a statistically significant difference exists in spiritual transcendence among the various age groups  $F_{[4, 245]} = 2.857, p < .05$ .

**Table 6:**

*Univariate statistics of Spiritual Transcendence for the age group categories*

Age Group	N	M	SD
60 – 64	61	40.0	3.66
65 – 69	55	39.3	3.14
70 – 74	58	40.4	3.36
75 – 79	32	40.8	3.16
80 and older	44	41.4	3.35

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Following this outcome, a post hoc comparison was done using the Tukey HSD and the results gave an indication of a statistically significant difference between older adults who were between 60 and 64 and those who were 80 years and above ( $p = .035$ ). Similarly, older adults between 65 and 69 years differed significantly from those who were between 75 and 79 years ( $p = .043$ ) and those who were 80 years and above ( $p = .002$ ). Those who were between 65 and 69 years also differed significantly from those who were between 75 and 79 years ( $p = .043$ ).

No significant difference was however recorded between the 60 to 64 years and 65 to 69 years groups of older adults ( $p = .218$ ). Additionally, older adults who were 60 to 64 years did not differ significantly from those who were 70 to 74 years ( $p = .547$ ) and 75 to 79 years ( $p = .310$ ). Further results indicate that those who were 65 to 69 years did not differ significantly from those who were 70 to 74 years ( $p = .072$ ). For those who were 70 to 74 years, they did not differ significantly from those who were 75 to 79 years ( $p = .613$ ) and 80 years and above ( $p = .124$ ). Finally, older adults who were between 75 and 79 years did not differ significantly from those who were 80 years and above ( $p = .397$ ). As a result the hypothesis that “*There will be a statistically significant difference in Spiritual Transcendence between older adults who are in their early 60s and those who are 80 years and above.*” was supported.

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**Hypothesis 6**

*There will be a statistically significant difference in the dimensions of social support among older adults based on education level and gender differences.*

To test this hypothesis, multivariate analysis of variance (MANOVA) was used. Preliminary analysis revealed that the dependent variables met the assumptions of multivariate normality. Also, the univariate equality of variance was met. This was confirmed by a nonsignificant Bartlett’s test. The multivariate result was significant for Education level,  $F_{[3,246]} = 3.2, p < .05$ . The MANOVA results in table 7 below clearly indicates that level of education has a statistically significant effect on Friends’ Support  $F_{[3, 246]} = 9.014, p < .001, \text{partial } \eta^2 = .099$  but not Family support  $F_{[3, 246]} = .494, p = .687, \text{partial } \eta^2 = .006$ .

**Table 7:**

***Summary of Means, Standard Deviations (SD) and MANOVA Results of the Influence of Education level on the Social Support types***

D.V	No Edu. (n=61)	Primary (n=126)	Secondary (n=39)	Tertiary (n=24)	df	F	p	$\eta^2$
Family Support	10.62 (2.81)	10.27(2.86)	10.79(2.92)	10.75(3.25)	3,246	.494	.687	.006
Friends’ Support	4.13 (4.18)	5.08 (3.73)	7.95 (4.46)	6.96 (3.57)		9.014	.000*	.099

*\*Statistically significant difference:  $p < .05$*

Following this outcome, post hoc comparison for Friends’ Support among the education level categories was done using Tukey HSD. Older adults who had No Education differed significantly from those who had Secondary Education ( $p = .000$ ) as well as Tertiary Education ( $p = .017$ ). Those who had Primary Education also differed significantly from the group that had Secondary Education ( $p = .001$ ) but not Tertiary Education ( $p = .144$ ). No significant difference

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was also observed between those with No Education and those with Primary Education ( $p = .415$ ) as well as those with Secondary Education and those with Tertiary Education ( $p = .768$ ).

### ***Hypothesis 7***

*General self-efficacy will significantly moderate the relationship between spiritual transcendence and mental health of older adults.*

To determine whether general self-efficacy of older adults will significantly moderate the relationship between spiritual transcendence and mental health, hierarchical regression was done. The dependent variable in the analysis was mental health, the independent variable was spiritual transcendence and the moderating variable was general self-efficacy. Table 11 below presents a summary of the results.

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**Table 8:**

*Hierarchical regression of the moderation effects of General Self-Efficacy between Spiritual Transcendence and Mental Health*

Predictors	B	SEB	$\beta$	<i>t</i>	<i>P</i>
Model 1					
Constant	36.17	4.52		8.01	.000
ST	.60	.11	.32	5.41	.000
Model 2					
Constant	28.15	4.62		6.09	.000
ST	.46	.11	.25	4.21	.000
GSE	..38	.08	.29	4.91	.000
Model 3					
Constant	28.97	4.56		6.35	.000
ST	.48	.11	.26	4.37	.000
GSE	.35	.08	.27	4.59	.000
ST*GSE	-1.7	.40	-.17	-2.92	.004

*Dependent Variable: Mental Health. R<sup>2</sup> = .10, .18, .21 and  $\Delta R^2$  = .102, .178, .203 for steps 1, 2 & 3 respectively. ST = Spiritual Transcendence, GSE = General Self-Efficacy.*

Before the hierarchical regression was carried out to test the hypothesis that general self-efficacy will significantly moderate the relationship between spiritual transcendence and mental health, the centering of the independent and moderating variables was done. Subsequently, an interaction term was computed using the centered variables (Baron and Kenny, 1986). Following this, moderation analysis was conducted to find out the extent to which the relationship that exists between spiritual transcendence and mental health will change as a result of the influence

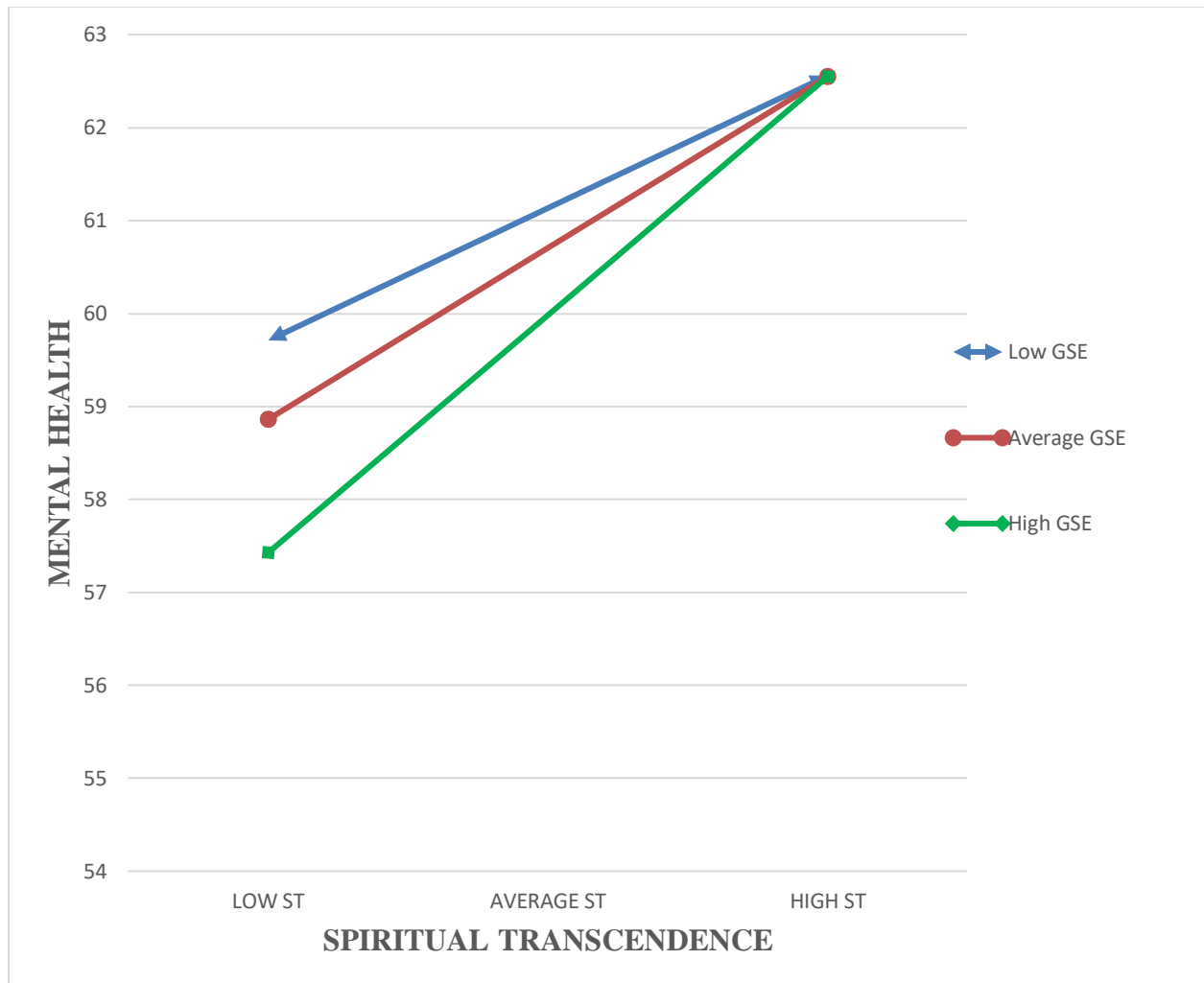
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of the moderator variable. The independent variable (spiritual transcendence) and moderator variable (general self-efficacy) were both centered. By this a subtraction of each variable's mean from the individual observations was performed to get deviation scores. Subsequently, an interaction term of the centered independent and moderator variables was created.

