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ORIGINAL PAPER

The Coping Mechanisms and Strategies of Hypertension Patients in Ghana: The Role of Religious Faith, Beliefs and Practices

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Abstract This qualitative study explored the role of religious faith, belief and practice systems in the coping mechanisms and strategies of essential hypertension patients in Accra, Ghana. Six participants were recruited for participation, of which five were Christians and one was a Muslim. Interviews were conducted and interpretative phenomenological analysis was used to analyze the data. Results showed that participants used their religious faith, beliefs and practices as coping resources. Participants used a deferring-collaborative style of religious coping, which seemed to have provided them with an avoidance strategy that protected the participants from conscious confrontation with their illness. Religious faith and beliefs also afforded the participants a sense of coherence that enabled the participants to manage their stress, reflect on their external and internal resources to promote effective coping and adaptive functioning in a health promoting manner. Implications of a deferring-collaborative style of religious coping and religious reappraisal are discussed.

Keywords Religion · Collaborative coping · Deferring coping · Sense of coherence

Introduction

In the USA, the notion of linking religious and medical interventions has become widely popular in the not only complex history but also complex present of the relationship between religion and science (Sloan et al. 1999). In Ghana, religious practices take a central place in the life of many people and religion is considered a relevant social force

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reflected in everyday life experience (Assimeng 2010; Yirenkyi 2000). The 2010 population and housing census by the Ghana Statistical Service (2012) reported a total population of about 24 million people in Ghana. Population by religious affiliation showed that there are about 71.15% Christians, 17.62% Muslims and 5.15% Traditionalists. Relatively, few (0.80%) people adhere to other religious bodies such as Hinduism and Buddhism and 5.30% do not have any religious affiliations.

A number of studies, both qualitative and quantitative, have explored the relationship between religion and health in Ghana (see Akotia et al. 2014; Osafo et al. 2013, 2014), but a lot more remains to be done in studies that exclusively focus on the separate religious groups' faiths, beliefs and practices on health. One of such previous studies (Asamoah et al. 2014) examined the views of 20 male Pentecostal clergy on the role of their churches in mental healthcare delivery. Using thematic analyses, the authors found that, from the clergy's perspective, the churches' role in mental health delivery was threefold namely, exorcism, provision of social support, and health education. The authors contended that exorcism was borne out of a prevailing supernatural belief system in cultural traditions in Ghana. Social support and health education were the results of both classical and modern roles of faith-based groups around the world, with social support reflecting the caring role and health education reflecting a public health role of religion. Studies of specific religious faiths, beliefs and practices on health are particularly important because not all the religious groups in Ghana share a common faith, belief and practice systems. For example, a predominant belief in the traditional religion is that the etiology of certain diseases and illness may be ascribed to forces of angered ancestral spirits, evil spirits or the machination of witchcraft. Therefore, Western medicines can neither provide an explanation nor a cure (Awusabo-Asare and Anarfi 1997).

Acquah (2011) discussed an account of a Methodist catechist and a historian of Mfantse people (anglicized as Fantis) by name J. B. Crayner who recounted that at a time in history the Mfantse ethnic group was almost wiped out by a deadly plague and it was only through consultation with the shrine gods which "revealed that human sacrifices was needed in order to stop it" (p. 67), whereas Christianity rejected "sacrifices to the ancestors and other spirits" (p. 184). In modern days, certain traditional "religious rituals such as animal sacrifices have been removed from public spaces to certain excluded traditional sacred grounds" (p. 214).

A recent study in Ghana about suicide attempters reported that violations of religious practices were perceived as injurious to personal relationship with God and therefore required a responsibility to re-establish the injured relationship by pleading for forgiveness and guilt feeling. Consequently, regular abidance to religious practices such as church attendance was perceived as a protective resource which can enhance an individual's coping resources during crises in life (Akotia et al. 2014). During crises in life, one way in which people could withstand is through religious faith. Prayers could serve as a means by which people can reach a divine Deity (God) for support during crises in life. Suicidal behavior was accordingly perceived as a consequence of having disregarded religious faith (Osafo et al. 2013).

The present study aimed to explore the role of religious faiths, beliefs and practices in the coping mechanisms of essential hypertension (hypertension that has no specific underlying cause) patients. This aim was just one of four aims of a larger study which explored the sick role behavior of essential hypertension patients in Accra.

