UNIVERSITY OF EDUCATION, WINNEBA

PSYCHOSOCIAL WELL-BEING OF THE ELDERLY AT MAMFE TOWNSHIP IN THE AKUAPEM NORTH MUNICIPALITY

JULIANA ESI ARKAH

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JULIANA ESI ARKAH
(200020318)

A thesis in the Department of Counselling Psychology, Faculty Applied Behavioural Sciences in Educational, submitted to the School of Graduate Studies, in partial fulfilment of the requirement for the award of the degree of Master of Philosophy (Counselling Psychology) in the University of Education, Winneba

MAY, 2022

DECLARATION

Student's Declaration

I, Juliana Esi Arkah (Rev.), hereby declare that, this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has been submitted, either in part or whole, for another degree elsewhere.

Signature: ……

Date: ……

Supervisor's Declaration

I hereby declare that the preparation and presentation of this thesis was supervised in accordance with the guidelines for supervision of dissertation as laid down by the University of Education, Winneba.

Mrs. Epiphania Emefa Bonsi (PhD) (Supervisor)

Signature: ……

Date: ……

DEDICATION

To God be the glory great things He has done. This project is dedicated to my loving husband, Samuel Emmanful Arkah for his love and concern to make me climb the academic ladder, my children Nana Kweku Acquah Arkah, Kweku Adu- Boateng Arkah and Kodwo Sempeh Arkah, and my mother Grace Yanney for their cooperation during the period of my studies.

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ABSTRACT

The study assessed the psychosocial well-being of the elderly in Mamfe Township in the Akuapem North Municipality of Ghana. Psychosocial well-being is an aspect of personality often overlooked when assessing the health of an elderly individual. While greater importance is being placed on helping elderly individuals remain active in the community, little interest has been generated on the topic of psychosocial well-being. The purpose of the study is to explore the psychosocial well-being of the elderly. A purposive sample of ten (10) elderly in the Methodist and Presbyterian Churches, and pensioners association completed a survey interview. An in-depth interview was conducted in eliciting the lived experiences of the elderly in the Mamfe Township. All recorded data (audio and written) was transcribed verbatim and coded using SPSS, a qualitative data analysis computer software. Also, two hundred and one (201) questionnaires were given out as a random sampling for the elderly in the area for the quantitative aspect. Responses were grouped under the themes of the interview and the questionnaires, and this guided the discussions which followed. The results of the study revealed that most of the elderly sampled felt good, blessed and privileged to attain that age. Again, their economic status and support systems put in place by their caregivers were highly catered for. There is therefore the need to recommend pastoral care counselling, education, day-care centers to the elderly and strengthen current preventive rather than remedial measures through pastoral and counselling programmes in churches, work places, communities and through better education of school-going youth to plan toward aging to improve the psychosocial well-being of the elderly in the Mamfe township of the Akuapem North Municipal in the Eastern Region of Ghana at this modern era to curb the burden on children or young family.

CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

Throughout history of human existence, aging has been a blessing to any family. Older adults attribute successful aging to quality life. That is why there is this adage in Akuapem that –Opanyin nyi wo fi a due" (If there is no elder in your family sorry for you). There is also another saying by Becky Collins (2005) –He who does not honour age does not deserve age". Aging, its problems and potentialities is an issue for discussion, research and social policy in many developed and developing countries (Ayetey-Nyampong, 2008). In Ghana (as well as in many other African States), the realization of the problems of aging is emerging as a result of social changes that have weakened the traditional support system and plunged the once respected, venerated and cared for elderly people into difficulties relating to their status, potential value and well-being within the Ghanaian society). Aging as an issue of concern is gradually gaining awareness in the Ghanaian society. As the population of the people aging in the developing world increases at a phenomenal rate, governments and other non-governmental agencies are becoming conscious of the need to establish the necessary conditions that will promote the quality of life of the aging population (Ayetey- Nyampong, 2008).

Whilst this awareness is a welcome sign of sensitivity to the deplorable conditions of older adults in our society, many nations have not moved beyond this stage of sensitivity to real practical approach to addressing the issues of aging (Ayetey-Nyampong, 2008). Much is yet to be seen about the tackling of challenges that confront the aging population in contemporary Ghana. It is evident that the reliance

on the extended family system to cater for the older population is becoming less tenable due to the rapid social changes being experienced in the Ghanaian society. The migration of the youth from rural to urban centers in search of jobs and the gradual shift from the extended to the nuclear family unit in Ghana have, together with other socio-economic factors, led to the isolation and sometimes abandonment of the elderly population, many are widowed and poor (Ayetey- Nyampong, 2008). Mba (2004), in his writing –Population Aging and Survival Challenges in Rural Ghana", has confirmed that, _because of modernization and urbanization, the traditional solidarity network, particularly the extended family system, is disintegrating, leaving the elderly with little or no means of support and care. As a result, Ghana's rapidly increasing older population is in a precarious situation that is likely to perpetuate poverty.'

According to the World Health Organisation (WHO) (April 6, 2020), between four to six per cent of the elderly worldwide suffer from a form of abuse physically, emotionally and financially. A statement issued on April 6, 2020 by the United Nations General Assembly copied to Ghana News Agency said such abuse was an unacceptable attack on human dignity and human rights and some of the cases often remained unreported and unaddressed. It was said by UN Secretary General on 6 April 2020, emerging research suggested that abuse, neglects and violence against the elderly both at home and in institutions were much more prevalent than currently acknowledged. The statement said alarmed at this widening problem, the Assembly had proclaimed World Elder Abuse Awareness Day, a new observance to be marked annually on June 15. It said respect for the elderly was an integral part of many societies as people lived longer and strive for sustainable and inclusive development, it was time to revive and expand the appreciation for those who had advanced in age.

–A modern civilization can only live up to that name if it preserves the tradition of honouring, respecting and protecting society's elders," it added, Commemorating the maiden Day, it urged all and sundry to join in reaffirming that the human rights of elderly were as absolute as those of all human beings.

According to the statement, the UN body called on governments and stakeholders to design and undertake more effective prevention strategies and stronger laws and policies to address all aspects of elderly abuse. –Let us work together to optimize living conditions for the elderly and enable them to make the greatest possible contribution to the world." This research is an attempt to lay bare again the psychosocial well-being of the elderly people in the Ghanaian society and challenge the myth that they are being provided for by the extended family and community. It was also anticipated that families and government's sensitivity to the plight of older adults will be re-awakened so that a comprehensive programme and policy will be established to promote the quality of life of the aging population in modern Ghana. Non-governmental organizations, Churches and other groups have a role to play in creating conditions for people to age gracefully in modern Ghana. Collaborating with government and other social institutions will ensure that services and programmes designed for older adults are appropriate adequate and well managed to achieve set goals.

There come questions as to how the aged are being treated in the country. Are they given the necessary attention that they deserve by families, churches and the country as a whole? Some of the occurrences depicting an abuse or ill-treatment of an aged person(s) include:

1. Physical abuse: the infliction of physical harm, injury, physical coercion, sexual molestation and physical restraint.
2. Psychological abuse: the infliction of mental anguish.
3. Material abuse: the illegal or improper and / or use of funds or material.
4. Active neglect: the refusal or failure to undertake a care-giving obligation (including a conscious and intentional attempt to inflict physical or emotional stress on the elderly).
5. Passive neglect: the refusal or failure to fulfill a caring obligation (excluding a conscious and intentional attempt to inflict physical or emotional distress on the elderly).

In an article published in the magazine ‗Aging in Africa' on the topic ―Calling for an End to Elder Abuse", incidents of abuse in Africa has been summarized. The article noted that in Africa, some of the abuses are: ―Older people suffer all forms of abuse in the hands of the communities they live among and even close family members.

1. Cases of rape older women by much younger men are on the increase in parts of Africa. These arise from the mistaken notion that having sex with an older woman can cure AIDS.
2. Incidents of murder of older people for various reasons by family members are capturing headlines in the media. In Ghana, stories of abuse of the elderly now attract media interest. Newspapers do not hesitate to carry stories of reported cases of granny bashing or abuse of older men or neglect of older people who need social and government support and care. The Gambaga Witch Camp in the Northern Ghana is full of older women and men who have been abandoned and isolated from society for allegedly being witches (Linda R. Phillips and Lisa Marie O'neill, June 14, 2019).

The Conversation Elder abuse is far more common than many believe, making an already challenging time of life harder for those who are victims of it. Credit: *SpeedKingz/Shutterstock.com*. About 16% of older adults are victims of some form of mistreatment and the number of reported cases of elder abuse is steadily increasing. Because of poor record-keeping, however, those of us who study elder abuse don't know if the trend reflects an actual increase, an increase because of growing numbers of older adults, or only an increase in reporting due to greater awareness. Elder abuse involves intentional or unintentional acts that result in physical, emotional or financial harm to an individual who is 65 years or older.

As part of Brazil's demographic transition, the country's population is following the worldwide trend and becoming increasingly older (Kalache, Veras & Ramos, 1987). Compared to the European countries, in Brazil the phenomenon has been more intense and rapid, coinciding with an urbanization process, often associated with industrialization, but without the corresponding improvements in quality of life for the majority of the population. Thus, populating aging, combined with the stress of modern living, aggravates individual and family problems and conflicts in collective life in both the public and private spheres. Such problems mount up and can be expressed in the form of violence. In this context, the elderly population becomes vulnerable due to physiological, psychological, and socioeconomic issues.

The World Health Organization (WHO) (2002), defines violence as the intentional use of physical force or power, whether real or threatened, against oneself or another person, group, or community, resulting or with the possibility of resulting in injury, death, psychological harm, developmental disability, or deprivation. According to the WHO and the Brazilian National Policy for the Reduction of Morbidity and Mortality

from Accidents and Violence, can be classified as: physical, psychological, sexual, or financial abuse, neglect, abandonment, or self-neglect. Physical abuse of elders, the object of this study, relates to the use of physical force to compel older persons to act against their wishes, to hurt them, or to cause them pain, incapacity, or death. Elder abuse is a public health problem. Elder abuse was described for the first time in 1975, and the first publications on the issue came from the United States, Canada, and the United Kingdom and other European countries. In Brazil, despite the issue's public health relevance, the phenomenon did not gain visibility until the 1990s.

Stories about elder abuse, including one in April 2018, involving a 70-year-old woman who was kept in a dog kennel and tortured by a family member, are not uncommon. Two sisters were arrested in March 2019 for murdering their 85-year-old father. In April 2019 fraud and embezzlement charges were levelled against the manager of Stan Lee, age 95, the late comic book legend. And most recently, a sheriff in rural Georgia was arrested May 29, 2019 for allegedly grabbing a 75-year-old man by his throat.

1. Older people are wrongly accused of practicing witchcraft, which they are blamed for deaths of family members, droughts, floods, disease and other calamities in the communities they live in. The accused aged may be set upon by community members with beatings that may be fatal or that leave them with disabilities, or they are burned in their houses.

These trends are increasing at an alarming rate in many parts of Africa. Eniola Olubukola Cadmus-First Online: 10 August 2019, Author-A Myth or Reality? Wrote; Population aging in Nigeria is occurring alongside poverty, high levels of unemployment among the youths and poor economic and social support systems by

the government. Furthermore, changes in the family structure as a result of modernization, urbanization and increased presence of women in the work force have led to a significant reduction in available primary caregivers and void of care for older persons. In Nigeria, as well as the traditional setting in many African countries, the family has the responsibility of providing care and support for older persons. However, due to the present economic realities in the country, there are many instances whereby the family is either unwilling or unable to provide adequate care and support for older persons. Likewise, the downward slope of economic indices in the country has also encouraged emotional and economic nucleation in the country. Therefore, older persons are increasingly placed at risk for abuse and neglect. Although abuse of older persons is regarded as taboo in many African countries, available literature suggests it is a reality and in fact, may be underestimated.

Principal Secretary Ali Noor, of Kenya‘s Ministry of Labour, addressed the crowd in 2013, pledging the continued support of the government to its older citizens. He noted an increase in Kenya‘s aged population, a demographic trend that is accompanied by rapid urbanization. "In particular, the increased movement of younger persons from rural to urban areas in search of employment has led to major challenges in family structures, resulting in the breakdown of the extended family support systems to older persons in society, with its in-built social protection systems," Noor said. Though the rights of elders are protected in the 2010 Kenyan constitution, cases of elder abuse and neglect persist in the country.

According to a U.N. Department of Economic and Social Affairs (UN DESA) report on aging, released on Sunday, June 16 2013, witchcraft accusations used to justify extreme violence against older women are reported in 41 African and Asian countries,

including Burkina Faso, Cameroon, India, Kenya, Malawi, Nepal and Tanzania. Older women are at particular risk due to widespread discriminatory attitudes and practices, U.N. Secretary-General Ban Ki-moon said in his message about the awareness day posted on the United Nations news website. But there is no clear picture of the actual scope of the neglect, violence and abuse of older women, its complexity and diversity, UN DESA reported. The U.N. World Health Organization (WHO) said that abuse is under-reported by as much as 80 percent. The global population of people aged 60 years and older is expected to more than double, from 542 million in 1995 to about 1.2 billion in 2025, the report stated. The share of older persons (aged 60 years or older) in the total population increased from 9 percent in 1994 to 12 percent in 2014, and is expected to reach 21 percent by 2050.

However, aging is influenced by many variables including one's social, psychological, economic and health experiences and disparities in living standards throughout Ghana and Mamfe in the Akuapem North Municipality in the Eastern Region is no exception. Psychosocial well-being of the elderly status depends on a combination of variables, including psychological, social relationship, economic, health and place of residence of the elderly.

Ensuring healthy lives and promoting well-being for all at all ages is essential to sustainable development at every stage of life. From the Sustainable Development Goal 3, psychosocial well-being is an aspect of personality often overlooked when assessing the health of an elderly individual. While greater importance is placed on helping elderly individuals remain active in the community, little interest has been generated on the topic of psychosocial well-being. Psychosocial well-being includes having a positive self-image and feeling like an important part of social relationships.

To help ensure psychosocial well-being in an elderly individual, the person should be kept active in community activities and feel a sense of independence. However, all elderly people can enjoy a better quality of life if the psychosocial well-being of the elderly is assessed and found to be positive. For some elderly residents of a skilled nursing facility, a change in routine can trigger a lack of psychosocial well-being. Other residents may become depressed because the residents are no longer able, for various reasons, to participate in all of the activities that such patients formerly participated in. A decline in psychosocial well-being is marked by signs of depression and, potentially, delusions. Maintaining psychosocial well-being can lead to a higher quality of life for an elderly individual.

1.1 Statement of the Problem

In the years gone by, older men and women were highly respected and were called upon for advice and their immense wisdom did help in solving problems (Apt 1989). Sociologist Allan Glicksman sees respect for elderly as tied to the more dominant issue of authority in the Jewish community. The assumption was made that if one lived a long time, that person learned a great deal about the Jewish tradition and was consequently deemed wise (Glicksman, 1990). It was, however, only a decade and half ago that interest was aroused in, and research into social gerontology was endangered in Ghana (Apt, 1993). The probable reason is that problems related to aging in modern society had not been envisaged as post-independent governments embraced modernisation programmes in Ghana (Africa).

The current research interest of Professor Nana Araba Apt has opened the field aging to many interdisciplinary studies. It is an indisputable fact in Ghana (and Africa as a whole) that under the traditional system, elderly people enjoyed respect and care (Apt,

1989). However, various scholars and university students who have undertaken research into the situation of elderly people in two settings: traditional and modern, for example, Nana Araba Apt (1991), has confirmed in her article ‗Care of the Elderly in Ghana: An Emerging Issue' that; under the traditional system, the aged are respected because they never cease to be productive. They are consulted by the young and this interaction gives them a sense of self-worth.

Rev. Dr. Samuel Ayetey- Nyampong's (2008), research published in his first book "Pastoral Care of the Elderly in Africa", and "Aging in Contemporary Ghana" dealt with the status of older adults within the typical traditional African system in Africa. Some reasons that accounted for their status include the fact that they possess good knowledge of the family history and are regarded as the respiratory of wisdom and knowledge. Today the story has changed; society has lost the respect and honour held for aged in our midst. Also due to socio-economic challenges, the aged are left alone by their children in the care of other family members, grandchildren or caregivers to work and to live with the spouse in a different place. It is in this regard that this research is focused on the factors that influence the psychosocial well-being of the elderly in Mamfe Township.

The 1992 Constitution clearly states in Article 37(6b) that the "State provides social assistance to the aged such as will enable them to maintain a descent standard of living" (Okraku, 1985). However, there is no policy that protects the rights of the aging currently. A draft on National Aging Policy presented to Cabinet in 2003 has since not been given any attention. This shows how little the country is concerned about the aging population. Although the State has agreed to provide an assistance, the constitution did not clearly state the actual assistance that would be given to the

aged. As a result of this, most elderly people are facing psychosocial challenges in terms of relationship, emotional, economic, healthcare, and perception of witchcraft, which the study of psychosocial well-being of the elderly is interned to explore and find solution.

1.2 Purpose of the Study

The purpose of the study was to explore the psychosocial well-being of the elderly, find out the responsibility of the family, church and the nation towards the elderly and how to reduce the negative effects on the well-being of the elderly.

1.3 Objectives of the Research

The objective of the research was:

1. To identify the psychosocial well-being of the elderly in Mamfe township.
2. To examine the roles family, church and the nation play to assist in the care of the elderly in the Mamfe township.
3. To find out the factors that influence the psychosocial well-being of the elderly at Mamfe.
4. To establish measures that can be put in place to improve the psychosocial well-being of the elderly in Mamfe.

1.4 Research Questions

The following research questions will be formulated to guide the study:

1. What is the psychosocial well-being of the elderly in Mamfe township?
2. What roles do family, church and the nation play to assist in the care of the elderly in the Mamfe township?
3. What are the factors that influence the psychosocial well-being of the elderly at Mamfe?

4. What measures can be put in place to improve the psychosocial well-being of the elderly in Mamfe?

1.5 Significance of the Study

The significance of this research was to establish the family, church and nation's responsibility towards the aged through guidance and counselling activities provided by the church, public and private institutions. This research was to create awareness to the counsellors, aging groups and researchers about the benefits of aging and how to handle people who are aged in the society. The research aims to reduce complaints and improve functioning related to mental disorders and/or social problems (e.g., problems with personal relationships, or work) by addressing the different psychological and social factors influencing the aged. For example, a psychosocial intervention for an older adult with a mental disorder might include psychotherapy and a referral to a psychiatrist while also addressing the caregiver's needs in an effort to reduce stress for the entire family system as a method of improving the aged quality of life.

The research was a means that if the aged been abused is afraid of acting, the support group can help them to bring the case to the attention of the authorities. The fundamental issue that has given birth to the spread of elder abuse in society is the negative attitude that people often carry towards the elderly. The first step is therefore, creating an atmosphere, which encourages a positive attitude towards the elderly. Many people, especially the youth have stereotypes, negative attitudes, and discrimination towards the elderly. The elderly are believed to be of no great significance to the society because they are thought to basically rely on others for physical assistance, housing, financial support, medical help, among others. Since

they are physically frail and worn out, they have little control over their own life (including personal activities like physical hygiene, feeding, etc.) and are therefore believed to be of little value to the society. This reasoning affects the way relatives, caregivers, friends, and society as a whole treat the elderly (Kathryn & Mary, 2012). The study is intended to encourage people to have more respect and warmth for the elderly which is a major step towards eradicating elder abuse. This comes in the form of public education where the social media is used to raise awareness of elder abuse in the society. Knowledgeable people make informed decisions, which are likely to bring transformation in the society. Movements that support the elderly starts campaigns which create awareness. Some important elements highlighted in this research were increasing respect for the elderly, seeing the valuable experiences, skills and abilities in the elderly people, and treating them as fellow human beings who can make a change in the society. In all, the research was a means by which society is reminded about their role in giving older people the opportunity to live in dignity, free of exploitation and mistreatment, and participate in cultural, economic and spiritual activities.

1.6 Delimitations

Delimitations are choices made by the researcher which should be mentioned. They describe the boundaries that the researcher has set for the study. Just like any other research, the investigation had its own scope or delimitations. These delimitations were the kind of instrument used, time and again to enable the sample and general experience of the researcher. The investigator used questionnaire to collect data needed for this study. This study focused on the elderly in Mamfe Community. The study covered the psychosocial well-being of the elderly among some denominations and pension association in the area for the qualitative aspect. These denominations are

the Methodist and Presbyterian churches, in the locality. This delimitation notwithstanding, it is hoped that the information from the questionnaire, interview and findings produced useful and comprehensive research. The usual reasons for choosing a particular sampling technique for example are related to available resources, local circumstances (practical access), ethical and permit considerations or time constraints. Various scholars and university students have undertaken research into the situation of elderly people in two settings: traditional and modern. For example, Nana Araba Apt (1989), a prominent African (Ghanaian) Social Gerontologist and President of the African Gerontological Society, has confirmed in her article ‗Care of the Elderly in Ghana: An Emerging Issue' that; Under the traditional system, the aged are respected because they never cease to be productive. They occupy important places in the family system. They are consulted by the young and this interaction gives them a sense of self-worth.

Rev. Dr. Samuel Ayetey-Nyampong did a research and in his first book ―Pastoral Care of the Elderly in Africa", and ―Aging in Contemporary Ghana" (2008), dealt with the status of older adults within the typical traditional African system in Africa. Traditionally, every Ghanaian is located within a family. Each family is composed of a complex network of relationships in which elderly members are accorded respect and dignity. Some reasons that accounted for their status include the fact that they possess good knowledge of the family history and are regarded as the respiratory of wisdom and knowledge. These attributes make them community counsellors who settle disputes, conflicts and cases of litigation, and determine who is innocent, or culpable in all cases brought before them.

In conclusion, the researcher decided to use these methods as the boundaries or limits of the work so that the study's aims and objectives do not become impossible to achieve. Thus, the study's theoretical background, objectives, research questions, variables under study and study sample.

1.7 Organisation of the Study

The study has been organized under five main chapters. The first chapter gives the general introduction of the research, defines the main problem under investigation and research questions. It further states the specific objectives of the study, significance and finally outlines the delimitations of the research.

The second chapter reviews the relevant literature in the research area of the aged which includes the issues of concept of psychosocial well-being, roles of family, church and the nations, factors that influence the aged well-being and measures to improve their well-being. The chapter also provides the theoretical, conceptual and empirical framework. It also identify the gaps in the literature in which the study attempt to fulfil.

Chapter three gives information on research design, study area of the municipality including the location and size. This includes sampling techniques and ethical consideration, equipment used in both data collection and analysis.

The forth chapter presents and in-depth analysis of the data collected from the field. It also provides answers to the research question on tables and forms the basis for the recommendations made to ensure the well-being of the elderly.

The fifth chapter which concludes the study brings out the findings and implications of the study. It also offers the recommendations and draw conclusions to ensure the well-being of the elderly for national development

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter dealt with the review of some related literature. This served as a link between past works and the current study. The literature review discussed the following headings: concept of aging, concept of psychosocial well-being of the elderly. It also discussed family, church and the nation's responsibility toward the aged, factors that influence the psychosocial well-being of the elderly and the measures to improve the effects. Also, the theoretical, conceptual, empirical framework was reviewed and finally summary of identified gaps were discussed.

2.1 Concept of aging

Aging is generally determined by external appearance. The physical features that give indications of person's age include grey hair, wrinkles on the skin, and slowness in movement, the age-related illnesses and disabilities. Scholars have different ways of defining aging. In the book, "The Psychology of Aging", Ian Stuart-Hamilton (2012) has described various ways of defining aging, based on characteristics found in elderly subjects.

a. Universal aging features - are those common to all elderly people (such as wrinkled skin)
b. Probabilistic aging features – are conditions which are likely to occur in individuals but are not universal in all (eg. Arthritis).
c. Primary aging – these are age related changes that occur in the body.
d. Secondary aging – these are changes that occur with greater frequency in old age.

e. Tertiary aging – this refers to rapid physical deterioration immediately before death.

f. Chronological age – is usually the defining line used to determine someone's age based on his or her date of birth. This does not always tell much about the features of a person since a 70-year-old may look younger (agerasia) whilst a young person may look older or may in some rare instances suffer from progeria, a disease in which patients appear to age at an abnormally fast rate and die in their early teens.

According to Lauer (2002), in his book –Social Problem and the Quality of Life", he says, most of us hope to live long life. At the same time, the aging process, which few people look forward to experiencing, usually reminds us of our inevitable death. While aging does not discontinue life, it does bring characteristic biological and developmental changes.

2.1.2 Biology of aging

Senescence is biological aging: it occurs in all people. It is rooted in our physiological makeup, and it does involve certain deteriorations. The causes of senescence are unclear, but the characteristics identifiable. These characteristics do not appear at the same ages in all people, however, for we age at different rates. Although the characteristics of senescence are rooted in our physiological makeup, various sociocultural factors combine with the biological factors to produce those characteristics. On the other hand, there are some specific ways in which the body changes as it ages. Kart (1976:181-183) lists eight different system of the body that are affected by aging.

1. The skin tends to become wrinkled, rough, and mottled (marked by spots or blotches). The skin is broken more easily but heals more slowly.
2. The skeletal-muscular system is marked by some stiffening of the joints, height reduction, and a reduction in the total mass of muscle tissue. Muscular strength and coordination decline.
3. The senses and reflexes are generally dulled by age. The sense of taste diminishes, so that facilities for the aged feel it necessary to provide more spices, hot sauces, and strong flavourings to compensate for inactive taste buds. The sense of touch becomes less acute, and the sense of vision is affected by various changes in the structure and functioning of the eye. There is a diminished ability to detect the pitch and intensity of sound. (Incidentally, loss of hearing begins at about the age of twenty.) The older the person reacts more slowly, although reaction time may be due to decreased exercise. In one study, the reaction times of a group of men whose age ranged from sixty-eight to eighty-six were compared with two groups of men whose ages ranged from eighteen to twenty-five – one group of athletes, the other nonathletic (Botwinick & Thompson, 1970, pp.186-93). Men in the elderly group were significantly slower than the athletes but were not significantly slower than the non-athletes. The extent to which some of the characteristics of senescence are due to sociocultural rather than biological factors still unclear.
4. The nervous system undergoes some specific changes, including a loss of substance and weight of the brain and a reduction of the speed of impulses to nerve tissues.
5. The circulatory system is characterized by reduced cardiac output resulting from hardening of the arteries.
6. In the respiratory system, the capacity of the lungs is diminished.

7. The digestive system is hampered somewhat by reduced muscular functioning, though many of the digestive problems of the aged may be traced to other causes.
8. Finally, there is a decline in the functioning of other systems, including the reproductive, temperature control, and kidney filtration. Normally, they decline in other systems does not result in any serious problems for the aged.

2.1.3 Aging as development

Human life is a process. A number of psychologists have attempted to identify the particular tasks that must be accomplished at each stage of development. Successful completion of tasks at one stage means that the individual normally proceeds to the next stage and a new set of tasks. It is not always recognized, however, that there are new tasks for the aged as well as for those who are younger. Ageing, in other words, is a new stage in the developmental process of life (Motenko & Greenberg, 1995).

What are the developmental tasks faced by the aged? Some tasks are similar to the tasks of other generations, and some are unique. Some are similar to those of other age groups, and some are peculiar to the elderly. In the nineteenth century, for instance, most men had no transition to retirement. Typically, a man worked until disability or death. Few people had to deal with the ―empty nest" problem, since children either did not leave the family house or returned there to live with their elderly parents (Chudacoff & Hareven, 1979)

Today, when an increasing number of people are living into their seventies and eighties, there are at least five developmental tasks facing the elderly. First, the aged must come to terms with the physical limitations inherent in their stage of life. They will no longer be able to engage in certain activities as often or as successful as they once could.

Secondly, having come to terms with limitations, the older person must redefine the scope of his or her activities. Thirdly, the older person must find new sources for satisfying his or her needs. This may be particularly acute at the time of retirement for those who hold to the work ethics.

A forth task is to reassess the criteria for self-evaluation. The question the elderly person must face is –Am I a worthwhile person because of the kind of individual I am, because of the various qualities I possess, or am I worthwhile only as long as I can function in some kind of job?" a man who lost his job in advertising when he was sixty-one told the author that he could not find another job in his field. He has done some freelance work, but he still mourns the loss of his job. –I loved what I did," he said –and I resented being thrown out on the scrap heap. There are times when I think I'm just not worth anything anymore.

Finally, the aged face the task of finding ways to give meaning and purpose to their lives. This task arises throughout the individual's life and must be faced in different contexts in the various stages of development. Some of the activities that give meaning and purpose to the younger person – education for a career, the responsibility of rearing children, and productive work – are no longer available to the older person.

As in every other stage of life, then, aging presents the individual with certain developmental tasks that must be resolved. Old age is not – or at least need not be – a time of stagnation. Many elderly people find challenges, struggles, and gratifications just as they did in their earlier years. Professor W. J. McLennan (1990), has defined aging simply as –a set of changes associated with the progress of time".

Aging is not an entirely negative process, but old age is undoubtedly a difficult period, worsened by the inadequacy of social institutions to care for the aged. Some studies have found no differences among the young and the elderly on measures of satisfaction, morale, and general happiness, and some studies show that elderly have a more positive self-concept than the younger ones.

Older people are simply, you and I at a particular point in our lives. Though aging creates new needs, the essence of the individual remains very much the same: we do not stop being one person as he or she really is not as just another representative of an age group. Aging proceeds at different rate in different people. Simply knowing someone‘s age is likely to tell us a great deal about their individual characteristics or needs.

_Old age‘ is defined in different ways for different purposes. Most of us are familiar with using retirement as the point beyond which we regard someone as being old. But with early retirement being commonplace in industry and commerce, this may become less and less reliable. Social and health services often choose an age after which social and treatment needs are dealt with by different groups of specialists. Hence, we have geriatricians (medical consultants who deal exclusively with older client), and specialist nurses and social workers in the care of older people. With more people now living to a healthy old age, these age boundaries are progressively being pushed back. For example, some specialist services for older clients only deal with people over the age of 70 rather than 65. And under the government‘s new contracts for general practitioners in Britain, it is patients over 75 who have to be offered a home visit each year to assess physical, social and mental well-being.

Old age is often said to begin at 60, which in our society (Ghana), is a typical age of retirement. In some part of the world, where life expectancy is lower, a person might be old at 35 or 40. Even in our own society (Ghana), we see enormous variation among older people. Aging is a series of processes that begin with life and continue throughout the life cycle. It represents the closing period in the lifespan, a time when the individual looks back on life, lives on past accomplishments and begins to finish off his life course. Adjusting to the changes that accompany old age requires that an individual is flexible and develops new coping skills to adapt to the changes that are common to this time in their lives (Warnick, 1995).

The definition of ‗health' with regard to old age is a subject of debate. There is consensus that health in old age cannot meaningfully be defined as the absence of disease because the prevalence of diagnosable disorders in elderly populations is high. Instead, health is considered to be multifaceted: The diagnosis of disease should be complemented by assessment of discomfort associated with symptoms (e.g., pain), life threat, treatment consequences (e.g., side effects of medication), functional capacity and subjective health evaluations (Borchelt et al., 1999). Furthermore, Rowe & Khan (1987) suggested that the health of subgroups of older adults be defined in terms of their status relative to age and cohort norms.

There is a growing body of evidence that suggests that psychological and sociological factors have a significant influence on how well individuals age. Aging research has demonstrated a positive correlation of someone's religious beliefs, social relationships, perceived health, self-efficacy, socioeconomic status and coping skills, among others, with their ability to age more successfully.

2.2 Concept of Psychosocial Well-Being of the Elderly

Psychosocial well-being of the elderly depends on the following factors; psychological, social, emotional, economic, health, spiritual and the residence of the elderly. These are explained below:

Psychosocial well-being: The term psychosocial underscores the close connection between psychological aspects of our experience (e.g., our thoughts, emotions, and behaviour) and our wider social experience (e.g., our relationships, traditions and culture). Psychosocial is a combination of two words psychology and social. Psychology is the scientific study of human mind and behaviour. Social is how a person‘s interaction and relationship with each other are. The designation ‗social‘ comes from the Latin socius meaning ―friend.‖ When you are being social, you are everyone‘s friend. Social is someone or something that enjoys being with others or has to do with people living or gathering in groups.

Social processes thoughts, feelings, and actions are affected by input from the people and groups around us: the groups to which we belong, our personal relationships, the teachings of our parents and cultures, and the pressures we experience from other people and groups. Attention to the needs of the elderly is a social necessity, and it seems that evaluating the social network and quality of life of the elderly can be useful in a better understanding of their needs. Staying physically active in one‘s autumn years offers a variety of health benefits, like lessening chronic pain, delaying and preventing certain diseases, and helping you recover faster from an illness or injury. And, while exercise is extremely important for a high quality of life, the connections you make with others and the relationships you continue to build also have a major impact on your overall wellness.

Studies show that seniors who stay socially active and engaged experience a variety of benefits, including:

Better cognitive function: Social activities keep us sharp and mentally engaged, and this is important to prevent the onset of dementia or Alzheimer‘s disease.

Maintaining good emotional health: Connecting with others helps keep you in a positive mood, which in turn wards off depression.

Improving physical health: Socially active seniors tend to be more physically active, too. Plus, you tend to eat more and make better food choices when you eat with others.