In Step 1 of the hierarchical regression presented in Table 10 above, spiritual transcendence was entered. The ensuing results indicate that the model explained 10.2% of the variance in mental health ( $.102 \times 100$ ), [ $F_{[1, 248]} = 29.22, p = .000$ ]. This means that spiritual transcendence as a single variable was significantly related to mental health. The moderator (general self-efficacy) was then entered in Step 2 and the entire model predicted 17.8% of the variance in mental health ( $.178 \times 100$ ), [ $F_{[2, 247]} = 28.02, p = .000$ ]. This was statistically significant because the moderator variable explained an additional 7.6% of the variance in mental health. R squared change = .076, [ $\Delta F_{[1, 248]} = 35.89, p = .000$ ]. This was a statistically significant contribution.

In the final step, the independent variable as well as the interaction between the centered moderator variable were included in the analysis. The results indicate that the model as a whole predicted 20.3% of the variance in mental health ( $.203 \times 100$ ), [ $F_{[3, 246]} = 22.08, p = .000$ ]. This indicates a statistical significance, the interaction between the independent variable and the moderator variable accounted for an additional 2.5% of the variance in mental health. R squared change = .025, [ $\Delta F_{[1, 248]} = 9.95, p = .004$ ]. This contribution was statistically significant as a result the hypothesis that “*General self-efficacy will significantly moderate the relationship between spiritual transcendence and mental health of older adults.*” was supported.

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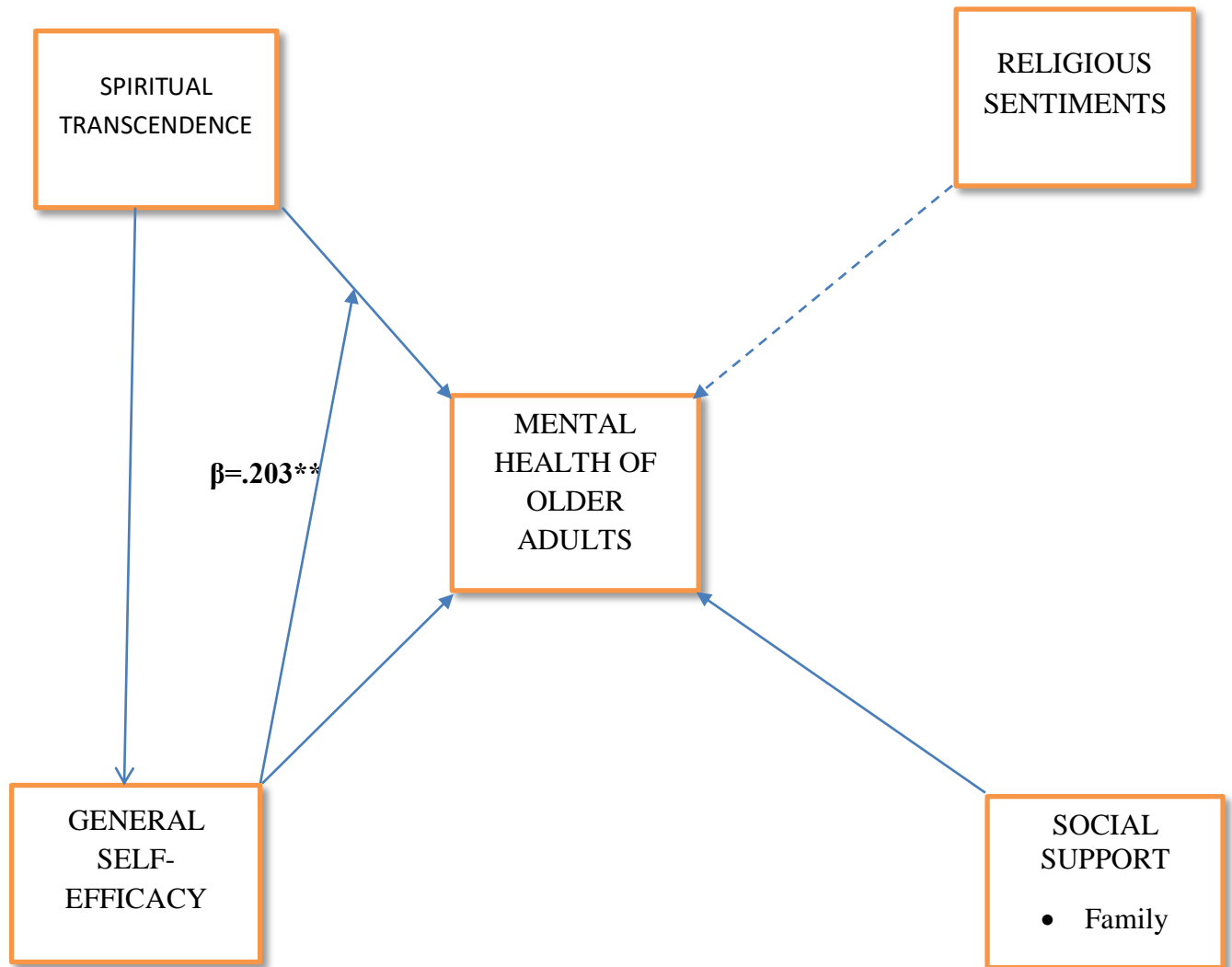
**Figure 2: Modeled Mental Health of older adults as a function of Spiritual Transcendence and General Self-Efficacy**

The interaction plot above indicates an enhancing effect such that as older adults' Spiritual Transcendence and General Self-Efficacy increase, their Mental Health also improves.

**Summary of Findings:**

Eight hypotheses were tested in this study in order to assess religiosity/spirituality, general self-efficacy, social support and mental health among community dwelling older adults in Accra. The summary of the findings is as follows:

1. Spiritual transcendence was significantly and positively related with mental health.
2. The family dimension of social support was significantly and positively related to mental health
3. General self-efficacy was found to have a significant positive relationship with mental health.
4. Spiritual transcendence and general self-efficacy were observed to have a significant positive relationship.
5. Statistically significant difference was observed between older adults in their early 60s and those who are 80 years and above in the experience of spiritual transcendence.
6. Education level and gender were both observed to account for statistically significant difference in the friendship dimension of social support.
7. General self-efficacy significantly moderated the relationship between spiritual transcendence and mental health.
8. Religious sentiments and the friends' dimension of social support did not significantly relate with mental health.



**Figure 3: Observed Model**

It was observed from the above model that unlike Spiritual Transcendence, Religious Sentiments did not significantly predict Mental Health among older adults. A significant relationship also existed between General Self-Efficacy and Mental Health. Additionally, the Family dimension and not the Friendship dimension of Social Support was significantly related to Mental Health. General Self-Efficacy had a significant moderating effect on the relationship between Spiritual Transcendence and Mental Health.

