UNIVERSITY OF CAPE COAST

# SOCIAL SUPPORT AND RELIGIOUS FAITH AS DETERMINANTS OF HELP-SEEKING BEHAVIOUR AMONG MEN WITH BENIGN PROSTATIC HYPERPLASIA AT HOMEOPATHIC CENTRES IN GREATER ACCRA REGION, GHANA

BY

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# DECLARATION

**Candidate's Declaration**

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: …… Date: …..…….

Name: …….

**Supervisors' Declaration**

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: …….…….. Date: ……...

Name: ……

Co-Supervisor's Signature: …….. Date: …….

Name: ……

## ABSTRACT

The study examined social support and religious faith as determinants of Benign Prostatic Hyperplasia (BPH) patients' help-seeking behaviour at homeopathic clinics in the Greater Accra Region of Ghana. A cross-sectional survey was used for the study, and a questionnaire was used to elicit data from one hundred and forty-eight participants who were chosen through convenience sampling. The data were analysed using frequencies, percentages, multiple regression, simple linear regression, and mediation analysis with Hayes PROCESS. Among other aspects, the study showed that the association between social support and help-seeking behaviour of BPH patients was statistically significant. However, the association between religious faith and patients' help-seeking behaviour with BPH was not statistically significant. Again, the association between religious faith and help-seeking behaviour of BPH patients was not significantly mediated by social support. Based on these analyses, the researcher assumes that the variables significantly associated with BPH patients' help-seeking behaviour were support from family and significant others. The study recommended that patients living with BPH be sensitized and appropriately educated by practitioners on BPH related complications. These will lay the groundwork for health experts to offer client-centred and gender-specific assistance to clients, especially in Ghana.

KEYWORDS

Help-seeking behaviour

Social Support

Religious faith

Benign Prostatic Hyperplasia

Homeopathy

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DEDICATION

To my late grannies, Awushie Korkor and Auntie Bea.

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# CHAPTER ONE

# INTRODUCTION

This chapter offers comprehensive background information on Benign Prostatic Hyperplasia (BPH) from a global viewpoint down to the Ghanaian level. The chapter looks at the diagnosis, treatment modalities, and prostate enlargement prevalence. The background information sheds light explicitly on factors including social support and religiosity and how it influences the help-seeking behaviour of patients with BPH. The background also includes a description of the research issue, study intent, study goals, description of hypotheses, study importance, delimitation and study limitations, the definition of terms and study organisation.

## Background to the Study

Men's healthcare facilities usage varies dramatically with age as males under 16 years have equal, if not better, access to health resources than females (Courtenay, 2000, Wang et al., 2013). However, as males move past this age level up to 60 years, their health service utilisation declines with relation to their female counterparts (Wang et al., 2013). Facts based on the literature implies that men are hesitant to seek health care providers' support for various problems such as depression, drug abuse, physical disorders, and traumatic events in life (Tompkins, 2015, Banks, 2001, McKay et al., 1996).

While other factors may contribute to men's unequal access to healthcare, there is always an overarching belief that men will find courage in dealing with their health problems. Again, those who support and enforce these

ideas about masculinity in their own lives seem less likely to pursue preventive treatment. Moreover, they seem more likely to withhold treatment while suffering from medical conditions such as BPH, diabetes and other ill-health situations (Kraft et al., 2009).

Research denotes that BPH is amongst the most prevalent conditions among ageing males. Thus, as men age, incidence of BPH increases (Akpo & Akpo, 2011; Ali As-ghar, 2012). BPH is already confirmed in about 25 percent among males aged 40 and over and well over 30 percent of men over 65 years of age (Emberton, Marberger & De La Rosette, 2008). It has also been reported globally that by 80 years of age, over 80 percent of men will have BPH (Kumar & Clark, 2009). Furthermore, it is predictably the most prevalent cause of lower urinary tract symptoms (LUTS), and its effects tend to interfere with everyday life and diminish well-being. Thus, the impact of BPH can extend beyond the physical effects of the disease to include psychological and social problems such as anxiety, depression and insomnia (Kumar & Clark, 2009).

A significant problem in BPH-related science, considering predicting incidence or defining risk factors, seems to be the lack of a generally agreed case description, especially a case concept that can broadly be applicable in population-based epidemiological studies (Wanyangah, 2015). Although prostatic inflammation's root cause remains unknown, it plays a significant role in BPH's growth and progression. Lim (2017) also agrees with this assertion, indicating inflammation's potential role as a source of BPH occurrence. Lu and Chen (2014) also described ageing as the primary determining factor for BPH due to the hormone derived from regularly functioning experiments.

According to Lim (2017), biology, diet and lifestyle can also play a part in BPH development and progression. Again, researchers have explored an elevated likelihood of BPH with reference to a particular ethnicity. Some scholars claim no support for this, while others assume that statistics show a diminished risk in the Asians relative to the Western white population (Guess, Arrighi, Metter & Fozard, 1990). A follow-up assessment by Platz and colleagues (2000) showed a slight disparity in BPH between black and white males. One possible explanation for the racial disparity, the researchers noted, is that men of African origin may have a lower chance than whites to notify urinary tract symptoms to a physician (Patel et al., 2020)

The general direction of help-seeking behaviour of people with health conditions globally is to seek medical attention from healthcare facilities. However, this does seem to be apparent in most developing countries. In Ghana, for instance, some people commonly seek spiritual attention from churches and shrines other than hospitals for cure (Okraku, Ofori-Atta, Danquah, Ekem & Acquaye, 2009). In the same vein, while there has been an increased understanding of prostatic diseases in recent years, this has not resulted in improved screening and treatment of people in developing countries such as Ghana. Thus, help-seeking is a significant aspect that must be considered in BPH management (Moe, 2007). Help-seeking is a method of needing help and receiving it (Addis & Mahalik, 2003). Aiming for assistance makes patients feel less depressed and more contented by discussing their medical issue, seeking ideas or strategies to deal with it, having a new view on the situation, creating good partnerships, and preventing worsening of the medical condition.

From the literature, it has also been identified that some patients with a form of formal education have a better chance of showing productive help-seeking behaviour. Kamal et al. (2013) discovered that education level was an influential factor in deciding the living standards of men diagnosed with illnesses associated with prostate enlargement. Self-reported population studies have indicated that higher utilisation rates of specialist health facilities are often seen in persons with higher education (Vasiliadis et al., 2005).

Social support is an essential factor influencing help-seeking (Rothi & Leavey, 2006). Positive family and friends' responses have been described to promote decision-making (Moe, 2007). In a general context, social support refers to the valuable psychological and material services that can be effective and accessible to individuals experiencing stress (Kvande, Reidunsdatter, Lohre, Neilsen & Espnes, 2015). As a significant mediating factor, social support is also suggested to strengthen the interaction between religiosity and various health consequences (Koenig et al., 2012).

Religiosity has also been related to the frequency and efficacy of social networks, which leads to positive results for well-being, both mental and physical (Liu et al., 2012). Through interactions and shared experiences with others, individuals are encouraged to control their feelings, perceptions and behaviours that could affect health outcomes (Lakey & Orehek, 2011; Waldrop and Resick 2004). People find support to solve their problems; hence one's faith may significantly affect help-seeking behaviour (Nagai, 2010). However, some authors (Oman and Thoresen 2002, Aukst-Margetić, B., & Margetić, B. 2005) claim that religiosity can also lead to health issues across several avenues. For instance, some seriously ill patients rely on their faith without seeking

medical attention leading to poorer health outcomes. Additionally, patients with stronger beliefs focus less on their recovery due to their existential beliefs in the afterlife.

BPH diagnosis starts with a comprehensive medical history with a summary of the signs and symptoms from the urinary tract that the patient may experience (Gupta et al., 2006). While the occurrence and costs associated with BPH treatment remain considerable, the past decade has provided tremendous improvements in BPH knowledge with increasing stakeholder involvement in its management (Gupta et al., 2006). More than 75 percent of men above the age of 50 with symptoms related to prostatic enlargement, and 20 to 30 percent of men over age 80 need surgery as part of treatment (Roehrborn et al.,2009, Parsons & Kashefi, 2008). Patients with typical prostate enlargement symptoms are managed with alpha-blockers to alleviate the lower urinary tract (Lepor, 2011). BPH patients endure side effects resulting from surgical treatment and long-term sexual complications (Gerber, 2004). While helpful, surgical procedures are costly and have complications. According to Walles & Alamrew (2014), patients with BPH could explore available treatment alternatives and understand the treatment plan to alleviate fear and anxiety, as it may encourage compliance with the treatment regimen and prevent future complications. With the essential aim of medical treatment being avoiding disease development, homeopathy has been regarded as one of the treatment methods for BPH (Gupta et al., 2006).

Homeopathy is the world's second most frequently used health care system (Gupta et al., 2006) and is one among the most common Complementary and Alternative Medicine (CAM) methods globally. Although no definitive

conclusions can be made from data on the population, a few trends emerge. According to traditional medicine guidelines, CAM seeks to address medical problems that are difficult to treat or do not have encouraging or straightforward treatment responses (Bellavite, 2015). Generally, patients using CAM have high incomes, as they pay for these programs out of pocket (Cauffield, 2000). More recent findings show that doctors are more open to discussing CAM than patients consider (Cauffield, 2000).

Homeopathy often provides a reasonable care choice for patients with BPH since homeopathy treats without side effects and offers exceptional results (Gupta et al., 2006). A study by Reddy et al. (2009) had shown efficiency of homeopathic medicines such as Pulsatilla nigricans, Thuja occidentalis in older men's BPH care. Similarly, the homeopathy sector in Ghana has excellent talented professionals who assist in bringing change in the country's development and aid management of BPH in Ghana (Gerber, 2004). Additionally, homeopathy care has appeared helpful when some drugs have failed, as in the Bristol Homeopathic Hospital research (Spence, Thompson & Barron 2005). CAM's philosophy allows clinicians to properly listen to patients and discuss specific emotions and conditions with their patients, as these factors influence treatment. Homeopathy seeks to enhance patients' quality of life or well-being by prescribing individually chosen medications following the concept of similarity (Bellavite, 2015). Most mild to moderate prostate gland enlargement cases usually respond exceptionally well to natural treatment (Gupta et al., 2006).