Boosted immune system. Studies show that seniors who stay engaged with others, and life around them, have higher levels of immune-system functioning.

Enjoying restful sleep: If you have difficulty sleeping at night, it could be that you‘re feeling isolated and lonely. Research shows that people who have more fulfilling relationships in their lives tend to sleep better than those who don‘t.

Increased longevity: Live a longer, happier life by keeping your social circle strong. Friends and loved ones help you deal with life‘s daily stresses, and are often key to encouraging you to live a healthier lifestyle, too.

In addition to the health benefits above, staying connected with others helps give you a sense of purpose and a true sense of belonging. What are some ways to get involved with your peers? Here are just a few suggestions:

Join a club or group**:** Think about activities that interest you. Do you like gardening? Golfing? Reading? Meeting up with others on a regular basis is a great way to meet new people and enjoy experiences with those who share your interests.

Become a volunteer: Volunteering within your local community provides a sense of accomplishment and purpose that can‘t be denied. Many hospitals, schools, community centers and animal shelters are always looking for reliable volunteers of all ages.

Enjoy lifelong learning opportunities: Many colleges or adult education centers provide classes designed specifically for seniors where you can continue to learn new things and expand your mind.

Join a senior fitness center: If a regular gym seems too intimidating, consider trying out a fitness center specifically for the older generation. You‘ll meet other active seniors who are looking to stay healthy and physically fit.

Reach out to family: When you‘ve got free time, offer to babysit, grandkids or take a loved one out to lunch. These are great ways to maintain those familial relationships and stay involved in the lives of those who mean the most to you.

Try out new technology: Don‘t be leery of those computers and tablets! They provide the perfect way for you to connect via social media, email or Skype with friends or family who don‘t live nearby.

Pick up a part-time job: Going back to work is another great way to keep your mind stimulated and engaged. Plus, as a bonus, you‘ll make a little extra spending money to tuck away for a rainy day.

This study was performed to determine the relationship between the social network and the quality of life of the elderly in the Mamfe-Akuapem Township.

2.2.1 Psychosocial health factors of the elderly

Good health is vital for economic growth and the development of societies. Older people's capacity to earn a living and participate in national development, and community and family life to a large extent depends on their state of health. Though older persons are fully entitled to have access to preventive and curative care, including rehabilitation and sexual health care, they are often denied them in addition to other essential health care services. The training of health personnel gives little attention to older people and very few specialist services exist.

Currently, there are no special incentives to attract medical and health students to offer courses in geriatrics and gerontology. The negative attitudes of some health workers sometimes due to lack of exposure to older persons' health and other needs affect the quality of services provided to older persons. Many older people in Ghana are unable to afford basic treatment. This problem is expected to be addressed through the National Health Insurance Scheme but many diseases that affect older persons are yet to be included in the scheme still leaving older persons vulnerable. Older people are increasingly using traditional medicine but a lot of work still needs to be done to promote and support the development of traditional healers. Many older persons also play positive role as providers of traditional medicine and care providers for the family and community but their contributions are seldom recognized and appreciated. To reach old age in good health and well-being requires individual efforts throughout life and an environment within which such efforts can succeed. The responsibility of individuals is to maintain a healthy lifestyle; the responsibility of Government is to

create a supportive environment that enables the advancement of health and well-being into old age.

The psychosocial approach looks at individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function. This approach is used in a broad range of helping professions in health and social care settings as well as by medical and social science researchers.

People may not be fully aware of the relationship between their mental and emotional well-being and the environment. It was first commonly used by psychologist Erik Erikson in his description of the stages of psychosocial development. In 1941 Gordon Hamilton renamed the 1917 concept of "social diagnosis" as "psychosocial study". Psychosocial study was further developed by Hollis in 1964 with emphasis in treatment model. It is contrasted with diverse social psychology, which attempts to explain social patterns within the individual. Problems that occur in one's psychosocial functioning can be referred to as "psychosocial dysfunction" or "psychosocial morbidity." This refers to the lack of development or diverse atrophy of the psychosocial self, often occurring alongside other dysfunctions that may be physical, emotional, or cognitive in nature. Adolph Meyer in the late 1800s stated "We cannot understand the individual presentation of mental illness, [and perpetuating factors] without knowing how that person functions in the environment," psychosocial assessment stems from this idea.

Scholarly societies in this field bring together researchers, academics and practitioners who are interested in contributing to the development of this inter/trans-disciplinary field of study. There are organisations such as Transcultural Psychosocial

Organization (United Nations High Commissioner for Refugees), Association for Psychosocial Studies, etc. Psychosocial assessment considers several key areas related to psychological, biological, and social functioning and the availability of supports. It is a systematic inquiry that arises from the introduction of dynamic interaction; it is an ongoing process that continues throughout a treatment, and is characterized by the circularity of cause-effect/effect-cause. In assessment the clinician/health care professional identifies the problem with the client, takes stock of the resources that are available for dealing with it, and considers the ways in which it might be solved from an educated hypothesis formed by data collection. This hypothesis is tentative in nature and goes through a process of elimination, refinement, or reconstruction in the light of newly obtained data.

Healthy aging includes physical, psychological, social, and spiritual well-being in later years. The purpose of this study is to identify the psychosocial factors influencing healthy aging. Advances in medicine are allowing many adults to live longer lives than previous generations. In fact, the elderly population is becoming one of the largest growing sectors of the present population. Recently, researchers have begun studying what factors contribute to successful aging. These studies are showing that the impact of family and social relationships plays an important part in one‘s health and psychosocial well-being.

The Pennsylvania Department of Aging (2008) defines an elderly person as one who is age 65 or older. Those age 85 and above are considered to be the oldest old and are predicted to increase 44% in number by 2020 (PA Department of Aging). As one reaches these once unfathomable age researchers are interested in analyzing their psychosocial and health dispositions as to what these elderly adults ascribe to their

longevity. Older adults attribute successful aging to quality of life (Reichstadt, Sengupta, Depp, Palinkas & Jeste, 2010). Flood, Nies and Seo (2010) define successful aging as one's ability to successfully adapt to their physical and social surroundings. This satisfaction can be all encompassing contributing to an overall sense of a purposeful life (Flood et al.). Many older adults noted that a "feeling that somebody cares" played an important role in this sense of well-being (Reichstadt et al.). Social interaction and support with spouses, family and friends can provide one with an acceptance of self and lend to a decrease in mortality (Antonucci, Birditt & Webster, 2010).

There are many different types of relationships such as social, marital, and family. Each of these relationships can have a negative or positive influence on the individual. Trudel, Boyer, Villeneuve, Anderson, Pilon, and Bounader (2007) note that a positive relationship with a spouse can be one of the greatest buffers against physical and psychosocial problems. This relationship has the most impact on one's sense of purpose and mental disposition (Trudel et al.).

A study by David Sbarra (2009) found that C-reactive protein (CRP) levels in older married men were lower than in their single counterparts. He attributes this finding to one of the health benefits a quality marriage can offer (Sbarra). An article in the Harvard Women's Health Watch (2010) notes that stress levels are decreased for older couples in strong relationships. The sharing of experiences and closeness may have a far greater impact on one's health than previously realized (Gerstorf, Hoppmann, Kadlec, and McArdle 2009). Antonucci et al. (2010) find that the negative effects of a marital relationship may actually improve health and also contribute to depression. These negative effects may be real or perceived as the older

individual can interpret demands made on them as smothering or pressuring (Antonucci et al.). Other negative effects such as declining physical or cognitive functions of a spouse have been found to increase one's depressive symptoms (Gerstorf et al., 2009). It is interesting to note that wives with depressive symptoms were more likely to have an impact on their spouse's cognitive decline as well as their own (Gerstorf et al.).

Older adult relationships with children or other family members did not carry the importance of a spousal relationship unless the person is unmarried (Antonucci et al., 2010). Positive interaction with family did not show the decrease in mortality that one might expect (Antonucci et al.). It has been suggested that as one ages their family ties often remain intact as opposed to other relationships since family are thought to be a greater source of support, care, and emotional well-being than a social relationship (Shaw, Krause, Liang, and Bennett, 2007). Antonucci et al. (2010), suggest that families of those nearer to death may choose to hide any troubles and focus on the positive. Many elderly reports that social involvement contributes to a positive self-attitude and self-acceptance (Reichstadt et al., 2010). Shaw et al., (2007) note that social support is directly linked to decreased mortality and offers positive health benefits. One reason for this may be that social relationships as opposed to family and marital are chosen by the elderly person (Antonucci et al., 2010). This allows the individual to surround himself with an effective support system. A study by Shaw et al. (2007) finds that elderly women are often the ones providing and receiving more support than elderly men. However, the study also notes that men are happier with their support systems overall (Shaw et al.).

Interviews conducted among the elderly by Reichstadt et al. (2010) note that those who found a meaningful way to stay active in society by working, volunteering or interacting socially expressed a greater sense of happiness. Self-acceptance and a realistic approach to one's present circumstances greatly contributed to psychosocial well-being and a better quality of life (Reichstadt et al). Murray and Crummett (2010) find that participating in social activities can lead to a positive physical and mental state. They concluded that positive relationships with spouse, family or friends are a significant factor in the overall health and well-being of the elderly person (Antonucci et al., 2010). As one ages support systems tend to decrease and it is important for one to remain socially active (Antonucci et al.). Positive marital relationships seem to provide the greatest means of protection from health and mental disparities (Trudel et al., 2007). As Reichstadt et al. (2010) note, those that give of themselves to others, cherish each day, possess a positive self-attitude, and maintain a social support system are key evidence as to how one can age successfully.

Psychosocial exposure or ~~"m~~isery" is associated with physical disease, although misery is clearly a bad thing as it erodes people's quality of life, there is little evidence that psychosocial factors cause physical disease. Psychosocial factors such as stress, hostility, depression, hopelessness, and job control seem associated with physical health - particularly heart disease. Such factors include many mental states, psychological traits, or aspects of the social environment with a negative connotation. In this research we shall consider ~~"p~~sychosocial factors" to be any exposure that may influence a physical health outcome through a psychological mechanism.

What characterizes psychosocial health? This research focuses on the important factors that influence an individual's psychosocial health and the positive steps that can be taken to improve psychosocial health. Mental, emotional, social, and spiritual health is four components of psychosocial health. Their balance and interrelationships help a person leads a healthier life. But there are things in life that can throw them out of whack and send a person into a psychological tailspin if not caught early enough. These negative factors, and the positive steps you can take to ameliorate them, are something important for us to analyse.

2.2.2 Factors that influence psychosocial health

Psychosocial health is how we see, live and our experiences. There's actually quite a bit that can hit you from the outside or from the inside and influence your overall well-being. Internal and external factors influencing psychosocial health, considering how they may affect you or someone you know. Let's start with internal factors first. Self-esteem, a person's self-respect, sense of value, pride, and worth, is most definitely one of these. People with a high self-esteem: have pride in themselves and their accomplishments. Treat themselves with respect. Are confident, accepting of themselves, and believe they are valuable. In contrast, those who have a low self-esteem allow others to walk all over them, don't care much for what they look like or do, have little self-confidence, and avoid taking too many risks. Maybe you've heard of someone being called overly sensitive? That may be a result of low self-esteem. Other internal factors that influence psychosocial health include: Personality, which is based on a melting pot of genetics, environment, and culture. Hormones - whether due to disease or nature, fluctuating hormones can most definitely impact mental wellbeing or emotions.

The internal factors of psychosocial health are also important. This part is harder to see because it is what is inside you. Some of them are hereditary traits, hormonal functioning, physical health status, physical fitness level, and mental and emotional health. If something bad happens to any of these factors, it can decrease the wellness of anyone psychosocial health. People's expectations and successes are part of internal factors, and anything that has to do with your values and internal peace. Having personal control is important to have a health internal psychosocial health. Self-efficacy is important, which is a person's belief about whether he or she can successfully engage in. Some people have learned helplessness when they give up in trying to become better and succeed. Your personality has to do with all this, because depending on how mentally strong you are, internal things affect you. These are the key elements that people with good psychosocial health have: extraversion, ability to adapt to social situation; agreeableness, the ability to demonstrate friendly compliance; openness to experience; emotional stability; and conscientiousness.

They are affected by experiences in two ways, through external influences, and internal influences. The external influences are the parts of life that we have no control over, for example where we grow and who raises us. An important aspect of the external factors of psychosocial health is your family. Children who grow up in a happy family will have more chances of becoming a successful adult. However, kids that grow up in families with violence, negative behaviours, distrust, anger, dietary deprivation, drug abuse, parental problems, and sexual, physical or emotional abuse are more likely to have problems to deal with life.

Families in which these sorts of things happen are called dysfunctional families. On the other hand, not all children that grow up in these types of unions has a hard time, just like not all kids who grow up in happy families become well adjusted. But there's more: there are external factors that can influence psychosocial health. Two big ones in this respect are friends and family that may do everything from supporting financially, mentally, and emotionally, or abusing physically, mentally, and emotionally. These negative actions, as well as the stress they bring, play much more than bit roles in our lives. And don't forget that a combination of internal and external elements also impacts one way or another. Just think about diet and exercise too. If you lead an inactive lifestyle and overeat, you'll be prone to obesity, which negatively affects your body mentally and physically quite a lot!

Image and impressions of old age; our attitudes to old age and older people are shaped by many factors – for example, our upbringing, education, experiences, and media. Being an effective care worker means being aware of these influences, and the ways in which they may help or hinder the quality of care offered to clients. It is not just the attitudes of staff that matters. Older people themselves have attitudes to old age – and, as with care workers and their attitudes, some of these will be helpful, others not.

Myths about old age; (John Murphy, MDLinx | December 09, 2019) old people suffer misunderstanding probably more than any other stage of life. There are many myths and mostly they are unattractive. Amongst the various popular misconceptions about old age are the following:

i. All older people are much the same.

ii. Older people cannot learn new things, are set in their ways and cannot change.

iii. Most older people have no interest in sexual behaviour.

iv. All older people will eventually suffer from memory loss and dementia.

v. Most older people are ill.

vi. Most older people need residential care.

vii. Afro-Caribbean and Asian older people always live with their families and don't need help from the caring services.

viii. Older people are a drain on society and are unable to offer anything useful.

ix. Older people should be careful and not take risks.

x. Most older people like to be looked after and spoiled.

How is it that so many incorrect views are held about older people in general and then thoughtlessly applied to individuals? When we think of old age, we tend to envision a slowdown or a person napping in a rocking chair. The fallacy of judging another person's state of mind, actions or behaviours based on our own experiences, state of mind, actions or behaviours propagates widespread misconceptions about aging. Contrary to popular belief, there is no typical ~~-~~older personality." Our basic personality is formed probably before six months of age but is modifiable.

Retirement doesn't mean elderly people just want to sit around all day! While at a certain age and depending on health concerns, some elderly people may need to rest more throughout the day, many people of retirement age enjoy active lives, help with care for their grandchildren and volunteer. Older adults are highly valued employees and volunteers who contribute to their communities by tutoring, helping small businesses, assisting in placing foster children, providing fellow seniors who are homebound with companionship and help with daily tasks, and participating in other valuable endeavours. Older workers have a strong work ethic and are great mentors and models for younger generations. There is a certain amount of loss of function as

we age, but much can be done to prevent (or at least slow down) the physical and mental aging processes. Stem cells lose some of their potential and other cells weaken, but healthful habits hinder the process. Weight lifting helps retain muscle and bone integrity. Aerobic exercise and diet lessen the chances for physical and mental deterioration. Exercising the brain and continuously learning help to fight cognitive decline. Too much sedentary time spent watching TV is detrimental at any age but is particularly unhealthy for older adults, who often see their generation stereotyped in programming as feeble, forgetful, cranky and confused.

This myth of older people has no interest in sexual behaviour has persisted largely due to sexual activity and sexual health among seniors being infrequently discussed and studied. A 2017 University of Michigan National Poll on Healthy Aging asked a national sample of adults ages 50 to 80 about their perspectives on sex and relationships. The results showed that nearly two in three respondents (65 percent) were interested in sex, and most (76 percent) agreed that sex is an important part of a romantic relationship at any age. Forty percent of respondents indicated that they were still sexually active. Furthermore, studies have consistently found an association between positive sexual activity and overall well-being, even among seniors. Whether one causes the other is unclear, but the mutual benefit is real.

While the frequency of sexual activity tends to decline with age, one such study published in The Journal of Sexual Medicine found that sexual activity and feeling emotionally close to one‘s partner during sexual activity were associated with greater enjoyment of life in both men and women age 50 and older. Although frequency of sexual activity may decline in older adulthood, many older adults continue to enjoy a physically and emotionally fulfilling sex life. Like younger adults, older adults who

are in good health and have a willing partner are more likely to engage in sexual activity. Sexual activity offers physical, mental, and emotional benefits that are helpful to seniors, too, such as better sleep, less stress, more positive mood, and improved marital satisfaction.

Dementia is not a normal or inevitable part of aging. True, some cognitive changes are normal with age such as slower reaction times and reduced problem-solving abilities but many older adults can outperform middle-aged and younger adults on intelligence tests that draw on accumulated knowledge and experience. Also, many factors related to older age aside from dementia can affect memory and cognition, including prescription drugs, tiredness, stress, depression, and other medical conditions. There are also other parts of the external factors, like the environment you live in. Things like constant stress and pressure can cause big problems. If a person lives in a place where they're exposed to drugs, crime, violent acts and other things can happen to anyone. These programs or services can help maintain a healthy psychosocial mind. Social relationships are also important to have a healthy psychosocial spirit.

2.2.3 Socioeconomic factors of the elderly

One's socioeconomic status also is a major factor in whether or not an individual gets enough social support. The socioeconomic status is the measurement of level of income each person has to determine their level of economic status in our society. For example, if the specified person's income is rather low, compared to nationally average, that person would be considered as a part of the low socioeconomic status. As expected, anyone who comes from a lower socioeconomic class would be more likely to receive less social support. They basically do not have enough resources in

their environment available to assist with social support. The individuals with low socioeconomic status also tend to have less self-control. Consequently, they become more sensitive to stressors in their environment and less able to control their reactions. It means those adults would trigger some frustrations when they face any kind of stress. Unfortunately, the social strain, which is common in their daily lives, increases the risk for lower social class individuals to develop some kinds of physical and mental illness or a lower sense of well-being. This should not come to surprise that adults who have higher socioeconomic status tend to receive more social support (Gallo, Bogart, Vranceanu & Matthews, 2005).

Socioeconomic Status (SES) is often measured as a combination of education, income and occupation. It is commonly conceptualized as the social standing or class of an individual or group. When viewed through a social class lens, privilege, power and control are emphasized. Furthermore, an examination of SES as a gradient or continuous variable reveals inequities in access to and distribution of resources. SES is relevant to all realms of behavioural and social science, including research, practice, education and advocacy. SES affects overall human functioning, including our physical and mental health. Its effects can be observed across the life span. Variance in socioeconomic status such as disparities in the distribution of wealth, income and access to resources mitigate social problems that ultimately affect everyone.

The majority of older adults do not work and/or have fewer income. They are at risk for rising costs of living, which may place them at an economic disadvantage and potentially at lower levels of SES. Recent studies indicate that the quality of care afforded to older adults with medical conditions is substandard (Wenger et al., 2003).

Furthermore, older adults who work are less likely to maintain employment as their health declines.

SES has been found to affect the psychological health of aging individuals. Poverty is considered a risk factor for declines in mental health among older people. Those at the lower levels of socioeconomic status are often most likely to be afflicted with a psychological disorder. Of older adults, 20-25 percent may meet criteria for some form of psychological disorder (Administration on Aging, 2001). An estimated 15 million older adults will experience mental health problems by the year 2030 (APA, 2004). Older persons with less than a high school education are at greater risk for depression (APA, 2003).

Low educational achievement has consistently been associated with a higher incidence of Alzheimer‘s disease later in life. Blue collar work has also been associated with Alzheimer‘s and dementia (Fratiglioni, Winblad & Von Strauss, 2007; Karp et al., 2004; Fratiglioni & Rocca, 2001). Although good social networks have been shown to buffer stress (Krause, 2001), older persons living in poor neighbourhoods are more likely to have underdeveloped (Feldman & Steptoe, 2004) and poorly integrated social networks (Black & Rubinstein, 2000). About one in 10 persons‘ age 50 and older who report that a disability has reduced or eliminated their ability to work are assisted by Social Security Disability Insurance (Fleck, 2008). In 2002, 20 percent of health care costs for persons 65 years and older were not covered by Medicare, the federal program for older adults and/or disabled persons who qualify for Social Security (APA, 2005).

Older individuals of lower SES have increased mortality rates (Bassuk, Berkman, & Amick, 2002), higher stroke incidence (Avendano, et al., 2006), higher incidence of progressive chronic kidney disease (Merkin et al., 2007), lower health-related quality of life (Huguet, Kaplan & Feeny, 2008), smaller social networks and lower quality of social relations. Older individuals of lower SES have been found to be exposed to substandard prescription practices, such as receiving excessive amounts of prescription drugs for the same ailment and being prescribed combinations of drugs that may lead to potentially harmful interactions (Odubanjo, Bennett & Feely, 2004).

2.2.4 The religious factors that influence the well-being of the elderly

What might be some of the effect of religion on physical health? One example is cults or religious sects that encourage behaviours that are damaging to health. For example, some religious sects ignore sound medical advice or refuse pain-relieving medication. For individuals in the religious mainstream, there is generally either no link between religion and physical health or a positive effect. For example, in one review, five studies documented that religious commitment had a protective influence on blood pressure or hypertension rates (Levin & Vanderpool, 1989). Also, a number of studies have confirmed a positive association of religious participation and longevity (Hummer & Others, 1999; Thoresen & Harris, 2002).

Why might religion promote physical health? There are several possible answers (Hill & Butter, 1995):

a. Lifestyle issue: for example, religious individuals have lower drug use than nonreligious counterparts (Gartner, Larson, & Allen, 1991).

b. Social networks: the degree to which individuals are connected to others affects their health. Well-connected individuals have fewer health problems. Religious groups, meetings, and activities provide social connectedness for individuals.
c. Coping with stress: religion offers a source of comfort and support when individuals are confronted with stressful events. Although research has not clearly demonstrated prayer's positive effects on physical health, some investigators argue that prayer might be associated with such positive health-related changes as a decrease in the perception of pain and reduced muscle tension (McCullough, 1995).

It also has been emphasized that religious organizations might have a stronger influence on physical health by providing more health-related services. For example, they could sponsor community-based health education and health-testing programmes. What is the relation between religion and the ability to cope with stress? Some psychologists have categorized prayer and religious commitment as defensive coping strategies, arguing that they are less effective in helping individuals cope than are life-skill, problem-solving strategies. However, recently researchers have found that some styles of religious coping are associated with high levels of personal initiative and competence, and that even when defensive religious strategies are initially adopted, they sometime set the stage for the later appearance of more-active religious coping (Dunn & Horgas, 2004; Pargament & Park, 1995; Seifert, 1998).

The Religion and its importance in the lives of many older adults are as follows: In many societies around the world, older adults are spiritual leaders in their churches and communities. For example, in the Catholic Church, more Popes have been elected in their eighties than in any other 10-year period of the human life span.

Religion can provide some important psychological needs in older adults, helping them face impending death, find and maintain a sense of meaningfulness and significance in life, and accept the inevitable losses of old age (Daaleman, Perera, & Studenski, 2004; Fry, 1999; Koeing & Larson, 1998).

Socially, the religious community can provide a number of functions for older adults, such as social activities, social support, and the opportunity to assume teaching and leadership roles. Older adults can become deacons, elders or religion teachers, assuming leadership roles they might have been unable to take on before they retired (Cox & Hammonds, 1988).

Emotionally, changing life situations highlight emotional factors regardless of age. Never before has our society faced so many problems in human relationships. There are not enough physicians, psychiatrists, psychologists, psychoanalysts, sociologists, social care workers, and others who specialized in human behaviour to cope with the increasing need of ministering to our aging population. There is also a shortage of hospitals and homes for special care. Some of the people suffering from emotional problems turn to their physician while others seek their minister. The nature of minister‘s work throws in contact with the largest group of people encountered by single profession. With an understanding of emotional needs of parishioners, the minister can render a most valuable service to them. Although much good can come out of group therapy, and counselling through preaching, individuals with acute emotional problems must be dealt with personally.

2.2.5 The residence of the elderly

Housing and the surrounding environment are particularly important for older persons, inclusive of factors such as: accessibility and safety; the financial burden of maintaining a home; and the important emotional and psychological security of a home. It is recognised that good housing can promote good health and well-being. It is also important that older persons are provided, where possible, with an adequate choice of where they live, a factor that needs to be built into policies and programmes. In Ghana rapid demographic aging is taking place in a context of continuing urbanization and a growing number of persons who are aging in urban areas lack affordable housing and services. At the same time a large number of persons are aging in isolation in rural areas, rather than in the traditional environment of an extended family.

Housing has been defined by different people in different contexts to suit the condition of that environment. For instance, 2000 population and housing census, housing was defined in terms of shelter, that is, any enclosure with roof and this includes kiosk. However, for the purposes of adequate health and security, this study will adopt the definition of housing as a means of fulfilling physical needs by providing security and shelter from weather and climate. It fulfils psychological needs by providing a sense of personal space and privacy. It fulfils social needs by providing a gathering area and communal space for the human family, the basic unit of society. In many societies, it also fulfils economic needs by functioning as a center for commercial production (UN-Habitat, 1996). Appropriately, the wish of every elderly person is to have retired to homes of their own and not in any form of residential care. However, this has become a myth to majority of this group. Adequate housing is of importance to the elderly in many ways – to keep them warmth, easy

access to lavatory and other facilities, less stress in a future rearrangement of tenancy agreement as well as cost, conducive surroundings and above all desire/ability to live in the way they want in their own home (Schwab, 1989).

2.2.6 Types of housing arrangements

In Ghana, the main types of housing arrangement familiar to the society include rented housing arrangement, owner occupier housing arrangement and homelessness/slum. There are other variety of residential facilities for older adults that may serve as their places of abode namely institutional homes, children's houses, extended family houses, houses provided by grandchildren including where ever older adults choose to reside. We are seeing shifts in living arrangements among the elderly. The 2010 Ghana census enumerators report that 47.2 percent of dwelling units are occupied by their owners. 31.1 percent are rented out and 20.8 percent are rent-free. Of which some occupy one room, two rooms etc. and dilapidated home that have outdoor toilet and community faucets. Some seniors live in not properly repaired building which are hazardous for older people. The high mobility rate of the modern family imposes hardships on many older parents who live with adult children.

Living arrangements include living with a spouse, alone, with other relatives or with nonrelatives. Older people want to age in place. They want to stay in their homes as long as they can. A home means more than a physical place. To many older people their home reminds them of their family and their past. The rooms, decorations, the neighbourhood give a person a feeling of security and well-being. Some of the housing options for the elderly are; single-family home, apartment or townhouse, life care community or continuing care retirement community, granny flat housing, shared housing, board and care and assisted living and nursing home.

Owned housing/homeownership

Nationally, Ghana Statistical Service (2005) reported that, only about 43 percent of the population in Ghana owns a house. The American Housing Survey (1997) report indicated that about 67 percent of American households own their own homes. The report further assessed that, one of the most fundamental needs of the elderly nationwide is - the need for safe and affordable housing linked to appropriate services. Again, Housing Our Elders report revealed that older Americans live in quality housing that is within their means and located in neighbourhoods that they preferred (American Housing Survey, 1997). The majority of the aged population in Ghana sometimes lacked a decent housing accommodation due to either poverty or denial/rejection by their relatives. Available statistics from Ghana Living Standard Survey indicate that, the informal sector's share of total employment increased from 80.5 percent in 1988 to 88.6 percent in 2006. This includes farmers especially the food crops as well as fishing farmers and traders who are largely associated with poverty.

Again, poverty studies in Ghana, including various Ghana Living Standard Surveys (GLSS), have indicated that poverty has increased in predominantly food crops producing areas and fishing communities of Ghana (NDPC, 2010). This therefore suggests that, the earnings of the people in these communities may be low which may not afford them the opportunity to own a house to ensure adequate housing security; they may be either renting, perching or uncomfortably living in a family house. According to NDPC (2006), only about one in ten Ghanaians had access to secure housing. This implies that, most Ghanaians live under insecure housing tenure conditions and face the problem of possible eviction. Again, one in five Ghanaians live in slum areas with poor access to basic infrastructure including water, electricity

supply, proper drainage system and poor sanitation which may go a long way to affect their health condition negatively.

Rented housing

This is where a contractual agreement between a house owners referred to as landlord/landlady and an occupier also referred to as tenant for a colossal sum of money referred to as advance payment for a specific period of time usually twelve months and sometimes renewable. This sort of agreement is seen to be a very burdensome among Ghanaians especially the poor and the vulnerable including the aged. According to NDPC (2006), nine in every ten Ghanaians live under insecure housing tenure conditions and face the problem of possible eviction/ejection. Ghana Statistical Service (2005) also reported that, about 43 percent of the household population in Ghana lives in rented houses. Statistics has also shown that in Kumasi, as many as 57 percent of the population live in rented houses and this includes the aged population as well as those whose ages are close to the aged population (UN-HABITAT, 2010).

Homeless/slum

On housing delivery, according to the Minister of housing and water resources, Ghana's housing deficit is over one million. In order to reduce this to ensure that the majority of the people have access to housing accommodation, there is the need to produce housing at the rate of 100,000 per annum. However, the total supply rate is approximately 35 percent annually. This implies that about 65 percent of the total housing needs are not met putting pressure on the few supplies and as Brux (2008), put it –homes in areas with healthy economies and growing populations tend to gain in value over time, whereas the value of houses in depressed regions with declining

populations goes down". This has made some of the Ghanaian population homeless due to high demand over supply of housing. UN-HABITAT (2010) reported that, not less than 17 percent of the population in Kumasi is homeless.

Causes of slum/homelessness

According to NDPC (2010), the rapid increase in population has resulted in a large housing deficit, especially in urban areas. Due to imbalances in the supply and demand of housing, it has resulted to what is regarded as illegal settlement or slum. The cumbersome nature of land acquisition procedures and weak enforcement of development control and standards or codes in the design and construction of houses; ineffective rural housing policy; and haphazard land development has contributed to this slum. Another major challenge relates to housing according to the document, is housing finance. This is reflected in inadequate finance to support the construction industry; high cost of mortgages; and low production of, and poor patronage of local building materials are some of the causes of homelessness and slum.

2.2.7 The institutional care challenge

Populations around the world are aging rapidly, and this demographic transition is placing new demands on societies to provide comprehensive systems for long-term care at home, in communities or institutions. An institutional home denotes a place of residence for older adults who require continual nursing care and have significant difficulty in relation to coping with the essential activities of daily living (ADLs). In sub-Saharan Africa, 46 million older people live in the region and this number is expected to more than triple (to 165 million1) by 2050. A significant proportion of these people will require long-term care at some point in their lives (De-Graft Aikins & Apt, 2016).

The Westernization and/or modernization of our society has resulted in the challenge of caring for older people. With the increasing rate of population aging and increased life expectancy, the need for institutional homes may be required as a supportive measure. The upsurge in need for an institutional support system for older adults in Ghana is becoming imperative due to their inability to care for themselves, loneliness due to the loss of family relations including social change, the lack of spouses and children, modernization, urbanization, migration, multiple careers including busy work schedules. These factors have all made care for older people an impending challenge. Older people take up residence in institutions. This implies that social care even in a number of Western countries is a means tested, which is a key issue going forward (e.g., responsible for a considerable amount of bed blocking in UK hospitals) (Robertson et al., 2014), whereas in developing countries such as Ghana, it is not means tested as yet, perhaps because state institutional homes are non-existent. Besides, older adults requiring care are still looked after within the informal structure of the family (Apt, 2012) in some LMICs.

There is also an increase in the number of neglected, abused, and abandoned older adults. Further, the modern economic system has projected old age as a social problem. In developed countries, when older people become handicapped by virtue of illness and disability, they take up residence in institutional homes. However, such facilities are not extensively provided in developing countries. As a result, older people are cared for at home. The situation may be different in the near future, necessitating taking refuge in institutional homes. These homes may be classified as formal and informal, which may draw on paid and unpaid labor (Daly et al., 2015).

Relocation adjustment in nursing homes Lee (2010) purports predictors such as self-efficacy, self-reported health, preconception about nursing homes, emotional support from staff and other residents, family satisfaction and general satisfaction with the facility in question. Nursing homes are a relatively new phenomenon in the Ghanaian context. People do not cope or adjust to aging or old age in isolation. Instead, they do so in the company of others who provide social and emotional support. This may depend on the financial independence and sacrificial investments in their children, who may become adults with the moral duty to support their aged parents (Doh et al., 2014; Dovie, 2018a). This implies that prior lifestyle determines to a great extent the quality of care and support older adults are accorded, and when it becomes inevitable for them to depend on others.