## CHAPTER FIVE

### DISCUSSION

#### Introduction

It was the objective of this study to investigate how religious sentiments, spiritual transcendence, social support and general self-efficacy are related to mental health among community dwelling older adults. The experience of spiritual transcendence among age group categories of older adults was also examined. In addition, the influence of education level and gender on social support variations was ascertained. The moderating role of general self-efficacy between spiritual transcendence and mental health was also investigated. The findings from this study (in respect to whether the hypotheses were supported or rejected) are presented in this chapter. In discussing the findings that ensued from this study, previous studies and theories were referred to. Specifically, the theory of religious effects by Smith (2003), the social cognitive theory by Bandura (2001, 2011) and the theory of gerotranscendence by Tornstam (1989, 2005) served as the basis for the discussion in this chapter with due consideration to socio-cultural nuances. Subsequently, the implications of the findings for older adult population, practicing clinicians, the general health sector as well as future studies are discussed and recommendations made. The implications and recommendations subsequently formed the basis for discussing the limitations and conclusion to a large extent.

Among older adults, religious sentiments and spiritual transcendence have been identified to influence a substantial aspect of their lives especially in regard to mental health and well-being. Although religiosity and spirituality have been considered as similar constructs, their separate effects on the health and well-being of individuals have been widely explored. Not only does religiosity and spirituality influence the mental health of older adults but general self-efficacy

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has also been identified as a positive psychological construct that may promote positive mental health although not much is known about its moderating role in the relationship between spiritual transcendence and mental health. Additionally, social support cannot be delineated from matters relating to older adults' health and well-being especially within the Ghanaian sociocultural milieu where various indicators point to dwindling support systems for the elderly in recent times. The various dynamics determining support structures are continually being explored in order to help promote mental health among the elderly population.

The population that constituted this study were older adults in HelpAge Ghana zones at Osu, James Town, Achimota, Abofu and Apenkwa all within the Accra metropolitan area. Older adults who were found within these HelpAge zones formed part of the sample for this study. These zones were chosen because they are urban in feature and composition with ethnically diverse residents. This gives the study a wider sociocultural applicability in many respects. The sample comprised of (males and females) older adults who were 60 years and above.

### **Religious Sentiments, Spiritual Transcendence and Mental Health of older adults**

To examine whether religious sentiments and spiritual transcendence were significantly related to mental health, correlation analysis was carried out and the results indicated that while a significant positive relationship exists between spiritual transcendence and mental health, a significant relationship does not exist between the religious sentiments and mental health.

This means that the religious sentiments of the participants in the study have no relationship with their mental health. This finding is not in consonance with what is widely reported in empirical literature. Aukst-Margetic and Margetic (2005) assert that relatively, there are few empirical studies indicating either negative or no relationship between religiosity and mental health. Leondari and Gialamas (2009) however arrived at a finding in a study they conducted among a

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Greek population to the effect that the participants' personal faith in God and the supernatural was not significantly related to dimensions of psychological well-being. Similarly, the study by Waite (2017) also indicates that religiosity and depression among Africans are not significantly related. This is contrary to the popular view established by studies conducted by Bamonti et al. (2016); Lawler-Row and Elliott (2009) which indicates that religiosity is negatively related to depression and psychopathological symptoms.

This finding may be due to a number of reasons as highlighted by earlier researchers and needs to be looked at closely. For instance, Greenfield et al. (2009) found that spirituality is a better correlate and indicator of psychological well-being than organised religion and religious opinions. Another reason that might have accounted for the non-correlation between religious sentiments and mental health is the explanation that Chokkanathan (2013) offers. According to him, psychosocial factors including sense of mastery and support structures cannot be ruled out when studying the relationship between religiosity and mental health outcomes. Aukst-Margetic and Margetic (2005) have also established that the relationship between religious sentiments and health outcomes is sometimes inconsistent and weak. This they assert could partly be as a result of some underlying factors including psychosocial, demographic, or variables which might be health-related, hence the need to regularly subject these variables under control. In effect, religious sentiments may be related to mental health but through the pathways of other psychosocial factors that must be explored systematically.

Spiritual transcendence was found to have a significant positive relationship with mental health among the participants in the study. This means that the more spiritually transcendent an individual is, the more likely they are to report good mental health and this is in consonance with the theory of religious effects (Smith, 2003). The finding is also largely consistent with other

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similar empirical studies that have been carried out in the past. Wallace and Bergeman (2002); Ellison and Fan (2017); Lawler-Row and Elliott (2009); Harvey and Silverman (2013) have all arrived at similar findings in studies involving spirituality and mental health outcomes. Hamren, et al. (2015) as well as Bamonti, et al. (2016) have similarly found spirituality to have the tendency of bringing down the levels of depressive symptomatology among older adults. Additionally, Skarupski et al., 2013 have also found spiritual experience to be positively related to life satisfaction among older adults.

### **Social Support dimensions and Mental Health of older adults**

To determine whether social support dimensions (family's and friends') were significantly related to mental health, correlation was carried out. While the results of the analysis indicated that family support had a significant positive relationship with mental health, it also emerged that friends' support was not significantly related to mental health. This means that the more participants of the study received family support, the better their mental health. This finding is not entirely consistent with many empirical studies. For instance, although the findings of (Dosu, 2014; Nukunya, 2003; Aboderin, 2004; Cheng, et al., 2009) have all identified a significant positive relationship between family support and mental health among older adults, they also acknowledge the existence of a relationship between friends' support and mental health. Stokes and Moorman (2017) have recently underscored the importance of family support on mental health outcomes to the extent that they identified quality marital relationship as an essential buffer against depressive symptomatology. A probable reason for the nonexistence of a significant relationship between friends' support and mental health could be the explanation Wrzus, et al. (2013) has offered. They posit that friendship networks decline considerably as individuals grow older while family ties remain fairly stable over time. This phenomenon means

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that older adults are in regular contact with their family relations than friends hence they derive more emotional, social and psychological support from family members as compared to friends.

### **General Self-Efficacy and Mental Health of older adults**

In order to investigate whether a significant relationship exists between general self-efficacy and mental health of older adults, a correlation analysis was done. The results indicated that a significant positive relationship exists between general self-efficacy and mental health among the older adults in the study. What this means is that as the older adults experienced higher general self-efficacy, they had better mental health. This finding is supported by empirical literature to a large extent. For example, the findings of (Bowling & Iliffe, 2011; Morin and Midlarsky, 2016; Melato, et al., 2017) corroborates with this finding. Fry and Debats (2002) have also established in a similar study that self-efficacy beliefs constitute better predictors of psychological well-being and well-being and loneliness than physical health, social support and demographic variables. This finding indicates the relative salience of positive psychological factors in the ageing process. As people grow older, physical limitations set in due to health challenges. An active assessment of situations in order to find solutions is therefore important as highlighted by the social cognitive theory. This could also prove to be a positive pathway to maximizing positive mental health outcomes among the ageing population.

### **Spiritual Transcendence and General Self-Efficacy of older adults**

The relationship between spiritual transcendence and general self-efficacy was tested by way of correlation. The results give an indication of a significant positive relationship between spiritual transcendence and general self-efficacy of the study participants. This means that as the experience of spiritual transcendence among the older adults increase, their level of general self-efficacy also increases. Although this finding has not been reported by a lot of studies, a few

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studies such as (Schieman, et al., 2003; McCullough & Willoughby, 2009; Schieman, et al., 2005) have indicated the existence of such a positive relationship. Within the African context, van Dyk and van Dyk (2015) have also found that based on Mbiti's (1969) theory, spirituality and supernatural assumptions play a significant role in attribution and invariably does not enhance self-concepts. A positive spiritual experience therefore serves as an important basis for other positive mental health and life outcomes in the course of the ageing process. As highlighted by the theory of religious effects, the importance of personal spiritual experiences is vital in predicting indicators of well-being. As a result, effective pathways that would lead to positive religious and spiritual experiences among older adults ought to be identified and engendered.