**Statement of the Problem**

The problem of delayed appropriate help-seeking from men with different health conditions is widespread globally (Kraft et al., 2009). The diagnosis and appropriate treatment are further complicated by delays in seeking and receiving appropriate medical care for various health conditions leading to severe complications (Kraft et al., 2009). Moreover, inadequate attention is demonstrated towards the well-being of men globally, particularly in developing countries (Baker, 2002).

Society typically expects men to be strong, powerful, and unemotional. Also, men possess an unenthusiastic tendency to call for assistance should they face some physical health issues during their everyday lives (Winerman, 2005). Thus, men remain labelled as less likely to seek out for help in the face of a medical condition or concern (Gibbs, Oliffe, Macdonald & Crawford 2004). These create a significant gap in the interaction of male patients with physicians as men fail to establish either a short or long-term relationship with physicians (Kiss, 2004).

Despite attempts to decentralise the services, health facilities in Ghana remain underutilised by men. The help-seeking behaviour of Ghanaians appears to be dictated by their set of beliefs (Danquah, 2008). In Ghana, among the concerns associated with improving men's health is their reluctance to pursue health care facilities services.

Research on perceptions and attitudes to pursue medical assistance linked to prostate cancer have been undertaken by Yeboah-Asiamah, (2015). Other research conducted in Ghana focused on the awareness, prevalence, knowledge, perception, and screening of BPH among older men from 50 and

above (Mante 2018, Obu, 2014; Arthur et al., 2005). Nonetheless, there seems to be little information available as to whether social support and religious faith can influence men's help-seeking behaviour with BPH undergoing homeopathy care. Also, the purpose of social support and religious faith in BPH patients' help-seeking behaviour in Ghana is not clear.

Notwithstanding, studies on help-seeking behaviour have primarily been undertaken in western countries (Macdonald et al., 2004). Therefore, it is vital to identify how people seek support regarding their religious faith and social support networks in all types of health problems, how they end up dealing with these problems and how this ultimately affects their use of health services in Ghana. Given this problem, this study explores the psychosocial determinants of help-seeking behaviour of men with BPH.

**Purpose of the Study**

The study's main objective is to investigate psychosocial determinants of help-seeking behaviour among men with BPH at Homeopathic Centres in Greater Accra. The study also focuses on exploring the significant role of education on help-seeking behaviour among men with BPH. Specifically, the study intended to:

1. Determine the level of help-seeking behaviour of men with BPH.
2. Determine the level of satisfaction with homeopathy treatment among men with BPH.
3. Determine the impact of social support on the help-seeking behaviour of men with BPH.
4. Ascertain the impact of religious faith on the help-seeking behaviour of men with BPH.

5. Identify the role of social support and its mediating effect on religious faith and men's help-seeking behaviour with BPH.
6. Determine how educational level predicts the help-seeking behaviour of men with BPH.

**Research Questions**

The following research questions were formulated to guide the study.

1. What is the level of help-seeking behaviour of men with BPH?
2. What is the level of satisfaction with homeopathy treatment among men with BPH?

**Research Hypotheses**

$H_{0;}$ Social support will not predict help-seeking behaviour in patients with BPH

$H_1$ social support will predict help-seeking behaviour in patients with BPH

$H_{0;}$ Religious Faith will not predict help-seeking behaviour in patients with BPH

$H_1$ Religious Faith will predict help-seeking behaviour in patients with BPH

$H_{0;}$ Social support will not mediate the relationship between religious faith and men's help-seeking actions with BPH.

$H_1$ Social support will mediate the relationship between religious faith and help-seeking behaviours of men with BPH.

$H_{0;}$ Level of education will not predict help-seeking behaviour in patients with BPH

$H_1$ Level of education will predict help-seeking behaviour in patients with BPH

**Significance of the Study**

The research is essential as it will be beneficial to explain the help-seeking behaviour of men in Ghana. Secondly, most studies were conducted in western countries with a more individualistic culture than a collectivistic culture in Ghana. As such, this research will show whether Ghana's collectivist culture would make the results substantially different from those of individualistic cultures.

For men in the Greater Accra Region as well as other parts of the country, the study will help to explore how communication is successfully employed in the homeopathic management of BPH to ensure a sustainable doctor-patient relationship. Also, most research used a sample of both genders, while this study focuses on only the male gender. The findings from this study will therefore contribute to the existing literature on help-seeking behaviour among men with BPH. Furthermore, the study's findings will guide clinicians and policymakers in the management of BPH patients in Ghana.

**Delimitation**

This study was delimited to male patients with BPH above 18 years in the Accra Metropolis. The study was also delimited to three of the renowned homeopathy centres in the country, mainly based in Accra.

**Limitation**

There were some drawbacks to the study that are noteworthy. The first and most critical obstacle was indeed the data collection period, a bleak period of the COVID-19 pandemic; as such, only a limited number of people took part in the study. Thus, the generalization of the findings of the study is therefore constrained.

The study data were derived from a single region in Ghana, resulting in some degree of skewed outcomes. Also, to corroborate the data, more extensive, prospective and randomized studies are necessary. Furthermore, the study participants were recruited from only urban communities; hence, the study's findings might not apply to rural dwellers. The cross-cultural limitation might also be inherent in this study because most of the study sites were indigenous Ga communities; hence most of the participants representing the Ga ethnicity.

Low reliability scores from the pilot testing of 2 subscales was a significant limitation due to the number of participants used in the pilot testing. Although some estimates of Cronbach alpha were more variable with small sample sizes, results from the pilot study did not support this assertion because of the large number of participants involved in the study.

**The Operational Definition of Terms**

**Benign Prostate hyperplasia (BPH)** refers to the prostate glands non-cancerous enlargement, which is the most severe neoplasm in adult males and is a significant cause of urinary symptoms.

**Social support** refers to the different means of help and support offered by family members, acquaintances, neighbours, and others**.**

**Homeopathy** is a conventional Complementary and Alternative Medicine (CAM) treatment option that seeks to improve a person's health level according to the principle of similarity.

**Help-seeking behaviour** is seen as a series of actions or steps taken of one's own free will to seek others' advice.

**Religious faith** refers to beliefs and behaviours linked to a supernatural force that influences everyday life decisions.

**Organisation of the Study**

The research is subdivided into five chapters. The introduction is discussed in chapter one of the work. Chapter one consists of the study background, the problem statement, the study purpose, the significance, and the study organization.

Chapter two focuses on the work which deals with the theoretical, conceptual and empirical literature. Chapter three addresses the methodology used in performing the study, including the research design, population, sample and sampling procedures, the research instruments and data collection methods used, and data analysis. The analysis and the discussion of the findings are discussed in Chapter Four. In the final chapter of this work, the summary, conclusions and recommendations are provided.

# CHAPTER TWO

# LITERATURE REVIEW

This study chapter discusses related literature regarding the impact of social support and religious faith on BPH patients' help-seeking behaviour. The review of the literature was grouped into a theoretical framework, conceptual framework, and empirical review. Information on the social support's influence and religious faith of men with BPH was compiled from publications, abstracts, the internet, books, and other people's efforts.

## Theoretical Review

### Help-Seeking and the Theory of Planned Behaviour

Research on help-seeking usually reflects three main areas: attitudes (belief and willingness) to seek support, motivation to seek assistance, and real behaviour to seek help (Gulliver, Griffiths, Christensen & Brewer, 2012). Data indicate that actions are predictors of attitudes and intent.

### The Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) claims that the study of one's behavioural nature will predict one's intention to perform actions (Ajzen, 1985; 1991). The TPB underlines the importance of using a multidimensional view to consider the effect of an individual's desire to carry out a behaviour. For instance, if an individual is most affected by social standards as opposed to seeking help (for example, beliefs with strong negative perceptions), an effort to influence that person's intention to seek treatment may be thwarted if a change of attitude is the primary objective of an intervention (Hartong, 2011).

It is a further evolution of an earlier Theory of Reasoned Action (TRA) derived from social psychology. Help-seeking TRA was established to predict motivation or desire to seek support and provided a correlation between values, perceptions, purpose, and behaviour. In addition to a measure of subjective norm introduced in the theory of reasoned action (TRA), TPB introduced behavioural regulation. Both models emphasize the role of decision-making and seek to explain the implied associations between attitudes and behaviours (behavioural intent as a significant precursor to actual conduct) (Pitts & Phillips, 2003; Brannon & Feist, 2007; Albery & Munafo, 2008). TPB emphasizes that action is planned and that preparation is partly a feature of a person's actions. The model defines intent as the most critical behavioural determinant (Pitts & Phillips, 2003).

The theory suggests that intentions are the product of the following beliefs: attitude towards an action, either a genuine or adverse assessment of a particular action and expectation on the result of the behaviour, subjective norm consisting of the understanding of social norms and the pressure to perform a behaviour and an assessment of whether the participant is driven to comply with it (Albery & Munafo, 2008). According to the TPB, those three variables predict behavioural intentions linked to actions (Pitts & Phillips, 2003). TPB emphasizes that the more resources and incentives people think they have, the more strongly they feel they can regulate their actions (Brannon & Feist, 2007). The TPB also notes that behavioural performance is influenced by both motivation (intention) and ability (behavioural control), thus distinguishing the three types of beliefs -behavioural, normative, and regulation (behavioural, moral, and power). Many believe our actions are what define our behaviour.

However, the expected behaviour hypothesis implies more predicting actions than just understanding one's mood (Conner & Sparks, 2005).

According to Hagger & Chatzisarantis 2005, The TPB consists of five mechanisms that collectively constitute the actual regulation of an individual's behaviour. These include the following.

Attitudes refer to the extent to which an individual has a beneficial or harmful outcome of unusual behaviour. One's attitude requires remembering the effects of executing the behaviour.

Behavioural intention also applies to the motivating factors influencing the behaviour in question, where the more significant the intention to conduct the behaviour, the more probable the behaviour is.

Subjective expectations refer to the belief that other people endorse behaviour or disagree. It refers to a person's convictions about how peers and people believe they should be involved in the behaviour.

Social Norms describes the traditional behaviour codes in a community, individual, or broader cultural context. Social norms in a community are deemed customary or natural.

Perceived behavioural regulation applies to a person's sense of ease or difficulty in executing a new behaviour. Perceived behavioural regulation differs between circumstances and behaviours, resulting in an individual having different behavioural control expectations depending on the situation.

This theory is essential to explain the present research based on evidence that there is a substantial amount of work showing that the Theory of Planned Behaviour is valuable in anticipating health behaviours (Armitage & Christian,

2003). This theory thus predicts deliberate behaviour since actions can be intentional and organized.