Meanwhile, Apt (1993), hesitated to recommend residential care in Ghana because of the financial implications involved but most importantly because it is culturally unsuitable. The cultural unsuitability stems from the belief that an older person in the family is a living guardian of the society, an intermediary between the living community of humans and the ‗living-dead' community of ancestors. Since the survival of society, prosperity, fertility and long life depend on the continuous maintenance and strengthening of the relationship between the ancestors and the human community, it would be unthankful for many Ghanaians to re-locate their elderly people in a residential home, likely to be in a deferent town or community where they will be strangers. Their functionality would be impeded and consequently have an unfulfilled life. Although some elderly Christians may hold a different view and may be willing to change residence, the extended family which gives elderly people their proper social identity and functionality may oppose the individual view of the older person except of course where such elderly people are loosely bonded to

their extended families, like those living in the cities who have reduced contact with the larger family.

There are other sub-Sahara African countries such as Kenya, Zimbabwe, Botswana and Republic of South Africa who have been able to maintain various forms of residential care provision for older people. The countries mentioned above have a significant proportion of their population originally emigrating from Western Europe and Asian countries. The diffusion of culture in these countries therefore accommodates the new system of caring for elderly people in residential institutions. Whites, coloured and Black people are all participants in this system, tailored of course according to Western style. These elderly people also receive monthly, non-contributory pension (especially in the Republic of South Africa), a benefit which elderly people in Ghana do not receive unless they have worked for a public department or private firm with a pension arrangement. Elderly people in these countries are in a different situation from elderly people in Ghana and other West African States. However, like any of the above-mentioned countries, elderly people in Ghana have freedom and right to decide and choose appropriate welfare conditions for their lives, especially if it is available.

2.3 Family's Responsibility Towards the Aged

In the Holy Bible, (Exodus 20:12 and Ephesians 6:1-2 – NIV) read, "Honour your father and mother, so that you may live long in the land the Lord your God is giving you". Philo lived from 30 BCE to 40 CE in Alexandria. He wrote "The Special Law", a treatise in which he discusses the Ten Commandments, and other Jewish regulations and practices. In his exposition on the Fifth Commandment, he described the God-like

role that parents play and the honour due them. He wrote: –The duty of honouring parents… stands on the borderline between the human and the divine.

For parents are midway between the natures of God and man, and partake of both the human obviously because they have been born and will perish, the divine because they have brought others to birth and have raised not being into being. Growing old is a blessing, and honouring old age was an obligation on the generation of religious people as enjoined in the Old and New Testaments quotations. We live in a time when many have refused to honour their moral and spiritual obligations to their aging parents or grandparents. Even some Christians expect the church to support their parents even though they are capable of doing so themselves. The Church is not to be given the responsibility of caring for aged members when their children are still alive and capable of attending to their needs. Christians in the era of the Apostles sold their possessions and goods, and gave them to anyone to meet their needs (Acts 2:45 NIV). If they could do this for those who were not their relations, should not children be willing to do the same for their own parent? Children who neglect this obligation are worse than unbelievers (1Timothy 5:8 NIV). Taking care of an aged parent is simply paying back the love they gave us in our time of need with love in their time of need. Philo, of Alexandria, a Jewish philosopher said, –When old storks become unable to fly, they remain in their nests and are fed by their children, who go to endless exertions to provide their food because of their piety".

In the family support system, it appears that both the colonial British Administration and the post-independence regimes have implicitly relied on the ability of the family network to cope with the problem of individual aging. Indeed, no concretes policies have been evolved that anticipate the problems of aging population in Ghana. In the

traditional extended family system, the various divisions of labour on the farm by sex and by age often allowed an interchange of roles as the young grew into adults and as adults grew into old age. It was this inter-dependence that formed the strength of the family support system. The system undertook the many caring responsibilities of the elderly and, in a large measure; old people remained the responsibility of individual families, providing comfort and support in times of anxiety, loneliness and helplessness. With increasing social change, this inter-dependence which has formed the strength of the family support system has been eroded by the separation of the generations through migration, death of key family members and lack of surviving siblings of elderly persons, indeed, one could with some justification say that the onus of responsibility for the care of the elderly has shifted from extended family system towards the nuclear family with an important role being played by spouse and children. In this regard, the special role performed by one's children is seen to be very crucial. Brown (1984, pp. 76) has shown the important filial obligation which siblings have towards their parents in the form of providing food or money for food, running of errands, attending to the daily needs of their parents, occasionally paying for medical bills and house rents, supplying clothing, and providing emotional satisfaction and encouragement.

Apt (1981), had also indicated that while most Ghanaians are still willing to take responsibility for their aged parents, young people frequently complained of their own financial inability to care as much as they would wish for aged relatives. She points out that the overall effect of modernization pressure on the nuclear family of the younger wage earners to provide for themselves, with little available for aged parents who may be at distance and inaccessible to personal care. Although APT (1981) hopes for a continued system of family care the indicators suggest to her that, in

comparison with the present generation of people over 60, new generations of the elderly are likely to have less help and less security from fewer children. The problem, as she points out, is that not only will people have fewer children but that because of migration the children will simply be available less to support their aged parents, and frequently less able to contribute material assistance.

Family care has been one of the focal points in this study. Families have been the major resource, and until very recently their responsibility for relatives was enforced morally, culturally, and through law. For instance, relative responsibility laws held adult children responsible for the support of their parents. Today, if children could not take an older parent needing care into their homes, then they were responsible for paying at least some of the costs for caring for that parent in an institution or elsewhere. And although moral and cultural influences continue to pressure children to care for their parents, social change has made it increasingly difficult. However, elder care in the United States is provided primarily in two ways: institutions for the elderly and private care at home.

The latter is peculiar to the Ghanaian situation, whereby most care of older people is provided informally by families. Family members provide long-term care for the elderly. But in the United States both institutional care of elderly and private care at home were considered significant. Relatively, old people in Ghana generally live in and receive care at their homes or the residence of children or relations. Many older people, for instance, would prefer to remain in their own homes or homes of relatives simply because, home health care, meal and homemaker are available which may possibly prevent costlier institutional care.

One feature of the family support system which continues unabated is that of providing a fitting burial of the dead, especially when death occurs in old age. Subject to local ethnic and tribal variations and the impact of religious doctrine and affiliation, this last obligation is the main benefit of being survived by one‘s own children and relatives. A major weakness of family support in Ghana is that it is not formal – formal support refers to paid help from professional caregivers such as doctors, nurses, and social workers: its effectiveness depends on the demographic and life cycle. Despite the continuing importance of family support systems for the aged, historical changes have created new constraints on families in caring for aged. Demographic change has reduced the number of descendants to whom an older person may turn for assistance. Change in women's social roles, particularly the rise in work outside the home, has fostered obligations which compete with duties toward aging parents.

Transformations of the economy have decreased parents' power to insure their support by grown offspring. Material family support for older people in Ghana, as in other African countries, has declined in recent decades, exposing increasing numbers especially of urban elderly to destitution and poverty. The nature and causes of this decline remain poorly understood, in particular the relative role of growing material constraints, as proposed by political economy perspectives, or weakening traditional values, as suggested by modernization perspectives. The decline has been underpinned by two major shifts: (a) a declining resource capacity of the young to provide support and (b) a shift in the basis of filial support toward an increasing dependence on parents' past conduct and the principle of reciprocity. Normative expectations emphasizing self-reliance in old age are emerging as a result of the decline. The shifts have been caused by a complex interaction between growing

resource constraints and changing values not captured by existing accounts. The dominant factor driving the change in support norms and patterns has been the change in families' material circumstances.

Current debates on aging in sub-Saharan Africa center on a concern about the growing threat of poverty among older people and its impact on all other aspects of their well-being (Barrientos & Lloyd-Sherlock, 2002; International Association of Gerontology, 2002). In most countries, this concern is inextricably linked with debates about a decline and –crisis" in the customary family support for older people (Apt, 1992). In the absence of formal welfare systems, such family support has been responsible for ensuring economic security for the old. Today, however, whereas the majority of older Africans continue to rely on material help from younger kin, indications are that the adequacy of such help has declined (Help Age International, 2002).

At the social level, Ghana has seen widespread unemployment and underemployment and rising costs of living, health care, and education. Hardship and poverty are the norm: Almost 80% of the population now live on under $2 a day (United Nations Development Programme, 2002). It is in this context that the concern over declining family support for older people has arisen. Traditionally, the family has held the exclusive responsibility for the material support of the old in Ghana. The duty of the young, especially of adult children, to provide such support is enshrined in the customary moral code and encapsulated in the proverb –When your elders take care of you while you cut your teeth, you must in turn take care of them while they are losing theirs" (Apt, 1996, p. 22). Though most continue to live with their families, destitution among the old has become increasingly evident, as has the –abandonment"

of impoverished older people in hospitals by their families. Charitable organizations such as Help Age Ghana have emerged as a result, trying to respond to some of these problems. The choice of relying on family, charity, or own work will likely also face the next generation of older people. Although a potentially universal, contributory pension scheme was introduced in 1991, its informal sector coverage remains minimal, and its ability to sufficiently protect those in the formal sector is doubtful. Unaffordability, low salary, and thus low contribution and benefit levels are among the major reasons, highlighting the limits of such individual saving schemes in contexts of poverty.

2.4 The Church's Responsibility to its Aged Members

The ‗Role of Religion' in the aging process shows that, the Judeo-Christian religion, portrays the aging of every generation from the beginning of time as honoured people Brown (1971). In describing a prominent citizen, the writer of the book of Samuel said, ―Barzillai was a very aged man" (II Samuel 19:32 NIV). Kings and noblemen respected him for his integrity pertaining to governmental affairs. Also when Joshua recognized the limitations of his own increasing age, he called the elders together and assigned them to places of leadership. Length of days was something to be greatly desired. The fifth Commandment, ―Honour your father and your mother," carries the promised reward, ―that your days may be long upon the land, your God gives you" (Exodus 20:12 NIV). The wisdom of the Proverbs also attests to this, ―My son forgets not my law: but let your heart keep my commandments; for length of days, and long life, and peace, shall they add to you" (Proverbs 3:1-2 NIV).

Human values are entrenched in the Bible. From early times, people were instructed to honour aging, –Thou shall rise up before the hoary head, and honour the face of the old man" (Leviticus 19:32 NIV). The scripture sets a premium on old age as well as on youth, –The glory of young men is their strength; and the beauty of old men is the grey head: (Proverbs 20:29 NIV). Religion down to the time of Jesus was linked with political system through the influence of the elders. They were the chief instructors of the law. The elders made up the jury and acted as the judges. It was the elder who became the leaders in the early Christian church. The apostle Paul appointed elders, or senior citizens, as overseers and administrators of the church.

The Church, as the body of Christ, has been engaged in a holistic ministry since it was established and is uniquely equipped to respond to the challenge of the growing numbers of the aged in its midst. The important focus of this research is the involvement of churches pastoral care for elderly people.

The following are some practical ways of caring for the elderly:

1. Remember the aged regular visits, telephone calls, gifts helpful deeds especially on special occasions (birthday, anniversaries, and holidays) will help the aged feel part of the members of the body of Christ. These actions could be taken up by a team of people put together by the church as well as by individuals. The Church has members who have practically no opportunity for Christian fellowship and little contact with the church itself. They are confined and isolated in a home situation. They cannot attend church because of illness, invalidism, or infirmities of age. They seldom (and sometimes never) meet anyone outside particularly as a member of the church. Some of these people have fears, anxieties, loneliness, and unhappiness. Most of them have a quiet faith and Christian devotion. These people

need friendship, companionship and help. The church must look upon them as people; fellow church members who happen to be sick or lonely or victims of circumstance. If the church does that sincerely, prayerfully, and friendly manner, they can be of great help to them and render a real pastoral service. Going into the homes as a representative of the church is a high responsibility.

Rev. Dr. Samuel Ayete-Nyampong (2008), in his book ―Pastoral Care of the Elderly in Africa, states that, ―Pastoral visitation (or visits) implies the taking of Christ's love by a representative of the Christian community to another person in his or her experiential and situational context so that the response elicited by this reception promotes the well-being of the receiver and enriches that of the giver. Pastoral visits are an important part of the ministry of the church because they serve as the hinges on which hangs the door which opens to bring in grace, healing, sustenance, reconciliation and guidance into people's lives." Also, in the Ghanaian context, visiting elderly people should be remembered that a communal pastoral care approach involves both the clergy and the laity in a share vocation as they participate in God's praxis to bring love and eventual realization of the Kingdom of God into people's lives. In this approach. Participant are trained and adhere to basic principles of establishing rapport and maintaining helping relationships. It is a reflective action guided by the minister whose _after visit' engagement with the pastoral carers includes sharing of feedback to help develop new strategies and goals for future visits.

Professor Kwesi Dickson (1984), has stated clearly that; ―It is a common place that the sense of community is strong in Africa". This sense of community, evident in the interconnectedness and strengths of relationships, is always maintained and

expanded by human activity called visitation: the movement of people into other people's contextual situations (their places of abode or where they can be found, and within their experiences). The goal of this visits is always to maintain relationship by promoting the well-being of the visited whilst the visitor is also enriched by the positive outcome of the visit.

Conduct –official" visits – a church should make sure such structures already in place are working effectively. Visits by Minister, Leaders, organizational officers and others are special opportunities to be attentive to the needs of the elderly and to minister to them, especially giving the Holy Communion, praying and conversing with them.

2. Sharing of experiences - give opportunities to members, including the elderly, to tell their stories during special worship services. Such sharing can enrich the lives of the whole congregation.
3. Initiate an –Adopt an Elderly Friend" programme – create some type of plan in which organizations in the church, families or individuals adopt an elderly member and regularly attend to them. This will do aged members whose families for various reasons are not able to visit them a lot of good.

Ayete-Nyampong (2008), states a community-based programme of ‗shared support'. The community-based ‗shared support' programme is an innovative system of care to be established within various centers of the local community. Its aim is to mobilise and utilise resources within the community to provide basic care, encourage and stimulate the elderly and empower them to re-assert their ‗usefulness' and independence within their families and local communities. It is therefore not a programme designed in the church and imposed on the community, but a joint church and local community initiative which is based on the needs and

contexts of the community. The programme is therefore an ecumenically organised system of providing care in local communities with the involvement of volunteers, families, the elderly and local traditional leaders. The goal is to promote the well-being of older adults, and to give them social identity. It will also promote intergenerational interaction and to provide a basis for education on aging.

4. ―Senior Citizens Group"- elderly church members aged sixty years and above could be brought together in one special group so that they meet during the day possibly four o'clock to five o'clock in the evening. This will enable those who have to deal with dimness of their sight and other challenges that make it difficult for them to go out when it is dark to attend meetings.

Ayete-Nyampong, (2008), uses ‗Mpanyinfo Kuo' (Older Adults Group). The term mpayinfo is an Akan word for an older adult. Mpayinfo is an inclusive term for both men and women who range in the life cycle from mature adulthood to very old age. The mpayinfo kuo is therefore a communion of older adults who meet regularly on church premises, in school classroom or at convenient places to encourage one another, share information, receive information in the form of education on aging, health and nutrition and enhance or develop the potential to contribute to life in society and in church. The mpayinfo kuo is different from the day care programme organised by statutory and non-statutory agencies in Britain in the sense that apart from a few young volunteers from the youth group who can help to set up the meeting place and run errands, the older adults run their own programmes with little supervision from the minister and elders. Being a ‗religious' group, the church or churches which participate in the work of the group donate to provide light refreshment. The elderly people themselves can contribute financially

or in kind for the upkeep pf the group. Eternal donors could be enlisted. The aims of the group are:

i. To provide an opportunity for group interaction and relationship Companionship).

ii. To serve as a forum for the discussion of issues pertaining to aging (Education).

iii. To encourage people in their life stages to achieve self-actualisation (Growth).

iv. To enable people experiencing crises or other debilitation situations whether real or perceived to receive intervention through care and counselling or referral (Healing).

v. To share common interests such as and activities together either within the group or as a joint inter-church or ecumenical programme (Leisure).

2.5 The Nation Ghana's Responsibility toward the Elderly

A nation that fails to look after its old people loses a whole living library and museum of institutional memory, and may be looked upon as cursed to doom. The demographic figures show that the active working age group of 25 years to 54 years has a population of 8 million in Ghana. This works out to a dependency load of 1 worker to 2 people on average, assuming all those in the active age group are in full employment, which is plausible because some could be housewives, and unskilled and uneducated people in the informal sector. The dependency load could well be 1 worker to 3 dependents, because the formal sector comprising teachers, nurses, civil and public servants, soldiers, policemen, prison wardens, immigration officers, among others cannot number more than I million. Thus, the remaining 7 million could be in the informal sector as retailers, artisans, farmers, commercial drivers, personal service providers, among others. These statistics show clearly the distribution of poverty in Ghana, especially in a country where our per capita income is said to have reached

only sub-thousand dollars per annum. Our national debt currently works out to the same per capita income of 1000 dollars, so if we are to pay off our debts, we all have to starve for one year to amortise our debts. Ghana's urban population is currently put at 51%, and it is growing fast at 3%. This means that the rural-urban migration leaves behind many old people in the rural areas where public infrastructure and social amenities are lacking. Which people then are left to tend the farms, one may ask?

The focus of this research is, how do we care for the 1million and above elderly men and women in our midst who are 65 years and above, and who are senior citizens? Should we exempt them from paying transport fares, should we exempt them from paying hospital charges, should we pay them a pension whether they worked or not? These old people are a national heritage as they have a wealth of human capital to share with the young. Some of these in advanced countries sit in the second chambers in the House of Lords, or Senate, or Council of State, and they are much revered and honoured because they are harnessed for their rich experience and insight.

Ghana at present has no clear policy on provision for old age support, save the statutory pensions for those who were in formal employment. Many will agree with me that our state institutions such as SSNIT, SIC, and the National Pensions Board have not lived up to their remit of looking after our old, especially where pensioners and retirees are subjected to a lot of bureaucracy when they retire and they have to claim their terminal benefits. Some pension monies are indeed laughable, pitiable and an insult to our retirees, especially in the security services. The pension scheme has been neglected in Ghana since time immemorial, and it is time we examined and evaluated the stipends paid to our retirees. Of course, pensions and gratuities are all salary or wage-determined and wage-dependent.

Nowadays, many investment products, financial derivatives, and insurance and assurance schemes and packages are replete and on offer on the market for workers for them to make some informed financial plans and decisions before they retire. Of course, retirees have to be extra careful about Ponzi schemes, pyramid scandals, and bubble money mirages, the likes of the Enron collapse. What about those who work for themselves and are living from hand to mouth? What investment plans can they make? These are the subsistence farmers or the bread-sellers, or peasant fishermen who catch barely enough fish hardly enough for home consumption. The state has a binding duty to look after its citizens, judging by the precepts put forward by J.J. Rousseau's Social Contract. These ideas and ideals are neither Socialist nor Capitalist in orientation but rather they were spawned by the philosophers of the Age of Enlightenment during the era of Diderot, Voltaire, John Locke, Rousseau, Tom Paine, John Stuart Mill, and a whole school of social reformers. They advocated for the greater good to the greater number or –sommumbonum or pro bono publicio." The EU have their Social Charter, the Scandinavian Countries and Canada came up with their Welfare State of looking after their citizens from cradle to grave, Robert Owen came up with his Utopian factories' ideas, among others.

The debate of the duty of the state towards the individual's welfare have been raging for ages in Thomas Hobbes Leviathan and the state of man without an organized society, Karl Marx and Frederich Engels? Das Kapital, and all the gamut of literature dating from Nicomachean ethics of Plato, ad nausea. In Britain, there were times when poverty and utter penury led to the Poor and Corn Laws being instituted with churches and parishes being put in charge to distribute welfare food and largesse to their congregants, and free Soup Centers were set up in the USA during the Great Depression of 1929 to serve the needs of thousands of famished citizens.

What prevents our government in Ghana from coming up with policies to cater for our old as a palliative towards poverty reduction, in line with the UN Millennium Development Goals launched in 2000, and which come s to an end in 2030? In Ghana, at the moment, there are neither laws nor a comprehensive national policy which caters specifically for the needs and welfare services of the aged, although the general laws on retirement and pension affect the aged. Indeed, it was not until 1982 that a National Commission on the Aged was established by the Government to advice on all matters related to the welfare of the aged. While one would argue that there are no specific policies for the welfare of the aged, some government departments which deal with social welfare, community and rural development, public health and adult education cater, in some ways, for the needs of the elderly. For example, the problems of the needy, including the aged in the urban areas, come under the schedule of the Department of Social Welfare, whereas the Department of Community Development caters for the elderly in the rural areas. Similarly, the social security and pension schemes make some provisions for the elderly. Under the Social Security Act, 1965, (Act 279), and the Social Security Decree, 1972 (N.R.C.D. 127), all workers, whether in the public or private sector, should be covered by the Social Security Fund. Workers were required to contribute 5 percent of their earnings towards the fund, while their employers contribute 12 ½ percent, thus making a total of 17 ½ percent of the worker‘s wage. Under the scheme the worker has the following retirement benefits:

i. A superannuation or old-age benefit

ii. An invalidity benefits

iii. A survivor‘s benefit

With these benefits the retired worker was supposed to take care of him or herself and the family for the rest of the life. However, since these benefits were not constantly adjusted to take care of inflation and changes in the cost of living, they did not provide the elderly with an adequate level of protection sufficient to maintain their financial independence. This was, indeed, a far cry from the lofty and laudable ideals which the initiators of the Social Security Bill had in mind when it was introduced in February 1965: –We require the assistance of our workers so that they continue to work till, and if possible, after superannuation to ensure carefree, comfortable and happy old age, instead of living like parasites on the all too meagre income of some relations…" (Government of Ghana, 1965).

2.6 Effects of Psychosocial Well-being on the Elderly

The effects of psychosocial well-being of the elderly can be positive and negative on social, physical, economic, health, emotional and psychological.

2.6.1 Economic status

After health, the most important factors in the quality of life of the elderly are economic and social resources (Soldo & Agree, 1998:23). That makes sense, because we all value the ability to do what we please, but what we please to do usually requires certain financial resources. While the desires of the elderly may not be as wide-ranging as those of younger people, what they would like to do is often stifled by their lack of money. Insofar as the aged are harassed by financial problems, their autonomy is threatened and the quality of their lives is diminished. It is important to keep in mind, of course, that income is only one indicator of the financial status of the elderly. It excludes other assets they may have accumulated and the fact that the elderly may have fewer demands on their budget (such as a mortgage or various needs

of children). Nevertheless, a certain amount of income is important for both the necessities of life and various discretionary activities, such as travel, that enhance the quality of life.

Generally, personal income drops by one-third to one-half when an individual retires (Soldo and Agree 1988:26). With that kind of decrease, some older people will experience poverty for the first time in their lives. The poverty rate of the aged is lower than those of twenty-four years and younger, but higher than those twenty-five to sixty-four years. In 1994, almost 3.7 million older Americans were living in poverty (U.S. Bureau of Census, 1996:473).

In discussing the statistics on poverty among the elderly, it is important to keep in mind that as with poverty generally, some groups are more likely to suffer. For example, the ~~–o~~ldest old" have higher rates than others. The rate among those eighty-five and older is about twice as high as the rate among those aged sixty-five to seventy-four. Widows also have high rates (Hurd, 198+). And the black elderly is more likely to be impoverished than are whites. The problems of sexual and racial inequality intersect with the problem of aging to compound the difficulties of the blacks and female elderly.

2.6.2 Social status

Social changes in Ghana have been a subject of much research and they constitute broader and interrelated categories of human operations such as the sociological, economic, religious, education and medical spheres of development. Social change is dynamic, and every nation has experienced and continues to experience varying degrees of internal and external forces of change although developing countries in the Third World experience a greater degree of external factors than internal. In this

research, a broader examination was undertaken of the impact of social changes on the status, role and well-being of elderly people in Ghana, and a detailed study of the effect of Western Protestant and Catholic mission on the image of elderly people in terms of modernisation, industrialisation, migration and urbanisation.

Modernised or marginalized is a term used to describe socio- cultural changes which result from the influence of the contemporary industrial world. Prosperity gives as its fruit longer life times and modernization clearly plays its role in bringing about prosperity. However, modernisation also brings with it circumstances which contribute to the marginalisation of the elderly: more tightly defined occupational roles, a narrowing of the definition of the family with a resultant narrowing in the perceived social obligations of the young. Modernisation makes possible a longer life but at the same time eradicates many of the sources of social esteem which traditionally gave quality to old age. Ghana is currently a focus of international policy attention given its economic recovery programmes with both advocates and critics of these changes recognizing the major social changes in process.

Industrialisation and Job Opportunities: This tends to make the youth more independence and ignore and sometimes even challenge the authority of the elderly. Industrialisation has always been welcomed by the global economic market as the key to economic boom, modernisation, creation of jobs and the betterment of the well-being of people and societies. What is of interest here, apart from the positive side of industrialisation, is the negative effects it has had on the cultural fabric of Ghanaian society and its consequences on the well-being of the elderly. With the introduction of the machinery for factory and agricultural production to achieve economic gains, the inevitable disruption of some cultural practices and behaviours has weakened the role

and social status of elderly people (Peil, 1972). This situation has been discussed in several conferences and research paper. For example, at the International Conference on Gerontology organized by the International Centre of Social Gerontology in Dakar, Senegal, in December 1984, African Gerontologist (Nana Araba Apt and Ag Rhaly) pointed out that the abandoning of agriculture (in Africa traditional societies) in favour of Industrialisation by African governments after independence from colonialists has contributed to the marginalisation of aged persons whose wisdom is wasted. Delegates at the conference acknowledge that: the disintegration of the family, its resignation of its social role, and the abandonment of old persons are inescapable results of the model of industrial civilization.

Peil (1972) also observed that, there has been a considerable shift in interest from peasant farming in rural areas to factory and white-collar jobs in cities. From these observations and discussions about industrialisation, it can be appropriately summed up the even though industrialisation has brought improvement in the health, economic and political sectors of Ghanaian society, it has also resulted in the continued influx of migrants from the rural areas to urban centers leading to urbanisation, and the consequent weakening of the extended family bonding and responsibility towards elderly persons. Some of the negative effects of this development include the weakening of the hold of traditional authority on the migrants, a lowering of the value (or indispensability) of village elders whose status partly results from:

1. Their title as moral and religious guardians.
2. Their possession of ancestral lands and the experience required for any successful land cultivation and animal rearing.
3. Their intermediary role between the living and the supernatural.

Urbanization and Migration: the attraction of the youth to the urban centers from the rural areas generates a melting pot of cultures and the new migrants turn to their peers, instead of the elderly or their parents for advice. Also, with the migration of the youth to the urban areas, the elderly is deprived of the care they would have had from the youth under traditional practices.

Christianity and Islam: the advent of Christianity and Islam has weakened the influence of the elderly in traditional structures and practices. For example, traditional herbal practices in which the aged played an important role are now frowned upon by some Christians and Muslims because of the traditional rituals involved. The aged are therefore losing their authority as custodians of traditional healing practices among some sections of the population.

Finally, the decline of traditional technology in which the youth served their apprenticeship under the aged has resulted in the loss of their authority. Sociability plays an important role in protecting people from the experience of psychological distress and in enhancing well-being. George (1996) summarized some of the empirically well-supported effects of social factors on depressive symptoms in later life, and reported that increasing age, minority racial or ethnic status, lower socioeconomic status and reduced quantity or quality of social relations are all associated with increased depressive symptom levels. Social isolation is a major risk factor for functional difficulties in older persons. Loss of important relationships can lead to feelings of emptiness and depression. Persons involved with a positive relationship tend to be less affected by everyday problems and to have a greater sense of control and independence. Those without relationships often become isolated. Having few social contacts or living alone does not assure a state of loneliness

(Mullins, Johnson & Anderson, 1987). In fact, for elderly people the time spent with family may be less enjoyable than a visit to a neighbour or someone of their age group. This can be attributed to the fact that relationships with family tend to be obligatory whereas those with friends are a matter of choice. This further emphasizes the need for a perceived internal locus of control over social interaction as a means of alleviating loneliness. Posner (1995) points out that older people tend to make friendships predominantly with those within the same age cohort. Thus with advancing age, it is inevitable that people lose their friendship networks and that they find it more difficult to initiate new friendships and to belong to new networks. However, those with more physical, material and intellectual resources also have more social ~~e~~apital," which allows them to continue to seek out new relationships and forms of social involvement.

2.6.3 Physical status

The physical functioning of older adults usually weakens as they become older. It is the key factor in predicting the health outcome of older adults is their status at the time they retire. The body and immune system of older adults usually become fragile as they become older. The resource of social support also tends to decrease somewhat. Physical appearance of adult changes and it affect their movement as well. In late adulthood, these changes become more pronounced (Gilhar & others, 2004). The changes are most noticeable in the form of facial wrinkles and age spots. Aged people also get shorter when they get older. From 30-50 years of age, men lose about ½ inch in height, then may lose another ¾ inch from 50-70 years of age. The height loss for women can be as much as 2 inches from 25-75 years of age (Hoyer & Roodin, 2003). Note that there is large variation in the extent to which individuals become shorter in middle and late adulthood. The decrease in height is due to bone loss in the vertebrae.

Our height usually drops after we reach 60 years of age. This likely occurs because we lose muscle, which also gives our bodies a more ―sagging" look. The good news is that exercises and appropriate weight lifting can help to reduce the decrease in muscle mass and improve the older person's body appearance. Older adult moves slower than young adults and this difference occur across a wide range of movement difficulty. General slowing of movement of older adults has been found in everyday tasks such as reaching and grasping, moving from one place to another, and continuous movement. The ability to walk rapidly over a distance requires not only muscle strength but also the integration of cardiovascular fitness, vision and postural stability (Morley, 2004). Regular walking has been shown to decrease the onset of physical disability in older adults (Wong & others, 2003).

2.6.4 Emotional status

Socioemotional selectivity theory states that older adults become more selective about their social networks. Because they place a high value on emotional satisfaction, older adults spend more time with familiar individuals with whom they have rewarding relationships. Developed by Laura Carstensen (1995, 1998), this theory argues that older adults deliberately withdraw from social contact with individuals' peripheral to their lives while they maintain or increase contact with close friends and family members with whom they have had enjoyable relationships. This selective narrowing of social interaction maximizes positive emotional experiences and minimizes emotional risks as individuals become older. Socio-emotional selectivity theory challenges the stereotype that the majority of older adults are in emotional despair because of their social isolation.

2.6.5 Health status

Successive generations have also been healthier in late adulthood as better treatments for a variety of illness (such as hypertension) have been developed. Many of these illnesses have a negative impact on intellectual performance (Hultsch, Hammer & Small, 1993). In one study, hypertension was related to decreased performance on the WAIS (Wechsler Adult Intelligent Scale) by individuals over the age of 60 (Wilkie & Eisdorpher, 1971). In one study, physical health and physical activity were positively related to cognitive performance in older adults (Anstey & Smith, 1999). The older the population, the more persons with health problems. Thus, some of the decline in intellectual performance found for older adults is likely due to health-related factors rather than to person‘s age (Comijs & others, 2002). K. Warner Schaie (1994) concluded that some diseases are linked to cognitive drop-offs – these diseases include heart disease, diabetes, and high blood pressure. Schaie does not believe the diseases directly cause mental decline. Rather, the lifestyles of the individuals with the disease might be the culprits. For example, overeating, inactivity, and stress are related to both physical and mental decay (Christensen & others, 1996).

Although a substantial portion of population can now look forward to a longer life, that life may unfortunately be hampered by mental disorder and sensory development in old age. This prospect is both troubling to the individual and costly to society. Mental disorders make individuals increasingly dependent on the help and care of others. Although mental disorders in older adults are a major concern, older adults do not have a higher incidence of mental disorders than younger adults do (Busse & Blazer, 1996).

Sensory Development: Sensory changes in late adulthood involve vision, hearing, taste, smell, touch and pain. As you age, the way your senses (hearing, vision, taste, smell, touch) give you information about the world changes. Your senses become less sharp, and this can make it harder for you to notice details. Sensory changes can affect your lifestyle. You may have problems communicating, enjoying activities, and staying involved with people. Sensory changes can lead to isolation. Your senses receive information from your environment. This information can be in the form of sound, light, smells, tastes, and touch. Sensory information is converted into nerve signals that are carried to the brain. There, the signals are turned into meaningful sensations. A certain amount of stimulation is required before you become aware of a sensation. This minimum level of sensation is called the threshold. Aging raises this threshold. You need more stimulation to be aware of the sensation. Aging can affect all of the senses, but usually hearing and vision are most affected. Devices such as glasses and hearing aids, or lifestyle changes can improve your ability to hear and see.

Vision: Vision occurs when light is processed by your eye and interpreted by your brain. Light passes through the transparent eye surface (cornea). It continues through the pupil, the opening to the inside of the eye. The pupil becomes larger or smaller to control the amount of light that enters the eye. The coloured part of the eye is called the iris. It is a muscle that controls pupil size. After light passes through your pupil, it reaches the lens. The lens focuses light on your retina (the back of the eye). The retina converts light energy into a nerve signal that the optic nerve carries to the brain, where it is interpreted. All of the eye structures change with aging. The cornea becomes less sensitive, so you might not notice eye injuries. By the time you turn 60, your pupils may decrease to about one third of the size they were when you were 20. The pupils may react more slowly in response to darkness or bright light. The lens

becomes yellowed, less flexible, and slightly cloudy. The fat pads supporting the eyes decrease and the eyes sink into their sockets. The eye muscles become less able to fully rotate the eye. Vision with aging, declines in visual acuity, colour vision and depth perception occur. Several diseases of the eye also may emerge in aging adults.