Methods

A qualitative method approach was chosen in order to study in-depth perceptions and experiences of essential hypertension patients about their coping mechanisms in their life worlds (Willig 2013). The approach in this study was the interpretative phenomenological analysis (Smith et al. 2009). IPA enables detailed exploration of the lived experiences of participants and the sense they make of those experiences. In exploring participants subjective reflected personal experiences, IPA has been found to be a suitable approach (Smith and Osborne 2003).

Participants and Procedure

In all, there were six participants aged between 45 and 60 years. Only one was a Muslim and the other five were Christians. Since there was only one Muslim participant whose responses were significantly different from the other five, he was not included in the final analyses. Essential hypertension patients were purposively selected with permission from the head of Korle Bu Polyclinic (KBP) to assist in the recruitment. Self-addressed stamped envelopes with information letters and consent forms were handed out to prospective participants by the head of KBP. Participants were instructed to return completed consent forms by post mail but only one did so, while the rest hand delivered their consent forms to the head of KBP. With permission from the participants, the interviews were audio-recorded and later transcribed verbatim. The study was approved by the Regional Committee for Medical and Health Research Ethics in Central Norway and the Korle Bu Teaching Hospital (KBTH) Medical Directorate in Ghana.

The Study Site—Ghana

The capital of Ghana, Accra, was chosen as the site for the study. The study took place at the Korle Bu Polyclinic which is a subdivision of the Korle Bu Teaching Hospital. Ghana was chosen because hypertension was considered nonexistent or rare in most African societies but has emerged as a challenging force to reckon with particularly in sub-Saharan Africa (Agyemang 2006; Van der Sande et al. 2000). Blood pressure levels and hypertension rates in Ghana are among the highest in Africa (Cappuccio et al. 2004). Secondly, as a developing nation many factors such as low income, low levels of education, large household sizes and unemployment have been found to be associated with mental health problems (Dzator 2013). Despite these challenges which negatively impact psychological health, some studies (see Boyce et al. 2009; Songsore and McGranahan 1993) have found that strong social support networks such as affiliations with religious bodies and organizations in Ghana mediate socioeconomic challenges and psychological health outcomes.

Instrument for Data Collection

Interviews were conducted with a semi-structured interview guide, which was designed to explore the different contexts and action radii for coping. For example, a question about coping was "How are you dealing with your condition?" which was followed by probing questions such as "Do you have particular strategies for helping yourself to deal with the condition and ways of coping." The interview guide was translated into Ga and Hausa since two of the participants could not satisfactorily communicate in English and preferred

their local language. The two translators were carefully selected based on their proficiency in and wider knowledge of indigenous social and cultural practices relating to the two languages. Some terms such as medical regimen and medical schedules which were originally used in the interview guide were reformulated to a common term such as "prescriptions" and "check-ups," respectively, before translating the interview guide.

Analyses

Two of the interviews were done and transcribed with the assistance of the translators and marked to distinguish first-hand information from what had been translated afterward. Transcripts were generated from the audio recordings. The aim in the analyses was to understand "what it is like" from the point of view of the participants. That is, the double hermeneutical analysis of IPA suggests that "participants are trying to make sense of their world" and the researcher is trying to make sense of the participants trying to make sense of their world (Smith and Osborne 2003). As such, the researcher is thought to assume an insider perspective where he/she produces a report by means of standing in the shoes of the participants.

The analyses began by identifying central themes and summarizing associations and connections in the first case and proceeded to subsequent cases, looking out for what themes cut across the group. Recurrent themes were then summarized and quotes were selected to represent them as emergent themes, followed by making logical connections between these themes to create a lucid theoretical and analytical framework for general categorization (Smith and Osborne 2003). The major themes were:

- Christian religious faiths, beliefs and practices provide optimism and hope for coping.
- Christian religious faiths, beliefs and practices engender sense of coherence.

More commonly, rather than nomothetic studies, IPA is described as a an idiographic mode of inquiry conducted on small samples to ensure a painstaking analysis of cases of participant's personal experiences, understandings and perceptions in a fairly homogenous sample (Smith and Osborne 2003). As Dibley (2011) puts it, IPA involves collecting rich (quality) and thick (quantity) data that initiates the data saturation process. In addition, structuring interview questions in a way to enable follow-up questions and interviewing multiple participants consolidates data saturation (Guest et al. 2006). In the present study, the approach of IPA sacrifices the breadth of the data for the depth of the data (Smith and Osborne 2003). In addition, interview questions were structured in a way to enable follow-up questions; the semi-structured interview guide that was used was tested and piloted to explore different contexts and action radii for coping. The second author and other members of the academic staff connected to similar research themes have thoroughly interrogated and debated every stage of this study and the depth of the data with the first author who is a native of Ghana to ensure the exhaustion of all findings.