### **Spiritual Transcendence among older adult age groups**

To determine whether differences exist in spiritual transcendence among the age group categories of older adults, a one way Analysis of Variance (ANOVA) was carried out. The results indicated that a statistically significant difference exists in spiritual transcendence among the various age groups. This finding is consistent with empirical literature. For instance the findings of (Dalby, 2006; Wink and Dillon, 2002; Gupta & Chadha, 2013) all corroborates with the present finding. What this means is that as individuals grow older, their experience of spiritual transcendence increases significantly. Thus confirming Tornstam's (1989, 2005) theory of gerotranscendence. The ageing process is also accompanied by a shift in value systems as the theory of gerotranscendence proposes. Older adults tend to focus more on cosmic and transcendent worldviews rather than materialism and this leads to life satisfaction. As the present study highlights, spiritual transcendence increases as people grow older. This positive life experience can no means be underestimated when it comes to conceptualizing well-being and life satisfaction among older adults. Although the incidence of health challenges and loss of

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social networks are debilitating factors to their well-being, promoting individual positive experiences such as spiritual transcendence could be a key factor in maximizing the positive health outcomes to ensure that older adults attain life satisfaction and do not disengage.

### **Social support types based on Education level**

In order to investigate the difference in the (family and friends) dimensions of social support based on education level among the participants in the study, multivariate analysis of variance (MANOVA) was conducted. The results indicated that level of education has a statistically significant effect on the friendship dimension of social support in particular. This means that among older adults in the study, their level of social support from friends (but not family) is determined by their education level. This finding is consistent with what is reported in previous studies including studies by (Cornwell et al., 2008; Ajrouch et al., 2005; Wrzus et al., 2013). Chatters et al. (2018) have however found that unlike family income, educational level is not significantly associated with reported isolation either from friends or family. This outcome is particularly not surprising considering the fact that education affords people the opportunity to build friendship networks from class/school mates and colleagues. As a result, older adults who had little or no formal education are most likely to have less friendship connections than those who had significant levels of formal education. Since social support has been found to be positively related to mental health, it is imperative for individuals with no or lower levels of formal education to build friendship networks from community social clubs and religious organizations for instance. This will help meet the critical need of belongingness and support in several dimensions across the developmental lifespan.

**Moderating role of General Self-Efficacy on the relationship between Spiritual  
Transcendence and Mental Health**

To determine whether general self-efficacy moderated the relationship between spiritual transcendence and mental health among the older adult participants in the study, hierarchical multiple regression was carried out and it was observed that general self-efficacy significantly moderated the relationship between spiritual transcendence and mental health. This finding corroborates with other studies in similar regard. For instance the findings of (McCullough & Willoughby, 2009; Fry & Debats, 2002; Shea et al., 2016) all point to the same direction. Fergusson and Goodwin (2010) also assert that varied psychosocial factors determine both subjective and psychological wellbeing among older adults. General self-efficacy moderating the relationship between spiritual transcendence and mental health means it strengthens the relationship between spiritual transcendence and mental health. General self-efficacy plays a significant role in predicting mental health among community dwelling older adults and this is consistent with the social cognitive theory (Bandura, 2001; 2011). This finding largely underscores the relevance of the agency of the self in gerontological studies. Self-concepts are critical in defining and shaping positive human experiences and this leads to the attainment of well-being and mental health outcomes. In this regard, individual psychological factors ought to be examined within the context of relevant self-concepts since the underlying social cognitive theory posits that human behavior is determined by individual belief systems within the broader social milieu. The collectivistic nature of Ghana notwithstanding, this self-concept proves to be a veritable link to mental health outcomes among older adults.

### **Limitations of the study**

Although attempts were made to reduce weaknesses that come along with research, some limitations were still encountered. When it came to sampling the participants from the various HelpAge groups, most of them had the preconception that the study was being conducted under the auspices of an organization or the government hence they expected to receive a direct reward from participation. This misconception was however addressed during the process of seeking informed consent but a few of the participants still held on to this view to the extent that they declined participation because they were not assured of any direct benefit. There were also eight surveys that were not included in the study due to incomplete responses to the items on the questionnaire. The study participants were also recruited from only urban communities hence the findings from the study might not be applicable to rural dwellers. Cross-cultural limitation might also be inherent in this study because most of the study sites were indigenous Ga communities hence the overwhelming majority of the participants representing the Ga ethnicity. Because the study was solely based on self-report responses, there is the likelihood that the study participants might have premised their responses on social desirability and responded to questions in more appealing and favorable ways.

### **Direction for Future Studies**

Future studies should focus on using qualitative methods to explore the relationship between religious sentiments and mental health as well as spiritual transcendence and mental health. This will lead to an in-depth understanding of mental health outcomes among older adults in relation to both religious sentiments and spiritual transcendence. Additionally, since all the positive ageing constructs in the present study apart from religious sentiments correlated positively with mental health, future studies should focus on establishing the reason behind this finding. Using

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different (and more objective) measures of religious sentiments to test this relationship is also recommended in order to corroborate or contest this present finding among community dwelling older adults within the Ghanaian context. The different dimensions of positive mental health were not systematically explored in relation to sociodemographic characteristics and the independent variables in this study. To this end subsequent studies that will be conducted should ascertain whether differences exist in emotional, social and psychological well-being among older adults based on their socioeconomic and demographic variations. Sociodemographic differences in relation to religious sentiments, spiritual transcendence and general self-efficacy should also be systematically explored in future studies. This will further contribute to the understanding of the dynamics of positive/successful ageing constructs. Comparative studies should also be done in the future to ascertain whether the experience of spiritual transcendence differs significantly between young adults and older adults in light of the finding that depict age related differences in spiritual transcendence among community dwelling older adults. In future studies, community dwelling older adults in urban areas can be compared with those living in rural areas on the positive ageing measures to ascertain whether significant differences exist between them.

### **Recommendations**

Just as Religious Sentiments, the friends' dimension of Social Support was found not to be significantly related to Mental Health. To this end, community dwelling older adults should endeavor to build quality friendship ties with their peers in order to promote their positive mental health. Similarly, community dwelling older adults should readily take up social roles and responsibilities in order to maintain their social and relational ties. This will consequently minimize their likelihood of disengagement from society. Older adults should also take practical

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steps to ensure a healthy religious experience within the context of their spiritual maturity and experience in order to foster a holistic drive towards positive mental health outcomes throughout the period of old age.

Considering the fact that the participants in this study are members of community based self-help groups yet friendship among them does not relate to positive mental health, it is imperative for counselors and mental health professionals working with older adults to identify and promote ways of strengthening healthy friendship ties among them in order to engender positive mental health outcomes. Religious leaders can also play a significant role in the religious experience of older adults in their congregation. Teachings and doctrines that are in connection with their changing needs should be highlighted since this study corroborates Tornstam's (1989, 2005) theory of gerotranscendence in the sense that the spiritual experience among individuals transform with increasing age. It is also important for practicing clinicians and counselors to come to terms with the separate roles of religious sentiments and spiritual transcendence in predicting the mental health of older adults (as highlighted in this present study) rather than assuming that they both have similar effects. In this regard, a non-judgmental spiritual assessment should constitute any form of mental health assessment involving older adults.

Interventions that will enhance the general self-efficacy of older adults should also be identified and promoted by mental health professionals, religious leaders and gerontologists. This will invariably contribute to positive mental health since general self-efficacy has been identified as a significant moderator of the relationship between spiritual transcendence and mental health.

The outcome of this study also has implications for policy direction in the health sector. This is in view of the overemphasis on stigma and negative health outcomes in relation to old age and the phenomenon of ageing within the medical landscape. The non-biomedical constructs of

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positive ageing that have been explored in this study should be promoted by public health professionals and mental health practitioners such as clinical psychologists and psychiatrists in order to engender positive outcomes. This approach will buffer community dwelling older adults against adverse psychological problems that may suffice in the course of the ageing process.