Visual Acuity: In late adulthood, the decline in vision that began for most adults in early or middle adulthood becomes more pounced (Crews & Campbell, 2004; Fozard, 2000). Night driving is especially difficult, to some extent because tolerance for glare diminishes. Dark adaptation is slower, meaning that older individuals take longer to recover their vision when going from a well-lighted room to semidarkness. The area of the visual field becomes smaller, suggesting that the intensity of a stimulus in the peripheral area of the visual field needs to be increased if the stimulus is to be seen (Fozard & Gordon-Salant, 2001). This visual decline often can be traced to a reduction in the quality or intensity of light reaching the retina. In the extreme old age, these changes might be accompanied by degenerative changes in the retina, causing severe difficulty in seeing. Large print books and magnifier might be needed in such cases.

Colour Vision: Colour vision may also decline with age in older adults as a result of the yellowing of lens of the eye (Weale, 1992). This change in colour vision is most likely to occur in the green-blue-violet part of colour spectrum. As a result, it may be more difficult to accurately match up closely related colours such as navy socks and black socks.

Depth Perception: as with many areas of perception, there are few changes in the depth perception following infancy until adults become older. Depth perception typically declines in late adulthood, which can make it difficult for the older adult to

determine how close or far away, or how high or low something is. A decline in depth perception can make steps or street curbs difficult to manage. A decrease in contrast sensitivity is one factor that determines the older adult's ability to perceive depth. Light-dark contrast is produced by the amount of light reflected by surfaces (a light object is brighter than a dark object). Older adults need sharper contrasts and sharper edges around the object to differentiate the object from its background than younger adults.

Diseases of the eye: Three diseases that can impair the vision of older adults are cataracts, glaucoma and muscular degeneration.

- Cataracts; involve a thickening of the lens of the eye that cause vision to become cloudy, opaque, and distorted (Fujikado & others, 2004). By age 70, approximately 30 percent of individuals experience a partial loss of vision due to cataracts. Initially, cataracts can be treated by glasses; if they worsen, a simple surgical procedure can remove them (Hylton & others, 2003).
- Glaucoma; involves damage to the optic nerve because of the pressure created by a buildup of fluid in the eye (Babaloa & others, 2003). Approximately 1 percent of individuals in their seventies and 10 percent of those in their nineties have glaucoma, which can be treated with eye drops, but if left untreated can ultimately destroy a person's vision (Mok, Lee & SO, 2004).
- Macular degeneration -- disease in the macula (responsible for central vision) that causes vision loss.

Hearing: Ears have two jobs. One is hearing and the other is maintaining balance. Hearing occurs after sound vibrations cross the eardrum to the inner ear. The vibrations are changed into nerve signals in the inner ear and are carried to the brain

by the auditory nerve. Balance (equilibrium) is controlled in the inner ear. Fluid and small hair in the inner ear stimulate the auditory nerve. This helps the brain maintain balance. As one age, structures inside the ear start to change and their functions decline. The ability to pick up sounds decreases. You may also have problems maintaining your balance as you sit, stand, and walk.

Hearing impairment usually does not become much of an impediment until late adulthood (Crews & Campbell, 2004; Fodard, 2000). Age-related hearing loss is called presbycusis. It affects both ears. Hearing, often the ability to hear high-frequency sounds, may decline. You may also have trouble telling the difference between certain sounds. Or, you may have problems hearing a conversation when there is background noise. One way to manage hearing loss is by getting fitted with hearing aids. Even then, some but not all hearing problems can be corrected by some hearing aids. Wearing two hearing aids that are balanced to correct each ear separately can sometimes help hearing-impaired adults. Persistent, abnormal ear noise (tinnitus) is another common problem in older adults. Causes of tinnitus may include wax build-up or medicines that damage structures inside the ear. Impacted ear wax can also cause trouble hearing and is common with age.

Smell and Taste: The senses of taste and smell work together. Most tastes are linked with odours. The sense of smell begins at the nerve endings high in the lining of the nose. One has about 10,000 taste buds. Your taste buds‘ senses - sweet, salty, sour, bitter, and umami flavours. Umami is a taste linked with foods that contain glutamate, such as the seasoning monosodium glutamate (MSG). The number of taste buds decreases as you age. Each remaining taste bud also begins to shrink. Most older adults lose some of their sense of smell or taste, or both (Schiffman, 1992). These

decrements can reduce their enjoyment of food and their life satisfaction. One negative outcome for a decline in the sense of smell is less ability to detect smoke from fire. Smell and taste losses often begin around 60 years of age. Your sense of smell can also diminish, especially after age 70. This may be related to a loss of nerve endings and less mucus production in the nose. Mucus helps odors stay in the nose long enough to be detected by the nerve endings. It also helps clear odors from the nerve endings.

Certain things can speed up the loss of taste and smell. These include diseases, smoking, and exposure to harmful particles in the air. Many older adults often prefer highly seasoned foods (sweeter, spicier, and saltier) to compensate for their diminished taste and smell (Hoyer & Roodin, 2003). This can lead to eating more low-nutrient, highly seasoned ~~–~~junk food."

Touch and Pain: Changes in touch are associated with aging (Gescheider, 1997). One study found that with aging, individuals could detect touch less in the lower extremities (ankles, knees and so on) than in the upper extremities (wrists, shoulders and so on) (Corso, 1977). For most older adults, a decline in touch sensitivity is not problematic (Hoyer & Roodin, 2003). Older adults are less sensitive to pain and suffer from it less than younger adults (Harkins, Price & Martinelli, 1986). Although decrease sensitivity to pain can help older adults cope with disease and injury, it can be harmful if it masks injury and illness that need to be treated.

A number of research studies have found that exercise is linked to improve cognitive functioning (Kramer & others, 2002). Here are the results of two of these studies:

i. Community dwelling women 65 years of age and older did not have cognitive impairment or physical limitations when they were initially assessed (Yaffe &

others, 2001). Six to eight years later, the women with higher physical activity when they were initially assessed were less likely to experience cognitive decline.

ii. One hundred and twenty-four individuals 60-75 years of age whose primary activity was sitting around the house were tested for their level of aerobic endurance and their level of cognitive functioning (Kramer & others, 1999). Cognitive functioning was assessed by tasks on working memory, planning and scheduling. Half the group was randomly assigned to engage in yoga- type stretching activities and the other half was randomly assigned to start walking three times a week. After six months, the walkers averaged a mile in 16 minutes, a minute faster than at the beginning, and the stretches had become more flexible. When their cognitive functioning was retested after six months, the walkers scored up to 25 percent higher on the cognitive tests than the stretchers did.

Other researchers have found that aerobic exercise is related to improved memory and reasoning (Clarkson –Smith & Hartley, 1989). Walking or any other aerobic exercise appears to get blood and oxygen pumping to the brain, which can help people, thinks more clearly.

Psychological Status: One reason old age is a devalued role is that Ghanaians tend to have negative attitudes toward being old. These negative attitudes are reflected in the various myths about old age, which can become self-fulfilling prophecies. People who believe the elderly have lost the capacity to enjoy living may make life more difficult for the elderly and may themselves plunge into despair when they become old. Negative attitudes about old age are easy to pick up in our society. In an experiment with undergraduates, the students were asked to teach a task via videotape (Harris et al., 1994). Some thought they were teaching another student, while others thought

they were teaching an elderly woman. Those who thought they were teaching the elderly women taught less material, were more nervous, and were less friendly. The students' discomfort with the elderly women is not surprising, for negative attitudes are found in everything from arts to music. An analysis of the cover art and lyrics of sheet music since the 1830s found some positive but a good deal of negative images of the old (Rovner 1990). Among other things, the music depicted undesirable physical changes, glorification of the youthful stage life, and fear of poverty, loneliness, and debility in old age. Similarly, children's books may portray villains as old. Think of the appearance of witches, they are always old –looking and ugly. Children can develop negative attitudes about the aged from such sources, particularly if they have little contact with older people. Caspi (1984) set up an age-integrated preschool facility) it used a number of elderly aids) and compared the attitudes of the children with those in another facility that had no elderly staff. The children in his preschool had more positive attitude toward the elderly than did the children in the other facility.

The attitudes that people have toward the aged are important for three reasons: They cast the elderly into a devalued role; they create self-fulfilling prophecies; and they influence public policy. Negative attitudes about the capabilities of the aged help maintain policies that restrict the elderly to socially devalued activities. Those negative attitudes must be altered in support of the kind of changes the elderly need. In Ghana, stories of abuse of the elderly now attract media interest. Newspapers do not hesitate to carry stories of reported cases of granny bashing or abuse of older men or the neglect of older people who need social and government support and care. The Gambaga Witch Camp in northern Ghana is full of older women and men who have been abandoned and isolated from society for allegedly being witches. The inhuman

treatment meted out to some of these alleged witches differs from society to society. While some societies may lynch them, others are mistreated at home, entailing neglect of care which may lead to death from malnutrition and other mental illness like dementia, depression etc. Next, the concept of depression and how it affects the elderly is discussed.

Depression: Depression is a mood disorder which prevents individuals from leading a normal life, at work, socially or within their family. Seligman (1973) referred to depression as the ‗common cold' of psychiatry because of its frequency of diagnosis. One of the most common mental illnesses that affect elderly people, especially those up to the age 75 years in depression. It is a mental condition in which the symptoms can be confused with other pathological and normal states. Sufferers are unhappily moody but not all unhappiness is depression. Depression is not a normal part of growing older, and it should never be taken lightly. Unfortunately, depression often goes undiagnosed and untreated in older adults, and they may feel reluctant to seek help.

Symptoms of depression

Symptoms of depression may be different or less obvious in older adults, such as: Memory difficulties or personality changes, physical aches or pain, fatigue, loss of appetite, sleep problems or loss of interest in sex — not caused by a medical condition or medication. Often wanting to stay at home, rather than going out to socialize or doing new things. Suicidal thinking or feelings, especially in older men. The person does not feel well, loses stamina easily, has a poor appetite, and is listless and unmotivated. Areiti and Bemporad (1980) attempted to distinguish between depression and other mental illness. They wrote: ―A syndrome can be called

depression when the depressive mood constitutes the main characteristics irrespective of whether this mood belongs to a primary or secondary form of depression."

Behaviorist Theory

Behaviorism emphasizes the importance of the environment in shaping behaviour. The focus is on observable behaviour and the conditions through which individuals learn behaviour, namely classical conditioning, operant conditioning and social learning theory. Therefore, depression is the result of a person's interaction with their environment. For example, classical conditioning proposes depression is learned through associating certain stimuli with negative emotional states. Social learning theory states behaviour is learned through observation, imitation and reinforcement.

Operant Conditioning

Operant conditioning states that depression is caused by the removal of positive reinforcement from the environment (Lewinsohn, 1974). Certain events, such as losing your job, induce depression because they reduce positive reinforcement from others (e.g. being around people who like you). Depressed people usually become much less socially active. In addition, depression can also be caused through inadvertent reinforcement of depressed behaviour by others, for example, when a loved one is lost; this leads to inactivity. The main source of reinforcement is now the sympathy and attention of friends and relatives. However, this tends to reinforce maladaptive behaviour i.e. weeping, complaining, and talking of suicide. This eventually alienates even close friends leading to even less reinforcement, increasing social isolation and unhappiness. In other words, depression is a vicious cycle in which the person is driven further and further down.

Also, if the person lacks social skills or has a very rigid personality structure, they may find it difficult to make the adjustments needed to look for new and alternative sources of reinforcement (Lewinsohn, 1974). So, they get locked into a negative downward spiral. There are other causes of depression which are of importance. These are the social and psychological origin. Low morale, for example, among widows living alone can cause depression. Bereavements, loneliness, poverty, pain and disability have also been found by McLennan to precipitate a depression condition. Depression or the occurrence of depressive symptomatology is a prominent condition amongst older people, with a significant impact on the well-being and quality of life. Many studies have demonstrated that the prevalence of depressive symptoms increases with age (Kennedy, 1996). Depressive symptoms not only have an important place as indicators of psychological well-being but are also recognized as significant predictors of functional health and longevity. Longitudinal studies demonstrate that increased depressive symptoms are significantly associated with increased difficulties with activities of daily living (Penninx et al., 1998).

Community-based data indicate that older persons with major depressive disorders are at increased risk of mortality (Bruce, 1994). There are also studies that suggest that depressive disorders may be associated with a reduction in cognitive functions (Speck et al., 1995). Though the belief persists that depression is synonymous with aging and that depression is in fact inevitable, there has been recent research which dispels this faulty notion. Depression has a causal link to numerous social, physical and psychological problems. These difficulties often emerge in older adulthood, increasing the likelihood of depression; yet depression is not a normal consequence of these problems. Studies have found that age isn‘t always significantly related to level of depression, and that the oldest of olds may even have better coping skills to deal

with depression, making depressive symptoms more common but not as severe as in younger populations.

When the onset of depression first occurs in earlier life, it is more likely that there are genetic, personality and life experience factors that have contributed to the depression. Depression that first develops in later life is more likely to bear some relationship to physical health problems. An older person in good physical health has a relatively low risk of depression. Physical health is indeed the major cause of depression in late life. There are many reasons for this, which include the psychological effects of living with an illness and disability, the effects of chronic pain; the biological effects of some conditions and medications that can cause depression through direct effects on the brain; and the social restrictions that some illnesses place upon older people's life style resulting in isolation and loneliness. There are strong indications that depression substantially increases the risk of death in adults, mostly by unnatural causes and cardiovascular disease (Wulsin et al., 1999). Some population-based studies did find that this independent relationship does exist in later life, while others did not. There's no sure way to prevent depression. However, these strategies may help, to take steps to control stress, to increase your resilience and boost your self-esteem. To reach out to family and friends, especially in times of crisis, to help you weather rough spells. Get treatment at the earliest sign of a problem to help prevent depression from worsening. Consider getting long-term maintenance treatment to help prevent a relapse of symptoms.

Dementia, Alzheimer Disease: Among the debilitating of mental disorders in older adults are the dementias. Dementia is a global term for any neurological disorder in which the primary symptoms involve a deterioration of mental functioning.

Individuals with dementia often lose the ability to care for themselves and can lose the ability to recognize familiar surroundings and people (including family members). The most common form of dementia is Alzheimer disease, a progressive, irreversible disorder that is characterized by gradual deterioration of memory, reasoning, language and eventually physical functioning. Alzheimer disease was first diagnosed in 1906 by the German doctor Alois Alzheimer, but significant research on the disease did not begin until the 1950s, as Alzheimer disease became more clearly distinguished from other types of dementia.

In the 1970s, it was discovered that Alzheimer disease involves a deficiency in the important brain messenger chemical acetylcholine, which play an important role in the functioning of the memory (Sayer & others, 2004). Although scientists are not certain what cause Alzheimer disease, age is an important risk factor and genes also likely play an important role (Huang & others, 2004). Researchers have revealed older adults with Alzheimer disease are more likely to also have cardiovascular disease than individuals who do not have Alzheimer disease (Fitzpatrick & others, 2004). The mental health and psychosocial consequences of disasters may be of a predominantly social or psychological nature. Whilst this is an effective way of classifying the issues into domains, this should not undermine the interconnectedness of mental health and psychosocial well-being.

2.7 Measures to Improve the Effects on the Elderly

The research dealt with how to improve the psychosocial effects on the well-being of the elderly. Psychosocial well-being is something often overlooked when assessing the health of an elderly individual. While greater importance is being placed on helping elderly individuals remain active in the community, little interest has been

generated on the topic of psychosocial well-being. Psychosocial well-being includes having a positive self-image and feeling like an important part of social relationships. To help ensure psychosocial well-being in an elderly individual, the person should be kept active in community activities and feel a sense of independence. Obviously, assessing the psychosocial well-being of an elderly person in the advanced stages of Alzheimer's or other form of dementia is exceedingly difficult. For many years, scientists have known that a healthy diet, exercise and weight control can lower the risk of cardiovascular disease.

Now, they are finding that these healthy lifestyle factors may also lower the risk of Alzheimer disease. A special concern is caring for Alzheimer patients. Health –care professionals believe that the family can be an important system for the Alzheimer patient, but this support can have costs for the family, who can become emotionally and physically drained by the extensive care required for a person with Alzheimer (Gaugler, Zarit & Perlin, 2003). For example, depression has been reported in 50 percent of family caregivers for Alzheimer patients (Redinbaugh, MacCallum & Kiecolt-Glaser, 1995). Respite cares have been developed to help people who have to meet the day-to-day needs of Alzheimer patients. This type of care provides an important break away from the burden of providing chronic care.

However, all elderly people can enjoy a better quality of life if the psychosocial well-being of the person is assessed and found to be positive. For some elderly residents of a skilled nursing facility, a change in routine can trigger a lack of psychosocial well-being. Other residents may become depressed because the residents are no longer able, for various reasons, to participate in all of the activities that such patients formerly participated in. A decline in psychosocial well-being is marked by signs of

depression and, potentially, delusions. Maintaining psychosocial well-being can lead to a higher quality of life for an elderly individual.

2.8 Assessing Psychosocial Well-Being Using Care Plan Information

The worksheet included in Care Plan Information can help families to assess the psychosocial well-being of an elderly loved one. The ability to accurately assess psychosocial well-being can prevent the development of more serious emotional problems and lead to a better quality of life for an elderly loved one. The staff of a skilled nursing facility should be equipped to encourage the psychosocial well-being of the residents.

The model of social support and integration; individuals go through life embedded in a personal network of individuals from whom they give social support. Social support can help individuals of all ages cope more effectively. Social support can improve the physical and mental health of older adults. Social support is linked with a reduction of symptoms of diseases and with the ability to meet one‘s own health-care needs. Social support also decreases the probability that an older adult will be institutionalized (Antonucci, 1990). Social support is associated with a lower incidence of depression in older adults (Joiner, 2000). Social integration plays an important role in the lives of many older adults. Being lonely and socially isolated is a significant health risk factor in older adults. In one study, being part of a social network was related to longevity, especially for men (House, Landis & Umberson, 1988). And in a longitudinal study, both women and men with more organizational memberships lived longer than their counterparts with low organizational participation (Taylor and Turner 2001).

Social support is one of most important factors in predicting the physical health and well-being of everyone, ranging from childhood through older adults. The absence of social support shows some disadvantage among the impacted individuals. In most cases, it can predict the deterioration of physical and mental health among the victims. The initial social support given is also a determining factor in successfully overcoming life stress. The presence of social support significantly predicts the individual's ability to cope with stress. Knowing that they are valued by others is an important psychological factor in helping them to forget the negative aspects of their lives, and thinking more positively about their environment. Social support not only helps improve a person's well-being; it affects the immune system as well. Thus, it is also a major factor in preventing negative symptoms such as depression and anxiety from developing.

The social support and physical health are two very important factors that help the overall well-being of the individual. A general theory that has been drawn from many researchers over the past few decades postulate that social support essentially predicts the outcome of physical and mental health for everyone. There are six criteria of social support that researchers used to measure the level of overall social support available for the specific person or situation (Cutrona, Russell & Rose, 1986). First, they would look at the amount of attachment provided from a lover or spouse. Second, measuring the level of social integration that the individuals involved with, it usually comes from a group of people or friends. Third, the assurance of worth from others such as positive reinforcement that could inspire and boost the self-esteem. The fourth criterion is the reliable alliance support that provided from others, which means that the individual knows they can depend on receiving support from family members whenever it was needed. Fifth, the guidance of assurances of support given to the

individual from a higher figure of person such as a teacher or parent. The last criterion is the opportunity for nurturance. It means the person would get some social enhancement by having children of their own and providing a nurturing experience.

Social support can only be beneficial if it is adaptable to the environment; furthermore, social support has to be geared towards an individual's specific needs. We have to be more aware of what our friends, family members, and even ourselves need in terms of support. Once we are aware of this, we can more effectively enhance the positive effect of networks, rather than be burdened by the negative. Social support is supposed to protect us, make us happier and healthier, and keep us sane; at least, that is the argument presented in Corey M. Clark's report (1953), "Relations between Social Support and Physical Health." As emphasized throughout Clark's report, social support acts as our mind's defense against stressful life events and provides the necessary coping skills to deal with these events. But what happens when our network of family members, friends, and colleagues are causing the stress? Clark neglected the negative effects of social support and the damage it can cause on our psychological and physiological well-being. Clark accurately pointed out that "social support essentially predicts the outcome of physical and mental health for everyone." However, he assumed that this social support is positive. In fact, social support can be detrimental to a person's overall well-being. For example, people with schizophrenia are more likely to relapse when they return home to live with family than if they live alone (Butcher, Mineka & Hooley, 2004).

A common perception is that older adults need to be given help rather than give help themselves. However, researchers recently have found that when older adults engage in altruistic behaviour and volunteering they benefit from these activities. One recent

study followed 423 older adult couples for five years (Brown & others, 2003). At the beginning of the study, the couples were asked about the extent to which they had given or received emotional or practical help in the past year. Five years later, those who said they had helped others were half as likely to have died. One possible reason for this finding is that helping others reduces the output of stress hormone, which improves cardiovascular health and strengthens the immune system.

Researchers also have found that volunteering as an older adult is associated with a number of positive outcomes. An early study of individuals 65 years and older found that volunteer workers compared with non-volunteers were more satisfied with their lives and were less depressed and anxious (Hunterv & Linn, 1980). In other instances, internal factors play a bigger role than external ones. Therefore, the aged should try cultivate an optimistic view of life from the inside to further your spiritual, mental, and emotional health. Learned optimism is the idea that an individual can learn positive ways of thinking about and explaining both positive and negative events in their life. There are three core concepts to a pessimistic or optimistic perspective in life. They are:

Permanence: This is the dimension that shows that pessimists think bad events are permanent and use words like never, forever, and always, as opposed to optimists, who see that bad events are temporary and qualify what they say by using words like sometimes, often, or frequently instead. Pessimists will say things like 'That will never work,' whereas optimists may say 'It didn't work today.' Therefore, optimists are more likely to quickly recover from setbacks. Another concept is pervasiveness: Pessimists are more likely to see a problem of universal proportions as opposed to optimists. Optimists view a problem as part of a small compartment of their lives. So,

if an optimist fails a math test, they may say they are bad in calculus but great in algebra. A pessimist, however, will claim they are terrible at all math, period.

And the third concept is personalization: Optimists are more likely to give themselves credit for success and are unlikely to belittle themselves when something goes wrong. Yet, pessimists will say it was just sheer luck if they achieve something great and that it's their entire fault if something bad happens to them. Contribute to the body of research on the societal barriers experienced by older persons, particularly low-SES groups and/or persons of minority status, and the impact of these barriers on health and positive well-being. Consider how SES affects older clients' presenting problems, ways of coping and the development of effective treatment strategies. Practice proactive screening of older clients for psychological and physical distress and coordinated care with other health professionals.

2.9 Theoretical Framework

Theoretical framework provides a well-supported rational to conduct a study and also help the reader to understand the researcher's view point. It demonstrates an understanding of theories and concepts that are relevant to the topic of the research study and that relate to the broader areas of knowledge being considered (Kivunja 2018).

The psychology of aging is in a permanent identity crisis. As Birren and Lanum (1991, p. 114-115) would say, –There is no major theory or underlying metaphor that links the various areas of psychology. Its state is much like physics was in the first decades of this century in which there was little unifying theory that linked the topics of optics, sound, levers, heat, and light. Contemporary psychology has similar topical islands of knowledge organized under the headings of sensation and perception,

memory, learning, psycholinguistics, social psychology, motor skills, psychometrics, and developmental psychology. It is not surprising that the psychology of aging takes on a complexion derived from these subdivisions."

The following overview aptly illustrates Birren and Lanum's point.

2.9.1 Modern Theories

Life-span Development and Aging: Since the beginning of the 1980s, Paul B. Baltes and his associates (Baltes, 1987; Baltes, Reese, & Lipsitt, 1980; Baltes, Smith, & Staudinger, 1992) have conducted a series of studies on psychological processes of development and aging from a life-span perspective. In line with the tradition of life-span developmental psychology, development and aging are conceived as synonyms for behavioural changes across the life span. Starting from these studies, Baltes has developed a theoretical framework of seven propositions about the nature of human aging from a psychological point of view: (1) there are major differences between normal, pathological, and optimal aging, the latter defined as aging under development enhancing and age-friendly environmental conditions; (2) the course of aging shows much interindividual variability (heterogeneity); (3) there is much latent reserve capacity in old age; (4) there is aging loss in the range of reserve capacity or adaptively; (5) individual and social knowledge (crystallized intelligence) enriches the mind and can compensate for age-related decline in fluid intelligence (aging losses); (6) with age, the balance between gains and losses becomes increasingly negative; and finally, (7) the self in old age remains a resilient system of coping and maintaining integrity.

Based on this framework of propositions, a psychological model of successful aging has been devised, called "selective optimization with compensation." The central focus of this model is on the management of the dynamics between gains and losses, i.e., a general process of adaptation, consisting of three interacting elements. First, there is the element of selection, which refers to an increasing restriction of one's life to fewer domains of functioning because of an age-related loss in the range of adaptive potential. The second element, optimization, reflects the view that people engage in behaviours to enrich and augment their general reserves and to maximize their chosen life courses (and associated forms of behaviour) with regard to quantity and quality. The third element, compensation, results also (like selection) from restrictions in the range of adaptive potential. It becomes operative when specific behavioral capacities are lost or are reduced below a standard required for adequate functioning. The lifelong process of selective optimization with compensation allows people to age successfully, i.e., to engage in life tasks that are important to them despite a reduction in energy. For instance, the famous pianist Rubinstein remarked in a television interview that he conquers the weaknesses of aging (adaptation) in his piano playing in the following manner: First, he reduces his repertoire and plays a smaller number of pieces (selection); second, he practices these more often (optimization); and third, he slows down his speed of playing prior to fast movements, thereby producing a contrast that enhances the impression of speed in the fast movements (compensation).

2.9.2 Psychosocial theory of personality development

In 1950 Erik Erikson formulated a psychosocial theory of eight stages of personality development, each with its own characteristic crisis that arises out of the conflict between two opposite tendencies. The developmental task of each age period is to

resolve its conflict, which requires the integration of personal needs with the demands of society. The successful resolution of each conflict leads to developmental strength in terms of a new virtue. Failure, however, to deal adequately with a task during its period of ascendancy is damaging to personality development.

Erikson's psychosocial stages of development are not tied closely to specific age periods. The early stages are defined in much more detail than the later ones: post adolescence, for example, includes about three quarters of the life span, but only the last three stages. This division reflects the increase in psychosocial variability with age: the developmental tasks of an infant are relatively universal, but the tasks in later life are dependent as much on personal experiences as on general principles.

Erik Erikson‘s stages of psychosocial development are perhaps the best known of the stage theories of adult personality. The sequence of Erikson‘s eight stages of development is based on the epigenetic principle, which means that personality moves through these stages in an ordered fashion at an appropriate rate. Two of the eight stages describe personality change during the adult years. Although the identity crisis is placed in adolescence, deciding ―who you are‖ is a continual process that is reflected throughout adulthood, even in old age. In the midlife stage of generativity versus stagnation, individuals seek ways to give their talents and experiences to the next generation, moving beyond the self-concerns of identity and the interpersonal concerns of intimacy. Successful resolutions of this stage result in the development of a sense of trust and care for the next generation and the assurance that society will continue. Unsuccessful resolution of this stage results in self-absorption. Ego integrity versus despair is Erikson‘s final stage of ego development, beginning around age 65 and continuing until death.

In this stage, individuals become increasingly internally focused and more aware of the nearness of death. Successful resolution of this stage results in being able to look back on one's life and find meaning, developing a sense of wisdom before death. Alternatively, meaninglessness and despair can ensue if the process of life review results in focus on primarily negative outcomes. Difficulties arising from attempts to empirically investigate Erikson's theory include the assertion that stages must be encountered in order and the lack of specification regarding how developmental crises are resolved so that an individual may move from one stage to the next. However, the environmental influences of culture and cohort on adult personality have been minimized. One 22-year investigation found significant age changes supportive of Erikson's theory. 12 Middle-aged adults expressed emotions and cognitions consistent with successful completion of more psychosocial developmental crises than younger adults. In addition, Ackerman et al found a stronger association between generativity in midlife compared with young adulthood. Some theorists postulate that the ego integrity versus despair period initiates a process of life review.

Two major theories explain the psychosocial aspects of aging in older adults. Disengagement theory views aging as a process of mutual withdrawal in which older adults voluntarily slow down by retiring, as expected by society. Proponents of disengagement theory hold that mutual social withdrawal benefits both individuals and society. Activity theory, on the other hand, sees a positive correlation between keeping active and aging well. Proponents of activity theory hold that mutual social withdrawal runs counter to traditional American ideals of activity, energy, and industry. To date, research has not shown either of these models to be superior to the other. In other words, growing old means different things for different people. Individuals who led active lives as young and middle adults will probably remain

active as older adults, while those who were less active may become more disengaged as they age.

As older adults approach the end of their life span, they are more apt to conduct a life review. The elderly may reminisce for hours on end, take trips to favorite childhood places, or muse over photo albums and scrapbooks. Throughout the process, they look back to try to find the meaning and purpose that characterized their lives. In their quest to find life's meaning, older adults often have a vital need to share their reminisces with others who care, especially family.

2.10 Conceptual Framework

Conceptual framework is a research tool intended to assist a researcher to develop awareness and understanding of the situation under scrutiny and communicate it (Smyth, 2004). Every person marks each stage of human development with certain achievements, and each stage is affected by the previous stage while additionally affecting the next one. Quality of life in old age is therefore influenced by the individual‘s lifestyle as an adult, and preparation for senescence should be made during adulthood. But because such preparation is crucial in determining the quality of life in old age and other health-related attitudes, relevant education may play an important role even from childhood. Therefore, it is important to investigate the recognition process of healthy aging and identify the influential factors in healthy aging at each stage of life.

Healthy aging is a lifelong process of optimizing opportunities for improving and preserving physical, social and mental wellness, independence, and quality of life, as well as enhancing successful life-course transitions. This definition includes the physical, psychological, social, and spiritual well-being of old adults. It also signals

an increasingly positive perspective on elderly health and well-being. In recent studies, certain terms such as active aging, successful aging, positive aging, and productive aging are used interchangeably to indicate healthy aging. For example, Kim and Chung (2008), use "successful aging" synonymously with healthy aging. However, while successful aging is more of a goal of old age, healthy aging can be considered as a series of processes for achieving successful aging, and is therefore a concept more pertinent to daily living. Healthy aging is what should be taken into consideration for maintaining autonomy and independence towards successful aging.

Nowadays, current trends indicate a populace unsatisfied with just the basic necessities of life in elderly living (in other words, being merely disease- and disability-free), showing instead a desire to maintain their current lifestyles, complete with their entire usual social and leisure activities. Healthy aging extends beyond the mere absence of disease or infirmity, and now includes physical, mental, and social well-being. The mental health of old people, consequently, also encompasses both positive mental health as well as disease prevention. For this reason, much research on healthy aging related to mental health have focused more on identifying the psychological factors for active or successful aging or for psychological well-being, differing from previous studies that tended to concentrate on mental ill-health. Consequently, many studies focus on the beneficial or risk factors for positive mental health, such as depression, self-esteem, self-efficacy, loneliness, and isolation, all factors that influence healthy aging.

In the present study, we propose to examine perceived health status, depression, self-esteem, self-achievement, ego-integrity, participation in leisure activities, and loneliness as affecting factors on healthy aging. According to Mossey and Shapiro

(1985), well-being and mortality in old people are influenced by their belief in their own health as being good or poor, and old people who perceived their health more positively show higher well-being and less mortality. Individual psychological resources such as self-esteem, self-achievement, and ego-integrity are also important psychological factors for healthy aging. Several previous studies additionally indicate that self-esteem is significantly correlated to our life outcomes such as human relationships, work, health, and healthy aging. However, the debate continues as to whether self-esteem is a cause and or consequence of healthy aging due to causal effect.

A sense of self-achievement also increases feelings of self-worth and self-efficacy, improving positive mental health status as well as the ability to have the psychological well-being necessary for healthy aging. It seems that old people possess a sense of self-achievement through the participation of social or leisure activities; many studies report leisure activities as a good indicator related to healthy aging. Other studies report that participation in leisure activity relates to depression especially in old people. Depression negatively correlates with mental health, with some studies reporting depression as a significant risk factor affecting healthy aging. Loneliness and isolation among old people may increase due to decreased personal relationships, with such social isolation inducing or exacerbating geriatric depression. This study investigates the ego-integrity effect on healthy aging because of how it can be a completion of psychological well-being in old age, according to Erikson‘s psychosocial developmental theory. Erikson‘s concept of ego-integrity is complex for it may develop with integrating one‘s life experience. Erikson also considered ego-integrity as the result of seven stages of psychosocial development. According to certain cross-sectional studies, generativity affects ego-integrity as an important

predictor and Erikson's prior stages are significantly correlated to ego-integrity. Torges et al (2012). Using a longitudinal dataset investigated how attaining successful generativity in midlife corresponds with higher levels of ego-integrity in later life. Psychological well-being acquired through ego-integrity may also influence healthy aging, but there are fewer studies examining ego-integrity as a factor influencing healthy aging.