The TPB has many drawbacks, including the following:

It implies that an individual has acquired the resources and possibilities to achieve the desired behaviour Regardless of intent. Also, other variables factoring in behavioural intent and motive, such as fear, anger, emotion, or experience, are not considered. Considering normative causes, it does not consider environmental and economic factors that can affect a person's intent to behave. Finally, it assumes the behaviour results from decision-making in linear processes and does not consider variations in behaviour over time.

**Theory of Religious Effects**

Kenin (2018) argued that the Theory of Religious Effects illustrates how religiosity and spirituality influence an individual's overall health. The theory argues that religiosity's advantages to individuals exist within the framework listed under three key factors: social and organizational relations, acquired skills and moral order (Smith, 2003). In a study involving the elderly, Chokkanathan (2013) used this model while Smith (2003) used it mainly among the youth. The factors that come under moral order have much to do with acculturation into religious belief structures and having an outlet that makes sharing specific conventional values natural (Kenin, 2018). Also, the paradigm of Chokkanathan (2013) establishes acquired skills and social relations as underlying concepts. Acquired skills apply to skills learned when one engages in confidence-building religious activities and gives access to various cognitive and behavioural coping skills (Kenin, 2018).

Social and organizational relations highlight the relationships which offer interaction opportunities. This relationship can eventually transcend the walls of churches and religious organizations. Simultaneously, in separate religious institutions, these variables may or may not be found in the same volume or consistency (Kenin, 2018). Different observational results have shown that healthy well-being, often linked to higher religiosity rates, often goes beyond the advantages of various tools, including access to social and community networks, marital status, and income alone (Koenig & Larson, 2001).

Through religious traditions, people learn to focus on caring for other's needs, forgiving others, and displaying compassion and empathy. Routines from religious organisations can contribute to distracting people from their issues and therefore encourage positive psychological outcomes. Religion also engenders social bonds and interactions that go far further than family relationships and play a supportive role in times of stress and suffering (Chokkanathan, 2013; Koenig & Larson, 2001). While this theory establishes a conceptual framework for comprehending how religion relates to human behaviour, it does not emphasize how individual psychological factors could affect this relationship. Thus, social and cultural practices, typically enshrouded in religious belief, surround people's beliefs about illnesses and health care (Okyerefo & Fiaveh, 2017).

**Biopsychosocial Model to Help-Seeking Behaviour**

The Biopsychosocial (BPS) model discusses biological, psychological, and social influences that play an essential role in providing wellness and health care in human development (Santrock, 2007). Engel (1977) established the

pattern. The biological dimension explains how the cause of the disease occurs from body cell dysfunction. The psychological dimension looks for psychological triggers for a health problem. The social dimension explores how health may be influenced by societal influences such as culture, socio-economic class, social support, and religion. The BPS model is premised on the idea of social cognition. It discusses the claim of the "mind-body relation," which, on a conceptual basis, could be understood that the working body will influence the mind as well as the other way around (Halligan & Arylward, 2006). Hence the components must be treated as a body of interaction that influences an individual's health and well-being, contributing to a more comprehensive care model that considers a patient in their most entire whole.

The concept has been developed to also include spiritual component, and many researchers have supported this. A study by Katerndahl (2008) recognises the importance of the spiritual symptoms and how it interacts with healthcare and its outcomes. Sulmasy (2002) also justifies the inclusion of the spiritual component as it further addresses the totality of the patient's existence. These ultimately lead to a more comprehensive form of care (Sulmasy, 2002).

Consumer perceptions of health and its barriers in the social or cultural domain affect patient participation in treatment behaviour (DiMatteo, Haskard, & Williams, 2007). For this research, the biopsychosocial model is essential because it aids our understanding of the role of biological, psychological, social and spiritual variables in help-seeking.

## Conceptual Review

### Benign Prostatic Hyperplasia (BPH)

BPH seems to be the most prevalent prostate disease among men worldwide (Kirby, 2000). All people over 50 years are at an increased risk of BPH (Smith et al., 2014), affecting approximately 50% of people aged 51-60, and up to 90% of people aged over 80 (NIDDK, 2014). BPH is chronic and significantly grows in prevalence and symptomatology as men age (Pettaway et al., 2011).

BPH refers to the prostate glands' non-cancerous enlargement. Physiologically, the prostate goes through two primary developmental cycles. The first takes place when the prostate expands to double its original size, early in puberty. The second progression starts at the age of 25 and lasts for much of a man's life. However, some risk factors, such as age, race, androgen, diet, genetics, tend to precipitate the prostate's continuous swelling, resulting in its benign enlargement (Mante, 2018). Symptoms are mainly lower urinary tract symptoms (LUTS), which include waking up to urinate at night, urgency, frequency, urine incontinence, and the failure to clear the bladder fully and sluggish urine stream (Wang et al., 2015) and erectile dysfunction (Obu, 2014).

Although BPH rarely results in symptoms before the age of 40, the incidence and symptoms advance with age (O'Sullivan et al., 2004) and do not raise the likelihood of prostate cancer, but BPH and prostate cancer symptoms can be comparable (Silvera-Ndure, 2016).

A Nigerian hospital study recorded an 88% prevalence of BPH comparable to an Ethiopian hospital study with an 84. 4% prevalence (Adegun & Popoola, 2011). In India, however, there was a lower prevalence of 40 per

cent (Berhanu, 2008, Rao et al., 2004). A survey showed that 88.9 per cent of men between the ages of 50 and 90 had BPH in the Kumasi metropolis in Ghana (Kenneth et al., 2016). Although not fatal, BPH is followed by severe morbidities such as depression and reduced health-related quality of life such as sleep and psychological difficulties (Wang et al., 2015), which pressures an individual's mental health (Parsons, 2010).

**Aetiology of BPH**

The exact mechanism causing BPH is not fully understood (Mante, 2018). However, risk factors associated with the condition's development are present, including age, race, androgen, diet, genetics, and growth. Since no identified causes of BPH exist, there are no known ways of preventing it. However, improvements in lifestyle may help stop BPH's symptoms from worsening and help alleviate symptoms. Males develop testosterone, a masculine hormone, and decreased estrogen levels (female hormone) in their lifetimes. The amount of active testosterone in men's blood diminishes as they age, leaving a higher proportion of estrogen in their blood., enhancing the development of substances stimulating prostate cell formation (NIDDK, 2014).

Another hypothesis is on dihydrotestosterone (DHT), a hormone produced by men that aids in the growth and progression of the prostate. Studies show that older men tend to develop and maintain elevated DHT levels in the penis, even with decreased testosterone levels in the blood (NIDDK, 2014). The accumulation of DHT may promote the continued growth of prostate cells.

Historically, BPH diagnosis and treatment has generally been symptom-surgically-driven, respectively. However, the care approach has changed from surgical intervention to medical management, mainly due to a concerted attempt

to change early illness rather than merely symptomatic control (Pettaway et al., 2011). The responsibility for finding treatment rests with both the doctor and the patient. The doctor must clarify all the treatment choices to the patient, and it is the patient who makes the final decision about his choice of treatment based on the doctor's advice (Mante, 2018).

**Diagnosing BPH**

A urologist uses medical tests to help determine and administer treatment for BPH. Medical tests can include urinalysis with a prostate-specific antigen (PSA) and a urodynamic test with a transrectal ultrasound biopsy. PSA is a protein that the prostate gland produces and is measured within the blood. Enhanced rates above four ng/ml suggest that the prostate gland has an abnormality (CDC, 2013). One of the initial steps that a health care professional can take to help detect stable prostatic hyperplasia is to take the patient's clinical history and family life.

A Digital Rectal Examination (DRE) is a physical examination of the prostate, requires prostate gland palpation to be tested for any growth anomalies (CDC, 2013). The test lets the health care professional check to discover if the prostate is bloated or tendered or whether any anomalies need further inspection.

**Treatment of BPH**

Good treatment choices for BPH may include dietary changes, drugs, minimally invasive treatments, surgery. It takes several years for signs of early BPH to become embarrassing problems. Lifestyle changes may include limiting the consumption of fluids prior to heading out to the public or before bedtime, preventing or minimizing caffeinated beverages and alcohol consumption,

restricting or regulating the use of pharmaceutical items such as decongestants, antihistamines, antidepressants, and diuretics (NIDDK, 2014).

Medications used to treat BPH may often have severe adverse effects. Urologists use the transurethral technique to perform minimally invasive procedures involving injection into the prostate through a catheter into the urethra. Further studies have shown that about 15% of patients with healthy sex life before BPH developed had surgery performed on them to correct erectile dysfunction (ED), particularly among middle-aged patients (Wang et al., 2015).

**Help-Seeking Behaviour**

Some individuals may unexpectedly face conditions that challenge their health efficiency and eventually trigger a dynamic process of adopting appropriate help-seeking behaviour (Harrison et al., 2001). During the last three decades, the medical profession has undergone a silent revolution. Patients are brought into the decision-making phase of treatment as never before. The growing use of joint decision-making has changed the way patients and their doctors communicate. The varied treatment choices result in near-equivalent results for many conditions. More recently, the internet's democratization of medical knowledge has made the patient a much better-educated user, and thus a more involved participant in their treatment (Hellenthal & Ellison, 2008).

Help-seeking behaviour is seen as the series of actions or steps taken of one's own free will to seek help from others through the exchange of information relating to their challenges with a feeling of expectation of getting the necessary help through guidance, support and receiving medical care in response to their challenges (Asamoah-Adjepong, 2018). Often affecting the decision to seek treatment is a person's social and economic standing, the degree

to which the individual is anxious about the symptom and its duration. (Katung, 2001; Amaghionyeodiwe, 2008).

In Ghana, almost all medical problems called in are attended to at the in public medical hospitals and clinics for care. Still, treatment is primarily restricted to conventional methods as the ideal treatment modality (Asamoah-Adjepong, 2018). A more comprehensive motive for the choice of help-seeking behaviour lies in the firm belief that one may return to the normal state of health and overcoming the complications of a condition after receiving adequate treatment. Visiting healthcare providers, both formal and informal, are all principal determining factors to managing BPH. In the same vein, Azu et al. (2018) note that some men also self-medicate and directly purchase drugs over the counter.