### **Conclusion**

The concept of ageing in the developmental milestone has mostly been viewed from the perspective of disease and pathology. Successful ageing however acknowledges and emphasizes on the positive constructs which are related to the ageing process rather than disease and pathology. To a large extent, empirical literature highlights Religiosity, Spirituality, General Self-Efficacy and Social Support as positive ageing constructs. These positive constructs have been found to be correlates of well-being and Mental Health in the context of ageing. In this regard, this study sought to investigate the influence of Religious Sentiments, Spiritual Transcendence, General Self-Efficacy and Social Support on positive Mental Health among the older adult population. Age difference in the experience of Spiritual Transcendence was investigated. Additionally, the influence of education level on Social Support types was tested. The study also investigated how General Self-Efficacy moderated the relationship between Spiritual Transcendence and Mental Health.

It was observed that Spiritual Transcendence has a positive relationship with Mental Health among the study participants whiles Religious Sentiments is not. General Self-Efficacy had a positive relationship with Mental Health as Spiritual Transcendence also did. The family dimension of Social Support was significantly and positively related to Mental Health. Differences were observed among age group categories with respect to the experience of Spiritual Transcendence, corroborating the theory of gerotranscendence to a large extent. The

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friendship dimension of Social Support was observed to be significantly determined by the education level of the study participants. The relationship between Spiritual Transcendence and Mental Health was significantly moderated by General Self-Efficacy.

This study has provided further evidence for the need to promote successful ageing concepts in order to achieve positive mental health among community dwelling older adults. This is pertinent in an era of increasing biomedical concerns and the global disease burden. The findings from this study also call for further studies in line with the interrelationship between the successful ageing variables. This will inform practicing clinicians about how to engender evidence based interventions in order to promote mental health outcomes among older adults and more so to inform specialized care taking into consideration individual socio-demographic and psychological differences.

In an era where rapid population growth, polarizing social structures, and the global disease burden are pertinent issues, it is imperative for researchers and stakeholders of health to identify effective but simple ways of helping the elderly among the population to maximize improved health outcomes and not disengage. As a result, successful ageing concepts explored in this study and other empirical studies ought to be regarded and acknowledged as important pathways towards realizing improved outcomes with regard to psychological, emotional and social well-being of community dwelling older adults.

## REFERENCES

- Aboderin, I. (2004). Modernisation and ageing theory revisited: current explanations of recent developing world and historical Western shifts in material family support for older people. *Ageing and Society*, 24(1), 29–50.
- Adams, B. R. G., Blieszner, R., Rebecca, G., & Blieszner, R. (1995). *Friendship and Happiness - Across the Life-Span and Cultures*, Arizona: Springer.
- Addai, I., Opoku-Agyeman, C., & Amanfu, S. K. (2015). Marriage and Subjective Well-being in Ghana. *African Review of Economics and Finance*, 7(1), 53–79.
- Ajrouch, K. J., Blandon, A. Y., & Antonucci, T. C. (2005). Social Networks Among Men and Women : The Effects of Age and Socioeconomic Status. *Journal of Gerontology: Social Sciences*, 60(6), 311–317.
- Al-Kandari, Y. Y. (2011). Religiosity, Social Support, and Health among the Elderly in Kuwait. *Journal of Muslim Mental Health*, 6(1), 81–98.
- Apt, N. . (2002). Addressing income security needs of older persons in developing countries. *International Social Security Review*, 55(1), 39–47.
- Apt, N. A. (2012). Aging in Africa: Past Experiences and Strategic Directions. *Ageing International*, 37(1), 93–103.
- Atefoe, E., & Kugbey, N. (2014). Social Relationships among Women in Ghana: “A Blessing” or “A Curse” to their Psychological Well-being? *Journal of Advocacy, Research and Education*, (1), 15–19.

Mental Health of community dwelling older adults

- Aukst-Margetic, B., & Margetic, B. (2005). Religiosity and Health Outcomes : Review of Literature. *Coll. Antropol.*, 29(1), 365–371.
- Ayernor, P. K. (2012). Diseases of ageing in Ghana. *Ghana Medical Journal*, 46(2 Suppl), 18–22.
- Bamonti, P., Lombardi, S., Duberstein, P. R., King, D. A., & Van Orden, K. A. (2016). Spirituality attenuates the association between depression symptom severity and meaning in life. *Aging and Mental Health*, 20(5), 494–499.
- Bandura, A. (1998). Self-efficacy. *Encyclopedia of Human Behavior*, 4(1994), 1–65.
- Bandura, A. (2001). Social Cognitive Theory : An Agentic Perspective. *Annual Review of Psychology*, 52(1), 1–26. <https://doi.org/10.1146/annurev.psych.52.1.1>
- Bandura, A. (2011). Una perspectiva social cognitiva de la psicología positiva. *Revista de Psicología Social*, 26(1), 7–20.
- Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, 51(6), 1173.
- Bigdeloo, M., & Bozorgi, Z. D. (2016). Relationship between the Spiritual Intelligence, Self-Control, and Life Satisfaction in High School Teachers of Mahshahr City. *Review of European Studies*, 8(2), 210.

Mental Health of community dwelling older adults

- Bisschop, M. I., Kriegsman, D. M. W., Beekman, A. T. F., & Deeg, D. J. H. (2004). Chronic diseases and depression: The modifying role of psychosocial resources. *Social Science and Medicine*, 59(4), 721–733.
- Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *British Medical Journal*, 331(7531), 1548–1551.
- Bowling S., A. and I. (2011). Psychological approach to successful ageing predicts future quality of life in older adults. *Health and Quality of Life Outcomes*, 9, SP-13.  
<https://doi.org/10.1186/1477-7525-9-13> PMID: PMC3063186
- Brar, R., Kaur, J., & Sharma, I. (2013). Mental Health Of Elderly As Related To Their Well Being And Self Esteem. *International Journal of Humanities and Social Science Intervention*, 2(11), 54–57.
- Brown, A. D., Kouri, N. A., Rahman, N., Joscelyne, A., Bryant, R. A., & Marmar, C. R. (2016). Enhancing self-efficacy improves episodic future thinking and social-decision making in combat veterans with posttraumatic stress disorder. *Psychiatry Research*, 242, 19–25.
- Buchanan, J. A., Lai, D., & Ebel, D. (2015). Differences in perception of gerotranscendence behaviors between college students and community-dwelling older adults. *Journal of Aging Studies*, 34, 1–9.
- Calys-Tagoe, B. N. L., Hewlett, S. A., Dako-Gyeke, P., Yawson, A. E., Bad-Doo, N. A., Seneadza, N. A. H., Biritwum, R. B. (2014). Predictors of Subjective Well-Being Among Older Ghanaians. *Ghana Medical Journal*, 48(4), 178–184.

Mental Health of community dwelling older adults

- Carver, C. S., & Scheier, M. F. (1998). *On the self-regulation of behavior*. New York: Cambridge University Press.
- Carver, L. F., & Buchanan, D. (2016). Successful aging : considering non-biomedical constructs. *Clinical Interventions in Aging, 11*, 1623–1630.
- Chatters, L. M., Taylor, H. O., & Nicklett, E. J. (2018). Correlates of Objective Social Isolation from Family and Friends among Older Adults. *Healthcare, 6*(24), 1–14.
- Cheng, S., Lee, C. K. L., Chan, A. C. M., Leung, E. M. F., & Lee, J. (2009). Social Network Types and Subjective Well-being in Chinese Older Adults. *Journal of Gerontology: Psychological Sciences, 64B*(6), 713–722.
- Cheung, S., & Sun, S. Y. K. (2000). Effects of Self-Efficacy and Social Support on the Mental Health Conditions of Mutual-Aid Organization Members. *Social Behavior and Personality: An International Journal, 28*(5), 413–422.
- Chokkanathan, S. (2013). Religiosity and well-being of older adults in Chennai, India. *Aging & Mental Health, 17*(7), 880–887.
- Cohen, A. B., & Koenig, H. G. (2004). Religion and Mental Health. *Encyclopedia of Applied Psychology, 3*, 255–258.
- Cornwell, B., Laumann, E. O., & Schumm, L. P. (2008). The Social Connectedness of Older Adults : A National Profile. *American Sociological Review, 73*, 185–203.