Results

Christian Religious Faith Belief and Practices Provide Optimism and Hope for Coping

The findings are based on the five Christian participants who exhibited consistent pattern of responses and behaved similarly to each other. There were emphatic responses that showed

that participants deferred their condition to an active and a divine Deity (God), thereby taking a less active role in the coping process. It seemed that after turning over the condition to God the participants re-appraised their condition in spiritual (religious) terms which were engendered by participants' identification with and involvement in religious faiths, beliefs and practices. This re-appraisal seemed to have provided some relief to the participants. The participants also seemed to be convinced that God is responsive and all powerful, and therefore, through collaboration God could be influenced to act on their behalf to enable them to cope with the illness. Two forms of coping were found: a *deferring* form, where participants took on a less active role and waited for God after turning over their condition to God, and a *collaborative* form, where participants engaged God in a mutual problem-solving process. It seemed that after participants have turned over their illness to God they followed it by collaborating with God to resolve their situation (provide healing). While it appears that a deferring style is associated with a reduced sense of control and personal competence in coping, a collaborative style appears to foster a sense of empowerment in the face of a difficult life situation (Pargament and Park 1995).

Christian religious faith and practices seemed to create a relationship between a person and an active Deity (God) in whom an individual can perceive that some help could come from (Osafo et al. 2013). Levin (2010) suggested that there is a considerable evidence to conclude that people's involvement in and identification with religious faith and practices seems to suggest optimism about their coping behavior. By this, Levin argued that a person's religious life has something to say about his/her coping behavior. When a question was posed about how patients coped with their condition, this was the response from one participant.

> I make sure to pray always…well everything is in the hands of God, God does everything or am I lying?… but yourself you know what you want, but God has the power….so it is in the hands of God; the future is unknown and so you just have to leave everything for God to take care of you (Participant V, 55 years).

In the quote above, the participant indicated that she makes *sure to pray always* as a way of coping with her condition. Leaving everything to God to take care suggests deferring the condition to God, while making sure to pray always suggests collaborating with God. Prayer seemed to be a way of expressing a personal relatedness with a benevolent God who is perceived as an active Deity and from whom some help could come. Prayer is a coping behavior which reduces the sense of isolation and increases a patient's sense of control over the illness (Gall et al. 2005; Koenig et al. 2001). For this participant, it seemed to imply that it will depend on God to regain control over her condition and fully recover from her illness. She indicated that God has the power to regulate the situation. Therefore, she has to leave everything to God since God can take care of her.

She also demonstrated future optimism and the need to not worry by adding that "so it is in the hands of God; the future is unknown and so you just have to leave everything for God to take care of you." It is important to notice that sometimes patients have little control over their health conditions which can create anxiety and relentless attempts to regain control. Koenig (2002) noted that religious faith seemed to provide an indirect form of control by breaking the cycle of anxiety and relentless attempts to regain control. In the present study, it seemed that Christian religious belief and practices seemed to be a useful utility that interrupted the cycle of anxiety and relentless attempts to regulate the distress associated with participants' illness. Gall et al. (2005) contended that in the case of trusting and believing in God, as exemplified by Participant V, the belief constitutes a coping

resource and that such religious beliefs may reduce the sense of loss of control and helplessness; it provides a cognitive framework that can reduce suffering and increase one's purpose and meaning in his/her condition (Koenig et al. 2001). Another participant emphasizes that Christian religious faith and belief can be a useful utility in coping and gaining control over the condition,

> Mm….I know God will help me and I know God…Not exactly so, but you have to pray and pray and worship God, because God is watching over me and if I have faith in Him; He can do all things…I have faith that I will be fine… (Participant IV, 46 years).

This participant seemed to imply that since God is almighty she will be fine and did not need to worry about her condition. God is all powerful and responsive to her needs; therefore, having faith in God and trusting God could ultimately lead to influencing God to act on her behalf. This participant has turned her health situation over to God which interrupted the otherwise cycle of trying to regain control over the condition and the participant stopped ruminating and worrying about the illness. Another participant had this to say:

> It (learning of the illness) was a bit surprising but it was OK; even though, truly, it was worrying to me…my wife too confronted me and told me not to be thinking about it too much, because God was going to heal me (Participant II, 58 years).