Psychosocial determinants of help-seeking behaviour are most widely considered and have been extensively used as different coping resources when an individual is exposed to any adverse life event. These psychosocial determinants, such as religious faith and social support, have emerged as powerful platforms and play an essential role in addressing how people deal with these uncomfortable life events such as BPH and other long-term illnesses (Aslund et al., 2014). However, these resources' relative importance has been subject to considerable discussion, particularly when people are exposed to adverse life events that are primarily life-threatening (Navarro-Abal et al., 2018).

Nuworza (2013) establishes that there are numerous health outcomes concerning patients enduring any form of illness. Medical management is usually the most reliable option for patients with chronic disease and is

practically determined by their social factors and behavioural components. Acting on the social and behavioural factors relies on how patients appraise their illness. These factors will determine how the patient acts in response to the chosen treatment protocols.

Notwithstanding, several individuals are still hesitant and disinclined to seek assistance in any form. Thus, some studies conducted linked a person's choice to request help to factors such as age, sex, educational standings, social support networks, and religion, as well as other factors like cultural beliefs, stigmatization, accessibility, and treatment (Barwick, de Man & McKelvie, 2009; Doherty & Doherty, 2010; Andrews, Stefurak & Mehta, 2011; Girma & Tesafe, 2011; Boafo, 2013). Moreover, the demographic characteristics that include their educational status are investigated to ensure their roles in the individual's help-seeking behaviour.

**Level of Education and Help-seeking Behaviour**

The educational status is also crucial to their health and well-being. Recent investigations have associated a level of education with the intention of whether to seek help or not seek advice when faced with unfavourable circumstances that have damaging consequences. These circumstances could be mainly physical or psychological (Zimmerman, Woolf, & Haley, 2015).

It is well recognized that social impact plays a crucial role in the health outcomes apart from the treatment received at the health facilities. Social health factors, such as education and income levels, bring significant disease improvements (Mante, 2018). It is also believed that an individual's geographical location and the rules that regulate the individual also play an important function in morbidity and mortality.

**Homeopathy**

Homeopathy is gaining increasing popularity with the lay population among the various complementary and alternative medicine (CAM) in Ghana. Originating from Christian Friedrich Samuel Hahnemann's ideas and experiments (1755–1843) in the late eighteenth century, homeopathy is the sole Western medical technique that has 'survived' medicine in the present times (Bellavite, 2015). Along with its scientific origins, the work of Vigano et al. (2015) explores the historical and philosophical foundation of homeopathy. The report stresses that homeopathy has arisen as an experimental field instead of emerging from a series of empirical theories. Homeopathy is a form of medical practice that seeks to strengthen a person's health level by prescribing chosen medicinal ingredients according to the principle of similarity (Teut et al., 2010). Since homeopathy is entirely individualized and considers the physical, social, behavioural, cultural, biographical, and environmental circumstances, it is a whole person's medication (Bellavite, 2015).

Homeopathy remains a standard treatment option worldwide, with growing numbers of people preferring it for a comprehensive and individualized treatment. Recent studies show that many people adopt, use, and value homeopathy as a supportive treatment option. Homeopathy is estimated to have more than 200 million users worldwide (Manchanda, 2018). The WHO Traditional Medicine Strategy 2014–2023 also endorses homeopathy to ensure traditional medicines' safety, effectiveness, and efficiency. Furthermore, taking into account the resolution on traditional medicine adopted by the World Health Assembly in 2003 and the findings of the World Health Organization's Global Survey on Traditional Medicine (World Health Organization, 2005), the WHO

aims to provide the Member States with technical assistance in developing an active research system, with recommendations and testing and evaluation methodologies to ensure quality (Manchanda, 2018).

**Social Support of BPH Patients**

Research has demonstrated several challenges that affect men after being diagnosed with BPH, further impacting their physical role function, energy level, social functioning, and mental ability (Emberton & Martorana, 2006; Mante 2018). Hence, the need for social support.

In Ghana, as in many other countries, the magnitude and quality of social support received by older adults facing life-threatening issues may differ based on their gender and ethnic background. This situation reasonably indicates a variation in levels of social support made available to older adults as they face adverse life events. Social support is vital to everyone, regardless of the essence of one's condition.

While a variety of definitions of the term social support has been proposed, this study will consider Amissah and Nyarko (2020) elaboration of social support, as they saw it as the multiple facets of social interactions that are convenient to most individuals in the most challenging periods of their life when faced with anxiety-ridden events. The concept of social support remains complex, but Ayernor (2016, p. 98) has adopted a broader perspective, presenting social support as "various forms of aid and assistance supplied by family members, friends, neighbours and significant others".

Older people who are rooted in more extensive, more profound, and more stable social networks have more excellent health, both physical and mental; they continue to live with fewer symptoms of psychological distress and

longer lives than those who are lonely and isolated. (Holt-Lunstad et al., 2010; Smith & Christakis, 2008). Social support serves as an essential resource that aids many old-aged individuals the majority of developing nations, including Ghana. However, this is quite different concerning the various ethnic groups in Ghana and differs by gender in most older adults in Ghana. In general, social support can be classified into two groups, namely, structural and functional support. Structural support describes the availability of numerous close social links that an individual holds on throughout their lives. Whereas structural support concentrates on the numeral depths of relationships, functional support focuses on the social networks available to older adults, consisting of esteem support, informational support, and instrumental support.

All these forms of social support have substantial out-turn on individuals' health and well-being (Cohen, 2003; Uchino, 2004). However, it is crucial to understand that known structural factors such as the size of one's household, social interaction involvement, and perceived relationship content are directly related to a person's well-being. These suggest that although the absence of social ties may be slightly damaging to health and well-being, attention must be given to the quality of existing social relationships. Therefore, social support establishes itself as necessary when considering moderating the impact of BPH. Additionally, other researchers have looked at social support and its connection to health and well-being and have found BPH as an obstructive incident in one's life, stressful whose results can be curtailed earnestly through social support (Burns & Machin, 2013).

**Religious Faith of BPH Patients**

While the historical connections between healthcare and religion are well known, only in the last few years has the medical literature been more interested in studying the function of religious and moral views and their impact on patient outcomes. (Bjarnason, 2007). There is interest within the health care community related to understanding the influence of religious faith on patient care and those who support patients in the health care environment.

Religious faith as a concept offers several viewpoints which investigate the cognitive, emotional, and behavioural dimensions as one embraces a precise system of religious beliefs. Although religion has been a subset of spirituality, every religious person is seen as spiritual (Rusu & Turliuc, 2011). Sedikides (2010, p. 3), in a brief and clearly expressed manner, defined religiosity as "beliefs and behaviours linked to a supernatural force". Religion is a vital part of daily life for a sizable percentage of the population. In a Gallup poll in 2009, 64% of those polled responded "yes" when asked if religion is a significant part of their everyday lives (Gallup, 2009; Crosby & Bossley, 2012). Whenever religion is at one's disposal and easily accessible, an individual is likely to adopt the religious dimension to tackle challenges when human resource restrictions become clear. Religion thus becomes the ideal choice for seeking help considering the condition the individual is subjected to. According to Harrison et al. (2001), the most extensive survey studies usually ascertain an individual's religious involvement and participation, for example, frequency or prevalence of church attendance or prayer.

The worldly accepted confirmation indicates that women have a higher religiosity levels than males (Herstad, 2009). Being the principal character, women hold on to their beliefs with resolute determination, exercise their faith more constantly and working as a potent force for the congregations. Especially in Ghanaian society, religious faith is valued as a resource that benefits individuals through adverse life events (Ghana Statistical Service, 2012).

Persons who adopt religious dimensions as a process of seeking help use their faith to understand why adverse events happen to them. Help-seeking behaviour that adopts the religious dimension to deal with a health challenge is typically backed by social, personal, and situational factors.

**Empirical Review**

**Help-Seeking Behaviours of Men**

It has been stated that men do not often utilize the available treatment services and exhibit an unwilling and hesitant behaviour to seek early healthcare interventions and their associated services (Azu et al., 2018). However, men's characteristics may be attributed to unawareness or disinterest in their health issues as they do not seem troubled by it (Azu et al., 2018). Enhancing healthcare habits like finding medical assistance is one clear means of improving men's lives. Recognized gender inequalities in health services should be used in public health platforms to increase awareness of the men's reluctance to seek appropriate medical help.

Lange et al. (2001) claimed that males might have a higher propensity to drop out of a treatment program than females, accounting for female predominance in statistics on care. Feagin (2019) also indicated that if men undergo a shift in care, they are more likely to withdraw from care faster than

women, thereby explaining some discrepancies in treatment data. Sandén, Larsson and Eriksson (2000), in a study in Sweden, noted participants initially found medical problems to be anything capable of curing itself (for instance, a common cold) and seeking professional guidance was thought unusual for people in general. The study discussed above (Sanden et al., 2000) has consistently shown that, on average, men of varying ages, ethnic classes, and socio-economic classes are less likely to seek medical attention for physical health issues. People's apparent inability to find support is in direct contrast to the scope and nature of the issues affecting them.

Recent findings provide a fertile base for further study of the trend, highlighting essential themes of male well-being, religious faith, social support networks, masculinity, and behaviour-seeking assistance (Galdas, Cheater, & Marshall, 2005). In Africa and most cultures, getting any health condition that becomes a challenge to one's life is mainly attributed to some force beyond the scientific understanding of nature's natural laws. Additionally, most religious people interpret these manifestations as retribution for men's unacceptable behaviour, thereby tagging them as supernatural inflictions (Azu et al., 2018).

**BPH in Ghana**

Previous research (Mante, 2018) within the Ghanaian community showed that 83.6 per cent of participants had Prostate-specific antigen (PSA) rates above the upper reference range limit (4.0ng / ml) with a range of ages from 56 to 85. The predisposing factor for urinary retention and haematuria in adult men is BPH based on ultrasonic abdominal examinations at Korle Bu Teaching Hospital (KBTH) (Mante, 2018). Prostate enlargement among 40 to 70-year-old Ghanaian men is estimated to be 64 per cent (Obu, 2014).

Histological evidence of BPH can be seen in about 20 per cent of men 40 years of age, a figure that increases to 70 per cent by 60 years of age and to 90 per cent by 70-year (Kumar et al. 2005).

The Korle-Bu Teaching Hospital (KBTH) announced that 30% of genitourinary cases were BPH in their 2012 Annual Report (Mante, 2018). Cases increased between 5years (from 2012 to 2017) to 79 per cent, indicating a significant rise in the number of cases with BPH (Mante, 2018). Fifty percent of patients seen at the urology clinic at Komfo Anokye Teaching Hospital had BPH based on their 2016 Annual Report.