Mental Health of community dwelling older adults

Crowther, M. R., Parker, M. W., Achenbaum, W. A., Larimore, W. L., & Koenig, H. G. (2002).

Rowe and Kahn's Model of Successful Aging Revisited: Positive Spirituality—The Forgotten Factor. *Gerontologist*, 42(5), 613–620.

Dalby, P. (2007). Is there a process of spiritual change or development associated with ageing? A critical review of research, *Aging & Mental Health*, 10(1), 4-12.

Department of State, U. S (2015). Japan 2015 International Religious Freedom Report.

Desai, A. (2016). Efficacy of Gender and Age on Spirituality and Psychological Well-Being of Adults. *The International Journal of Indian Psychology*, 3(2), 83–92.

Domfe, G., & Aryeetey, E. B. (2017). Household Composition And Well-Being of Older Persons In Ghana. *Ghana Studies*, 19, 130–153.

Dosu, G. S. (2014). Elderly Care in Ghana. *Human Ageing And Elderly Service*, 1–46.

Drake-Brassfield, C. (2008). An Analysis of African-Centered Psychology, Diversity, and Cultural Trends Using The Social Theory Model. *American Journal of Psychological Research*, 4(1), 29–36.

Egwu, C. (2013). Modernization and Ageing Patterns in NIgeria. *International Journal of Social Sciences and Humanities*, 4(1), 116–119.

Elliott, M., & Hayward, R. D. (2007). Religion and well-being in a church without a creed. *Mental Health, Religion and Culture*, 10(2), 109–126.

Ellison, C. G., & Fan, D. (2008). Daily Spiritual Experiences and Psychological Well-Being among US Adults. *Social Indicators Research*, 88(2), 247–271.

Mental Health of community dwelling older adults

Erikson, E. H. (1950). *Childhood and society*. New York: W. W. Norton.

Erikson, E. H. (1982). *The life cycle completed: A review*. New York: W. W. Norton.

Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1986). *Vital involvement in old age*. New York: W. W. Norton.

Ferguson, S. J., & Goodwin, A. D. (2010). Optimism and Well-Being in Older Adults: The Mediating Role of Social Support and Perceived Control. *The International Journal of Aging and Human Development*, 71(1), 43–68.

Fiori, K. L., Antonucci, T. C., & Cortina, K. S. (2006). Social Network Typologies and Mental Health Among Older Adults. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 61(1), 25–32.

Frazier, C., Mintz, L. B., & Mobley, M. (2005). A Multidimensional Look at Religious Involvement and Psychological Well-Being Among Urban Elderly African Americans, *Journal of Counseling Psychology*, 52(4), 583–590.

Fry, P. S., & Debats, D. L. (2002). Self-efficacy beliefs as predictors of loneliness and psychological distress in older adults. *International Journal of Aging & Human Development*, 55(3), 233–269.

Fuller-Iglesias, H. R. (2015). Social ties and psychological well-being in late life: The mediating role of relationship satisfaction. *Aging and Mental Health*, 19(12), 1103–1112.

Mental Health of community dwelling older adults

Gildner, T. E., Liebert, M. A., Capistrant, B. D., D'Este, C., Snodgrass, J. J., & Kowal, P.

(2016). Perceived Income Adequacy and Well-being Among Older Adults in Six Low- and Middle-Income Countries. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 0(0).

Gore, C. (2002). *Religion in Africa*. in (P. Fletcher, H. Kawanami, & D. Smith, Eds.). London and New York: Routledge.

Greenfield, E. A., Vaillant, G. E., & Marks, N. F. (2009). Does Spiritual Perceptions Have Independent Linkages with Diverse Dimensions of Psychological Well-Being ?, *Journal of Health and Social Behavior*, 50, 196–213.

Gull, F., & Dawood, S. (2013). Religiosity and Subjective Well-Being amongst Institutionalized Elderly in Pakistan, *Health Promotion Perspectives*, 3(1), 124–128.

Gupta, V., & Chadha, N. K. (2013). Spirituality : Investigating the effects of age and gender, *Indian Journal of Positive Psychology*, 4(4), 478-485.

Gyekye, K., "African Ethics", in *The Stanford Encyclopedia of Philosophy* ( 2011 Edition), Edward N. Zalta (ed.), URL = <<https://plato.stanford.edu/archives/fall2011/entries/african-ethics/>>.

Halpern-Manners, A., Hernande, E. M., Silberg, J. L., & Eaves, L. J. (2016). The Relationship between Education and Mental Health: New Evidence from a Discordant Twin Study. *Social Forces*, 95(1), 107–132.

Mental Health of community dwelling older adults

- Hamren, K., Chungkham, H. S., & Hyde, M. (2015). Religion , spirituality , social support and quality of life : measurement and predictors CASP-12 ( v2 ) amongst older Ethiopians living in Addis Ababa. *Aging & Mental Health, 19*(7), 610–621.
- Harvey, I. S., & Silverman, M. (2013). Illness among Older African and Whites. *J Cross Cult Gerontol, 22*(2), 205–220. <https://doi.org/10.1007/s10823-007-9038-2>.
- Hewlett, S. A., Yawson, A. E., Calys-Tagoe, B. N. L., Naidoo, N., Martey, P., Chatterji, S., ... Biritwum, R. B. (2015). Edentulism and quality of life among older Ghanaian adults. *BMC Oral Health, 15*(1), 1–9.
- Hill, T. D., Ellison, C. G., Burdette, A. M., & Musick, M. A. (2007). Religious involvement and healthy lifestyles: Evidence from the survey of texas adults. *Annals of Behavioral Medicine, 34*(2), 217–222.
- Ibitoye, O. G., & Sanuade, O. A. (2015). Psychological Well-being and the Elderly in Nigeria. *Population Association of America 2015 Annual Meeting*.
- Ibitoye, O. G., Sanuade, O. A., Adebawale, A. S., & Ayeni, O. (2014). Psychological well-being of the Elderly in Nigeria. *Nigerian Journal of Sociology and Anthropology, 12*(1), 75–85.
- Jeon, G., Jang, S., Rhee, S., Kawachi, I., & Cho, S. (2007). Gender Differences in Correlates of Mental Health Among Elderly Koreans. *Journal of Gerontology: Social Sciences, 62*(5), 323–329.

Mental Health of community dwelling older adults

- Jones, T. G. (2001). Cognitive and psychosocial predictors of subjective well-being in older adults. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 62(3-B), 1582.
- Karademas, E. C. (2006). Self-efficacy, social support and well-being: The mediating role of optimism. *Personality and Individual Differences*, 40(6), 1281–1290.
- Keyes, C. L. M., Wissing, M., Potgieter, J. P., Temane, M., Kruger, A., & van Rooy, S. (2008). Evaluation of the mental health continuum- short form (MHC-SF) in Setswana-speaking South Africans. *Clinical Psychology and Psychotherapy*, 15(3), 181–192.
- Koenig, H. G., & Larson, D. B. (2001). Religion and mental health: evidence for an association. *International Review of Psychiatry*, 13(2), 67–78.
- Kwate, N. O. A. (2005). The Heresy of African-Centered Psychology. *Journal of Medical Humanities*, 26, 215–236.
- Lawler-Row, K. A., & Elliott, J. (2009). The role of religious activity and spirituality in the health and well-being of older adults. *Journal of Health Psychology*, 14(1), 43–52.
- Leondari, A., & Gialamas, V. (2009). Religiosity and psychological well-being. *International journal of psychology*, 44(4), 241–248.
- Levin, J. S., & Taylor, R. J. (1997). Age Differences in Patterns and Correlates of the Frequency of Prayer, *The Gerontological Society of America*, 37(1), 75–88.
- Litwin, H., & Shiovitz-Ezra, S. (2011). Social network type and subjective well-being in a national sample of older Americans. *Gerontologist*, 51(3), 379–388.