2.11 Empirical Framework

Empirical research is research that is based on observation and measurement of phenomena, as directly experienced by the researcher. The data thus gathered may be compared against a theory or hypothesis, but the results are based on real life experience.

We are no longer a youthful society. As more individuals live to older ages, the proportion of individuals at different ages has become increasingly similar. Indeed, the concept of a period called –late adulthood" is a recent one – before the twentieth century most individuals died before they reached 65. Although much greater percentage of persons lives to an older age, the life span has remained virtually unchanged since the beginning of recorded history. Life span is the upper boundary of life; the maximum life span of human beings is approximately 120 to 125 years of age. Life expectancy is the number of years that will probably be lived by the average person born in a particular year. Improvements in medicine, nutrition, exercise, and lifestyle have increased our life expectancy an average of 30 additional years since 1990.

The average life expectancy of individuals born today in the United State is 77 years (80 for women, 74 for men). There is still a gap (7years) between the life expectancy of non-Latino Whites (77) and African American (70) in the United States but the gap is narrowing. In 1970 the gap was 8 years (National Centre for Health Statistics, 2004). Another example Japan has the highest life expectancy at birth today (81years) (UNICEF, 2004).

Life expectancy at age 60, female in Ghana was reported at 16.35 in 2017, according to the World Bank collection of development indicators, compiled from officially recognized sources. Ghana-Life expectancy at age 60, female - actual values, historical data, forecasts and projections were sourced from the World Bank on July of 2020. Life expectancy at age 60, female is the average number of years that a female at age 60 would live if prevailing patterns of mortality at the time of age 60 were to stay the same throughout her life. Ghana life expectancy from 1950 to 2020, United Nations projections are also included through the year 2100.

The current life expectancy for Ghana in 2020 is 64.17 years, a 0.4% increase from 2019. The life expectancy for Ghana in 2019 was 63.91 years, a 0.41% increase from 2018. The life expectancy for Ghana in 2018 was 63.65 years, a 0.58% increase from 2017. The life expectancy for Ghana in 2017 was 63.28 years, a 0.58% increase from 2016. According to the latest WHO data published in 2018 life expectancy in Ghana is: Male 62.5, female 64.4 and total life expectancy is 63.4 which gives Ghana a World Life Expectancy ranking of 155. Differences in life expectancy across countries are due to such factors as health conditions and medical care throughout the life span. The life expectancy figures cited indicate the years that a person born in a particular year can be expect to live.

According to a systematic review of Cosco et al. (2014), they report that physiological factors such as physical status, disability, and disease presence are more effective on healthy aging, but psychosocial factors such as affective status, social relations, and psychological well-being are more salient similarly in all countries from studies analysing 84 research articles published in between 2011 and 2013 in developed European, American, and Asian countries including South Korea. Koreans generally had a negative perspective of retirement and aging because in the past, Korean old people tended to be physically and economically dependent on their children and had to live together. Therefore, their scope of life and social activities were relatively limited. In the last decade, the perception of retirement and aging has changed more for the positive, but not as much as to the level of Westerners. According to a research report in 2010 from The Korea Institute for Health and Social Affairs, Korean old people spend more money on leisure activities, medical care, and exercise not only for maintaining physical status and avoiding diseases, but also for positive life-experiencing achievement, improving social relationships, avoiding depressive feelings, and integrating into society. Recent studies from South Korea on healthy aging emphasize the importance of psychosocial factors including ego-integrity, similarly to our study‘s outcome, which were not regarded as important in studies on healthy aging in the 90s.

2.12 Empirical Framework in Ghana

We can define old people as all those above the pensionable age in Ghana, which is 65 years. The vulnerable groups in Ghana include the old, invalids or physically-, mentally-, and socially-challenged individuals of all age groups and gender. Dependents include those less than 14 years who are about 9 million in Ghana, those above 65 years who are about 1 million in Ghana, and those 15 to 24 years who are 5

million. In total, we have about 15 million dependents in Ghana, excluding the invalids across all age groups. Ghana's latest total population is estimated at 34 million. The subject of interest of this research is the 1 million people who have reached the twilight or evening of their lives, or those who are 65 years and above. Percentage distribution of elderly persons aged 60 and above in Ghana by selected characteristics from 1984–2000, suggests that while majority of the older men are likely to be married, majority of their female counterparts are likely to be widowed/divorced/separated. In all, while there are 98 males for every 100 females in the entire population, there are only 87 older men for every 100 older women for the elderly population. The disparities with respect to these characteristics may be due to the fact that women, on average, live longer than men in most populations and typically marry men older than themselves, and men are more likely than women to remarry after divorce or the death of a spouse.

Additionally, since many young adults, especially males, are more likely to migrate to cities in search of work and schools, some of them may choose to remain in the cities where social amenities and other benefits of modernization are concentrated after retirement, while others return to their villages to subsist on agriculture due to inadequate or lack of financial base to cope with the demands of city life. (It should be noted that social attachments of the migrants with their childhood areas may also induce some of them to return to the rural areas after retirement).

Although the percentage of the elderly persons has risen significantly in rural Ghana, there is no evidence to suggest a corresponding social care for the aged. In spite of the demographic shift, older persons' concerns have remained marginal to the major social and economic debates in the country. As a result, many older people, who

cannot engage in large-scale agricultural activities, are faced with inadequate and insecure income in the absence of extended family support. With increasing social change, this inter-dependence which has formed the strength of the family support system has been eroded by the separation of the generations through migration, death of key family members and lack of surviving siblings of elderly persons. Indeed, one could with some justification say that the onus of responsibility for the care of the elderly has shifted from the extended family system towards the nuclear family with an important role being played by spouses and children. In this regard, the special role performed by one's children is seen to be very crucial. Brown (1984, p. 76) has shown the important filial obligation which siblings have towards their parents in the form of providing food money for food, running errands, attending to the daily needs of their parents, occasionally paying for medical bills and house rent, supplying clothing, and providing emotional satisfaction and encouragement.

On the other hand, Apt (1981) has indicated that while most Ghanaians are still willing to take responsibility for their aged parents, young people frequently complained of their own financial inability to care as much as they would wish for aged relatives. She points out that the overall effect of modernization is pressure on the nuclear family of the younger wage earners to provide for themselves, with little available for aged parents who may be at a distance and inaccessible to personal care. Although Apt (1981), hopes for a continued system of family care, the indicators suggest to her that, in comparison with the present generation of people over 60, new generations of the elderly are likely to have less help and less security from fewer children. The problem, as she points out, is that not only will people have fewer children but that because of migration the children will simply be available less to support their aged parents, and frequently less able to contribute material assistance.

Mba (2007), conducted a study on the topic, –Population aging in Ghana and correlates of support availability.” The study sought to examine the demographic, social, and economic characteristics of the aged special needs. The study presented data on the phenomenon of population aging in Ghana, using the household rosters of the 1993-2003 Ghana Demographic and Health Surveys, and results of the 1960-2000 national census. The study characterises the living arrangements of the elderly in demographic and socio-economic terms in order to portray the economic and social disadvantages experienced by this group. The result of the study revealed proportion of the elderly to the total population increased from 9% in 1960 to 12% in 2000, while the number rose from 0.6 million to 2.3 million over the same period. There are generally more elderly women than men during the period 1993-2003, as about 52% of the total elderly population are females. The overwhelming majority of the older population has no formal education. Of Ghana‘s 10 administrative regions, elderly persons are more concentrated in the Ashanti Region than any other region (15% in 1993, 13% in 1998, and 14% in 2003).

About 11% of older adults live alone, while women are more likely to live alone than men. Although extended household living is still prevalent, there are great variations in living arrangements by gender. Regression analyses suggest that the probability of solitary living, and hence the need for support and care, is more pronounced among the elderly from the Northern, Upper West and Upper East Regions, rural dwellers, persons without formal education, and those aged 80 years and over. In conclusion the prevalence of extended living arrangements of the elderly in Ghana may reflect an attempt to alleviate economic hardships on the one hand, while this may be indicative of a cultural dimension of exchange relationships typical of traditional societies on the other hand.

Also, Adei, Anning and Mireku (2015), conducted research on –Basic needs for the aged in selected districts in Ashanti region of Ghana." This study therefore sought to investigate the healthcare, housing, social and financial support given to the aged in the Kumasi Metropolis and Bosomtwi District within the Ashanti Region of Ghana. Purposive sampling technique was adopted for the selection of the study area while random sampling was used in selecting 264 aged respondents. Their care givers were also interviewed; where the aged gave permission to. The religious institutions they attend and other philanthropic institutions that support them were also purposively sampled. Interview guide and questionnaire were used for the collection of data.

The survey revealed that 48.9% of the aged respondents lived in their family houses and has some form of social interaction. About 64% however lived without their spouses and visited friends to break boredom. About 58% of the aged respondents suffer from multiple illnesses which are usual of the aged and most of them (63.3%) went for regular medical check-ups to sustain themselves. The study also revealed that, 91.3% of the aged respondents depended on remittances from their children for financial sustenance, which was not reliable as any hiccup in the finances of their children would affect their wellbeing. The implementation of the –Aged Fund" would oversee the wellbeing of the aged; and the establishment of Community Social Centers for social interactions has been recommended. Again, the age limit for the subsidized premium payment of the National Health Insurance Scheme should be reduced from 70 years to 65 years as 28.4% of the aged respondents fell within the 65–69-year age cohort.

Again, a pilot study was carried out by Mba, Addico and Adanu (2007), to explore the living arrangements, health and socio-economic conditions of Ghana's elderly population with particular reference to one urban slum and two middle class residential areas in the Greater Accra Region, as well as one rural HIV / AIDS endemic locality in the Eastern Region of Ghana. The localities were selected in order to reflect the different infrastructure, culture and social contexts in rural and urban areas in Ghana. In-depth interviews were held for two weeks in October 2006 with a view to unearthing important information relating to persons aged 60 years and above. The findings show that 60% of the respondents were aged 60-69 years while over 80% of them were below 75 years. There were roughly equal numbers of elderly men and women interviewed (47% versus 53%). Although a majority of the respondents did not have formal education (40%), substantial proportions attended primary (33%) and secondary or tertiary schools (27%). Seventy percent of the respondents were in marital relationships as at the time of the study, while 20% had lost their spouses. Over 80% of the elderly lived with their spouses and children.

But less than 40% had received monetary support from their adult children in the last month preceding the interview, while for most cases the financial support was not regular. Also, 70% of the respondents received non-monetary support, while over 60% said they were satisfied with that level of support. Most respondents said they had a physical or medical condition that seriously interfered with their ability to work or manage day-today activities. Almost half of the respondents felt their life was good or getting better compared to twelve months ago, while almost all of them had heard of AIDS and associated it mainly with unprotected sexual intercourse. Modernization appears to be impacting on the living arrangements of the elderly in Ghana. In spite of

the low financial support for the elderly, they have managed to develop some coping mechanisms (which the study did not explore in great detail).

2.13 Summary of the Identified Gaps

The empirical review indicated that, though there were enough studies with similar features to the current study, most of them were conducted outside Ghana on the well-being of the aged. But the current study focused on the psychosocial well-being of the elderly. Additionally, none of the studies reviewed discussed implications for counselling of which this study considered. Again, the empirical review indicated that, most of the studies were done in the urban areas but in this current study semi-urban area was considered.

However, the empirical review revealed that, most of the researchers used qualitative or quantitative strategy while the current study used the exploratory sequential mixed method strategy. The results of this study open new avenues for future research and may serve as a source for further studies.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discussed the Research Approach, Study Area, Population, Sample and Sampling Technique, Research Instruments used. Again, the Validity, Trustworthiness of Instrument, Data Collection Procedure, Data Analysis Procedure, and the Delimitations or Ethical Issues analyzed.

3.1 Research Approach

This research was purely mixed method. According to Creswell and Clark (2007), Mixed Method Research ~~is~~ a methodology that involves a philosophical assumption that guides the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process". The researcher builds a complex holistic picture, analyses words, reports detailed views of informants and conducts the study in a natural setting. Other approaches are qualitative and quantitative.

Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. The final written report has a flexible structure. Those who engage in this form of inquiry support a way of looking at research that honours an inductive style, a focus on individual meaning, and the importance of reporting the complexity of a situation. 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 analysed using statistical procedures. The final written report has a set structure consisting of introduction, literature and theory, methods, results, and discussion. Like qualitative researchers, those who engage in this form of inquiry have assumptions about testing theories deductively, building in protections against bias, controlling for alternative or counterfactual explanations, and being able to generalize and replicate the findings (Creswell and Plano Clark 2007).

This research on strongly to mixed methods approach because it is used to provide an alternative perspective in a study. The focus is on collecting, analyzing, and mixing both qualitative and quantitative data in a single or series of studies. A mixed method research provides more comprehensive evidence for studying a research problem than either quantitative or qualitative research alone. The use of the mixed method makes the objectives and research questions explore an in-depth information to the study.

3.2 Research Design

The exploratory sequential mixed method design of data collection was used in order to validate the qualitative data with the quantitative data to transform the data for comparison (Creswell and Plano Clark, 2007). In the exploratory sequential approach, the researcher first begins with a qualitative research phase and explores the views of participants. The researcher presents the study in two phases, with the first phase involving qualitative data collection (e.g., interviews) with a small number of individuals. This design is to explore a phenomenon, identify themes, design an instrument, and subsequently test it. This is followed by quantitative data collection (eg. a survey) with a large, randomly selected number of participants. The data is then analysed, and the information used to build into a second, quantitative phase. The

qualitative phase may be used to build an instrument that best fits the sample under study. The intent of the researcher is to use the quantitative data results to refine and extend the qualitative findings. The initial qualitative exploration leads to detailed, generalizable results through the second quantitative phase. The data collected included qualitative and quantitative, and was analysed with emphasis on understanding the use of language; meaning and interpretation. The research also used illustrations to support and justify the findings. Psychosocial well-being of the elderly at Mamfe community in the Akuapem North Municipality of Eastern Region of Ghana is a social problem and a social research design seemed most appropriate therefore a mixed method research was adopted to address the problem.

Convergent design is a mixed method strategy in which a researcher collects both quantitative and qualitative data, analyses them separately, and then compares the results to see if the findings confirm or disconfirm each other. The key assumption of this approach was to provide different types of information from these research participants of both qualitative and quantitative. This method was used to describe the characteristics that existed in the population. This gave detailed view of population at a single point in time and measurement of exposure in relation to the psychosocial well-being of the aged and later yielded results that confirm each other. Therefore, the result obtained from the study predicted the measures used to improve the well-being of the elderly.

Data analysis in a convergent design consists of three phases. Firstly, the qualitative database is analysed through coding of the data and collapsing the codes into broad themes. In the second stage, the quantitative database in terms of statistical results is analysed followed by the third phase analyses the mixed data. This analysis thus

consists of integrating the two databases by merging the results from both the qualitative and the quantitative findings Classen and colleagues' (2007). This method helped in merging both data collected in the study, the results of both data confirmed the factors that influence the psychosocial well-being of the elderly. Data were collected in these designs to provide more information about results from the earlier phase of data collection and analysis, to select participants who can best provide that data. Also, to generalize findings by verifying and augmenting study results from members of a defined population (Creswell & Plano Clark 2007:121). Sequential designs in which qualitative data were collected first were used to determine in-depth interview findings to augment the next phase.

3.3 Study Area

The study was carried out in the Mamfe community in the Akuapem North Municipality in the Eastern Region. The Akuapem North Municipality, formally District is one of the twenty-one (21) districts of the Eastern Region of south Ghana. Koforidua being the Regional capital. The capital of Akuapem North is Akropong. Akuapem Mamfe (also: Akwapim Mamfe or only Mamfe or in similar spellings) is a small town in the contemporary Akwapim North Municipal District of the Eastern Region of Ghana. The foundation of this town goes back on the 15th or 16th century, as Guang people (the La nation) began to settle into this area. The core area of Mamfe is located around: Object location 5° 56′ 17.59″ N, 0° 07′ 08.05″ W. Greater Accra and Eastern regions of Ghana. Major towns and cities along the route of the N4 include Madina, Adenta, Aburi, Mamfe, Koforidua, and Asokore. It is a semi-rural agrarian setting popular for the street-hawking of ―Poloo" (Ghana Coconut Biscuit). ―Poloo" is a Ghanaian snack which is referred to as fried coconut dough or fried biscuit. The town is known for the Methodist Girls' Senior High School (Mamfe). It is

a second-cycle institution for girls at Mamfe, in the Akuapem North Municipality of the Eastern Region who won the 2019 World ROBOFEST at Michigan in the United State of America.

3.4 Population

Mamfe-Akuapem has a settlement population of 5,236 people according to 2010 population and housing census. Population of the municipality is 136,483 (2010). The population of the municipality has been increasing and this is attributable to the influx of government employees from other parts of the country. The population of the aged 65+ years in the municipality is 11,165. This data was collected from the Municipal Assemble Statistical Department at Akropong Akuapem. The population study on psychosocial well-being of the elderly at Mamfe-Akuapem community in the Akuapem North Municipality consisted of 428, comprised of the aged selected from two churches in Mamfe-Akuapem community. The churches that participated in the study were: Methodist and Presbyterian churches and Pensioners' Association in the area. Ten (10) aged were selected from these churches and the association.

3.5 Sample and Sampling Techniques

A purposive sampling procedure was used to select 10 respondents for the study. Included in the sampled respondents were (4) aged from the Methodist, (4) from Presbyterian Churches and (2) from the Pensioners Association. This was done to have the opinions of the strata of the society in psychosocial well-being and to determine whether psychosocial well-being of the elderly cuts across the locality. One of the factors that influenced the selection of a reasonable sample size for studies located within the interpretive-qualitative framework is manageability. In such studies, researchers aim to explore a phenomenon for a better understanding and,

therefore, it is necessary for them to select a sample size to achieve this purpose Creswell (2008). The sample size for the quantitative aspect, the researcher used Krejcie and Morgan (1970) table for determining sample size for a given population. Based on calculation using Krejcie and Morgan (1970) table for determining sample size, the estimated sampling size for population of 428 is 201 which was used to represent a cross section of the population.

Table for Determining Sample Size from a Given Population

N	*S*
300	169
320	175
340	181
360	186
380	191
400	196
420	**201**
440	205
460	210
480	214
500	217

Source: Adapted from (Krejcie and Morgan, 1970)

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

3.6 Data Collection Instrument

The Researcher employed two instruments to gather data for the study. These were interview guides and questionnaire. These instruments provided two data sets that

were used to complement each other. Some of the data include structured and semi-structured interview for the qualitative aspect and for the quantitative aspect, structured and semi- structured questionnaire was used. Cohen and Mason (1994) described a structured interview in the following way; the one in which the content and procedures are organized in advance. This means that the sequence and wording of the questions are determined by means of a schedule and the interviewer is left little freedom to make modifications. One of the most common tools or techniques employed in gathering data in qualitative studies is semi-structured interviews. These instruments are flexible to a greater extent, offer interviewees the opportunity to express their views, feelings and experience freely, and the interviewers the freedom to divert from the items/ questions in the schedule to seek clarification (using probes) during the interview process. O'Leary (2005) argues that: Semi-structured interviews are neither fully fixed nor fully free and are perhaps best seen as flexible. Interviews generally start with some defined questioning plan, but pursue a more conventional style of interview that may see questions answered in an order natural to the flow of conversation. They may also start with a few defined questions but be ready to pursue any interesting tangents that may develop.

Wragg (2002) notes that this instrument allows the interviewer to ask initial questions, followed by probes meant to seek clarification of issues raised. Probes are either pre-stated or posed in the course of the interview, making the interview process flexible.

For the quantitative aspect, questionnaire in the study comprised of both open-ended and close ended items. The open-ended items allowed free responses from respondents and the close-ended items sought to limit responses and to ensure uniformity in responses. A structured questionnaire is a data collection instrument

which is often used in quantitative studies. A structured questionnaire contains predetermined standardized questions or items meant to collect numerical data that can be subjected to statistical analysis. The questions in the schedule are close-ended and answers outlined, giving respondents the opportunity to respond to simple dichotomous questions (questions that require ‗yes' or ‗no' responses), Likert scale items (those that require responses such as ‗Agree Strongly', ‗Agree', ‗Somewhat', ‗Disagree', and ‗Disagree Strongly'), or rank some pre-determined responses, concepts, items or phrases in an orderly fashion like 5,4, 3, 2, and 1 respectively. A semi-structured questionnaire differs from semi-structured interviews in several ways. Whereas the former prevents researchers from conversing with the respondents, because of its mood of administration (e.g. by post), the latter allows interviewees, because it is either conducted face-to-face or by telephone with them. Also, whereas researchers using the semi-structures interviews have the opportunity to use probe to seek clarification of responses, they denied the opportunity to do this when using the semi-structured questionnaire. A semi-structured questionnaire has a number of strengths. One of them is that ‗respondents can offer any information, express any opinion they wish, though the amount of space provided for an answer will generally limit the responses' (O'Leary, 2005:159). In all 201 questionnaires were administered and (193) were retrieved, giving a response rate of (96.02%). The interview and the questionnaire aimed at eliciting information from the respondents on the factors influencing psychosocial well-being of the elderly in the Mamfe community in the Akuapem North Municipality and the measures being used to prevent, intervene and reduce the negative effects.

3.7 Validity

To ensure validity of the study the researcher reviewed extensive literature and used respondent or communicative validation. According to Marvasti (2004), research participants can be given the opportunity to review the findings by asking them questions such as: _What do you think about the findings?‘ Do you agree or disagree with my conclusion? (pg.114). Marvasti believes that research participants may consider research findings invalid if findings do not reflect their experiences or findings.

3.8 Reliability

Reliability is the extent to which data are consistent, accurate and precise. That is, the extent to which procedures, such as measurement, yields consistent data, stability and equivalence (Hackman, 2002). Reliability refers to precision and consistency of information obtained in a study. The researcher‘s measure of reliability includes; the stability of measure, the internal consistency and equivalence (Polit & Beck, 2010, 106.) It can be tested through administering questionnaire on two different occasions. Slight changes in the questions can be made with change in form or an order. Then, the responses can be compared. Same result needs to be obtained repeatedly to ensure the reliability of questionnaires (Parahoo, Kader 1997). The study used parallel forms reliability to measure the correlation between two equivalent versions of test (qualitative and quantitative). It was used to assess sets of questions design to measure the same thing.

3.9 Trustworthiness of Instrument

Trustworthiness is one of the most popular criteria for judging the quality of a study within the interpretive-qualitative framework propounded by Guba (1992). The

elements of criteria include credibility or authenticity, transferability or fittingness, dependability or consistency, and conformability. Credibility (confidence in the ‗truth' of findings) of a qualitative study can be ensured through triangulation (Cohen et al., 1994, Gall et al., 2007). This in the research involves the use of two methods of data collection.

Triangulation means using more than one method to collect data on the same topic. This is a way of assuring the validity of research through the use of a variety of methods to collect data on the same topic, which involves different types of samples as well as methods of data collection. The researcher used methodological triangulation which involves using more than one method to gather data, such as interviews and questionnaires. The purpose of triangulation in this research is to increase the credibility and validity of the results. Several scholars have aimed to define triangulation throughout the years. Cohen and Manion (2000) define triangulation as an "attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint." Altrichter et al. (2008) contend that triangulation "gives a more detailed and balanced picture of the situation." According to O'Donoghue and Punch (2003), triangulation is a "method of cross-checking data from multiple sources to search for regularities in the research data."

Triangulation has also received much attention in social research in recent times. It refers to ‗the practice of employing several tools (instruments) within the same research design' (Sarantakos, 2005:145). Flick (2000) indicates that the strategy enables researchers to address all possible dimensions of a phenomenon, collect sufficient data foe advancing knowledge: and address the limitations associated with

using single technique for data collection. In this case the researcher went back to the interviewees and played back their responses to them to authenticate it.

3.10 Data Analysis

The data collected from the field was thoroughly edited to eliminate errors in order to ensure accuracy in analysing the data that was collected. Results from the questionnaires were analysed descriptively. The statistical package for the social sciences (SPSS) 20 version was used for this analysis based on descriptive, frequencies and multiple responses to arrive at these tables and percentages for both the qualitative and quantitative analysis. The reason for the combination of the techniques ensured a credible and reliable generalization. The data from the interview was analysed into themes.

In the first phase, in-depth interview data were collected followed by the survey data. The in-depth, semi structured interviews were entirely open-ended, and the response categories were developed survey questions in consultation with respondents. The subsequent survey questions were entirely close-ended consisted of individualized questions intended to explore particularly interesting or ambiguous survey responses as well as standard questions intended to explore the general perspectives on the well-being of the elderly. This two-phased approach allowed study participants to respond to the in-depth discussions of emergent themes and reduced the time required for survey on their own time. It provided the researcher with the opportunity to review and analyse the in-depth interview instrument to survey results and tailor the subsequent follow-up on confusing or significant responses. This iterative analytic approach also simplified subsequent attempts to integrate the coded qualitative data collected in in-depth interviews with survey data. The qualitative data collected used

the design described to be quantized to create a single comprehensive dataset. The common strategy counts the number of times a qualitative code occurs. The qualitative data analysis software programme (such as IBM SPSS Statistics 20) generated these reports.

3.11 Data Collection Procedure

The researcher first obtained an introductory letter from the Department of Psychology and Education - University of Education, Winneba to the various Churches and the pensioners association to collect data. Interview was personally conducted in the local language. The participants were informed on the audio recordings of the interview sessions and reasons why it was recorded. Each interview session lasted for one hour. The researcher used one week for the interview in collecting data from the respondents and four weeks for sharing and collecting the questionnaire in the Mamfe community and the instrument that was used, was administered by the researcher.

3.12 Ethical Issues

Proper permission was taken from the authorities of the Churches, family members before the field work was embarked on. Concerning the administration of the interview schedule and the questionnaire, consent was sought from the aged before they were interviewed and questioned. Also, the participants consent was sought for the audio recording of their responses and were assured that the transcribed data would be saved with a password for the sake of confidentiality. In addition to this, the researcher introduced herself to the respondents to avoid false impression. The purpose of the study and the nature of the interview schedule were also made known to the respondents. Participation in the study was not compulsory and anonymity of

respondents was respected. During the field work all forms of identification including respondents' names, address and telephone numbers were avoided.

CHAPTER FOUR

RESULTS AND FINDINGS DISCUSSIONS

4.0 Introduction

This chapter presents data analysis and the discussions of results that affect the psychosocial well-being of the elderly using the exploratory sequential mixed methods design. The research site was the Eastern Region of Ghana, particularly in Mamfe Township of the Akuapem North Municipality. The chapter was organized in two parts; the first part dealt with demographic characteristics and the second part dealt with the analysis of the research questions which include the socio-economic conditions, health status, religious and other institution, psychological and measures to improve the well-being of the aged. The first analysis is the qualitative aspect and compared with the quantitative.

Other approaches for qualitative data include enumerating the frequency of themes within a sample, the percentage of themes associated with a given category of respondent, or the percentage of people selecting specific themes (Onwuegbuzie & Teddlie, 2003). In all these cases, the data can be statistically compared to the

quantitative data collected separately. This was the strategy employed in the studies described earlier, and was detailed how the process was conducted. The application and transformation of qualitative to quantitative data owes some impetus to the development of software programmes that allow qualitative researchers to process a large volume of qualitative data (Bazeley, 1999). IBM SPSS was used to transform individual responses to the open-ended survey and interview questions into a series of coded response categories that were, in turn, quantified as binary codes and integrated into the associated survey responses. This process involved an analytic step: The survey data were entered into IBM SPSS database (Figure 1- 21). This process was fairly straightforward and similar to that used to manage any structured database.

4.1 Demographic Characteristics

Socio-demographic characteristics help to give a true picture of the characteristics that the respondents possess. Although the study was not geared towards analysing the socio-demographic characteristics of psychosocial well-being of the elderly at Mamfe Township in the Akuapem North Municipality, these background features helped reveal the basic characteristics that the elderly have which facilitate the comparison with other elderly across the world. Socio-demographic characteristics covered in this study are age, sex, educational background, and professional background. All the respondents are elderly, their bio data was taken by the researcher and the responses were presented.

The age at which the elderly psychosocial well-being is looked at is a problem that many researchers have spoken a lot about. To find out the dominant age of psychosocial well-being of the elderly at Mamfe Township, the selected elderly were asked to indicate the age at which they experience some challenges in the interview.

Table 1 and 2 give a full account of the demographic distribution of the respondents interviewed and surveyed respectively.

Table 1: Demographic information on the qualitative

Years	Frequency		Percentage
	Male	Female	
60-69	1	1	10.0
70-79	2	3	40.0
80-89	1	2	30.0
90-99	-	1	10.0
Total	**4**	**6**	**100.0**
Sex of the Respondents	4	6	100.0
Educational Background			
None	-	1	10.0
Basic	2	3	50.0
Tertiary	2	1	30.0
Other	-	1	10.0
Total	**4**	**6**	**100.0**

Source: IBM SPSS Statistics, 2020

Results in Table 1 show 10 respondents interviewed from the Methodist, Presbyterian churches and the pensioners association of which the majority (40%) of the respondents was between the ages of 70-79 and 80-89 whiles the latter is with the high cumulative percent. 10% were between the ages of 60-69 and 90-99 years. The sex of the 10 respondents 4 (40%) were males, while 6 (60%) were females. The educational attainment of respondents ranked from basic to tertiary. Data render that 3 (30%) had tertiary education, while 1 (10%) did not have any formal education and

other training respectively. However, a larger number of the respondents 5 (50%) had basic education.

Table 2: Demographic information on the quantitative

Years	Frequency		Percentage
	Male	Female	
60-69	10	44	27.8
70-79	18	62	41.2
80-89	12	30	21.6
90-99	4	8	6.2
100 and Above	3	2	2.6
Total	**47**	**146**	**100.0**
Sex of the Respondents	47	146	100.0
Educational Background			
None	5	10	7.7
Basic	15	60	38.7
secondary	10	32	21.6
Tertiary	16	39	28.4
Other	1	5	3.1
Total	**47**	**146**	**100.0**
Professional Background			
Farming	20	11	16.1
Health	2	30	16.6
Trading	1	40	21.2
Teaching	3	20	11.9
Security	10	2	6.2
Artisans	5	-	2.6
Civil Servant	3	7	5.2
Others	3	39	20.2
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

Result in Table 2 revealed a total of 193 demographic distribution of respondents questioned. Most of the respondents (41.5%) are between the ages of 70-79 and 90-99 whiles the latter is with the high cumulative percent (97.4%). 2.6% were between the ages of 100 and above years. Both results on table 1 and 2 show that majority of the respondents were between the ages of 70-79. Out of 193 respondents that participated in the quantitative study, the majority (75.6%) of the respondents were female and the

minority were male representing (24.4%). Table 1 & 2 give a full account of the sex distribution of the respondents interviewed and questioned. Both had the majority to be female respondents.

4.1.1 Educational status/level of aged respondents

Education allows an individual to gain access to better economic opportunities, earn a good salary and enhances his/her socio-economic conditions even after retirement. As one's income is higher, his/her standard of living relatively improves and all things being equal, he/she is able to save more to take care of his/her aged needs better than the one whose incomes are low and largely depends on that low income (NDPC, 2010). The educational attainment of respondents in table 2 ranked from basic to tertiary. Data render that 55 (28.4%) had tertiary education, while 15 (7.8%), 6 (3.1%) did not have any formal education and other training respectively. However, a larger number of the respondents 75 (38.9%) had basic education. The respondents for both databases show that a larger number had basic education represented by 5 (50%) and 75 (38.9%) respectively. The professional background of the respondents was collected by the researcher for the quantitative survey. The respondents had different professions that helped them for their standard of living as a means of economic in their well-being. 41 (21.2%) were trading, the others 39 (20.2%) are for those with different work expertise.

Research questions

4.2 Research Question 1: What is the psychosocial well-being of the elderly in Mamfe Township?

The first research objectives were to assess the psychosocial well-being of the elderly in Mamfe township. Psychosocial state explains changes in self-understanding, social relationships and one's relationship to society. These themes answer the stated research questionnaire.

4.2.1 Psychosocial state of the elderly

Psychosocial state of the elderly is about how the elderly feel about themselves; how they think about the way others see them, their reactions toward people and the effect it has on them. This research began with the qualitative and used descriptive and interpretative approach to analyze the data. The research was carried out by analyzing conversation of the aged in Mamfe township. The conversation by the aged were recorded and transcribed. The speech in Akuapem Twi was then translated into English. The research used construct in the qualitative face instead of valid and reliable instruments to assess the data. Research construct is an abstraction that researcher use to represent a phenomenon that's are not directly measureable. Because this data deals with the various aspects of an individual's well-being such as emotional stability, social relationships and economic status. It also reflects the perception of having assistance available from family members, friends and other networks. Also, construct tend to be more abstract than variables since they represent broad ideas and concepts, while variables are specific measures within those concepts.

All the ten respondents interviewed, expressed how they felt about themselves to be old to the extent that concerns about regret and sometimes not happy within themselves were expressed. It is a blessing to be old because they are seen as the older people in the family, which the younger ones come to them for advice. They said it is a stage in life they wish everyone should experience.

Three elderly remarked:

> *At my age I am always call upon to handle family matters. I often go out with the Chief of Mamfe to all functions. I attend funerals, marriage ceremonies, naming of children of family members. It is hard to meet me at home all the time. This is just the grace of God*. **(AD - 82yr).**

Another remarked that:

> *All my friends are dead and I am still strong, I can carry water and walk to the bathroom. I am not a burden to any family member, no one abuses me and I am free.* **(PG – 96yr)**.