A demographic survey conducted in Ghana recorded an incidence rate of BPH in 19.9% of men between 45-60 years of age and 62.3% for men over 65 years of age, using the Digital Rectal Examination (DRE) and the International Prostate Symptom Score (IPSS) as an evaluation tool (Obu, 2014). On the other hand, ultrasound BPH prevalence observed an enlarged prostate of 40 percent among men between 31-90 years (Obu, 2014). While BPH is not fatal, its clinical expression as LUTS diminishes the patient's quality of life (Barry, 2010). There would also be adverse impacts on the quality of life (QOL) of patients and families due to high medical expenses (Speakman et al., 2015). Many of the untreated BPH cases causes the entire patient household to face a more significant economic problem (Wang et al., 2015).

**BPH and Help-seeking Behaviour**

Prevalence values for BPH in Ghana are at disposal, but available statistics and facts for analysis on individuals help-seeking behaviours are limited. A sympathetic awareness of men's knowledge of BPH and its aetiology and the various determinants that influence a person to seek or not to seek help

is crucial for the successful treatment and management of the enlargement of the prostate. Many works conducted in Ghana focused on recognition, prevalence, understanding, interpretation, and BPH screening among older men (Mante, 2018; Kenneth et al.2016; Obu, 2014; Arthur et al., 2005). Also, research at Komfo Anokye Teaching Hospital on BPH centred on screening, understanding, and evaluating prostate disorders (Kenneth et al., 2016). However, research on the quality of life of BPH patients in Ghana is inadequate.

Men's help-seeking behaviour related to BPH is often delayed or postponed in low and middle-income countries like Ghana. There is a demand for early treatment-seeking care for all prostate-related conditions and, more specifically, BPH as it has a psychological toll on the individual.

According to Mante (2018), the only significant reason patients seek medical advice is when they cannot control BPH symptoms. Mante (2018) performed a cross-sectional sample of males attending Komfo Anokye Teaching Hospital's urology department diagnosed with BPH to determine the patients' predicted quality of life. This study finds that the quality of life expected for patients with BPH is low.

Aspects that helped most people deal with BPH were their religious/spiritual values and faith, the available support services, family, significant others and friends, and individuals' optimistic disposition to seek assistance in handling and to treat the disorder (Sharma et al., 2016). Positive help-seeking behaviour was found in 44 per cent of people who reported their issue to a doctor within a month (Deep et al., 2010). A more substantial fraction of the literates were conscious of an enlarged prostate's possible signs and engaged as their first step the services of a professional health care practitioner.

After being referred, more literates visited the health care facility and had complete confidence in the allopathic form of medicine (Deep et al., 2010). The study further found that most BPH patients were unaware of their disease, and their health-seeking behaviour was low and may be pertaining to literacy. The report demonstrates the need for a public advertising program aimed at the younger male demographic to ensure early diagnosis and treatment (Deep et al., 2010).

Surveys on the treatment of BPH reveal variations in patient preferences and physicians' opinions. For patients, prevention of the development of BPH is an important goal. Despite this, clinicians appear to underestimate patient fears concerning health conditions; this is reflected through the predominance of medical treatment prescriptions directed at offering symptom relief (Harkaway, 2007).

The lack of a better understanding and information regarding BPH exposes most of the male population to the possibility of experiencing the extreme effects and accompanying BPH symptoms and their associated implications, which could be physical or psychological. Ignorance and misinformation about the mode of progression of BPH and its related conditions are substantial barriers to seeking treatment.

**BPH and Homeopathy**

Since the beginning, homeopathy has exhibited a dual complexity. One is a systematic approach seeking to treat the patient (individualized treatment); the other is a method based on data utilizing unconventional methods (Bellavite, 2015). Homeopathy's key challenge is determining their treatment's validity using strict statistical supporting evidence (Vigano' et al., 2015).

Homeopathy views life and energy source as not material but spiritual (Sharma et al., 2016). Homeopathy also attracts scrutiny for its plausibility, health, and efficacy despite the increasing prevalence and facts. Homeopathic treatments have been viewed as low-risk therapy with side effects as compared to traditional or conventional care. In measuring the standard of health care, patient satisfaction has also been recognized as a significant consideration (Marian et al., 2008).

The proportion of patients receiving homeopathic care has increased by fourfold over the last seven years (Teut et al., 2010). A study in Germany showed that about 10% of males and 20% of females in the general population used homeopathic medicines in the previous year (Teut et al., 2010). Homeopathy's increasing success comes to the importance of building on scientific evidence. As a result, there is a growing pool of evidence for the empirical and logical understanding of homeopathic medicine mechanisms; numerous clinical trials have appeared in indexed journals demonstrating the efficacy of homeopathy, along with systematic reviews and meta-analyses (Machanda, 2018).

Gupta et al. (2010) conducted clinical research that revealed the efficacy of homeopathic medications such as Lycopodium, Pulsatilla, Sulphur, and Calcarea carb. Other empirical work on BPH, an essential contribution from (Oberai et al., 2012; Dole et al., 2012; Hati et al., 2012; Weinstein, 2008), has shown the efficacy of homeopathic drugs in treating BPH.

A joint study was organized between the Central Council for Homeopathy Research (CCRH), New Delhi and the Lucknow Homeopathic Research Foundation. A total of 121 patients enrolled, 43 of whom completed

protocol-based research. Trial drugs chosen based on homeopathy principles were administered, International Prostate Symptom Score (IPSS), Ultrasonography, Uroflowmetry and Prostate Specific Antigen (PSA) were measured before and after homeopathic care. The variation in mean values of IPSS, prostate weight, PSA and average flow rates were considered statistically significant after comparing the pre-and post-treatment outcome. Results obtained from the study were promising, with findings that 93 percent of patients clinically improved with proof of significant improvements in diagnostic parameters (Gupta et al., 2010). This research shows that homeopathy can provide a safe, non-surgical, and successful treatment for massive BPH cases. However, there is a need for randomized control trials to confirm the role of homeopathic medicines in the event of enormous prostatomegaly (Gupta & Singh, 2016).

**Level of Education and Help-Seeking Behaviour of Men with BPH**

In the general context, education means possessing or acquiring knowledge in a broader sense. Some studies have related the education level of people (tertiary education, secondary education, or primary education) to seek help or not seek support for their health issues, including physiological and psychological health problems. Some researchers have claimed that people with tertiary and postgraduate degrees are more likely to understand their mental health challenges and are also more likely to obtain clinical psychiatric help than those with basic educational backgrounds (Zimmerman, Woolf, & Haley, 2015; Goldman & Smith, 2011; Olshansky et al., 2012).

A study of 502 men with BPH showed that two-thirds of patients discovered that they had prostate problems, one-third acknowledged that they

had BPH, and practically one-third felt that their symptoms might be related to prostate cancer, and these were mainly those with lower education (Emberton et al., 2005). Kamal et al. (2013) stated that education among patients with BPH substantially affected the quality of life. In comparison, relatively few findings have concentrated on the association between behaviour requiring specialized therapeutic support and education level. For example, Andrews and colleagues (2011) conducted a study that sought to explore the relative contributions of education, gender, age, history of psychological therapy, involvement in religious service, and religious problem-solving in determining attitudes about seeking psychological assistance.

They tested one hundred and eighty-nine participants who had either a Master's or a Bachelor's degree, made up of both college and community samples. Results found that Master's degree participants had slightly more favourable views towards psychiatric disorder help-seeking and a greater desire to access professional resources. However, Andrews and colleagues (2011) concentrated only on participants with tertiary qualifications, causing a void due to their failure to extend to other stages of education, such as those with a history in primary and secondary education.

Another research by Yuan and colleagues (2016) aimed to examine the underlying influences between the Singapore's general populace and the sociodemographic correlates of each factor in the Attitudes to Mental Illness questionnaire. The study used a cross-sectional survey and sampled three thousand and six participants from March 2014 to April 2015 between 18 and 65. Of the 3,006 participants, 31.3% had either 'A' Level, Polytechnic, and other diplomas, 29.6% had undergraduate degrees, 25.8% had higher education,

including 'O'/' Level, and eventually, 13.4% had primary and below educational histories. The study's outcome found that more negative views towards the mentally ill were correlated with older age, male gender, lower education, and socio-economic class. It indicated that people with higher education had more awareness of mental illness or had a more robust view of mental health conditions due to their higher education.

**Role of Social Support in Help-seeking Behaviour of Men with BPH**

Available data indicates a connection between social support and help-seeking behaviour that significantly affects one's decisions in seeking help (Vogel, Wade, Wester, Larson & Hackler, 2007).

Approximately 89 per cent of young people in need relate to friends, 81 per cent relates to family, and 32 per cent relate to their ministry and religious faith (Bilican, 2013). Males are exposed to a lack of a positive social network system. An Office for National Statistics survey carried out by Deviron and Babb (2005) reported that respondents of wide social networks were two times more likely to be women.

The reasons behind social support structures gender differences can theoretically be related to emotional intelligence, which is related to the factors underlying gender disparities in social support networks. Thus, there is an overlapping connection between emotional intelligence, social support, and the quest for assistance, making it more difficult for young people who lack the emotional intelligence to build and retain social support networks. It can be more difficult for people who lack emotional skills to ask for assistance and have fewer open sources of support (Rickwood et al., 2005).

Wrzus, Hanel, Wagner and Neyer (2013) published a meta-analysis to analyze shifts in social networks over the whole human lifespan. The research was an observational analysis of current literature from 2008 to 2009 and then revised in 2012. Consistent outcomes from the study showed that while social networks grow until the young adult stage, they gradually decrease into older adulthood.

New research by Stokes and Moorman (2018) corroborates the evidence that social network relations to older adults develop tighter because of careful selection and spontaneous loss as you age. Consequently, they tried to examine the effect social network has on the mental well-being of older adults. The research subjects were neighbourhood living elderly adults in the U.S. who engaged in the Regional Social Life, Wellness and Aging Programme. They screened a total of 3,371 for the analysis. From the results, it emerged that being married is a preventive factor against depressive symptoms. Apart from quality interpersonal partnerships, the social support network between family, significant others and friends have been described as increasingly important defences against depressive symptoms.