Mental Health of community dwelling older adults

- Luszczynska, A., Gutiérrez-Doña, B., & Schwarzer, R. (2005). General self-efficacy in various domains of human functioning: Evidence from five countries. *International Journal of Psychology, 40*(2), 80–89.
- Lyyra, T. M., & Heikkinen, R. L. (2006). Perceived social support and mortality in older people. *Journals of Gerontology - Series B Psychological Sciences and Social Sciences, 61*(3), 147–152.
- Mbiti, J.S. (1969). *African religions and philosophy*, London: Heinemann
- McCullough, M. E., & Willoughby, B. L. B. (2009). Religion , Self-Regulation , and Self-Control : Associations , Explanations , and Implications. *Psychological Bulletin, 135*(1), 69–93.
- Melato, S. R., Eeden, C. Van, & Rothmann, S. (2017). Coping self-efficacy and psychosocial well-being of marginalised South African youth. *Journal of Psychology in Africa, 27*(4), 338–344.
- Momtaz, Y. A., Ibrahim, R., Hamid, T. A., & Yahaya, N. (2011). Sociodemographic predictors of elderly ' s psychological well-being in Malaysia. *Aging & Mental Health, 15*(4), 437–445.
- Morin, R. T., & Midlarsky, E. (2016). Social support, mastery, and psychological distress in black and white older adults. *International Journal of Aging and Human Development, 82*(2–3), 209–228.

Mental Health of community dwelling older adults

- Ngaujah, D. ., & Dirks, D. . (2003). An Eco-cultural and Social Paradigm for Understanding Human Development: A (West African) Context. *Human Development and Learning*, 803, 1–12.
- Nukunya, G. K. (2003). *Tradition and change in Ghana : an introduction to sociology*. 2nd ed. Accra: Ghana Universities Press.
- Okumagba, P. O. (2011). Family Support for the Elderly in Delta State of Nigeria. *Studies on Home and Community Science*, 5(1), 21–27.
- Oldham, J. M. (2014). Commentary on “Individual and societal wisdom: Explaining the paradox of human aging and high well-being” by Dilip V. Jeste and Andrew J. Oswald: As the years go by. *Psychiatry: Interpersonal and Biological Processes*, 77(4), 337–339.
- Onuoha, U. C., & Bada, O. V. (2016). Spirituality , Self efficacy , Age , and Gender as predictors of Psychological Wellbeing among Flood Survivors in Nigeria, *Journal of Humanities And Social Science* 21(10), 43–49.
- Oppong Asante, K. (2012). Social support and the psychological wellbeing of people living with HIV/AIDS in Ghana. *African Journal of Psychiatry*, 15(5), 340–5.
- Parker, M., Roff, L. L. E. E., Klemmack, D. L., Koenig, H. G., & Baker, P. (2003). Religiosity and mental health in southern , community-dwelling older adults, *Aging & Mental Health*, 7(5), 390–397.

Mental Health of community dwelling older adults

Piedmont, R. L., Kennedy, M. C., Sherman, M. F., Sherman, N. C., & Williams, J. E. G. (2008).

A Psychometric Evaluation Of The Assessment Of Spirituality And Religious Sentiments (Aspires) Scale: Short Form, *Research in the Social Scientific Study of Religion*, 19, 163–182.

Pokimica, J., Addai, I., & Takyi, B. K. (2017). Religion and Subjective Well-Being in Ghana.

Published by : Springer Stable URL : <http://www.jstor.org/stable/41409374> REFERENCES  
Linked references are available on JSTOR for this article : , 106(1), 61–79.

Polzer, R.L., & Mile, M. S. (2007). Spirituality on African-Americans with diabetesL self-mnagement through a relationship with God. *Qualitaie Health Research*, 17(2), 176–188.

Rajani, F., & Jawaid, H. (2015). Gerotranscendence : A Critical Review. *Journal of Psychology and Clinical Psychiatry*, 4(1), 16–19. <https://doi.org/10.15406/jpcpy.2015.04.00184>

Redelinghuys (2010) General self-efficacy as a moderator between stress and positive mental health in an African context. *North West University*, 1-43. <http://hdl.handle.net/10394/4731>

Reindl Benjamins, M., & Brown, C. (2004). Religion and preventative health care utilization among the elderly. *Social Science and Medicine*, 58(1), 109–118.

Rejeski, W. J., Miller, M. E., Foy, C., Messier, S., & Rapp, S. (2001). Self-Efficacy and the Progression of Functional Limitations and Self-Reported Disability in Older Adults With Knee Pain. *Journal of Gerontology*, 56(5), 261–265.

Roothman, B., Kirsten, D., & Wissing, M. (2003). Gender differences in aspects of psychological well-being. *South African Journal of Psychology*, 33(4), 212–218.

Mental Health of community dwelling older adults

Schieman, S. (2008). The Religious Role and the Sense of Personal Control The Religious Role and the Sense of Personal Control , *Sociology of Religion*, 69(3), 273–296.

Schieman, S., Pudrovska, T., & Milkie, M. A. (2005). The Sense of Divine Control and the Self-Concept. *Research on Aging*, 27(2), 165–196.

Schönfeld, P., Preusser, F., & Margraf, J. (2017). Costs and benefits of self-efficacy: Differences of the stress response and clinical implications. *Neuroscience and Biobehavioral Reviews*, 75, 40–52.

Schwartz, E., & Litwin, H. (2017). The reciprocal relationship between social connectedness and mental health among older European Adults: A SHARE-based analysis. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 0(0), 1–9.

Seligman, M. E. P. (2002). Positive psychology, positive prevention, and positive therapy. *Handbook of Positive Psychology*, 3–9.

Shea, D. M. O., Dotson, V. M., & Fieo, R. A. (2016). Aging perceptions and self-efficacy mediate the association between personality traits and depressive symptoms in older adults. *Int J Geriatr Psychiatry*, 1-9.

Siddiqui, S. (2015). Impact of Self-Efficacy on Psychological Well-Being among Undergraduate Students, *The International Journal of Indian Psychology*, 2(3), 6-16.

Singh, A. P., Shukla, A., & Singh, P. a. (2010). Perceived Self Efficacy and Mental Health among Elderly. *Delhi Psychiatry Journal*, 13(2), 314–321.

Mental Health of community dwelling older adults

- Skarupski, K. A., Fitchett, G., Evans, D. A., Mendes, C. F., & Leon, D. (2013). Race differences in the association of spiritual experiences and life satisfaction in older age. *Aging & Mental Health, 17*(7), 888–895.
- Smith, C. (2003). Theorizing Religious Effects Among American Adolescents. *Journal for the Scientific Study of Religion, 42*(1), 17–30.
- Stokes, J. E., & Moorman, S. M. (2017). Influence of the Social Network on Married and Unmarried Older Adults' Mental Health. *The Gerontologist, 0*(0), 1–5.
- Sumavalee, C., Blair, P., Osmond, P., & Prasad, D. (2016). Elderly thermal comfort in tropical climates: identifying the knowledge gap. *The International Journal of Aging and Society, 6*(1), 45–58.
- Taiwo, O. (1998). Exorcising Hegel's Ghost: Africa's Challenge to Philosophy. *African Studies Quarterly, 1*(4), 1–16.
- Thomas, P. A. (2010). Is It Better to Give or to Receive? Social Support and the Well-being of Older Adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 65B*(3), 351–357.
- Tornstam, L. (2005). *Gerotranscendence A Developmental Theory of Positive Aging*. New York: Springer Publishing Company, Inc.
- United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Ageing (ST/ESA/SER.A/390)*.