One Female attested that:

> *Since I can visit family members around I feel good and no family member see me as a burden. All my play mates are dead and that make me feel blessed.* **(MA – 82yr).**

On the contrary, all the respondents expressed their unhappiness that to be old, one experiences regret, sometime forget things, become sad when they lost young ones in the family, children and friends whiles they were the ones to have died.

One Female commented that:

> *Now I cannot move around as before due to surgical operation on my knees. My son who fixed a date with the doctor to work on the knee died when the time was due and that has made me as I am till now.* **(MC 77yr).**

In one study, physical health and physical activity were positively related to cognitive performance in older adults (Anstey & Smith, 1999). The older the population, the more person with health problems. Thus, some of the decline in intellectual

performance found for older adults is likely due to health-related factors rather than to age person (Comijs & others, 2002).

The quantitative aspect of the research adopted descriptive survey to aid in describing the psychosocial wellness of the aged.

Psychosocial State: How do you feel about yourself?

The responses on the aged's psychosocial state pertained on the influence of social factors on their mind or behaviour, and were categorized into emotions - happiness, blessing, memory problem and regrets, which was analyzed using frequency and percentages as shown in the tables below. Emotional changes with age are complex. Old age is not a simple time of emotional well-being and tranquility. Strong emotions and reactions to important life events may increase with age. Happiness is subjective and varies among individuals.

As people progress into middle-adulthood, life satisfaction stabilizes, influenced by accomplishments and meaningful relationships. In later adulthood, happiness remains relatively stable but may slightly decline due to age-related challenges. However, older adults often prioritize relationships, fulfillment, and purpose, contributing to their overall well-being. Ultimately, happiness is a lifelong journey shaped by individual circumstances and values.

Table 3: Happy

Emotion	Frequency		Percentage
	Male	Female	
Not Happy	4	11	7.8
Happy	6	35	21.2
So Happy	19	20	20.2
Very Happy	7	40	24.4
Extremely Happy	11	40	26.4
Total	47	146	100.0

Source: IBM SPSS Statistics, 2020

From Table 3, 51 (26.4%) respondents feel extremely happy as they age while 15 (7.8%) are not happy because they have some medical problems which make them feel uncomfortable and they losing their love ones as well.

Table 4: Blessed

	Frequency		Percentage
	Male	Female	
Not Blessed	3	13	8.3
Blessed	13	12	13.0
Most Blessed	9	20	15.0
Highly Blessed	8	21	15.0
Extremely Blessed	14	80	48.7
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

This table shows that 94 (48.7%) respondents feel extremely blessed because not many people have had the opportunity to reach this age. 16 (8.3%) feel not blessed since they are not financially sound.

Table 5: Memory Problems

	Frequency		Percentage
	Male	Female	
No Memory Problem	15	65	41.5
Poor Memory	9	22	16.1
Short Memory	6	36	21.8
Very Poor Memory	15	15	15.5
Extremely Poor Memory	2	8	5.2
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

Table 5, shows that 80 (41.5%) respondents have no memory problem but 30 (94.8%) with a high cumulative percent record of very poor memory problem. The cause of the poor memory problem was due to forgetfulness in aging, depression, an infection or medication side effects and brain disorder such as Alzheimer's disease, which cannot be reversed (National Institute on Aging 21 Oct. 2020). Aging affects memory, experiences, and perception and has a greater impact on emotion regulation.

Table 6: Full of Regrets

	Frequency		Percentage
	Male	Female	
No Regret	15	70	44.0
Full of Regret	11	23	17.6
Much Full of Regret	7	30	19.2
Very Much Full of Regret	10	12	11.4
Extremely Full of Regret	4	11	7.8
Total	47	146	100.0

Source: IBM SPSS Statistics, 2020

85 (44%) respondents have no regret of being aged, on the other hand 15 (7.8%) are extremely full of regret since they are confined to their home and they see no reason for being alive. JAMA Network on the ~~-b~~biggest regrets at end of life." Loneliness and isolation on the other hand have been shown to lead to health disparities and depressive symptoms (Shiovitz and Leitsch, 2010).

How do others see you?

The respondents also talked about how others or people see them in that state, the comments people make and their perceptions about old age.

One Female said:

> *Some people see aged as a burden and others think they are witch. Recently, my first born a daughter said I am a witch and I summoned her to the elders and we have sort out and she has apologized*. **(ME - 78yr).**

Another Female said:

> *One doctor who was checking my health said I am blessed with my age because I look strong in my age. But I have a sister who always insults me without a course. She said when they are counting human being I am not part but people have advised me not to mind her*. **(MA - 82yr).**

Another Female attested that:

> *One doctor said because I do not keep wrong things of others in my heart, I have no blood pressure (BP) and that is a blessing looking at my age. All those who come around to see me are happy. Though I did not give birth but my sisters who are dead children still feel happy when they come home with their friends. One of the young men who was registering my voter ID card told my grandson, Mama still remembers everything in her age as she responds to our questions, she is really blessed*. **(CM – 80yr).**

All the respondents were also happy that people see them as being blessed by God to attain that age. None of them were been seen as a burden to the family.

How do others see you?

Responses on how people perceive the aged were grouped into yes and no which was analyzed using frequency and percentages in the tables below.

Table 7: How do others see you

	Yes		Percent	No		Percent	Total	
	Male	Female		Male	Female		M	F
Burden	13	10	11.9	34	136	88.1	47	146
Witch	1	9	5.2	46	137	94.8	47	146
Blessing	40	113	79.3	7	33	20.7	47	146

Source: IBM SPSS Statistics, 2020

The table above shows how others see the aged in the society. 170 (88.1%) respondents say their relatives do not see them as a burden but 23 (11.9%) respondents say people think they are a burden since they do not contribute to the development of the family financially. 183 (94.8%) respondents says no one has ever branded them as witch but the 10 (5.2%) respondents said people see them as such

since they perceive and say to some aged that they are witch. The above data shows that people see aging as a blessing so 153 (79.3%) respondents said people see them as being blessed by God to attain this age, while 40 (20.7%) attest that due to the bodily pain and its related weaknesses, it is not a blessing at all it is better to die early to avoid those challenges.

One reason old age is a devalued role is that Ghanaians tend to have negative attitudes toward being old. These negative attitudes are reflected in the various myths about old age, which can become self-fulfilling prophecies. People who believe the elderly have lost the capacity to enjoy living may make life more difficult for the elderly and may themselves plunge into despair when they become old. Negative attitude about old age are easy to pick up in our society, as to the Samia of Kenya, in Eastern Africa, Cattell (2009, p. 233) observes that the influence of elderly Samians has been "devalued, displaced, replaced and a significant basis of their respect has been eroded". Many elderly Samians identified education as the crucial element in this change and emphasized that it had reduced respect for them, the support and care given them and the seeking of advice from them. Now, one needs new knowledge, which old people, especially women lack (ibid, p. 236).

4.3 Research Question 2: What roles do the family, church and the nation play to assist the care of the elderly in the Mamfe township?

Social support is one of the most important factors in predicting the physical health and well-being of everyone, ranging from childhood through older adults. The reliable alliance support that is provided from others, which means that the individual knows they can depend on receiving support from family members whenever it was needed.

The following themes emerged in the study: financial, social and recreational activities. They are discussed below.

4.3.1 Financial

It is important to keep in mind, of course, that income is only one indicator of the financial status of the elderly. The elderly become handicapped when they retire so they need support from their children and society.

Children Support; all the respondents said their children supported them financially, of which two of the respondents have total support from their children to pay for electricity bills and feeding.

One of the two who have all their financial support from their children said:

> *It is my children who take care of me financially since I am not working now. The one in America has been doing well it was long ago she gave birth to twins after 21years of marriage so she is financially down but the other one has been bringing money for five months now.* **(MC - 77yr).**

On the other hand, four out of the remaining eight respondents who received financial support from their children had other forms of financial support.

One remarked:

> *Mama, I say to the glory of the Lord that I don't let my care be a worry for those who care for me, though I never gave birth but my sisters children and their friends whom I took care of send me money, provisions, credit and pampers from outside. I know that if somebody gives you something and it has not come you need not to worry them. So I also depend on the traditional herbs I sell here and send some to abroad and the alcoholic drinks which my care giver is in charge of it now* **(CM- 86yr).**

Another said:

> *My brother died early leaving two children behind, I took them as my own and cared for them. One is outside the country and the other one*

is assistant headmaster of a second cycle school and they also provide my financial needs **(PA - 84yr).**

Church Support; six of the respondents replied that the church sometimes supports them when the Rev. Minister visits every month to give them the Holy Communion.

One female remarked:

For the church, support is not often and sometimes the Women Fellowship come and donates something to me because of my commitment and hard work when I was strong **(MC - 77yr).**

One male stated:

I receive a token from the church when they come and give me communion every month **(PG - 96yr).**

The other four said they were not receiving any financial or other form of support from the church since they are strong enough to work and move around.

One of them commented:

Though I am not working and still attend church, but the church has never given me any financial support **(ME - 78yr).**

Family Support; three of the respondents said their family members and sometimes other loved ones support them financially and materially.

One female reported:

My family members do support me once they come around and when I call them for anything, they also respond to me quickly before my children will come **(MC - 77yr).**

The contrary view to this was that the other seven respondents said no family member supported them financially.

One male remarked that:

Since all family members who are old are dead, those who are left are my grandchildren and I don't border anyone with financial problem **(PG - 96yr).**

What Support Systems are used to assist you financially?

To answer research question two, children, church, and family members, were used to analyzed the data. Responses were based on yes and no.

Table 8: Support Systems

Financial Support	Yes		Percent	No		Percent	Total	
	Male	Female		Male	Female		M	F
Children	20	140	82.9	27	6	17.1	47	146
Church	5	30	18.1	42	116	81.9	47	146
Family Member	7	33	20.7	40	113	79.3	47	147

Source: IBM SPSS Statistics, 2020

160 (82.9%) respondents reported that their children support them financially, while 33 (17.1%) recorded that they got their financial support from another source. The financial support from church is less as 158 (81.9%) respondents recorded that they did not get any such support from their church. The remaining 35 (18.1%) got some sort of financial assistance from the church. Those who got financial support from family members were 40 (20.7%) and 153 (79.3%) did not get any support from the extended family members. The data showed that majority of the respondents did not get financial support from family members.

The research on both data collected agreed that the financial support systems of the elderly were mainly from their children since they were not in active work. Taking care of an aged parent is simply paying back the love they gave us in our time of need with love in their time of need. Philo, of Alexandria, (20 B.C - A.D.50), a Jewish philosopher said, ―When old storks become unable to fly, they remain in their nests and fed by their children, who go to endless exertions to provide their food because of their piety". In the Ghanaian cultural context, children are expected to reciprocate the care given by parents. So, it is the duty of children to care for their aged parents since

they can no longer work actively. And in this research the support children gave to their parents was good.

The church's responsibility was to visit and care for the aged. The research shows that the churches have done their part to care for the aged by providing some assistance to meets part of their needs. Despite the effort of the church, some of the older adults are still faced with challenges occasionally feeling side-lined and unwelcomed in the church mainly because not many pastoral givers take interest in considering their issues as matters of importance (Baloyi & Theology, 2008). Ayete-Nyampong (2008) describes this as the church being slow in their response to the adequate needs of the elderly people amongst them. In his study he came across categories of elderly persons within the church, those who were active or regular attendants and those who could not make it to church because of sickness or other reasons to administer communion and this group of people are referred to as elderly infirm or invalids or homebound. The Church, which is a body of individuals dedicated to ensuring a continual support of social justice, cannot afford to turn a blind eye to the predicament of the elderly persons in society but play a role that goes well beyond only religious or spiritual agenda (Biggs et al., 2016). According to Ayete-Nyampong (2008), the church has a central purpose to fulfill in inspiring the active presence of the older generations in family and social life. This role is a natural one for the reason that the church's visualization of human life is not one of deterioration but of growth.

In the traditional extended family system, the various divisions of labour on the farm by sex and by age often allowed an interchange of roles as the young grew into adults and as adults grew into old age. It was this inter-dependence that formed the strength of the family support system. The system undertook the many caring responsibilities

of the elderly and, in a large measure; old people remained the responsibility of individual families, providing comfort and support in times of anxiety, loneliness and helplessness. Others may be small mobile services offered at home for older persons with reduced mobility, such as meals on wheels, assistance in the household, shopping or mobile hairdressers. For older persons whose pensions are small, financial support may be feasible, for example in the form of discounted repair services or heating subsidies.

To avoid the unnecessary institutionalization of older persons who require frequent assistance, families should be empowered to provide care and support. This may involve respite care services or temporary institutional care to allow families to take holidays. Such encouragement for families may also take the form of financial support (Höhn, 2008).

4.3.2 Socially

The research question focused on whether the respondents received support from any Organisation or Political groups as a means of social responsibility toward the aged. All the respondents said no group comes to visit them, let alone, give them any financial support.

One female commented:

> *I have never received any support from any political group but what they do is when it is time for election that one they will come around and talk to you to get their vote after election, you will not hear from them (***ME - 78yr).**

Table 9: Analysis on Social Support given to the aged.

Social Support	Yes		Percent	No		Percent	Total	
	Male	Female		Male	Female		M	F
Political Group	8	2	5.2	39	144	94.8	47	146
Social Organization	10	12	11.4	37	134	88.6	47	146

Source: IBM SPSS Statistics, 2020

Only 10 (5.2%) got some financial support from political groups when it is election period, while 183 (94.8%) did not get anything from the groups. 22 (11.4%) respondents got financial support from some NGOs –Livelihood Empowerment Against Poverty (LEAP), Habitat for Humanity, Cassa Italia and community club. 171 (88.6%) did not get such support.

Social integration plays an important role in the lives of many older adults. Being lonely and socially isolated is a significant health risk factor in older adults. In one study, being part of a social network was related to longevity, especially for men (House, Landis & Umberson, 1988). And in a longitudinal study, both women and men with more organizational memberships lived longer than their counterparts with low organizational participation (Tucker & others, 1999).

4.3.3 Recreational activities

Social recreation can be anything from songs, skits, dances, sports, stretcher, active and passive games, brain teasers and relays. It is an expensive and fun way for people of all ages and abilities to enjoy themselves.

From the interview, three of the male respondents and two females enjoyed being involved in church activities and other form of entertainment.

One of the males said:

> *I help the chief and elders in the town to carry out social activities. When I am free, I do play draft, ludu and cards with friends to keep me happy* **(TN - 60yr).**

Another said:

> *I always play piano when I am alone in the house to keep me excited and that is my hobby* **(PG - 96yr).**

The other female said:

> *The only source of entertainment for me is attending church because I love to sing and dance. When I am alone I will be singing to make me joyful* **(CJ -75yr).**

On the contrary, the other three females were confined in the house so they were not involved in any recreational activities.

One commented:

> *I can no longer move to any place, if I want to even go to the hall they have to help me to hold my walking wheel and I will sit there the whole day until they come back to the house before they will take me to my bedroom* (**CM - 86yr).**

Social support can only be beneficial if it is adaptable to the environment; furthermore, social support has to be geared towards an individual's specific needs. We have to be more aware of what our friends, family members, and even ourselves need in terms of support. Once we are aware of this, we can more effectively enhance the positive effect of networks, rather than be burdened by the negative.

4.3.1.1 Social state of the elderly

Social well-being is how a person interacts and relates with others in the community. The research question focused on whether the respondents received calls from their children or they visited them often and also on those they spend most of their time with to avoid the risk of loneliness.

All the respondents spent most of their time with their relations, spouses, friends, caregivers and some others. All the respondents said their children, grandchildren and some of the church members visited them.

> *My children always visit me, buy food stuffs and bring them to me to prepare my food and store them in the refrigerator and my grandchildren who are not here whenever they come, they will come to the house, chat with me before they leave*. **(CJ - 75yr).**

Another one said:

> *I often receive calls from my children and grandchildren and since I am not able to go to church, some of the leaders pass by to see how I am doing* **(MO - 73yr).**

Three of the male respondents said they do things together with their spouses.

One of them remarked:

> *I virtually do everything together with my wife since we are alone here and the children are all gone. She supports me in everything since I have eye challenge* **(PA - 84yr).**

One of the males remarked:

> *I am use to staying alone in the house so when my wife goes to work, I don't see it as a problem for me at all. She is the one who has been with me throughout* **(PG - 96yr)**.

Two female respondents said they have caregivers who take care of them.

One reported:

> *Since I fell down and cannot walk alone, this lady who is Krobo has taken care of me for the past ten years and she is handling my business as well so I have also accepted her children who were not here to come and be with their mother so that they can also get the motherly love. She has been very good to me by taking care of me* **(CM - 86yr).**

The other one also said:

> *When I had the operation on my knee and could not walk, my children brought this woman to me and she has been with me and my twin daughter the senior who is sick for almost six years and we are all living as family members* **(MC - 77yr).**

The researcher had a chat with both the caregivers and they said they have taken them as their mothers and they too have been good to them.

Nine of the respondents said they had no friends since the friends they started life with were all dead.

This was a remark from one of them:

> *I have no friend now all my friends I started life with are dead and I am alone here waiting for my time to go.* **(PG - 96yr).**

Factors that influence psychosocial well-being of the elderly:

To answer research question three, the following findings were used to analyzed the data in table 10.

4.4 Research Question 3: What are the factors that influence the psychosocial well-being of the elderly at Mamfe?

Psychosocial well-being of the elderly depends on the following factors; social, economic, health, residence and religion of the elderly. Five themes were generated to support the research question.

Table 10: Social State: Those you spent most of your time with

People you spent time with	Frequency		Percentage
	Male	Female	
Children	10	70	41.5
Friends	17	15	16.6
Spouse	8	30	19.7
Family Members	6	15	10.9
Alone	2	12	6.2
Other	4	6	5.2
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

The table above show social state of the aged and the people they spend most of their time with to avoid loneliness. 80 (41.5%) respondents attested that their children are with them all the time. 38(19.7%) and 32(16.6%) respondent recorded that they spend their time with their spouse and friends respectively. 12 (6.2%) were staying alone. Social isolation is a major risk factor for functional difficulties in older persons. Loss of important relationships can lead to feelings of emptiness and depression. Persons involved with a positive relationship tend to be less affected by everyday problems and to have a greater sense of control and independence. Those without relationships often become isolated.

The negative effect of loneliness on health in old age has been reported by researchers (Heikkinen et al., 1995). The death of spouse and friends and social disengagement after leaving work or a familiar neighborhood are some of the ubiquitous life-changing events contributing to loneliness in older people. Those in the oldest age cohort are most likely to report the highest rates of loneliness, reflecting their increased probability of such losses.

4.4.1 Economic state of the elderly

It is important to keep in mind, of course, that income is only one indicator of the financial status of the elderly.

The interview guide sought for their sources of income and how their basic needs were met. All of the respondents said their source of income was from their children and grandchildren who always gave them money for their up keep and from other source.

Four of them commented that their other source of income was from pension:

> *I take my pension pay and my father left us a cocoa farm which my elder brother was handling it and when he died we share it among ourselves as siblings. Just recently my senior brother children have decided to share the money which I do not agree with them* **(MO - 73yr).**
>
> *My wife and I depend on our pension pay when the children's money is not ready and we also have some rented store we receive money from. So we are financially sound* **(PA -84yr).**
>
> *Apart from my children, I also enjoy my pension pay and interest from investment I made* **(AD - 82yr).**
>
> *I take my pension and also proceeds from my father's land but that one it only come yearly* **(PG - 96yr).**

Two of the other six who do not receive pension pay said:

> *When my pension was due as a security man, I was told by the SSNIT people that I am left with four more years before I can qualify for my gratuity so I have gotten security work in a private sector which I receive money and I am paying the top up of the SSNIT contribution* **(TN - 60yr).**
>
> *I still have the strength to work since my children asked me to stop hawking, they opened a store which I sell clothes and provisions. I go to Accra to buy the items to fill the store. Just recently my daughter has asked me to stop so when I need items I call her to buy those things. I always come to store just to keep active and get enough money* **(CJ - 75yr).**

Responses on aged source of income were categorized to children, family members, pension scheme and others which was analyzed using frequency and percentages as shown in Table 11.

Table 11: Economic State - Source of Income

Source of Income	Frequency		Percentage
	Male	Female	
Children	16	70	44.6
Family Members	5	15	10.4
Pension Scheme	22	56	40.4
Other	4	5	4.7
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

The source of income for the aged as represented on the table show that 86 (44.6%) received money from their children. 78 (40.4%) got their source of income from their pension. Other 9 (4.7%) received income from other sources such as family property – house rent, farm proceeds and sales of items.

The sources of the respondents' economic income were that their children bore most of their basic needs (feeding, clothing, medical bills). The majorities of older adults do not work and/or have fewer options for continued income. They are at risk for rising costs of living, which may place them at an economic disadvantage and potentially at lower levels of social economic status.

The most important factors in the quality of life of the elderly are economic and social resources (Soldo & Agree 1998:23). That makes sense, because people value the ability to do what they please, but what they like to do usually requires certain financial resources. While the desires of the elderly may not be as wide-ranging as those of younger people, what they would like to do is often stifled by their lack of money. Insofar as the aged are inundated by financial problems, their autonomy is threatened and the quality of their lives is diminished.

4.4.2 Health status of the elderly

Tinker in 1984 reported that the aged population is vulnerable/prone to illness and most of them usually have not less than one illness. The interview guide sorts for their general health, serious medical conditions, surgeries, disabilities and current functioning.

Eight of the respondents had medical conditions and surgeries which had restricted their movement and health functioning.

> *I cannot go to places and church because of the Blood Pressure (BP) when I finish taking my food and drugs, I become weak which I need to relax and by the time I regain my strength time will be far gone* **(MO - 73yr).**

> *Physically my joint, shoulders, thighs look heavy, and the sight too I cannot see anything* **(PA – 84yr).**

> *My only sickness is cold (catarrh) and since I fell down for many years I cannot walk unless I sit in the wheel to move around, even the walker they have to hold me and look at how heavy I am, so all my in-laws come around to help me* **(CM – 86).**

The remaining two do not have any health challenges and they look strong and healthy.

> *I have never gone to or being admitted at the hospital. When I am tired and feel bodily pain I only take pain killer and off I go, so I am perfectly strong and healthy* **(TN- 60yr).**

Besides seeking regular medical care, there were other means by which individuals sustained their health or better still, kept themselves healthy/fit.

Health State: How is your health condition in the following area?

The health condition are grouped in the following areas; emotional, physical, financial, mental, and others.

Table 12: Emotional/Behavioral Problems

Health Conditions	Frequency	Percentage
Emotional Behavioural Problems	14	7.3
M/AA	2	1.0
Family Problem	9	4.7
EB/EA/F	1	.5
Emotional Abuse	8	4.1
EA/AA	1	.5
EA/AA/PA	1	.5
Alcohol Abuse	2	1.0
None	25	13.0
EB/M	16	8.3
EB/F	4	2.1
EB/M/F	3	1.6
EB/FA	3	1.6
EB/EA/AA	1	.5
Medical Problems	93	48.2
M/EA	7	3.6
M/F	3	1.6
Total	**193**	**100.0**

Source: IBM SPSS Statistics, 2020

Medical/Alcohol Abuse (M/AA), Emotional Behavioural/ Emotional Abuse/ Financial Problem (EB/EA/F), Emotional Abuse/ Alcohol Abuse (EA/AA), Emotional Abuse/ Alcohol Abuse/ Physical Abuse (EA/AA/PA), Emotional Behavioural/ Medical Problem (EB/M), Emotional Behavioural/ Financial Problem (EB/F), Emotional Behavioural/Medical Problem/Financial Problem (EB/M/F), Emotional Behavioural/ Financial Abuse (EB/FA), Emotional Behavioural/ Emotional Abuse/ Alcohol Abuse (EB/EA/AA), Medical/ Emotional Abuse (M/EA), Medical/ Financial Problem (M/F).

The health challenges of the aged tabled here indicate that some of the respondents had multiple health problems. 93 (48.2%) had medical problems, 25 (13.0%) were without any medical problems. 16 (8.3%) respondents experienced both emotional behavioural (EB) and medical problems (M). 7 (3.6%) respondents with a high cumulative percent had both medical (M) and emotional abuse (M/ EA). According to

the health state on the table, 1 (0.5%) had different health issues – emotional behavioural, emotional abuse and family problems (EB/EA/F), emotional abuse and alcohol abuse (EA/AA), emotional abuse, alcohol abuse and physical abuse (EA/ PA) and emotional behavioural, emotional abuse and alcohol abuse (EB / EA / AA) respectively.

According to the World Health Organisation (WHO) (April 6, 2020), between four to six per cent of the elderly worldwide suffer from a form of abuse physically, emotionally and financially. A statement issued on April 6, 2020 by the United Nations General Assembly copied to Ghana News Agency said such abuse was an unacceptable attack on human dignity and human rights and some of the cases often remained unreported and unaddressed. It said emerging research suggested that abuse, neglect and violence against the elderly both at home and in institutions were much more prevalent than currently acknowledged.

Elder abuse has many forms. The Department of Justice estimates that the most prevalent form is financial exploitation, which affects about 5.2% of older adults, then neglect (5.1%), followed by psychological abuse (4.6%), physical abuse (1.6%) and sexual abuse (0.6%). As with the woman kept in a dog kennel, many victims experience multiple forms of abuse. Making it more complex is that elder abuse occurs in many different settings: private homes, nursing homes, assisted living facilities and public places. It also involves different types of perpetrators. A study funded by the National Institute of Justice showed that most perpetrators knew their victims and included spouses, family members, acquaintances and health care professionals. Yet even strangers can be perpetrators. As a result, identifying a single cause or a simple prevention strategy is very difficult because of the interaction

among the form of abuse, the setting and the relationship of the perpetrator to the victim.

Social isolation breeds elder abuse. Because the victims are usually socially isolated, no one is present to observe the perpetrator's behaviour. Even if there is someone to tell, the older adult may not be believed. To fully understand the various causes of elder abuse and possible remedies for the various forms of abuse, the various settings and the various perpetrators need to be studied separately. People need to take personal responsibility and report what they see or suspect. We should also be aware of the importance of continued federal and local support for programmes like those supported by the Area Agencies on Aging, which are typically designated by states to meet needs older people in local and regional areas. Finally, we need to provide personal contact for the older adults to area Agencies on Aging. For older adults, personal contact with caring others not only prevents elder abuse, it can save lives.

The concept of health is important for nurses to help individuals achieve the goal of health. According to King (1981), ―human beings' function in a social system through interpersonal relationships in terms of their perceptions, which influence their life and health". To have control over one's daily life is an essential aspect in one's well-being and no lesser in the life of the elderly; this allows for self-realization and development and hence, the loss of control may lead to poorer quality of life and thus further leads to lower immunity.

4.4.3 Residence of the elderly

One of the basic needs was their residence of which all the respondents were living in a comfortable place. Four live in their own homes which they built with their spouses. Five live in the family house in single room, one in rented house.

One of them said:

> *I live in a family house which my uncle built so many years ago and I have lived here since I became old and decided to come home because this is a single room my father gave to me* **(ME - 78yr).**

Another said:

> *Where I am living now is my grandparents"house that is my father's side and my father was the eldest son of his parent to the other man you visited* ***PG(96yr****), though he is older than me and is only the two of us are left here and the rest of the rooms are for rental* **(AD - 82yr).**

Table thirteen percentage analysis of residential arrangement of the elderly in Mamfe Township are classified living in family house, with children, self-owned house or rented apartment.

Table 13: Residential Arrangement

	Frequency		Percentage
	Male	**Female**	
Family	13	70	43.0
Children	8	28	14.5
Self-own	21	46	34.7
Rented	5	10	7.8
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

For the residential arrangement, the table show that 83 (43.0%) respondents stay in a family house, 67 (34.7%) live in their own apartment, 28 (14.5%) stay in the house of their children and 15 (7.8%) stay in a rented house.

Both data show that majority of the respondents live in a family house and very few are in a rented apartment.

Appropriately, the wish of every elderly person is to have retired to homes of their own and not in any form of residential care. However, this has become a myth to majority of this group. Adequate housing is of importance to the elderly in many ways

– to keep them warm, easy access to lavatory and other facilities, less stress in a future rearrangement of tenancy agreement as well as cost, conducive surroundings and above all desire/ability to live in the way they want in their own home (Schwab, 1989).

4.4.4 Spiritual state of the elderly

Religion can provide some important psychological needs in older adults. In many societies around the world, older adults are spiritual leaders in their churches and communities. Due to this, they always want to involve themselves in church activities.

The interview conducted centered on how their spiritual needs were met, if they can attend church, the role they play at church and how they feel about their involvement in church activities.

All the respondents admitted that their relationship with God was very good, and only four were able to attend church regularly.

One female said:

> *I was baptized as a Presbyterian and for the past ten years I don't have money to pay my tithe so I left to Church of Pentecost because over there you pay your tithe without any record in the tithe card. At Pentecost I am only a member of the Women's Fellowship* **(ME - 78yr).**

Another one said:

> *I feel strong so I always attend church except this Covid-19 pandemic which the aged have been ask to stay home but I will start going to Church again. I am a Women's" Fellowship member. I have no position in the fellowship because I cannot read and write. By 7:00am I am at church because I don't like lateness and if I don't go to church I don't feel comfortable* **(CJ - 75yr).**

Of those who cannot attend church, out of the six, one said:

> *From childhood all the people I lived with introduce me to Christ. At middle school I understood Christianity well, it was when I started working at Accra when I joined the Church of Pentecost until now. I was one of their National Broadcaster, Pentecostal Group and a Presenter. I worked under Rev L.A. Nyarko radio Pastor. I cannot attend church now because of my leg* **(MO - 73yr***).*

Their feelings about their involvement at church was very awesome though they do not hold any position now that they are housebound, but they are members; two of the respondents were happy that they could go for meetings. Six of the respondents were sad because they can no longer attend conferences and retreat programmes of the Church.

One of them commented:

> *I am not sick, I feel strong except my legs which I cannot stand on, I pray that I can go to Church and join the Singing Band again to sing* **(CM - 86yr).**

Frequency and percentage analysis on the spiritual state of the age were captured by yes and no in table 14 below.

Table 14: Spiritual State: Are you able to attend Church?

Church Attendance	**Frequency**		**Percentage**
	Male	**Female**	
Yes	35	118	79.3
No	12	28	20.7
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

Those who were able to attend church in their old age were 153 (79.3%) and 40 (20.7%) did not attend church due to ill health. The results of the data collected show that most of the respondents in the survey attend church.

How do you feel about your role and involvement in the Church?

Table 15: What role do you play in Church, if Yes?

Role in Church	Frequency		Percentage
	Male	Female	
Leader	10	15	13.0
Member	37	131	87.0
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

168 (87.0%) respondents recorded that they were just church members and do not hold any leadership positions in church, while 25 (13.0%) are leaders in their various churches.

Table 16: How do you feel about your role and involvement in the Church?

Involvement in Church	Frequency		Percentage
	Male	Female	
Happy/ Excited	30	70	51.8
Feel Active	17	76	48.2
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

100 (51.8%) respondents felt happy and excited and 93 (48.2%) felt active. Though not all of them attend church but believe that being involved in church activities make one active and happy. The result show that the respondents felt very excited and active in their involvement in church.

Socially, the religious community can provide a number of functions for older adults, such as social activities, social support, and the opportunity to assume teaching and leadership roles. Older adults can become deacons, elders or religion teachers, assuming leadership roles they might have been unable to take on before they retired (Cox & Hammonds, 1988).

4.5 Research Question 4: What measures can be put in place to improve the psychosocial well-being of the elderly in Mamfe?

What emerged from the fourth research question are; advice giving, avoidance of deviant acts, social and spiritual support. The measures one need to put in place to improve the psychosocial well-being of the elderly was that from the respondents each of them gave a solution that aging look attractive and all must desire to be in that state. All the respondents attributed their livelihood to the Almighty God who has been the source of their blessings.

Their views were as follow:

1. Every individual should not forget God in life but to serve Him to live long.

> *Do not sin, always tell the truth, tell God all your problems and nobody can harm you in life* **(MA – 82yr).**
>
> *The grace (Adom) of God has kept me; every human being must be truthful in everything and also remember your creator in life* **(PG – 96yr).**

The tables below show what will help improve the well-being of the elderly. These are their thought about what one is expected to do in life. There were five areas respondents were allowed to choose in relation to agreeing to people's ideas (Agree Strongly, Agree, Somewhat, Disagree and Disagree Strongly).

4.5.1 Measures to improve psychosocial well-being of the elderly.

To answer research question four, the frequency as well as their rank was used to analyse the data. Responses were graded on four-point Likert scale.