Participant II indirectly admitted to the expression of God's benevolence and all-powerfulness through his wife as his way of coping with his condition. It seemed that even though he was initially worried about his condition, his wife reminding him of God's power to heal him persuaded him to stop worrying about the illness. His belief coupled with a shared responsibility by praying to God, while God watches over him in return relieved him from his worries. This shared responsibility fostered a dyadic coping style: a deferring-collaborative style in which a person turns a health condition over to God, and while waiting for God to act on the person's behalf, the person collaborates with God through prayers in order to influence and validate an entitlement from God to act on his/her behalf.

One way religion helps patients to cope is by reducing the sense of losing control while increasing one's hope in the face of challenging health conditions (Koenig et al. 2001). The participants in the present study suggested that they can survive the future by means of their religious faiths, beliefs and the practices of prayer and worshipping God. This finding is similar to the findings by Osafo et al. (2013) who found that the kind of hope exuded by the participants in their study was different from what existed in the literature. Similar to the hope found in the present study, Osafo et al. (2013) found that the hope of the participants in their study stemmed from a religious perspective in which the participants perceived a connection between living and hope and also between death and hopelessness.

Christian Religious Faiths, Beliefs and Practices Engender Sense of Coherence

Religion seems to convey a sense of meaningfulness that provided a buffer for the participants against ruminating, loss and hopelessness. Religion contributed to elevate participants' purposes and meanings in their condition through benevolent re-appraisal. The search for meaning and purpose is important for survival and coping in difficult circumstances (Gunnestad and Thwala 2011). Antonovsky's sense of coherence (SOC)

(Antonovsky 1987, 1996) posits that if a person understands what is happening to him (comprehensibility), believes that the resources to cope are available to do something (manageability) and is motivated to cope (meaningfulness), he/she will have more strength to resist the stressor and be able to cope. When a question was posed about how participants see their life as essential hypertension patients and their efforts to cope, one had this to say:

> …I believe in God. God can do all things that you ask Him to do for you. Every day, every day but you see I also add a lot of prayers to this. For me I know by the grace of God I certainly will be healed and be happy too someday to come (Participant I, 55 years).

In this and other instances, the participants seem to be optimistic about their coping through their religious faith and beliefs. It seemed that it is their religious faith and belief that served as a means by which they make sense of their condition; their belief is more powerful than anything else and shapes their worldview. Participant I shows that he is waiting for God and implies that it is his faith in God which influences God to watch over him and to act on his behalf through collaboration—by praying. And this is how he manages his condition by doing something to influence his condition positively in addition to his positive outlook that gives him meaning in life despite his illness. Religion for this participant seemed to convey a sense of meaning in life and thereby provide a pathway to adaptive functioning. In the other similar instances, we can argue that the participants demonstrated a sense of coherence based on religion. This forms a resource that seems to have enabled the participants to manage their stress, reflect on their external and internal resources to mobilize them to promote effective coping and adaptive functioning in a health promoting manner.

In the quote by Participant I, was shown optimism and confidence when he implied that "…by the grace of God [he] certainly will be healed and be happy too someday to come." He shows that he has the available resources that enable him to do something about his condition through his faith in God and by praying. In Ghana, Osafo et al. (2013) found that prayers provided a means by which people reach God for support. Prayer is a coping behavior (Gall et al. 2005) which increases a person's relatedness with God and thereby prevents isolation (Koenig et al. 2001). Perceiving the benevolence and all-powerfulness of God, this participant seemed to indicate that the demands of the condition are worthy of engagement and commitment, hence his resort to "…add a lot of prayers…" This is also because the participant's religious faiths and beliefs provided an understanding of his condition and the resources to meet the demands of his condition that motivate him to sustain a health promoting agenda. According to Langeland et al. (2007), participants have a greater sense of meaningfulness (and typically a greater sense of the other two—comprehensibility and manageability) when they perceive the demands of a situation/condition worthy of investment and engagement.

Our participants showed that through faith, belief and collaboration with God, they could not only do something about their condition but also access sufficient resources to cope. For instance, one participant answered how he would describe his way of coping,

> I have no choice but to wait upon God…to help me find a proper medication to ease me of the illness and to protect myself (Participant III, 48 years).

This response was probed further to ascertain whether the participant did not believe that the medicines provided by the clinic were effective enough for treatment.

> Yes…..but it does not mean what I get from this hospital is not good. It is very good for me and I mean that I can get even a better one (Participant III, 48 years).