Mental Health of community dwelling older adults

- van Dyk, P. ., & van Dyk, A. . (2015). Religious coping strategies and perceived causes of sickness and health in South Africa. *Verbum et Ecclesia*, 36(1), 1–7.
- Vosloo, C., Wissing, M. P., Temane, Q. M., & Temane, Q. M. (2009). Gender , Spirituality and Psychological Well-Being. *Journal of Psychology in Africa*, 19(2), 153–160.
- Waite, D. (2017). The Relationship Between Religiosity and Depression Among Sampled Kenyans In The Twin Cities Metro Area. *All Theses, Dissertations, and Other Capstone Projects*, 691. Retrieved from <http://cornerstone.lib.mnsu.edu/etds/691>.
- Walker, A. (2006). Child Protection and Interagency Collaboration. *Policy Quarterly: The Institute of Policy Studies*, 2(4), 29–38.
- Wallace, K. A., & Bergeman, C. S. (2002). Spirituality and Religiosity in a Sample of African American Elders : A Life Story Approach. *Journal of Adult Development*, 9(2).
- Wheeler, E. A., Ampadu, L. M., & Wangari, E. (2002). Lifespan Development Revisited : African-Centered Spirituality Throughout the Life Cycle. *Journal of Adult Development*, 9(1), 71–78.
- White, S. (2015). Gerotranscendence Theory: A Fresh Look at Positive Aging. *Engaging Aging*, 10(1), 1–8.
- Williams, L., Zhang, R., & Packard, K. C. (2017). SSM - Population Health Factors affecting the physical and mental health of older adults in China : The importance of marital status , child proximity , and gender. *SSM - Population Health*, 3, 20–36.

Mental Health of community dwelling older adults

Wink, P., & Dillon, M. (2002). Spiritual Development Across the Adult Life Course : Findings From a Longitudinal Study, *Journal of Adult Development*, 9(1), 79-94.

Wrzus, C., Hänel, M., Wagner, J., & Neyer, F. J. (2013). Social network changes and life events across the lifespan: A meta-analysis. *Psychological Bulletin*, 139(1), 53-80.



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4. How often do you attend religious services?

- Never                                       Occasionally                                       Quite often  
 Rarely                                       Often

Section II

1. In the quiet time of my prayers and/or meditations, I find a sense of wholeness.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

2. I have done things in my life because I believed it would please a parent, relative or friend that had died.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

3. Although dead, memories and thoughts of some of my relatives continue to influence my current life.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

4. I find inner strength and/or peace from my prayers and/or meditations.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

5. I do not have any strong emotional ties to someone who has died.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

6. There is no higher plane of consciousness or spirituality that binds all people.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

7. Although individual people may be difficult, I feel an emotional bond with all of humanity.

- Strongly agree       Agree       Neutral       Disagree       Strongly disagree

8. My prayers and/or meditations provide me with a sense of emotional support.

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Strongly agree     Agree     Neutral     Disagree     Strongly disagree

9. I feel that on a higher level all of us share a common bond.

Strongly agree     Agree     Neutral     Disagree     Strongly disagree

**SECTION C: GENERAL SELF-EFFICACY SCALE.**

		Not at all true	Hardly true	Moderately true	Exactly true
1.	I can always manage to solve difficult problems if I try hard enough.				
2.	If someone opposes me, I can find the means and ways to get what I want.				
3.	It is easy for me to stick to my aims and accomplish my goals.				
4.	I am confident that I could deal efficiently with unexpected events.				
5.	Thanks to my resourcefulness, I know how to handle unforeseen situations.				
6.	I can solve most problems if I invest the necessary effort.				
7.	I can remain calm when facing difficulties because I can rely on my coping abilities.				
8.	When I am confronted with a problem, I can usually find several solutions.				
9.	If I am in trouble, I can usually think of a solution.				
10.	I can usually handle whatever comes my way.				

**SECTION D: LUBBEN SOCIAL NETWORK SCALE**

		None	One	Two	Three or Four	Five to eight	Nine or more
1	How many relatives do you see or hear from at least once a month?						
2	How many relatives do you feel at ease with that you can talk about private matters?						
3	How many relatives do you feel close to such that you could call on them for help?						
4	How many of your friends do you see or hear from at least once a month?						
5	How many friends do you feel at ease with that you can talk about private matters?						
6	How many friends do you feel close to such that you could call on them for help?						

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**SECTION E: MENTAL HEALTH CONTINUUM**

During the past month, how often did you feel the following ways ...	Never	Once or Twice	About once a week	2 or 3 Times a week	Almost Everyday	Everyday
1. Happy						
2. Interested in life						
3. Satisfied with life						
4. That you had something important to contribute to society						
5. That you belonged to a community (like a social group, school, neighborhood, etc.)						
6. That our society is a good place, or is becoming a better place, for all people						
7. That people are basically good						
8. That the way our society works made sense to you						
9. That you liked most parts of your personality						
10. Good at managing the responsibilities of your daily life						
11. That you had warm and trusting relationships with others						
12. That you had experiences that challenged you to grow and become a better person						
13. Confident to think or express your own ideas and opinions						
14. That your life has a sense of direction or meaning to it						

Appendix B: Consent Form

UNIVERSITY OF GHANA



Official Use only Protocol number
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**Ethics Committee for Humanities (ECH)**

PROTOCOL CONSENT FORM
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Section A- BACKGROUND INFORMATION
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Title of Study:	Religiosity/Spirituality, Social support, General self-efficacy and Mental health of community dwelling older adults in Accra.
Principal Investigator:	Abraham Kenin
Certified Protocol Number	

Section B- CONSENT TO PARTICIPATE IN RESEARCH
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**General Information about Research**

The surge in the elderly population has prompted many empirical studies into health, well-being and ageing within the context of religious beliefs and practices. Individual social and psychological factors that underpin the relationship between religiosity/spirituality and positive mental health constructs are however understudied. The current study therefore, will examine these factors. You will be given a questionnaire to respond to and there is no right or wrong answer. The completion of the questionnaire will take 30 minutes.

**Benefits/Risks of the study**

There will be no direct benefits to you. However, it is expected that the findings from this study will inform clinicians and other stakeholders of mental health about the relevance of religiosity/spirituality on individual psychological factors such as self-efficacy and well-being.

Any potential risk or discomfort likely to be experienced by the participants as a result of their involvement in the study will be managed by means of psychotherapy or psychoeducation after assessment of the participants.

Mental Health of community dwelling older adults

### **Confidentiality**

Please be assured that no information provided here will be divulged to a third party without your consent. Your name or any personal identifying information is not required. All the information you provide will be handled with care and used for academic purpose only.

### **Compensation**

There will be no material or direct compensation for participation in the study.

### **Withdrawal from Study**

Your participation in this research is voluntary and you have the right to withdraw or decline to participate in this study at any time without penalty. You are assured that you or your legal representative will be informed well before time if information becomes available that may be relevant to your willingness to continue in participation of this study.

### **Contact for Additional Information**

Should you decide to clarify anything about the research or seek for any additional information concerning the study, you may contact the principal investigator, Abraham Kenin, University of Ghana, Legon. Telephone:0247053588 or email: [akenin@st.ug.edu.gh](mailto:akenin@st.ug.edu.gh). If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at [ech@isser.edu.gh](mailto:ech@isser.edu.gh) / [ech@ug.edu.gh](mailto:ech@ug.edu.gh) or 00233-303-933-866.

### **Section C- PARTICIPANT AGREEMENT**

**"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."**

\_\_\_\_\_

Name of Participant

\_\_\_\_\_

Signature or mark of Participant

\_\_\_\_\_

Date

Mental Health of community dwelling older adults

**If participant cannot read and or understand the form themselves, a witness must sign here:**

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

\_\_\_\_\_

Name of witness

\_\_\_\_\_

Signature of witness / Mark

\_\_\_\_\_

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

\_\_\_\_\_

Name of Person who Obtained Consent

\_\_\_\_\_

Signature of Person Who Obtained Consent

\_\_\_\_\_

Date

**Appendix C: Ethical Clearance from ECH**



**UNIVERSITY OF GHANA**  
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

*P. O. Box LG 74, Legon, Accra, Ghana*

My Ref. No.....

1<sup>st</sup> November, 2017

Mr. Abraham Kenin  
Department of Psychology  
University of Ghana  
Legon

Dear Mr. Kenin,

**ECH 058/17-18: RELIGIOSITY/SPIRITUALITY, SOCIAL SUPPORT, GENERAL SELF-EFFICACY AND MENTAL HEALTH OF COMMUNITY DWELLING OLDER ADULTS IN ACCRA**

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 31/05/18  
On Agenda for: Initial Submission  
Date of Submission: 18/09/17  
ECH Action: Approved  
Reporting: Quarterly



Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante  
ECH Chair

CC: Dr. Maxwell Asumeng, Department of Psychology, University of Ghana.