A Dosu (2014) research within the Ghanaian framework sought to define the scope of assistance that older adults provide. It has been established that help from family links is the principal source of social help that older adults in Ghana get. The study results showed that while older adults experience psychological and physical challenges, they are also active as counsellors in their immediate family and community.

Furthermore, several quantitative and cross-sectional studies, especially in Western and Asian cultures, have shown that social support has strong

connections with older people's ability to attain and sustain general well-being and, particularly, Psychological Well-being, which is frequently influenced by values and simple human needs to have social relations (Chi & Chou, 2001; Chou & Chi, 2005; Hajek et al., 2017; Kauppi et al., 2018).

**Role of Religious Faith in Help-seeking Behaviour of Men with BPH**

In Ghana, religion prevails as a fundamental element of life for most people (Anarfi & Gyasi-Gyamerah, 2014; Gyasi-Gyamerah & Akotia 2016; Wright et al., 2018); principally for those enduring adverse life conditions (Adjei et al. 2017). It impacts the perception and understanding and how one acts and conducts oneself as a reaction to these obstructive life events. The benefits of religiosity provides life with a sense of purpose, a state of physical ease and freedom from pain and chronic constraint, the desire to recover, and social support to enhance one's coping ability (Holt et al., 2018).

Although we know that religious faith varies significantly in their perception of the well-being they encourage, There has not been a lot of focus on the conceptualization of homeopathy in the treatment and management of BPH in Ghana (Okyerefo & Fiaveh, 2017). In contrast to women, men appear to be less religious and moral, raising a possible concern as males lack a concrete path to health and well-being. Consequently, Ghanaian men are less likely to effectively make use of religion and spirituality to cope with prostate enlargement-related stress. Thus, it is essential to assess the degree to which these psychosocial services positively affect the capacity of Ghanaian men to deal with the adverse effects of BPH, considering the valuable purposes of religious faith. Moberg (2009) noted that being consistent at religious gatherings projects immense happiness levels and low-stress levels. It is not

unusual to find most churches in Ghana crowded by individuals searching for divine intervention to their predicaments. Therefore, the social, interpersonal, emotional, spiritual, and behavioural aspects of religion may contribute considerably to dealing with BPH and its related conditions. As such, religious faith is a vital psychological tool in helping these individuals cope with their discomfort.

In a study of 850 papers written on religion and mental health, researchers concluded a positive connection between religious participation and good mental health (Moreria-Almeida, Neto & Koenig, 2006). A national comorbidity survey (Mills, 2012) found that 25 per cent of participants consulted clergy for mental health issues more often than physicians. For several people, the clergy acted as the main source of mental health care and the first point of interaction (Ampadu, 2016).

In the life of many Ghanaians, religion and spirituality play a crucial part. According to Pokimica, Addai and Takyi (2012), religion greatly influences Ghanaians' views of their living conditions and equates their living conditions to others'. Religious institutions also became a tool for many Ghanaians to address their difficulties during their stay abroad.

In a survey of 235 college students (Gambrah, 2014), the emphasis was on factors associated with getting support from a religious practitioner for psychological trauma rather than a medical specialist. The result found that religiosity was a factor for the largest variance, approximately 20% of religious preferences for seeking help. Furthermore, religion is viewed to have a dominant impact on the individual and society at large.

**Religious Faith and Social Support in Men with BPH**

Individuals series of actions invariably performed have recorded positive and negative connections with health (Harrison et al., 2001). It appears that seeking religious support as a form of help-seeking behaviour has its positive health benefits. In addition to social support, carefully considered religiosity often serves as a convenient therapeutic benefit that combats the aftermath of prostate enlargement. Social support received from the church, also known as religious-social support, is a kind of social support in which one's engagement in religious events presents people with a way into social networks that includes support from the ordained officials and other individuals of the religious syndicate. The advantage gained from these religious relationships may be quite different from support received from non-religious networks (Holt et al., 2018).

In Chennai, India, research by Chokkanathan (2013) among older adults explored the implicit relationship between religiosity, social support, dominance, and psychological distress. In the process, 321 older adults, who were mainly Hindus, were randomly tested and questioned. The findings showed that psychosocial tools (social support) mediate the interaction between religiosity and psychological health.

Similarly, Lawler-Row and Elliot (2009) carried out a study among the United States older adults to determine the importance of religious practice and spirituality in their health and well-being. In the process, the participants completed a religiosity, spirituality, and health questionnaire. Mediator variables considered here were social support and healthy behaviours. Spiritual wellbeing and prayers, however, had a negative relationship with the physical

and depressive symptoms. Although social support and health behaviours were identified as mediators, they had a less significant impact on health effects.

In another research, Hamren, Chungkham, and Hyde (2015) explored the factors affecting the quality of life among elderly Ethiopians. Two hundred and fourteen adult participants, aged 55 and over, were tested and assessed on religiosity/spirituality, quality of life and social support steps. The analyses indicated that quality of life is positively linked to both social support and religiosity/spirituality. However, this study's outcome indicates that religiosity and social support may serve as significant buffers against isolation and poverty predominant among adults. To that end, aid organizations in Africa that support the elderly need to partner with religious bodies and informal social networks to produce holistic approaches.

**The Satisfaction of Homeopathy Treatment**

Using the simplest approaches and with the fewest risks, people are searching for ways to restore fitness. In some instances, the use of a single treatment procedure does not provide the desired result.

Several aspects impact patient satisfaction with homeopathic therapy, including the result, process and type of care, type of prescription, motivations for turning to homeopathy, and the homeopathic practitioner's efficiency. Healthcare quality is also measured using significant and universal metrics, with one such metric being patient satisfaction that can be used to assess the quality of healthcare offered by a specific facility (Brak, 2016).

Recent research has shown results that demonstrate the advantages experienced with the use of homeopathy medicines and further consultations. Patients' satisfaction following homeopathy implementation into traditional

health care, attitudes to extensive services, and enjoyment after consultation with homeopaths were measured in a more advanced study involving 456 participants. 98.8% were delighted with the overall services, demonstrating a high level of satisfaction when working with homeopaths (86.3 per cent of the total score) (Saha et al., 2015).

An institutional study was performed at a homeopathic medical hospital in Pakistan, and among 382 patients who participated in this research. Before initiating their treatment plan, most patients (69.4 per cent) were satisfied with the information presented by the specialist. This research found that patients were pleased with the homeopathic hospital's services, while patients who were not satisfied with the medical staff's services opened a window for hospital administration improvement (Raza, 2020).

With the availability and shared use of evidence-based therapies, the effectiveness of homeopathy drugs in BPH management can no longer be doubted by critics. Studies have found that some treatments, even unique to age ranges and other populations, are beneficial for treating specific diagnoses.

**Conceptual Framework**

The conceptual framework for this study explains how the variables in the study are related and connected. The predictor variables in the study are social support and religious faith, while help-seeking behaviour is the outcome variable. Thus, the expected outcome based on the influence of the psychosocial determinants, namely social support and religious faith, is the individual's help-seeking behaviour towards BPH management.

Social support, a main variable in this study, can influence both religious faith and help-seeking behaviour. Thus, it has been built into this study as a

mediator variable. All the above factors will merge to ensure that the individual's help-seeking behaviour towards BPH management is improved.

Mediation explains the process through which two variables are related or connected. Social support as a mediator helps to go beyond identifying the simple relationship between religious faith and help-seeking behaviour for a fuller picture of the extent of its entire connection. As such, social support explains the reason for such a relationship to exist. The mediation model looks at the relationship between the dependent variable and the independent variable, the independent variable and the mediator variable, and the dependent variable and the mediator variable in general.

Hence the mediation effect of social support could enhance (where the presence of social support would increase the effect of religious faith on help-seeking behaviour) or reduce (where the involvement of social support would decrease the effect of religious faith on help-seeking behaviour). The patient is viewed as a social entity whose actions and inactions are impacted and guided by psychosocial factors, according to the model. Thus, the treatment choice for an alignment is often informed not by one factor but multiples of factors. The conceptual framework is depicted in figure 1 below.

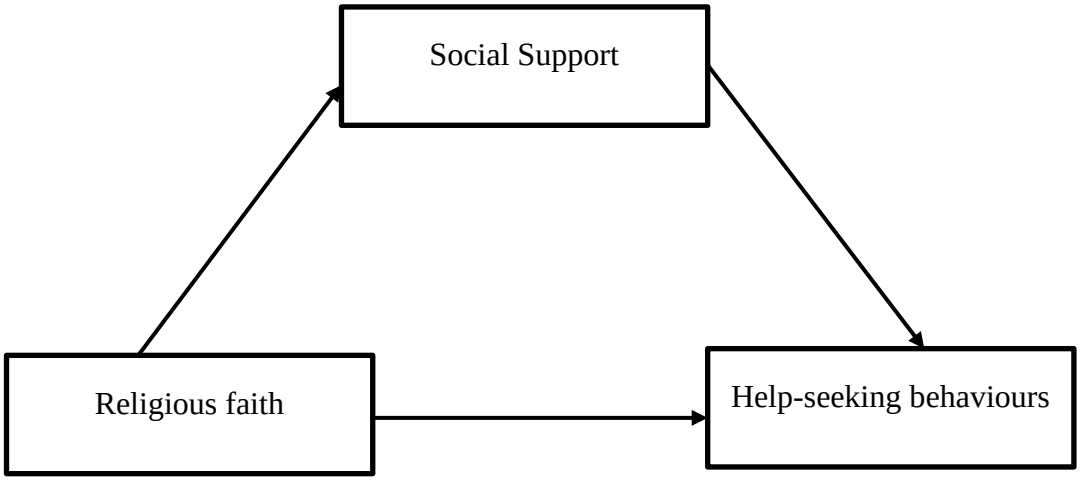


*Figure 1:* Proposed relationship between religious faith and help-seeking behaviour, with social support as a mediator

**Summary of Literature Review**

Several studies have found a link between the dependent variables (help-seeking behaviour) and the study's independent variables (Social support and Religious faith). It examines whether social support and religious faith are the main determinants of help-seeking behaviour in male BPH patients. This literature review looked at studies on BPH prevalence, patients' experiences, challenges, coping methods, and their level of satisfaction with homeopathy treatment. Studies on the prevalence of BPH included Kirby (2000), Kenneth et al. (2016), Adegun and Popoola (2011) and American Cancer Society (2014). All of the writers believe that the aetiology of the condition in men is becoming more prevalent with age, necessitating some form of intervention.