Table 17: To have a good relationship with God and others to live long

Good relationship with God	Frequency		Percentage
	Male	Female	
Agree Strongly	35	114	77.3
Agree	10	24	17.6
Somewhat	2	6	4.1
Disagree		2	1.0
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

For one to live long is to have a good relationship with God and others, 149 (77.3%) agree strongly to. 34 and 8 (17.6, 4.1 %) respectively agreed and somewhat neutral, whereas 2 (1.0%) disagree to that statement. The result of the survey attested to the interviewed that it is good to have a close relationship with God to live long. "Old age has much compensation, but it is always a discipline," J. R. P. Schlater notes. "The process by which God pries our fingers loose from their clutch on things material is not entertaining. The closing of the senses, the increasing feebleness of the physical powers, and the pathetic loneliness of great age make up a process of detachment which is stern in its mercy," (cf. the frank depression of Ecclesiastes 11:7-8). Little wonder that middle-aged Americans have so much trouble dealing with their own aging and coping with the rapidly increasing number of older people all around them. Christianity is all about being dependent, accepting that we do not live on our own and only for ourselves at any point in life, not just when we grow old. Paul's great statement captures the essence of the human problem and its solution: "It is no longer I who live, but it is Christ who lives in me" (Galatians 2:20). If we can assimilate the fact that we are totally dependent throughout life upon the creating, redeeming, and sustaining God, then perhaps it will be easier to accept increasing dependence upon other human beings as we grow older.

2. Elders are there to give advice to the young ones so that they can overcome life challenges to live long and avoid mistakes in life.

> *Is the elderly who know the history of the family and the family that do not have an elder is empty and if all of you are of the same age it will be let's go all the time. When the aged is there, he/she will always give advice for the young ones to save the society same from calamity* **(MO – 73yr).**

Another one commented that:

> *Parent should train and educate their children to respect elders. In those days, children were helping aged with their luggage when they close from school and meet that aged. But now courtesies are no longer in force. How we train them will show the support they will give to us when we grow old* **(MO – 73yr).**

Table 18: Elders give advice to the young ones to overcome life challenges.

Advice to the young ones	Frequency		Percentage
	Male	Female	
Agree Strongly	25	125	77.7
Agree	22	20	21.8
Somewhat	1		.5
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

150 (77.7%) respondents agree strongly that advice given by elders help the young ones to overcome life challenges. 42 (21.8%) agree and 1(0.5%) was indifferent about it. Both results gave a nod to the fact that elders should always give advice to young ones to understand life challenges because they(elders) have had first hand experiences from which they have become wiser.

3. Be in good terms with each other without holding any grudges to enjoy good health.

> *God said "if it be possible let live at peace with all people". A doctor once told my sister that when your younger sister* ***CM*** *get high blood pressure, then that pressure is very strong because when is angry, it does not take up to twenty minutes then she let it go that is why she is not having BP. He said anyone who does not harbor anything in the heart will be healthy* **(CM – 86yr).**

Table 19: Being on good terms with others, not fighting or holding grudges to enjoy good health.

Good relationship with others	Frequency		Percentage
	Male	Female	
Agree Strongly	26	121	76.2
Agree	16	22	19.7
Somewhat	5	2	3.6
Disagree		1	.5
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

147 (76.2%) and 38 (19.7%) respondents respectively agree strongly and agree that for one to enjoy good health in old age, one needs to be in good terms with others and not hold grudges. The above results showed the agreement of people living in peace with others to enjoy a healthy life.

Stay Connected: Over the years, people tend to drift apart, move on, and get busy with their own lives. Try to keep in touch with all of your old friends and family. Be socially active and widen your friend circle, Newport Home Care; July 22, 2020

4. Young adults should prepare toward aging.

> *Every adult should prepare a "Will" not only verbal but written so that there will be peace and unity in the family when the children and family members are sharing the property after the elder is dead. Also one should make sure that when working you must start with your pension scheme and if you see that the employer is not paying your SSNIT, you must stop that work and look for the one they will pay your SSNIT* **(TN – 60).**

Table 20: Young adult should prepare toward aging.

Preparation toward old age	Frequency		Percentage
	Male	Female	
Agree Strongly	36	115	78.2
Agree	10	28	19.7
Somewhat	1	3	2.1
Total	**47**	**146**	**100.0**

Source: IBM SPSS Statistics, 2020

Most of the respondents 151 (78.2%) agree strongly and 28 agree that young adult should prepare toward aging whiles the latter is with the high cumulative percent (97.9%). 2.1% were not sure of the statement. The respondents' results showed they agree strongly to the fact that young adult should prepare toward their old age.

Make a Retirement Budget: After you are done working, you'll need a certain amount of money to not only live but live comfortably. It is never too early to make a retirement plan. Most experts say that you'll need at least 70% of what you make now. Consult a financial planner to figure out the exact amount.

Get Rid of Debt Now: The last thing you want to be thinking about years from now is who you owe. Consider getting rid of all of your debt now, rather than later. If you do have debt, think about setting up a plan with a Credit Counsellor for a debt reduction plan.

Plan for Impairment and Death: If you don't have a will now, you should think about drawing one up. This will is going to let your family know about advance directives and whether it deals with your old age, or if you pass away. By Newport Home Care; July 22, 2020.

5. Young adults should stop taking alcoholic drinks, womanizing and check their dieting to live long.

> *One should be careful with the food they eat especially salty, fatty, spicy and alcohol. What you are taking should be in moderation so that it does not block the veins where the blood flows for you not to experience high blood pressure. I have practice this for long and I am free from BP* **(AD- 82yr).**

Stay Active: To live peacefully in your old age and retirement days, and to enjoy your hard-earned financial savings, you need to stay healthy and active. Keep your weight

in check, drink in moderation, quit smoking, and pick up a sport, or practice yoga and meditation.

6. Church should continue to visit the aged at home often to keep their relationship with God close.

> *When the church visits me, I become so happy since I can no longer attend church. If one joins organizational group in the church it keeps you strong in the Lord. The Women's Fellowship leaders do come and visit me* **(MC -77yr).**

Table 21: Care and Support from church, children and family members improves psychosocial well-being of the elderly

Care and support from others	Frequency		Percentage
	Male	Female	
Agree Strongly	32	124	80.8
Agree	12	19	16.1
Somewhat	2	4	3.1
Total	**46**	**147**	**100.0**

Source: IBM SPSS Statistics, 2020

156 (80.8%) agree strongly to this statement and 6 (3.1%) did not know whether to agree or disagree. When the aged receive care and support from children, church and family members, they improve on their psychosocial well-being.

In the face of the breaking down of traditional structures that were responsible for the care of the elderly such as the family support system (Nantomah & Adoma, 2015), the church has become the alternative caregiver for the elderly (Ayete-Nyampong, 2008) and this is not surprising because the older adults tend to be more religious (Deaton, 2009) as they age and their participation in religious and spiritual activities of the church increases. According to Mcgadney (1990), the black American churches visit their older adults who are sick or homebound to give communion and pray with them and also contribute financially towards the care of the elderly. This is in line with the study done by Ayete-Nyampong (2008) and Nantomah and Adoma (2015). In

Nantomah and Adoma (2015) study, Churches do contribute towards the provision for older people. They provided financial support and material support such as food and clothing. Caring for the elderly is actually the commonest means through which the church interacts with its environment which usually has a positive effect on church growth.

A general theory that has been drawn from many researchers over the past few decades postulates that social support essentially predicts the outcome of physical and mental health for everyone. There are six criteria of social support that researchers used to measure the level of overall social support available for the specific person or situation (Cutrona, Russell & Rose, 1986). First, they would look at the amount of attachment provided from a lover or spouse. In the research, some of the respondents are attached and receive support from their spouse, children, grandchildren, caregivers and loved ones. Second, measuring the level of social integration that the individuals involved with, it usually comes from a group of people or friends. The respondents were not isolated, their children, family members and friends do visit them always. Third, complements from others such as, positive reinforcement that inspires and boosts their self-esteem. The researcher realized that the respondents get their emotional support from their children, family members and friends which boost their self-esteem. The fourth criterion is the reliable alliance support that provided from others, which means that the individual knows they can depend on receiving support from family members whenever it was needed.

Most of the respondents depend on their children and family members for some sort of support. Fifth, is the guidance of assurances of support given to the individual from a higher figure of person such as a teacher or parent? The unfortunate part of the

research was that none of the elders receive any support from a higher figure like the government. But the aged agreed that they are to give guidance to the young ones as parents. The last criterion is the opportunity for nurturance. It means the person would get some social enhancement by having children of their own and providing a nurturing experience. The respondents in the research were of the view that it is good for the elderly to advice the young ones and also share their experiences with the youth to know their history.

The respondents also suggested that for one to enjoy psychosocial well-being in old age:

1. The aged must have confidence and not rely on others but God.
2. A home should be built for those who do not have relatives and friends to take good care of them.
3. We must love one another as Christ did so that we can live peacefully.
4. We need each other and the sooner we learn that the better.
5. Government (Ministry of Children and Gender Affairs) should help people without pension scheme.
6. We should educate children about life and aging.
7. The youth must obey and respect elders for the elderly to bless them to live long.
8. We must be truthful always and love to greet people we meet.
9. People asking for the aged welfare make them feel good because their plight will be known by others.
10. Children must be advice to take good care of their parents.
11. Happiness is not out there but within us.
12. We must think positively and not evil about people.

13. The youth should not see the aged as witches if things are not going on well with them.
14. The youth should not see aged as outmoded in decision making.
15. Too many friends destroy life, be content with what you have.
16. Check the dieting of the elderly.
17. Increment in pension pay.
18. Proper counselling measures for the elderly should be put in place to take care of the past horrible experiences.
19. Exercise patience in marriage to enjoy life.

In summary, aging is a blessing from God. However, it comes with its challenges which include health, financial, emotional abuse, psychological abuse, spiritual predicament etc., and these needs to be addressed.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMEDATIONS

5.0 Introduction

This section of the report being the concluding chapter of the study summarises the findings of the research. This also indicates how the objectives of the study were achieved. It also provides useful policy recommendations that address the issues raised in the analysis to ensure the well-being of the aged in Mamfe Township. This has been put under various headings to improve on the presentation.

5.1 Summary of Findings and Discussions

The findings of the study were based on the objectives of the research. This section therefore identifies issues concerning the overall analysis, the following factors, thus spiritual, health, social relationships, economic and emotional have given rise to the elderly abuse and also how the family, church and the nation support improve the well-being of the elderly. This has been listed under the various sub-headings for clarity.

Demographic information

The study revealed that:

- Results in table 1 and 2 show that majority of the respondents were between the ages of 70-79. Out of 193 respondents that participated in the quantitative study, the majority (75.6%) of the respondents were female and the minority were male representing (24.4%). Table 1 & 2 gave a full account of the sex distribution of the respondents interviewed and questioned. Both had the majority to be female respondents.

- The respondents for both databases show that a larger number had basic education represented by 5 (50%) and 75 (38.9%) respectively. The professional background of the respondents was collected by the researcher for the quantitative survey. Their different professions helped sustained their economic standard of living for their well-being. 41 (21.2%) were trading, the others 39 (20.2%) were for those with different work expertise.

Psychosocial well-being of the elderly: how the aged feel about themselves

The study revealed that:

- The respondents who were interviewed and questioned, 48.7% and 26.4% were feeling extremely blessed and happy respectively to attain that age. But on the contrary, they feel not happy and regretful due to loneliness as they are home bound, loss of spouse and love ones, and other challenge was their memory problem where they do forget things.

How others see them:

- All the respondents on the averagely received positive perception from people, their reactions toward the people on how they perceive them made them feel strong and healthy.
- In this study, majority of the respondents selected were in a good psychosocial state because none of their family members, people around them do not see them as a burden, neither were they accused of being witchcraft nor were negative things said about them except in few cases.

Roles the family, church and the nation play to assist the care of the elderly:

Financial support:

- The research on both data collected agreed that the financial support systems of the elderly are mainly from their children since they are not in active work.

Factors that influence the psychosocial well-being of the elderly:

Socio-economic factors

- Both research results show that the respondents have people they spend most of their time with – children, spouse, caregivers and others. Few were seen to be living alone. Their relationships make them feel strong, warmth and normal.
- The sources of the respondents' economic income were that their children bore most of their basic needs (feeding, clothing, medical bills). The majorities of older adults do not work and/or have fewer options for continued income. They are at risk for rising costs of living, which may place them at an economic disadvantage and potentially at lower levels of social economic status.

Health factors

- The health challenges of the aged indicate that some of the respondents had multiple health problems.

Residential Arrangement

- Both data show that majority of the respondents live in a family house and very few are in a rented apartment.

Spiritual state

- The results of the data collected show that most of the respondents in the survey were able to attend church while minorities attend church when interviewed.
- Though not all of them attend church they believe that being involved in church activities make one active and happy. The results showed that the respondents feel very excited and active in their involvement in church.

Measures put in place to improve the psychosocial well-being:

- The result of the survey attested to the interviewed that it is good to have a close relationship with God to live long.
- Both results gave a nod to the fact that elders should always give advice to young ones to understand life challenges.
- 147 (76.2%) and 38 (19.7%) respondents respectively agree strongly and agree that for one to enjoy good health in old age, one needs to be in good terms with others and not hold grudges. The above results showed the agreement of people living in peace with others to enjoy a healthy life.
- The respondents' results showed they agree strongly to the fact that young adult should prepare toward their old age.
- The respondents in the research were of the view that it is good for the elderly to advice the young ones and also share their experiences with the youth to know their history. This will help one to enjoy psychosocial well-being in old age.

If these are efficiently and effectively resolved would improve the psychosocial well-being of the elderly in the society. To improve on the state of the elderly, there must be government policy on aging, community day care centers, social security coverage, right of the elderly, and religious, social and family support.

In this study, the writer researched into the effects of psychosocial well-being of the elderly, the responsibility of family, church and the nation toward the aged. The research also focused on how to improve the negative effects of psychosocial well-being of the elderly. The research examined the research questions using qualitative and quantitative thus mixed methods and found that the aged in Mamfe, Akuapem were been treated well.

The elderly in Ghana and most especially Mamfe Akuapem and its environs are not exception when it comes to treatment they go through. This research has been able to establish the fact that if the elderly is treated well in the society, they would feel comfortable in the environment they find themselves. When this happens, they are able to become the wise old African elderly person we revere so much in our society. This confirms the adage in Akuapem that –Ɔpanyin nyi wo fi a due" (If there is no elder in your family sorry for you).

5.2 Conclusion

The results of the study have led to the following main conclusions with regard to the care for the elderly.

All the respondents interviewed and questioned received positive perception from people around them. They were seen as a blessing to the family and never a burden. The reactions from those people toward them on how they perceive them made them

felt strong and healthy. In this study, none of the respondents reported negative psychological impact in terms of being seen as a burden or labelled as a witch.

One reason old age is a devalued role is the Ghanaians tend to have negative attitudes toward old age. These negative attitudes are reflected in the various myths about old age, which can become self-fulfilling prophecies. People who believe the elderly have lost the capacity to enjoy living may make life more difficult for the elderly and may themselves plunge into despair when they become old. Negative attitudes about old age are easy to identify in our society. Social support can only be beneficial if it is adaptable to the environment; furthermore, social support has to be geared towards an individual's specific needs. Society must become knowledgeable of needs of the elderly in order to adequately meet them.

Again, most of the respondents received financial support from their children since majority are no longer working. They also have fewer options for sources of income. They are at risk for rising costs of living, which may place them at an economic disadvantage and potentially at lower levels of social economic status. The most important factors in the quality of life of the elderly are economic and social resources (Soldo & Agree 1998:23). That makes sense, because we all value the ability to do what we please, but what we please to do usually requires certain financial resources. While the desires of the elderly may not be as wide-ranging as those of younger people, what they would like to do is often stifled by their lack of money. So far as the aged experience financial problems, their autonomy is threatened and the quality of their lives diminishes. Socially, the religious community can provide a number of functions for older adults, such as social activities, social support, and the opportunity to assume teaching and leadership roles. Older adults can become deacons, elders or

religious teachers, and assume leadership roles they might have been unable to take on before they retired (Cox & Hammonds, 1988).

Also, socially the aged spend most of their time with their children, spouse, family members and friends. A general theory that has been drawn from many researchers over the past few decades postulate that social support essentially predicts the outcome of physical and mental health for everyone. There are six criteria of social support that researchers used to measure the level of overall social support available for the specific person or situation (Cutrona, Russell & Rose, 1986). First, they would look at the amount of attachment provided from a lover or spouse. Second, measuring the level of social integration that the individuals are involved with, it usually comes from a group of people or friends. Third, the assurance of worth from others such as positive reinforcement that could inspire and boost the self-esteem. The fourth criterion is the reliable alliance support that is provided by others, which means that the individual knows they can depend on receiving support from family members whenever it was needed. Fifth, the guidance of assurances of support given to the individual from a higher figure or person such as a teacher or parent. The last criterion is the opportunity for nurturance. It means their situation is socially enhanced through their own children who provide a nurturing experience.

5.3 Recommendations

The following recommendations were made in connection with the care of the elderly in Mamfe township. The underlying premise is that there is the need to adopt an approach with a proper balance between family support, church and the Ghana's responsibility toward the aged.

5.3.1 Family responsibility

1. The children of the aged should be assisted by family members and strengthened to continue to fulfill their function of caring for the elderly. In this connection, the important role being played by children and spouses in caring for the elderly should be recognized.
2. There is the need to introduce concrete policy measures by the family head that will provide resources in support of family care for the elderly. This may be done by paying older peoples' allowances to the aged below certain income levels which maintain elderly members.
3. The family members should advocate for government to grant income tax reliefs to such families.
4. The family members should seek counselling services, professional assistance, and financial aid from NGOs and institutions for members caring for the disabled or chronically-ill aging relatives.
5. There is the need to develop new types of informal care networks, backed by a range of medical and social services at the community level. Informal support refers to unpaid help given by friends, neighbours, and family. It takes many forms, including advice, nursing, affection, and companionship care.
6. The need to educate the caregivers on how to care for themselves to prevent burnout, especially if the aged have health concerns.

5.3.2 Church responsibility

1. The church leaders must acknowledge the role played by the aged, their involvement and spiritual contributions of the elderly. For if there was not the dedication of the older people to their spiritual convictions, the church would have no glorious past.

2. The leadership of the church should make membership meaningful for elderly. The awareness that religion can contribute to the aging process is indicated by the large numbers of older people in the church.
3. Counsellors in various churches should guide older people toward personal adjustment. Some older people say ―I don't know what I would do without the help that comes to me through my church. I just cannot understand how people get along without God." Such statements represent the influence of religion, as it helps the aged to make the transition from the routine of active employment to the uncertain conditions often found in retirement. As time goes on, the older people must confront the problems of limited income and constricted social activities, and we see them striving hard to adjust to these new situations. It will be helpful to identify some of the pressing needs of older people, and indicate how religious principles can be applied in solving their problems. Emphasis must be placed on the needs of older people and the ways in which the counsellor can utilize the social services to form a team which can give strength and meaningfulness to the later years.
4. The task of the minister must include counselling to cover the special needs – economic, social and emotional, as do the general counselling services. The minister must cooperate with the resources of the community to supplement his/her effort. Some larger churches are employing additional staff members, who have specialized training, to work with older people. In some churches the associate minister counsels the aging and, if the need arises, acts as the liaison person with the various social service agencies. Therefore, the pastor must broaden the scope of the ministry to include older people, if they are to be assured of the relevance of faith to their emotional, economic and social needs.

5. To relate church programmes to the needs of the older people. The church must develop a local church programme that will involve elderly in a continuing programme of personal enrichment. Such programmes should do four things for the elderly:

a. Nourish their faith.

b. Involve them in activities that will be gratifying.

c. Provide opportunities for fellowship through creative recreation.

d. Make available all the resources of the community for their welfare.

5.3.3 Ghana's responsibility

The role of the government in the nation's responsibility toward the elderly are as follows:

1. The coverage of the existing Social Security Law, PNDC Law 247, which attempts to provide a comprehensive coverage for all workers in the country, should also include the elderly who have not had the opportunity to contribute to pension funds earlier in life.

2. The Social Security benefits for the elderly should be designed to provide them with an adequate level of protection sufficient to maintain their financial independence. The government should establish a long term and generally accepted housing policy to support the people especially the aged to own a house while they were actively working. The already established associations/welfares, credit unions and other groupings could be used as a vehicle to realize this. Members of these groups could compulsorily be made to commit certain percentage of their monthly income towards housing like the SSNIT pension contribution for workers and the government guarantees for the beneficiary. Typical case is the SSNIT housing scheme where their housing units have been

given out for outright purchase by the occupiers. Another is the affordable housing scheme though the prices seem to be expensive, the concept was laudable. To make it relatively affordable, local building materials should be employed. This would help reduce the housing deficit, increase access to housing and finally improve the well-being of the aged.

3. In the area of service delivery, the government should devise a system that would coordinate the activities of the central government, regional and district councils, voluntary organizations and private agencies in a pyramidal system of service delivery. In effect, this arrangement should not only ensure that the service delivery system will be extended to the rural population but also attract adequate attention and the necessary funding.
4. The health insurance policy should be reviewed by government to reflect a reduction in the age at which one enjoyed free or subsidized premium payment from 70 years to 65 years. At age 65, everyone is expected to have gone on compulsory retirement from active formal employment, even if he/she had an extended employment contract, it might have ended.
5. It is said that ―knowledge is power…" Education should be made as accessible as possible to every child of school going age by the government. It has the power of shaping ones thinking and widens ones' horizon. There is a popular saying, ―if one thinks education is expensive, one should try ignorance". Education has the power to influence the kind of job one does and the best way of doing it. When the people are well educated their employment, status is improved for an enhanced remuneration. Even when one is in the informal sector, there is the possibility of improving the way things are done for an enhanced income or profit. It also makes one sensitive to one's health and therefore seeks knowledge

to improve its health conditions. It could also help increase the understanding of investments. All these would help improve the well-being of the aged.

6. There should be a policy to establish social centers in the communities by the government with support from other interest groups and managed by a Board. Human beings' function in a social system through interpersonal relationships which influences their life and health (King, 1981). The aged within the community meet to entertain and educate themselves on issues of common interest including health/nutrition and personal hygiene. The aged should be recognized as repository of culture and tradition, could make the place serve as experience and knowledge sharing center for the general public particularly the youth as well as the schools within the catchment area. This would help to educate the children and the youth about culture and tradition; it would go a long way to preserve culture as well. It would again be used as aged community health center where health personnel would visit them regularly to screen and administer the appropriate medicines to them and make the necessary referrals if special medical attention is required. This could help reduce the aged _flooding' the hospitals without receiving the necessary attention they require. It could also help reach out to the aged easily enough for any necessary educational issues including their health. The burden on caregivers as well as stress and self-medication could be reduced. These would possibly improve their social interactions and reduce health challenges; leading to improved well-being and also becoming useful in the society.
7. The religious groups should be encouraged by the government to support the aged by contributing to the Government's fiscal policies and programmes to improve the situation of older persons as their social responsibility. They should

continue providing spiritual and psychosocial support to the aged including regular visits to the aged at the centers; the essence of the existence of the religious bodies besides making people belonging to God. This would ensure that, the well-being agenda of the aged is realized.

8. There should be a policy which ensures that the capacity of the caregivers is built by the center on psychosocial and physiological understanding of the aged through training. This would help ensure proper handling of the aged especially the bedridden. Guidelines and code of conduct should be spelt out to direct the attitudes of the caregivers towards the aged that they care for. The management of the social centers would lead this training programme and Department of Social Welfare (DSW) monitors the activities and conducts of the caregivers. All this would ensure the well-being of the aged for national development.
9. There should be institutions put in place by government to ensure proper management and control of funds and activities for the benefit of the individual aged groups and the caregivers for total development.
10. The Ministry of Chieftaincy and Religious Affairs, the Ministry of Gender, Children and Social protection and the Ministry of Health together with the church should setup and train pastoral care teams to visit the elderly infirm or home-bound aged to interact with, to take care of their health needs and also help out with other things they need. This will help them feel loved, more connected and cared for. This can help them cope with the health issues they encounter at this stage of their lives.

Generally, there are other ways that can help in the psychosocial well-being of the elderly which needs to be considered. The results of the study have implications for aging social policy. First, long-standing gaps in knowledge about geriatric health

needs exist, while a rapidly aging population is presenting challenges to healthcare systems. In preparing for the increase in age-related medical conditions, medical doctors require specialized knowledge. Community health nurses should be used to provide similar services such as those provided by maternal healthcare and immunization for older adults.

Aging experts need to advocate the teaching of geriatrics and gerontology in medical schools nationwide. Second, the structuring and ordering of healthcare services to older adults needs to be regimented along the following lines: segregation of older adults‘ folders from those of the younger groups and treatment should not follow the first come first served modality but with consideration for older adults. Better still, health facilities need to consider creating separate clinics for older adults. The passage of the national aging policy bill into law is imperative. These go a long way to ensure optimal aging among older adults. Future research may explore the completion of vignettes by the staff most engaged in care provision in nursing home settings. This includes seeking to distinguish between differences in the quality of care between nursing units within the same facility to enable the targeting of nursing improvement efforts to those with lower performance. Third, the caring functions of the family must be strengthened using the provision of resources in support of care for older adults. Forth, factors of relocation, residence, social support, and facilities should be considered with regard to enabling older adults to achieve adjustment to institutional homes in general and old age in particular. Fifth, the government through the Ministry of Gender Children and Social Protection in collaboration with other stakeholders must institute state-owned institutional homes nationwide, which may serve the purpose of contributing to a wide variety of care for older adults at large. Perhaps, it will be worth having a guest house facility as part of such homes where relatives and

friends of inmates may visit and stay for a couple of days. This is particularly essential for emotional release and psychological stability. It is the believe of the researcher that if the church, the family and the nation should discharge their duties responsibly, the elderly in the society would enjoy the benefit of living long.

In conclusion, this research study was intended to address the impact of psychosocial well-being of the elderly in Mamfe-Akuapem township. From these findings, it was apparent that psychosocial well-being has the potential to affect the elderly negatively. By simply being made aware of the potentially devastating effects on the aged, the family, church and the nation are to take up their responsibility to combat the negative impact on the psychosocial well-being of the elderly.

REFERNCES

Altrichter, H., Feldman, A., Posch, P. & Somekh, B. (2008). *Teachers investigate their work; An introduction to action research across the professions.* Routledge. P. 78.

American Housing Survey (1997). *Assessing housing needs of the elderly, housing our elders: A report card on the housing conditions and needs of older Americans*, USA: Housing and Urban Development User.

Anstey, K. J., & Smith, G. A. (1999). *Interrelationships among biological markers of aging, health, activity, acculturation, and cognitive performance in late adulthood*. psycnet, apa.org

Antonucci, T. C. (1990). *Social support and reciprocity; A cross -ethnic and cross-national perspective. Journal of Social & Personal Relationships*, 7, 519-530.

Antonucci, T., Birditt, K. & Webster, N. (2010). Social relations and mortality: A more nuanced approach. *Journal of Health Psychology, 15(5),* 649-659. doi: 10.1177/1359105310368189 Flood.

APA's Office (2005). *Socioeconomic status* (OSES) website: www.apa.org/pi/ses

Apt, N. A. (1971). *The socio-economic conditions of the aged in Ghana*. Accra: Department of Social Welfare and Community Development Monograph

Apt, N. A. (1981). *Aging in Ghana.* University of Ghana, Legon.

Apt, N. A. (1989). *Impact and consequences of social change on aging in Ghana: A Study of the Central Region*. Doctoral Dissertation. Sociology Department, University of Ghana. Legon.

Apt, N. A. (1991). *Who is caring for the elderly in Ghana?* BOLD 1(4):5–10. (Malta).

Apt, N. A. (1992). Family support to elderly people in Ghana. In H. Kendig, A. Hashimoto, and L.C. Coppard, (Eds.), *Family support for the elderly: The international experience.* (Pp. 203–212). New York: Oxford University Press.

Apt, N. A. (1993). *Cross-cultural gerontol* 8: 301. doi:10.1007/BF00972559

Apt, N.A. (2012). Aging in Africa: past experiences and strategic directions. *Ageing Int., 37,* 93–103.

Apt. N. A. (1996). *Coping with old age in a changing Africa*. Ashgate Publishing Company Ltd. England.

Areiti, S. & Bemporad, J., (1980). *Severe and mild depression: The psychotherapeutic approach*. London: Tavistock Publishers.

Avendano, M., Kawachi, I., Van Lenthe, F., Hendriek, C., Boshuizen, J. P. Mackenbach, G. A., Van den Bos, M., Fay, M. E., & Berkman, L. F. (2006). Socioeconomic status and stroke incidence in the US Elderly. *Stroke, 37*(6), 1368–73.

Ayetey-Nyampong, S. (2006). *Ageing in contemporary Ghana*. Step Publishers Accra, Ghana.

Ayetey-Nyampong, S. (2008). *Pastoral care of the elderly in Africa*. Accra, Ghana: Step Publishers.

Ayetey-Nyampong, S. (2011). Pastoral care and gerontological needs in Africa. Testamentum Imperium: *An International Theological Journal. Focusing on Eternal Security of the Christian*, Vol. 3.

Babaloa, O. E., Murdoch, I. E., Cousens, S., Abiose, A. & Jones B. (2003). Blindness: how to assess numbers and cause. *British journal of ophthalmology 87*(3), 282-284

Baloyi, M. E., & Theology, P. (2008). *A pastoral investigation into some of the challenges associated with aging and retirement in the South African context*, 1–10. https://doi.org/10.4102/ids.v49i3.1866

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental Psychology*, *23*, 611-626.

Baltes, P. B., Reese, H. W., & Lipsitt, L. P. (1980). Life-span developmental psychology. *Annual Review of Psychology*, *31*, 65-110.

Baltes, P. B., Smith, J., & Staudinger, U. M. (1992). Wisdom and successful aging. In T. B. Sonderegger (Ed.), *Nebraska symposium on motivation: Psychology and aging*. Lincoln, NE: University of Nebraska Press.

Barrientos, A., & Lloyd-Sherlock, P. (2002). Older and poorer? Ageing and poverty in the South. *Journal of International Development*, *14*, 1129-1131.

Bassuk, S. S., Berkman F. L., & Amick C. B. (2002*).* Socioeconomic status and mortality among the elderly: Findings from four US communities*: American Journal of Epidemiology, 155*(6), 520-533.

Bazeley, P. (1999). The bricoleur with a computer: Piecing together qualitative and quantitative data. *Qualitative Health Researcher, 9*(2), 279–287.

Biggs, A., Davies, S., Jarvis, M., & Mcwilliam, A. (2016). *The impact of initiatives for older people* October 2016.

Birren, J. E., & Lanum, J. C. (1991). Metaphors of psychology and aging. In C. M. Kenyon, J. E. Birren, & J. J. F. Schroots (Eds.), *Metaphors of aging in science and the humanities*. New York: Springer.

Black, H. K. & Rubinstein, R. L. (2000). *Old souls: Aged women, poverty and the experience of God*. Cambridge: Cambridge University Press.

Borchelt, M., Gilberg, R., Horgas, A. L., & Geiselmann, B. (1999). Significance of morbidity and disability in old age. In Baltes, P.B. & Mayer, U. K. Eds, *The Berlin Aging Study: Aging from 70 to 100.* Cambridge University Press. Pp 403-429.

Botwinick, J. & Thompson, L. W. (1970). *Stimulation in different phases of the cardiac and reaction time*. Washington: Sage.

Brown, C. K. (1984). *Improving the social protection of the aging in Ghana*. Institute of Statistical, Social, and Economic Research Monograph, Legon: University of Ghana.

Brown, P. J. (1971). *Social structure and aging: A comparative study of the status of the aging in the United States and Ghana.* Report submitted to the Fulbright Foundation, Atlanta, GA, USA.

Brown, P. J. (1998). *Counseling with senior citizens.* Philadelphia: Fortress Press.

Brown, S. L., Nesse, R. M and Smith, D. M. (2003). *Providing Social Support may be more Beneficial than receiving it: Results from a prospective study of mortality*. Hhttps://doi.org/10.1111/1467-9280.14461

Bruce, M. L., Seeman, T., Merrill, S. S., & Blazer, D. G. (1994). The impact of depressive symptomatology on physical disability: MacArthur studies of successful aging. *American Journal of Public Health*, *84*, 1796–1799.

Busse, E. & Blazer, D. G. (1996). *The past and future of geriatric psychiatry*. American Psychiartric Association.

Butcher, J. N., Mineka, S., & Hooley, J. M. (2004). *Abnormal psychology* (12th ed.). Boston: Allyn and Bacon.

Cadmus, E. O. (2019). *A myth or reality?* - First Online.

Carstensen, L. L. (1995). Social and emotional patterns in adulthood: support for Socio-emotional selectivity theory. *Psychol. Aging, 7*, 331 – 8.

Carstensen, L. L. (1995). Evidence for a life span theory of Socioemotional selectivity. *Current Directions in Psychological Science, 4*, 151–156.

Carstensen, L. L. (1998). *A life-span approach to social motivation*. Cambridge: Cambridge University Press.

Caspi, A. (1984). Personality in the life course. *Journal of Personality and Social Psychology, 53*, 1203–1213.

Cattell, M. G. (2009). *Knowledge and social change in Samia, western Kenya*. Journal of Crosscultural Gerontology, vol

Chudacoff, H. & Hareven, T. K. (1979). *From the empty nest to family dissolution: Life course Perspective.* Newark, Delaware 19711.

Chung, S. D. (2007). *A comparative study on the successful aging for Korean elderly women and elderly men.* J Korean Gerontol Soc.