For Participant III, it seemed that the medication provided was insufficient for treatment. He seemed to imply that religious faith could lead him to obtain a better solution than the medication that is provided to him. Even though he does not downgrade the efficacy of the medication, it appears that he expects a better outcome of his condition by waiting upon God. This appears to be health promoting by retaining and preserving his hope for effective coping. He seemed to suggest a potential pathway to recovery by waiting upon God in addition to using medications.

Discussion

Generally, Ghanaians have been described as religious at the core of their being (Pobee 1992) and they observe religion in every aspect of their life from child naming to funeral (Acquah 2011). Their strong religious faith is embedded within their cultural framework. As a major cultural manifestation and a powerful social force (Assimeng 2010), it is religion more than anything else that pervasively shapes the worldview and participation in the sociocultural life of Ghanaians (Kwame 1996). For the participants in the present study, religion provided an opportunity to turn over their health condition to God and to follow it up by collaborating with God through prayers. This deferring-collaborative style of religious coping served a context-specific behavior in times of illness that provided an avoidance strategy to protect from conscious confrontation with a health condition. Christian religions in a way served as a coping mechanism and also as a resource that enabled the participants to manage their stress, reflect on their external and internal resources to promote effective coping.

When a stressor is appraised as controllable and a person has positive beliefs about self-efficacy and efficacy expectation, he or she is more likely to use effective coping strategies (Glanz and Schwartz 2008). How an individual views an event or a stressor is more likely to influence the type of coping strategy adopted. This means that when a person believes that he/she has the personal abilities to regulate and control a specific stressor and also has the belief that he/she is capable of performing the required behavior in order to regulate and control that specific stressor, then, ultimately, that person is more likely to use effective thoughts and behaviors to regulate the distress to gain control over the situation. It seemed from the interpretations of the study results that Christian religious faith and practices influenced how the participants in this study viewed their condition—*appraisal*, and the mechanism adopted to regulate and control their condition—*coping*. How the participants in the present study viewed and interpreted their condition and subsequently the type of coping strategy that was adopted (in reaction to how the condition was viewed by the participants) seemed to have some overarching Christian religious influence.

The belief in Christian religious practices replaced the belief about personal abilities to regulate and control the illness. Thus, self-efficacy—which focuses on personal abilities with regard to a specific condition, was replaced by personal beliefs in Christian religious practices. Additionally, efficacy expectation—which is the belief that one is capable of performing a behavior required to influence an outcome in a specific condition, was deferred to God to influence the outcome of the illness. The latter, in the broader religious coping framework, was described by Pargament (2001). Pargament suggested that religious people seek control of their condition by cooperating with God and engaging God in

a mutual problem-solving process, which is referred to as collaborative religious coping. Waiting upon God also seemed to enable participants to reflect on their internal and external resources to identify and mobilize them to promote effective coping and adaptive functioning in a health promoting manner.

It also seemed that the personal beliefs about religious faith and practices enabled the participants to construct positive meanings out of their conditions which in turn provided hope and optimism for their coping process. Pargament and Cummings (2010) argued that in religious coping, constructions of positive religious meanings are made out of a condition and associated with re-appraising the situation in religious term so that it is less threatening. This re-appraisal helps a person to not deny the illness but to accept it, which also reduces the threat of the illness.

To conclude, Christian religious faith, beliefs and practices seemed to have provided the participants with an avoidance strategy (albeit participants' compliance with the medical regimen), which protected the participants from conscious confrontation with their illness. The participants turned over their health condition to God and collaborated with God, and while waiting for God to resolve their situation, they re-appraised their condition in a spiritual (religious) way, reflected on and identified internal and external resources and mobilized them for effective coping. The re-appraisal seemed to reduce the impact of the illness on the participants. Turning over the health condition to God did not only result in a spiritual (religious) benevolent re-appraisal and some relief of the impact of the condition but also a belief in an "all powerful loving and responsive God [gave the participants] the sense that they can influence their own condition by possibly influencing God to act on their behalf" (Koenig et al. 2001, p. 355).

Recommendations

Through the use of a qualitative approach in this study, the role of Christian faith, belief and practice system in coping mechanisms and strategies has been highlighted. It is recommended that further studies explore the role of other religious faith belief and practice systems in coping mechanisms such as Islam and traditional religions. Engaging religious patients in religious coping would be a culturally relevant step in contributing meaningfully to the coping strategies and mechanisms of patients in Ghana. This should be exercised with caution since the religious coping framework requires adequate longitudinal studies to test the potential of mobilizing religious factors for coping across time (Pargament 2001).

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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