Mante (2018), Pettaway et al. (2011), CDC (2013), NIDDK (2014), and Wang et al. (2015) investigated the causes, diagnosis, challenges, and treatment choices individuals face while living with BPH. They found several challenges and adjustment problems that patients face daily. The prevalent themes in the studied literature were physical and psychological losses and feelings of

dependency. The enormous aggregation of adverse uncertainty and adjustments confronting the patient with BPH eclipsed any expressed feelings of hope.

Bellavite (2015), Asamoah-Adjepong (2018), Nuworza (2013), and (Zimmerman, Woolf, and Haley, 2015) were among the notable studies that looked into the help-seeking behaviour of people living with BPH. However, they did not provide enough information about their decision-making with homeopathic management of BPH, especially on the psychosocial, economic, and cultural dimensions of life.

Some research (e.g., Gallup, 2009; Crosby & Bossley, 2012, Harrison et al. 2001) demonstrated a consistent pattern of one's religious faith as a protective factor for managing BPH and the associated physical and psychological health problems. However, several studies (e.g., Herstad, 2009 and Sedikides, 2010) have found that religion can sometimes predispose persons to mental health difficulties related to BPH. As a result, the impact of religious faith on help-seeking behaviour is still a grey area.

With the knowledge gained from earlier studies, the researcher discovered limited research on psychosocial elements that have been believed to play a substantial role in the management of the condition of BPH patients. However, because most of the research examined are from developed countries, they may not accurately reflect the help-seeking behaviour of men living with BPH in Ghana. As a result, there is a theoretical gap and a literature knowledge gap. The study's findings are expected to aid in the creation of more efficient interventions to address the help-seeking behaviour of men with BPH.

Although many empirical studies are cross-culturally orientated, most do not capture contextual events inside the African and Ghanaian socio-cultural

environment (e.g., Morin & Midlarsky, 2016; Wallace & Bergeman, 2002; Frazier et al., 2005). Again, studies that tried to understand patients' perceptions and treatment options for BPH management used a qualitative approach and data collection tools such as interviews and questionnaires. These could pose issues with the sample size required for external validity. In order to provide data that can be more conviniently generalized, it is critical that these researchers become as precise and quantitative as feasible.

While most of the studies reviewed above show a positive link between the independent variables of religious faith and social support, particular studies, such as Cohen and Koenig (2004), claimed that religiosity could be either unfavourable or favourable for this relation. The scientific analysis highlighted that faith could induce neurotic and detrimental mental health habits in its adherents. Although the lack of social connections might be detrimental to one's health and well-being, the quality of existing social relationships must also be considered (Holt-Lunstad et al., 2010; Smith & Christakis, 2008). These point to a potential limitation of our findings when generalizing them to all older men and community-dwelling individuals in Ghana, in particular.

Reviewed studies used clinical samples of patients in conventional health facilities in Ghana to measure their treatment-seeking behaviour. In the present study, the researcher used homeopathy centres and compared participants across all educational (basic, secondary and tertiary) backgrounds relative to their help-seeking behaviours in the management of BPH.

# CHAPTER THREE

# RESEARCH METHODS

## Introduction

This chapter focused on the methods employed in the study. The chapter presents strategies used to conduct the study with regards to the research population, sample and sampling methodology, the design, and procedures involved in the data collection process. It starts from the design stage through data collection to analysis of the data collected. It details the study design, location (a brief description of the study area), variables of interest, sample size determination, data collection instrument, data processing and analysis, and ethical considerations. The measures taken to collect data to test the mentioned theories are detailed in this section.

## Research Design

The researcher adopted a cross-sectional design with a quantitative approach. A cross-sectional research design has the advantage that it enables a researcher to compare different variables (Kesmodel, 2018) concurrently. Studies involving quantitative approaches place a strong emphasis on objective measurements and statistical analysis of data. for generalization across groups of people. To this end, Creswell (2014) argues that quantitative analysis is an alternative to evaluating objective hypotheses through analysing the relationship between variables.

According to Koul (2009), the descriptive analysis includes existing incidents linked to existing occurrences. Ensuring findings of quantitative

research designs can, therefore, be generalized to more extensive populations. Other researchers can easily replicate it. Because the research aims and hypothesis tested in the study investigated the connection between independent variables (religious faith and social support) and a dependent variable (help-seeking behaviour), the cross-sectional survey methodology was appropriate for this research. This design allowed the researcher to elicit information from community-dwelling older adults about their level of religious sentiments, social support, and overall general help-seeking behaviour. Data was collected from the respondents by making use of appropriately designed questionnaires.

**Study Area**

The study was conducted in Greater Accra, with total estimated inhabitants of 4,010,054 made up of 1,938,225 males (Ghana Statistical Service, 2012). This demographic was selected because Greater Accra is the capital of Ghana and consists of individuals from all across the country. It is also the most populous city in the country. End Point Homeopathy Clinic, Grace Homeopathy Clinic and C4C Homeopathy Clinic were the Centres of interest since they serve as the various Municipalities' referral points. The various homeopathy clinics also receive referrals from other regions such as Central, Eastern, Western, and some parts of Ghana's Volta region.

**Population**

BPH patients visiting a homeopathy health facility receiving care for prostate enlargement in the Greater Accra region of Ghana were of concern to this study population. Maxfield and Babbie (2014) proposed that a target population corresponds to the group that a study hopes to generalize findings.

In comparison, the actual sampling frame from which a sample is taken constitutes a study population.

Therefore, this study's target population was all patients diagnosed with Benign Prostatic Hyperplasia seeking care in Greater Accra. In Ghana, BPH's prevalence rate in men aged 50 – 74 in the Greater Accra alone is 125,443 premised on the 2000 Population and Housing Census (Yeboah, 2016). However, BPH patients in Greater Accra seeking care at the three (3) Homeopathic Clinics were the accessible population. The accessible population was BPH patients who had been medically diagnosed and were undergoing BPH treatment at the Homeopathic Clinics of interest. This population was selected because it is a cosmopolitan location comprising teenagers, young adults, and old adults with different cultural and educational backgrounds.

**Sampling Procedure**

To arrive at a sample for the study, Delice (2010) recommend that when the population size is unknown, a sample greater than one hundred (n > 100) is appropriate for a quantitative study. Thus, based on Delice's (2010) recommendation, this study's sample size is one hundred and fifty (150). The researcher employed purposive and convenience sampling techniques. The technique employed had less rules to observe as it did not require going through a checklist to screen members of an audience. Here, collecting crucial information and data is simplified.

Despite the fact that all convenience samples are less generalizable than probability samples, homogeneous convenience samples are more generalizable than conventional convenience samples. Participants were selected based on their readiness and willingness to cooperate. The study focused on only

participants between 18-60 years and above who had voluntary control of their health. The study included both old and new cases.

**Inclusion Criteria**

The conditions for the inclusion of patients in the sample are given below.

1. Should be 18 years and above.
2. Participant must be an outpatient.
3. Be willing to participate voluntarily.
4. Recruited patients were male patients visiting the facility and diagnosed with BPH.

**Exclusion Criteria**

The conditions for exclusion of benign prostatic hyperplasia patients in the sample are given below

1. Below the age of 18 years
2. The participant is an in-patient.
3. Refrain from taking part in the study voluntarily.
4. Critically ill patients were excluded from the study.

**Data Collection Instruments**

The adopted questionnaires measured the study variables, and the sections below describe these measures in detail. For the quantitative research, a questionnaire, made up of five sections, was administered.

**Demographic data:** In this section, respondents' personal information was gathered. These questions included age, religious affiliation, and educational background.

**Santa Clara Strength of Religious Faith Questionnaire (Plante & Boccaccini, 1997)**

The Questionnaire on the Santa Clara Strength of Religious Faith (Plante et al. 2002) is intended to help determine how important your religious faith is to you personally. Religious identity is distinguished from religious devotion in that one's intimate and emotional connection to faith is most closely linked to religious faith. On the other hand, religious commitment explains how one's religion affects their daily activities and decisions. Strong religious faith has been related to improved emotional and physical wellbeing and more happiness with life.

This adopted questionnaire consists of 10 items for assessing the degree of the religious faith of a person. "I pray daily," "I look to my faith as a source of inspiration," and "I look at my faith as providing meaning and purpose in my life" are several examples of things on the scale. This scale contains a 5-point Likert answer format; 1 = strongly disagree, 2 = disagree, 3 = moderate, 4 = agree, 5 = strongly agree. Cronbach Alpha's and split-half reliability scores ranging from 0.90 to 0.96 were observed in experiments examining the scale's internal accuracy (Plante & Boccaccini, 1997). The scale produced a reliability coefficient of .87 after the main data collection.

**The Help-Seeking Scale**

Rickwood, Deane, Wilson, and Ciarrochi (2005) developed a modernized version of the General Help-Seeking Questionnaire, which was adopted and used to measure intentions to seek help from various sources. The questionnaire posed a problem scenario, provided 10 sources of help, and asked how these resources might be used. It used a 7-point Likert scale, with ratings

ranging from 1 to 7, with 1 being highly unlikely and 7 being quite likely.The questionnaire had a general Cronbach's alpha of .85 and test-retest reliability of .92 (Rickwood, Deane, Wilson, & Ciarrochi, (2005). This study's scores ranged from 10 to 70, with higher scores indicating higher desire for help-seeking. The scale produced a reliability coefficient of .63 after the main data collection.

**The Multidimensional Scale of Perceived Social Support (MSPSS)**

The MSPSS, an adopted instrument, is a short analysis technique to assess help experiences from three sources: families, friends, and significant others. A total of 12 items, with four items for each subscale, make up the scale. The MSPSS has been shown to have outstanding internal and test-retest reliability, good validity, and a reasonably consistent factorial structure over several trials. The scale has three subscales, and the items relate to the source of social support, namely family, friends or significant others. The MSPSS is a 7-point Likert scale. The Likert responses on MSPSS range from 1 to 7 (1= Very Strongly Disagree, 2= Strongly Disagree, 3= Mildly Disagree, 4= Neutral, 5= Mildly Agree, 6= Strongly Agree and 7= Very Strongly Agree). According to Wongpakaran, Wongpakaran and Ruktrakul (2011), the MSPSS has a Cronbach alpha of 0.91 and test-retest reliability of 0.84. The instrument also has moderate construct validity (Zimet et al., 1988). The MSPSS has acceptable reliability and convergent/discriminant validity, is easy to understand and complete and is appropriate for this study. The scale produced a reliability coefficient of .78 after the main data collection.