Clarkson-Smith, L. & Hartley, A. A. (1989). Structural equation models of relationships between exercise and cognitive abilities. *Psychology and Aging, 5*(3), 437.

Classen, S., Lopez, D. D. S., Winter, S., Awadzi, K. D., Ferree, N., & Garvan, C. W. (2007). Population-based health promotion perspective for older driver safety: Conceptual framework to intervention plan. *Clinical Intervention in Aging 2*(4), 677–693.

Cohen, L. Manion, L. & Morrison, K. (1994). *Research methods in education* (4th ed.). London: Routledge.

Cohen, L., Manion, L. & Morrison, K. (2000). *Research methods in education* (5th ed.). London: Routledge. p.25

Collins, B. (2005). *Dilemma of aging in Ghana.* Ghana News Agency (GIJ Intern) Accra.

Comijs, H. C., Pot, A. M., Smit, J. H., Bouter, L. M., & Jonker, C. (2002). Elder abuse in the community: prevalence and consequences. *J Am Geriatr Soc., 46*, 885-8.

Corey, S. M. (1953). *Action research to improve school practice*. New York: Teachers College, Columbia University of Chicago Press.

Corso, (1977). Neurological examination findings to predict limitations in mobility and falls in older persons without a history of neurological disease. *The American journal of ..., Elsevier*

Cosco, T. D., Prina, A. M., & Perales, J. (2014). *Operational definitions of successful aging: a systematic review*. Int. Psychogeriatric Assoc.

Cox, J. T., & Hammonds, (1988). *Practice and procedure in the Church of Scotland*. Edinburgh and London, William Blackwood and Sons Ltd.

Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research* (3rd ed.) Los Angeles: SAGE; 2011.

Creswell, J. W., & Plano Clark, V. L. (2008). *Designing and conducting mixed methods research* (4th ed.). Los Angeles: SAGE.

Creswell, John W., & Vicki L. Plano Clark (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications.

Crews, J. E. & Campbell, V. A. (2004). *Vision impairment and hearing loss among community-dwelling older Americans*: implications for health and functioning. American journal of public, ajph.aphapublications.org

Cutrona, C., Russell, D., & Rose, J. (1986). *Social support and adaptation to stress by the elderly*. Psychology and Aging, 1, 47-54.

Daaleman, T. P., Perera, S & Studenski, S. A. (2004). Religion, spirituality and health status in geriatric outpatients. *The Annals of Family Medicine, 2*(1), 49-53.

Daly, T., Armstrong, P., & Lowndes, R. (2015). Liminality in Ontario's long term care facilities: private companions' care work in the space ~~-b~~etwixt and between". *Compete. Change, 19,* 246–263.

De-Graft Aikins, A., & Apt, N. A. (2016). Aging in Ghana: Setting priorities for research, intervention and policy. *Ghana Stud. J., 19*, 35–45.

Dickson, K. (1984). *Theology in Africa*. London: Darton, Longman and Todd.

Doh, D., Afranie, S., & Bortei-Doku Aryeetey, E. (2014). Expanding social protection opportunities for older people in Ghana: a case for strengthening traditional family systems and community institutions. *Ghana Soc. Sci. J.,. 11,* 26–52.

Dovie, D. A. (2018a). Systematic preparation process and resource mobilisation towards postretirement life in urban Ghana: an exploration. *Ghana Soc. Sci. J. 15*, 64–97.

Dunn, K. S. & Horgas, A. L. (2004). *Religious and nonreligious coping in older adults experiencing chronic pain.* Pain Management Nursing, Elsvier

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

Feldman, P., & Steptoe, A. (2004). How neighbourhood and physical functioning are related: The roles of neighbourhood socioeconomic status, perceived neighbourhood strain, and individual health risk factors. *Annals of Behavioural Medicine, 27*(2), 91-99.

Fitzpatrick, Barry, and Irene Kingston for the Equality Commission for Northern Ireland. Older people's access to financial services. Dublin, 2008 (2004). Available from http://www.equalityni.org/archive/pdf/OLDERPEOPLEFinancialservices(F).pdf

Fleck, C. (2008). Older minorities are becoming America's poorest residents. *AARP Bulletin Today.* Retrieved from http://paydaystorefinder.com/article/aarp_older_minorities_are_becoming_americas_poorest_residents_cash_poor.html

Flick, U. (2000). *An introduction to qualitative research* (2nd ed.). London: Sage Publications.

Fozard, L. S. & Gordon-Salant, S. (2001). *Changes in vision and hearing with aging*. psycnet.apa.org

Fozard, L. S. (2000). *Sensory and cognitive changes with age*. books.google.com

Fratiglioni, L., & Rocca, W. A. (2001). Epidemiology of dementia. In F. Boller, & S. F. Cappa (Eds.), *Handbook of neuropsychology* (2nd ed.), Amsterdam, the Netherlands: Elsevier.

Fratiglioni, L., Winblad, B., & von Strauss, E. (2007). Prevention of Alzheimer's disease and dementia: Major findings from the Kungsholmen Project. *Physiology & Behavior, 92*, 98-104.

Fry, P. S. (1999). *Predicators of health-related quality of life perspectives, self-esteem, and life satisfactions of older adults following spousal loss: An 18-month follow-up study of widows.* The Gerontologist, academic.oup.com

Gaetner, J., Larson, D. B. & Allen, G. D. (1991). *Religious commitment and mental health: A review of the empirical literature*. journals. sagepub.com

Gallo, L. C., Bogart, L. M., Vranceanu, A. M., Matthews, K. A. (2005). Socioeconomic Status, Resources, Psychological Experiences and Emotional Responses: A Test of the Reserve Capacity Model. *Journal of Personality and Social Psychology*, 88(2), 386-399 https://doi.org/10.1037/00223514.88.2.386

Gaugler, J. E., Zarit, S. H., & Perlin, L. I. (2003). *The onset of dementia caregiving and its longitudinal implications.* Psychology of Aging, 18(2), 172-180. https://doi.org/10.1037/0882-7974,18.2.171

George, L. K. (1996). Social factors and illness. In: Binstock R.H, George L.K, editors. *Handbook of aging and the social sciences.* (4th ed.) San Diego, CA: Academic Press, pp. 229–253

Gerstorf, D., Hoppmann, C., Kadlec, K., & McArdle, J. (2009). Memory and depressive symptoms dynamically linked among married couples: longitudinal evidence from the AHEAD study. *Developmental Psychology* 45(6) 1595-1610. doi: 10.1037/a0016346

Gescheider, G. A. (1997). *The effects of skin temperature on the detection and discrimination of tactile stimulation*. Motor research, Taylor & Francis.

Ghana Statistical Service (GSS), (2005). *Population Data Analysis Reports*: Volume 1, Socio-economic and Demographic Trends Analysis. The GSS, Accra, Ghana.

Ghana Statistical Service, (2010). Eastern Regional Analytical Report 2010 Population and Housing Censuses

Gilhar, A., Ullmann.Y., Karry, R., Bedia, S., & Sima, A. (2004). Aging of human epidermis: reversal of aging changes correlates with reversal of keratinocyte fas expression and apoptosis. *The Journal of Gerontology Series A: Biological Sciences and Medical Sciences 59 (5), B411-B415,*

Glickman, A. (1990). –The new Jewish elderly: A literature review." *The Journal of Aging and Judaism 5(1);-21.*

Guba, E. C., (1992). *The alternative paradigm*. London: Sage

Hackman, J. R. (2002). *Leading teams: Setting the stage for great performances*. Boston, MA: Harvard Business School Press.

Hamilton, G. (1917: 1941, cited in Hollis. 1964). *Concept of "social diagnosis" as "psychosocial study"*. https://en.m.wikpedia.org

Harkins, S. W., Prince, D. D., & Martelli, M. (1986). Effects of age on pain perception: Thermo nociception. *Journal of Gerontology, academic.oup.com*

Harris, M. J., Moniz, A. J., Sowards, B. A. & Krane, K. (1994). Mediation of interpersonal expectancy effects: Expectancies about the elderly. *Social Psychology Quarterly, 36-48*

Harvard Medical School (2010). *The health benefits of strong relationships*. Harvard Women's Health Watch 18(4) 1-2. Retrieved from www.health.harvard.edu

Help Age International (2002). State of the world's older people. London: Author.

Hill, P. C., & Butter, E. M. (1995). The role of religion in promoting physical health. *Journal of Psychology and Christianity, psycnet apa.org*

House, J. S., Landis, K. R. & Umberson, D. (1988). Social Relationship and Health. Science. *New Series, 241*(4865), 540-545.stable URL:http://links.jstor.org/sici?sici=0036-8075%2819880729%3A241%3A4865%3C540%3ASRAH%3E2.0.CO%3B http://www.apa.org/pi/ses/ resources/publications/fact-sheet-references.aspx.

Hoyer, W. J., & Roodin, P. A. (2003). *Adult development and aging* (5th ed.). New York: McGraw-Hill

Huang, W., Qiu, C., Strauss, E.V., Winbolad, B., & Fratiglioni, L. (2004). *APOE Genotype, Family History of Dementia. And Alzheimer Disease Risk*. jamanetwork.com

Huguet, N., Kaplan, M. S. & Feeny, D. (2008). *Socioeconomic status and health related quality of life among elderly people:* Results from the Joint Canada/ United States Survey of Health. Social Science [?] Medicine 66(4):803-10

DOI:10.1016/j.socscimed.200.11.011 Source. PubMed.

Hultsch, D. F., Hammer, M., & Small, B. J. (1993). Age differences in cognitive performance in later life: Relations to self-reported health and activity life style. *Journal of gerontology, academic.oup.com*

Hummer, R., Roger, R. G., Nam, C. B., & Ellison, C. G. (1999*). Religious involvement and US adult mortality.* Department of Sociology and Caroline Population Center, University of North Caroline.

Hunter, K. I. & Linn, M. W. (1980). *Research on Aging*. journals .sagepub.com

Hylton, C., Congdon, N. Friedman, D. & Kempen, J. (2003). Cataract after glaucoma filtration surgery. *American journal of ophthalmology 135*(2), 231-232

International Association of Gerontology. (2002). *The Valencia report*. Retrieved September 24, 2003, from http://www.valenciaforum.com/vfr.html.

JAMA. 1964;187(8);611-612. doi:10.1001/jama.1964.03060210061019

Joiner, T. E. (2000). *Depression's vicious scree: Self-propagating and erosive processes in depression chronicity*. Clinical psychology Science and Practice, 7, 203-218. psycnet.apa.org

Journal International Federation of Aging. The Dialogue on Age Discrimination *Intensifies*. Volume XX, No. 3 (1993). Washington DC USA.

Kader, P. 1997. *Nursing Research: Principles, Process and Issues.* Palgrave Macmillan, New York.

Kalache, A., Veras, R. P., Ramos, L. R. O (1987). Envelhecimento da população mundial: um desafio novo. *Rev Saúde Pública, 21*, 200-10.

Kankam, G. & Weiler, J. (2010). *A guide to action research for colleges of education and universities.* Readwide Publishers Osu-Accra, Ghana.

Karp, A., Kåreholt, I., Qiu, C., Bellander, T., Winblad, B., & Fratiglioni, L. (2004). Relation of education and occupation-based socioeconomic status to incident Alzheimer's disease. *American Journal of Epidemiology, 159*, 175-183.

Kathryn, Z. & Mary, M. (2012). *Older adult and internet*.

Kennedy, G. J. (1996). *Suicide and depression in late life: Critical issues in treatment, research, and public policy.* psycnet.apa.org

Kim, M. R. (2008). *Factors of successful aging affecting the life satisfaction of older women*.

King. I. M., (1981). A theory for nursing systems, concepts, process. Albany NY: Delmar Publishers.

Kivunja, C. (2018). *Distinguishing between Theory, Theoretical Framework and Conceptual Framework: A Systematic Review of Lessons from the Field.* International Journal of Higher Education.

Koenig, H. G. & Weaver, A. J. (1989). *Counselling troubled older adults*. Abingdon Press Nashville.

Kramer, A. F., & Willis, S. L. (2002). *Enhancing the cognitive vitality of older adults*. Current Directions in Psychological Science, 11, 173–177.

Kramer, A. F., Hahn, S., Cohen, N. J., Banich, M. T., McAuley, E., Harrison, C. R., et al. (1999). *Ageing, fitness and neurocognitive function*. Nature, 400, 418–419.

Krause, E. A. (2001). *Professional group power in developing societies*. https://doi.org/10.1177/0011392101049004009

Krejcie, R. V., Morgan, D. W. (December, 1970). *Small-sample techniques.* Educational and Psychological Measurement. The NEA Research Bulletin, Vol. 38 (p. 99.

Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Geneva: World Health Organization; 2002.

Kusi, H. (2012). *Doing qualitative research a guide for researchers*. Emmpong Press Accra- New Town.

Lauer, R. H. (1998). *Social problems and quality of life*. McGraw Hill Companies, New York.

Lauer, R. H. (1998). *Social problems and the quality of life.* McGraw-Hill Companies, Inc. USA.

Laura, E. B. (2002). *Development through the lifespan.* Pearson Education, Limited, Allyn and Bacon 155-608.

Lee, G. E. (2010). *Predictors of adjustment to nursing home life of elderly residents: a cross-sectional survey*. Int. J. Nurs. Stud. 47, 957–964. doi: 10.1016/j.ijnurstu.2009.12.020

Levin. J. S. & Vanderpool, H. Y. (1989*). Religion therapeutically significant for hypertension?* Social Science and Medicine, 29(1), 69-78. https://doi.org/10.1016/0277-9536(89)90129-9

Lewinsohn, P. M. (1974). *A behavioral approach to depression*.

Lloyd-Sherlock, P. (2002). *Social policy and population ageing: challenges for north and south*. Int. Epidemiol. Assoc. 31, 754–757. doi: 10.1093/ije/31.4.754

M., Nies. M., & Seo, D. (2010). Successful aging: Selected indicators in a southern sample. *Health Care Management Practice*, 22(2), 111-115. doi: 10.1177/108482230943945

MacLennan, W. J. (1990). *Old age: A guide for professional and lay carers*. Edinburg: The Saint Andrew Press.

Marvasti, A. B. (2004). *Qualitative research in sociology*. London: Sage Publications.

Mba, C. J. (2004). "Population ageing and survival challenges in rural Ghana." *Journal of Social Development in Africa, vol. 19, no. 2, pp. 90–112*.

McCullough, M. E. (1995). Prayer and health: Conceptual Issues, research review, and research agenda. *Journal of Psychology and Theology*, journals sagepub.com

Merkin, S. S., Roux, A. V. D., Coresh, J., Fried, L. F., Jackson, S. A. & Powe, N. R. (2007). *Individual and neighbourhood socioeconomic status and progressive chronic kidney disease in an elderly population: The Cardiovascular Health Study*. Soc Sci Med. 2007 Aug; 65(4):809-21.doi:10.1016/j.socscimed.2007.04.011.Epub 2007May 11.

Meyer, A. (1800). *Schizophrenia: Emil kraepelin*. Ancestry .com Operations Inc; Publication, Repository.

Mok, K. H., Lee, V. W. H., & So, F. K. (2004). *Retinal nerve fiber loss in high and normal-tension glaucoma by optical coherence tomography*. optometry and vision science-journals.lww.com

Morley, J. E. (2004). *The metabolic syndrome and aging.* The Journals of Gerontology: Series A 59 (1), M24-M33, academic.oup.com

Mosey, J. M., & Shapiro, E. (1985). *Physician use by the elderly over as eight-year period. American journal of Public Health 75, no. 11: pp.* 1333-1334. https://doi.org/10.2105/AJPH,75.11.1333

Motenko, A. K. & Greenberg, S. (1995*). New stage in the developmental process of life.* Oxford Academic.

Mullins, L. C., & Johnson, D. P. (1987). *Growing old and lonely in different societies: Toward a comparative perspective.* Journal of Cross-Cultural Gerontology 2 (3), 257-275.

Murray, M., Crummett, A. (2010). „I don‘t think they knew we could do these sorts of things‘: Social representations of community and participation in community arts by older people. *Journal of Health Psychology* 15(5), 777-785. doi: 10.1177/1359105310368069 Pennsylvania Department of Aging (2008). Pennsylvania state plan on aging 2008-2012. Retrieved fromhttp://www.portal.state.pa.us/portal/server.pt

Murray, R., Caulier-Grice, J., & Mulgan, G. (2010). *The open book of social wnovition*. Social Innovator Series. London: The Young Foundation and NESTA.

NDPC, (2006). *Implementation of the growth and poverty reduction strategy* (2006-2009): Annual Progress Report, (2006), Accra, Ghana: Government of Ghana

NDPC, (2010). *Medium-Term National Development Policy Framework: Ghana Shared Growth and Development Agenda*, 2010 – 2013, vol.1; Accra, Ghana: Government of Ghana. NDPC, (2010), Implementation of the Growth and Poverty Reduction Strategy (2006-2009): Annual Progress Report, (2009), Accra, Ghana: Government of Ghana.

Newport Home Care (July 22, 2020). https://www.newportcare.com

Novak, M. (2006). *Issues in aging.* Boston: Pearson Inc.

Nukunya, G.K. (2003). *Traditional and change in Ghana: An Introduction to Sociology*. 2nd ed. Accra: Ghana University Press

O'Donoghue, T., & Punch, K. (2003). *Qualitative educational research in action: Doing and reflecting.* Falmer Press.

O'Leary, Z. (2005*). Research real-world problems: A guide to methods of inquiry*. London: Sage Publications.

Odubanjo, E., Bennett, K, & Feely, J. (2004). Influence of socioeconomic status on the quality of prescribing in the elderly – a population based study. *British Journal of Clinical Pharmacology/volume 58, Issue 5/ p. 496-502.*https://doi.org/10.1111/j.1365-2125.2004.02179.x

Okraku, I. O. (1985). *A study of Ghanaian public service pensioners.* Report presented at the XIIth International Congress of Gerontology, New York.

Okraku, A. J., & C. Teddlie (2003). *A Framework for Analyzing Data in Mixed Methods Research*. In Handbook of Mixed Methods in Social and Behavioral Research. A. Tashakkori and C. Teddlie, eds. Pp. 351-383. Thousand Oaks, CA: Sage.

Peil, M. (1972). *The Ghanaian factory worker: Industrial man in Africa.* Cambridge University Press.

Penninx. B. W., Guralnik, J. M, Ferrucci, L., Simonsick, E. M, Deeg, D. J., & Wallace, R. B. (1998). Depressive symptoms and physical decline in community-dwelling older persons. *Journal of the American Medical Association. [PubMed], 127:1720–1726*

Pennsylvania Department of Aging (2008). *Pennsylvania state plan on aging* - 2008-2012 https://www.aarp.org

Phillips, L. R.., & O'neill, L. M. (June 14, 2019). *The conversation*. https://theconversation.com

Polit, D. & Beck, C 2010. *Essentials of Nursing Research.* Appraising Evidence for Nursing Practice. Walters Kluwer. Baltimore, United States. 106.

Posner, R. A. (1995). *Aging and old age*. University of Chicago Press.

Pragament, K. I, and Park, C. L. (1995). Merely a defense? The variety of religious means and ends. *Journal of Social Issues, academia.edu*

Redinbaugh, E. M. MacCallum, R. C. & Kiecolt- Glaser, J. K. (1995). *Recurrent syndromal depression in caregivers.* Psychology and Aging, 10(3), 358-368, https://doi/10.1037/0882-7974.10.3.358

Reichstadt, J. G. Sengupta, M. D. Depp, C. A. Palinkas, L. A. & Jeste, D. V. (2010). Older adults perspectives on successful aging: Qualitative interviews. *American Journal of Geriatric Psychiatry 18 (7): 567- 575.*

Robertson, R., Gergory, S. & Jabbal, J. (2014). *The social care and health systems of nine countries.* Commission on the future of health and social care in England: the King's Fund- commed.vcu.edu

Rowe, J. W., & Khan, R. L. (1987). *Human aging*: Usual and successful. Science. [PubMed], 237:143–149

Santrock, J. W. (2006). *Life-span development.* (10th ed.) McGraw-Hill Companies, Inc., 1221 Avenue of the Americas, New York.

Sarantakos, S. (2005). *Social research* (3rd ed.). New York: Palgrave Macmillan.

Sayer, J. W., Nelson, L. D., Scheibel, K. E., & Ringmam, J. M. (2004*). An experimental approach to detecting dementia in Down syndrome*: a paradigm for Alzheimer's. Elsevier

Sbarra, D. (2009). Marriage protects men from clinically meaningful elevations in C-reactive protein: Results from the national social life, health and aging project (NSHAP). *Psychosomatic Medicine* 71, 828-835.

Schaie, K. W. (1994). The course of adult intellectual development. *American Psychologist, 49, 304–313.*

Schiffman, S. S., (1992). *Effect of environmental pollutants on taste and smell.* Otolaryngology-Head and Neck Surgery 106 (6), 693-700

Schwab, T. (1989). *Caring for an aging world: International models for long-term care, financing and delivery.* McGraw-Hill Information Services Company, USA. Publications, London, New Delhi: Thousand Oaks.

Seidu, A. (2012*). Research methods in education administration and management*. University of Education, Winneba- Ghana.

Seifert, L. S. (1998). Toward a psychology of religion, spirituality, meaning-search, and aging: Past research and practical application. *Journal of Adult Development, Springer.*

Seligman, M. E. (1993). *Depression and the perception of reinforcement*. Journal of Abnormal Psychology, 82(1), 62-73, https://doi.org/10.1037/h0034954

Shaw, B., Krause, N., Liang, J., & Bennett, J. (2007). Tracking changes in social relations throughout late life. *The Journals of Gerontology, 62B*(2), 890-899. Retrieved from http://proquest.umi.com.ezproxy2library.drexel.edu/pqdweb?

Shiovitz-Ezra, S., Leitsch, S. (2010). *The role of social relationships in predicting loneliness:* The national social life, health, and aging project. National Association of Social Workers. Retrieved fromhttp://web.ebscohost.com.ezproxy2.library,drexel.edu/ehost/pdfviewer?hid=105&sid=c00ff982-8d73-4065-fc79d3e4b479%40sessionmgr104&vid=17Trudel.

Smyth, R. (2004). *Exploring the usefulness of a conceptual framework as a research tool: A researcher's reflections.* ResearchGate

Soldo, B. J., & Agree, E. M. (1988). America's elderly. *Population Bullentin*, 43, 1-45.

Soldo, B. J., & Agree, E. M. (1998). S*ociology: Exploring the architecture of everyday life.* Cambridge, MA; National Bureau of Economic Research.

Speck, C. E., Kukull, W. A., Brenner, D. E., Bowen, J. D., McCormick, W. C., Teri, W. C., Pfanschmidt, M. L., Thompson, J. D., & Larson, E. B. (1995). History of depression as a risk factor for Alzheimer's disease. *Epidemiology. [PubMed], 6*, 366–369.

Stuart-Hamilton, I. (2012). *The psychology of aging: An introduction* (5th ed.) London and Philadelphia: Jessica Kingsley publishers,.

Taylor, J. and Turner, J. (2001). *A longitudinal study of the role and significance of mattering to others for depressive symptoms, journal of Health and Social Behaviour, 42*, 310-325

The Constitution of Ghana (1992). The Directive Principles of State, Article 37(6b).

The Holy Bible New International Version, © (1973, 1978, 1984). International Bible Society Used by permission of Zondervan Bible Publishers.

The Methodist Church Ghana, (2016).Weekly Bible Lesson July-December ed. Freeman Center Kumasi, Ghana.

Thoresen, C. E., & Harris, A. H. S. (2002). *Spirituality and health: What's the evidence and what's needed?* Annals of behavioural medicine, academic.oup.com

Trudel, G., Boyer, R., Villeneuve, V., Anderson, A., Pilon, G., and Bounader, J. (2007). *A positive relationship with a spouse.*

UN-HABITAT, (1996). *–Adequacy" Regards to housing is influenced by social, economic conditions,* HREA: Available from: (htt://www.hrea.org/index.php.doc.id). [Retrieved: July 8, 2012].

UN-HABITAT, (2010). *The State of African* Cities 2010, Governance, Inequality and Urban Land Markets, Nairobi: UN-HABITAT.

United Nations Development Programme. (2002). *Human development report* 2002. New York: United Nations Development Programme.7

United States, Bureau of the Census (1996). *Current housing reports*: Urban Development. Office of Policy Development.

Warnick, J. (1995). *Listening with different ears: Counseling people over sixty*. Ft. Bragg CA: QED Press.

Weale, R. A. (1992). *Aging and chromatic contrast sensitivity*. Springer

Wenger, N. S., Solomon, D. H., Roth, C. P., MacLean, C. H., Saliba, D., & Kamberg, C. J., … Shekelle, P. G. (2003). The quality of medical care provided to vulnerable community dwelling older patients. *Annals of Internal Medicine, 139, 740–747.* doi:10.7326/0003-4819-139-9-200311040-00008

Wilkie, F., & Eisdorfer, C. (1971). *Intelligence and blood pressure in the aged*. science.sciencemag.org

Wong, C. H., Wong, F. S., Pang, W. S., Azizah, M. Y., & Dass, M. J. (2003). Habitual walking and its correlation to better physical function: implications for prevention of physical disability in older persons. *The Journals of GerontologySeries A: Biological Sciences and Medical Sciences 58 (*6), M555-M560

World Health Organization. *Abuse of the elderly*. Fact sheet (2002). Available from http://www.who.int/violence_injury_prevention/violence/world_report/factshe ets/en/elde rabusefacts.pdf (accessed 4 December 2006).

Wragg, T. (2002). Interviewing. In Coleman M. and Briggs, A. R. J. (eds.), *Research methods in educational leadership and management.* London: Paul Chapman Publishing. Pp. 143-158.

Wulsin, L. R., Vaillant, G. E., & Wells, V. E. (1999). A systematic review of the mortality of depression. *Psychosomatic Medicine. [PubMed], 161:6–17*

Wythers, M. R. (1974). *Loneliness among residents in homes for elderly*. Lincoln: University of Nebraska.

Yaffe, K., Barnes, D., Nevitt, M., Lui, L. Y. & Covinsky, K. (2001). A prospective study of physical activity and cognitive decline in elderly women: women who walk. Archievs of Internal medicine, jamanetwork.com

APPENDICES

APPENDIX A

Letter of Introduction

LETTER OF INTRODUCTION
UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF COUNSELLING PSYCHOLOGY
P. O. Box 25, Winneba, Ghana psychology@uew.edu.gh
030 298 0904

18th February, 2022.

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you, JULIANA ESI ARKAH, the bearer of this letter who is a student in the Department of Counselling Psychology of the University of Education, Winneba. She is reading Master of Philosophy in Counselling Psychology with index number 200020318.

She is conducting a research on the topic: PSYCHOSOCIAL WELL-BEING OF THE ELDERLY AT MAMFE TOWNSHIP IN THE AKUAPEM NORTH MUNICIPALITY. This is in partial fulfillment of the requirements for the award of the above mentioned degree.

She is required to administer questionnaire to help her gather data for the said research and she has chosen to do so in your outfit.

I will be grateful if she is given permission to carry out this exercise.

Thank you.

Yours faithfully,

MRS. PATRICIA MAWUSI AMOS, PH.D
AG. HEAD OF DEPARTMENT

www.uew.edu.gh

APPENDIX B

Interview Guide for the Elderly

UNIVERSITY OF EDUCTION, WINNEBA

FACUATY OF EDUCATIONAL STUDIES

DEPARTMENT OF PSYCHOLOGY AND EDUCATION

(MPHIL COUNSELLING PSYCHOLOGY)

SECTION A: DEMOGRAPHICAL DATA OF THE RESPONDANT

Birth History

1. Where were you born?
2. Date of Birth
3. Age

Educational Background:

1. School history and last status:
2. Highest level of education.
3. Degree/s earned.
4. Special school/educational talents, challenges, goals.

SECTION B: PSYCHO-SOCIO-ECONOMIC CONDITIONS OF ELDERLY IN MAMFE-AKUAPEM

Economic Status:

1. What was your occupation?
2. How long did you work at your last job?
3. What was your longest period of employment?
4. What was your highest level of training?
5. What is your current financial status?
6. Do you have any debts to repay?
7. Do you own any assets?

Religious/Spiritual State:

1. Do you believe in religion?
2. What faith do you consider yourself to be?
3. How is Religion a part of your life?
4. Level of involvement with and support from religious community and/or spiritual practices and beliefs.

Health Status:

1. Physical development, general health, disabilities, and current functioning.
2. History of disease, accidents, genetic predispositions, and prescription medication.
3. Surgeries and Serious medical conditions?

Relationship/Support History

4. What other places did you live and for how long did you live there?
5. What is your partner or spouse's age? _____
6. Do you have any children? _____
7. What are their ages? _____
8. What are the living arrangements for yourself and children?
9. Do you have a caregiver? If yes, who is he/she, and what is your relationship with him/her?
10. How do you think your health condition has impacted your relationships and your perception of your family?
11. What are your priorities in your life? What goals are most important to you currently?
12. Have you ever physically hurt yourself/others?

Psychological State: History of physical, mental, and/ or sexual abuse or neglect

1. What is your perception about yourself and how others see you?
2. In the past one year, have you been physically abused by another person?
3. Are you in any abusive relationship?
4. If you ever been sexually abused? If yes, by whom?
5. Have you witnessed any form of abuse?
6. Do you ever experience hallucinations?

The social, community, and recreational activities:

1. Social functioning, (are there any significant: friendships, interpersonal relationships, support network)?
2. Use of community organizations or resources (e.g. member, volunteer)?
3. Hobbies/leisure involvement. (What do you like to do in your spare time)?

Is there any other information that has not been asked yet, that you want the researcher to know about you?

Is there any assistance that will be needed to?

APPENDIX C

Questionnaire for The Elderly

UNIVERSITY OF EDUCTION, WINNEBA

FACUATY OF EDUCATIONAL STUDIES

DEPARTMENT OF PSYCHOLOGY AND EDUCATION

(MPHIL COUNSELLING PSYCHOLOGY)

SECTION A: DEMOGRAPHICAL DATA OF THE RESPONDANT

Instruction: please kindly write or tick (√) the various responses in the appropriate bracket / space provided.

1. Sex: ( ) Male ( ) Female

2. Age: ( ) 60 – 69

( ) 70 – 79

( ) 80 – 89

( ) 90– 99

( ) 100 and Above

3. Educational Background :

( ) None

( ) Basic

( ) Secondary

( ) Tertiary

( ) Other

4. Professional Background: …… Rank: ……

SECTION B: PSYCHO – SOCIO-ECONOMIC CONDITIONS OF ELDERLY IN MAMFE-AKUAPEM

1. Psychological State: Put the following in order from best (1) to (5) in front.

I. How do you feel about yourself?

…….. Confident …….Memory Problems

…… Happy …….. Ill Health

…… Unhappy …… Full of Regrets

…….. Blessed

How do others see you? Tick Yes/No

A burden [ ] Yes [ ] No Witch [ ] Yes [ ] No Blessing [ ] Yes [ ] No

2. What Support Systems are used to assist you financially? Tick Yes / No

I. Children [ ] Yes [ ] No
II. Church [ ] Yes [ ] No
III. Family Members [ ] Yes [ ] No
IV. Political Group [ ] Yes [ ] No
V. Social Organization [ ] Yes [ ] No

3. Factors that influence psychosocial well-being of the elderly. Tick All Correct Answers.

I. Social State: those you spent most of your time with.
[ ] Children [ ] Friends [ ] Spouse [ ] Alone [ ] Family Members

II. Economic State – Source of Income.
[ ] Children [ ] Family [ ] Pension Scheme [ ] Other

III. Health State:
[ ] Emotional/Behavioral Problems [ ] Medical Problems

[ ] Emotional Abuse [ ] Family Problems

[ ] Alcohol Abuse [ ] Physical Abuse [ ] Other

IV. Residential Arrangement:
[ ] Family [ ] Children [ ] Self- own [ ] Rented

V. Spiritual State: Are you able to attend Church? Tick Yes / No
[ ] Yes [ ] No

What role do you play in Church if Yes?

……

……

……

How do you feel about your role and involvement in the Church?

……

……

……

4. Measures to Improve Psychosocial Well-being of the Elderly.
   Tick the Most Accurate Answer.

I. Elders give advice to the young ones to overcome life challenges.
   [ ] Agree Strongly [ ] Agree [ ] Somewhat [ ] Disagree

   [ ] Disagree Strongly

II. To have a good relationship with God and others to live long.
   [ ] Agree Strongly [ ] Agree [ ] Somewhat [ ] Disagree

   [ ] Disagree Strongly

III. Young adult should prepare toward aging
   [ ] Agree Strongly [ ] Agree [ ] Somewhat [ ] Disagree

   [ ] Disagree Strongly

IV. Be in good terms with others, not fighting or holding grudges to enjoy good health.
   [ ] Agree Strongly [ ] Agree [ ] Somewhat [ ] Disagree

   [ ] Disagree Strongly

V. Care and support from church, children, and family members improve psychosocial Well-being of the elderly.
   [ ] Agree Strongly [ ] Agree [ ] Somewhat [ ] Disagree

   [ ] Disagree Strongly

Do you have any other thoughts regarding the psychosocial well-being of the elderly that you would like to share which is not in the questionnaire?

……

……

……