**The Treatment Satisfaction Scale**

The scale was designed to assess patient treatment satisfaction with chronic diseases at the homeopathy clinics. The scale is comprised of a total of 6 items and has a 4-point Likert, which is scored on how satisfied men were with Homeopathy services; with 1= very satisfied, 2= satisfied, 3= slightly satisfied and 4= very dissatisfied. This scale scores ranged from 6 to 24, with higher scores indicating a higher satisfaction level for help-seeking from the homeopathy clinics. Scores ranging from 6 to 11 represented lower satisfaction levels, 12 to 17 represented moderate satisfaction levels, and 18-24 represented higher satisfaction levels for patients seeking help from homeopathy clinics. The Treatment Satisfaction Scale has a Cronbach alpha of .86.

**Pilot Testing of Instrument**

A pilot study was first carried out to determine the questionnaires' psychometric properties to be used in the study and to determine the comprehensibility of the questionnaires for participants. The pilot test was also conducted to enable the researcher to assess if all the five measures would assess the constructs they purport to measure. For the quantitative study, 15 participants were pilot tested at Nature's Cure Homeopathy Clinic in Accra. A pilot study sample should be 10% of the total sample size, according to experts for the more extensive parent study (Connelly, 2008). The participants were between the ages of forty (40) to sixty- five (65) years. The pilot study had Cronbach Alphas of .57 for the Santa Clara Strength of Religious Faith Questionnaire, .37 for The Help-Seeking Scale, .76 for MSPSS and .86 for The Treatment Satisfaction Scale, respectively. After pre-testing, the questionnaire

was reviewed according to the information gathered before the primary survey took place.

The use of the standardized scales for the pilot study resulted in low scores for the Cronbach alpha for Santa Clara Strength of Religious Faith Questionnaire (.57) and the Help-seeking scales (.37), respectively. Calculating the reliability of the scales, Cronbach alpha was used. Although the instrument was multidimensional as it consisted of different subscales, results of the Cronbach alpha for the two subscales showed low-reliability scores. It was as a result of the low sample size (15) used for the pilot study. Having used a small sample size for the piloting, it was concluded that the few participants used resulted in the low values obtained as it would be for any statistical analysis that employed such scales with a smaller sample for its piloting to determine its reliability.

**Data Collection Procedure**

Ethical consent for the procedure was received from the Institutional Review Board of the University of Cape Coast. Ethical clearance certificates and a letter of introduction from the Department of Psychology were presented. to the Homeopathy Centres for permission to use their facilities. The date for the start of data collection was set after permission was given at the respective clinics.

The clinics' outpatient services were used for the processing of results. The questionnaires were administered in a pen-and-paper form by the participants who could read and write. The questionnaire was interviewer-administered for respondents who could not read and write. Each participant was read and explained the items on the questionnaires, and answers were ticked

as they answered. Individual participants' permission was obtained before the questionnaires were delivered to them. The questionnaires were followed by details describing the purpose of the research, directions for completing the questionnaire and returning it. In achieving orderliness, The various measurement instruments were split into categories. Out of one hundred and fifty (150) questionnaires distributed, one hundred and forty-eight (148) questionnaires were received upon completion from the participants.

**Ethical Considerations**

Participation was voluntary, and each applicant received written informed consent. Respondents were informed of the privacy of their responses. First, an introductory letter from the Department of Psychology was shown to the prospective participants to confirm that the researcher was a student from the University of Cape Coast. The study was outlined to the potential participants, and they signed the informed consent document after they demonstrated a desire to participate in the study. Participants were told that the information gathered would only be used because it was collected to advance knowledge in the help-seeking behaviour of Ghanaians. Following that, they were given assurance that they could withdraw as participants at any moment. Participants explored issues of confidentiality and anonymity. They were advised not to write their names or anything else that could be used to contact them directly. Besides these, every facet of the study was carried out in accordance with the rules governing the conduct of research with human participants in the code of conduct of the American Psychological Association (2016). Administrative approval was obtained from the management of the Homeopathy Centres.

**Risks and Benefits**

There was no risk or cost involved with engaging in the study, aside from the time lost by study participants responding to the questionnaires. Participants will not achieve direct advantages. However, the research findings are intended to make health policy decisions that could help the study participants, the government, and the principal investigator.

**Voluntary Participation**

Respondents were notified that their involvement in the study was purely out of their free will. They could also decide to withdraw at any point in the survey. Respondents were assured that declining to complete the questionnaire would not affect their treatment even if they agreed to do so earlier.

**Summary of Chapter**

This chapter described the study's design, selection of participants, data collection tool, data collection process and data analysis. Research questions 1 and 2 were analysed using descriptive statistics. Data on research hypotheses 1 and 4 were analysed using multiple regression to establish the extent to which social support predicts help-seeking behaviour and how the level of education predicts help-seeking behaviour. Linear regression was also used to establish the extent to which religious faith predicts the help-seeking behaviour of men with BPH in research hypotheses 2. Data on research hypothesis 3 was analysed by conducting a mediation analysis using PROCESS by Andrew F. Hayes (a function in SPSS).

# CHAPTER FOUR

# RESULTS AND DISCUSSION

## Overview

The study, presentation and interpretation of the results arising from this research are discussed in this chapter. This study focused on investigating social support, religious faith, and help-seeking behaviour and identifying the role of educational level in patients with BPH in the Greater Accra Region of Ghana.

The study objective was to investigate psychosocial determinants of help-seeking behaviour among men with BPH at Homeopathic Centres in Greater Accra. Specifically, the study sought to:

1. Determine the level of help-seeking behaviour of men with BPH.
2. Determine the level of satisfaction with homeopathy treatment among men with BPH.
3. Determine the impact of social support on the help-seeking behaviour of men with BPH.
4. Ascertain the impact of religious faith on the help-seeking behaviour of men with BPH.
5. Identify the role of social support and its mediating effect on religious faith and men's help-seeking behaviour with BPH.
6. Determine the relationship between the level of education and help-seeking behaviour of men with BPH.

The analysis and data interpretation were carried out based on the research questions and hypotheses set for the study. A total number of one

hundred and fifty (150) questionnaires were distributed to the respondents. However, one hundred and forty-eight (148) questionnaires were collected from the participants, representing a response rate of 98.67%. The data was analysed using descriptive statistics (frequencies, percentages) and inferential statistics (Multiple Linear Regression, Linear regression, and Andrew Hayes Process). The first part of this chapter described the demographic characteristics of the respondents. The second part presented results based on the research questions and hypotheses formulated for the study.

**Demographic Information**

This section describes the participants' demographic information including age, level of education, and religion. Table 1 presents the results.

Table 1: *Demographic Characteristics of Respondents*

| Variable | Frequency | Percentage (%) |
|---|---|---|
| **Age** | | |
| 18-30 | 2 | 1.4 |
| 31-40 | 15 | 10.1 |
| 41-50 | 43 | 29.1 |
| 51-60 | 42 | 28.4 |
| 60+ | 46 | 31.1 |
| Total | 148 | 100.0 |
| **Religion** | | |
| Christianity | 138 | 93.2 |
| Islam | 10 | 6.8 |
| Total | 148 | 100.0 |
| **Level of education** | | |
| No formal education | 4 | 2.7 |
| Primary | 12 | 8.1 |
| Secondary | 66 | 44.6 |
| Tertiary | 66 | 44.6 |
| Total | 148 | 100.0 |

Source: Field Survey, 2020

Table 1 indicates the respondents' demographic information, including age, level of education, and religion. Out of one hundred and forty-eight (148) men who participated in the study, most respondents were between ages 41 and 60. The table's results indicate that 11.5% were between 18-40; 57.5% were between 41-60; 31.1% for those above 60 years. The study population was predominantly made up of more Christians than Muslims. As of the 2010 census, Christianity was the largest religion in Ghana, with approximately 71.2% and Muslims recording 17.6%, suggesting a fair representation of the results presented. Higher proportions of the participants also had formal education.

**Main Results**

This part presents the main results. The results are presented in the order of the research questions and hypotheses that guided the study.

**Research Question 1: What is the level of help-seeking behaviour in men with BPH?**

Research question one examined the level of help-seeking of men experiencing BPH where group statistics and results for the level of help-seeking of men with BPH seeking homeopathy treatment are shown. In answering this research question, ten items of the research questionnaire were used. The general help-seeking scale had a 7-point Likert that was scored on how likely men experiencing BPH would seek help; with 1= extremely unlikely, 2= quite unlikely, 3= unlikely, 4= neutral, 5= likely, 6= quite likely and 7= extremely likely. Data on this research question was analysed using frequencies and percentages. A score range was established. This study's scores ranged from 10 to 70, with higher scores indicating stronger willingness to seek help; scores

between 10 and 29 indicated lesser intentions to seek help, 30 to 49 represented moderate help-seeking and 50-70 represented a higher help-seeking for BPH patients. Table 2 presents the results.

Table 2: *Level of Help-seeking Behaviour in Men with BPH*

| Help-seeking Level | Frequency | Percentage (%) |
|---|---|---|
| Low | 26 | 17.6 |
| Moderate | 117 | 79.1 |
| High | 5 | 3.4 |
| Total | 148 | 100.0 |

Source: Field Survey, 2020

Table 2 showed results on the level of help-seeking behaviour of men experiencing BPH. The study found that most participants' help-seeking behaviour was moderate. About 79.1 per cent of respondents sought help in coping with their circumstances, indicating 117 people and 26 men (approximately 17.6 per cent) reported a low level of help-seeking. However, five people with 3.4 per cent showed a higher help-seeking behaviour indicating that majority of the respondents were neither recording a higher or lower help-seeking behaviour in the management and treatment of BPH in Ghana but moderately.

**Research question 2: What is the level of satisfaction with homeopathic treatment among men with BPH?**

Research question two examined the level of satisfaction with homeopathic treatment among men with BPH. In answering this research question, six items under Section E of the research questionnaire were used. The homeopathy satisfaction level scale had a 4-point Likert score on how satisfied men experiencing BPH were with Homeopathy services, with 1= very satisfied,

2= satisfied, 3= slightly satisfied and 4= very dissatisfied. Data on this research question was analysed using frequencies and percentages. A score range was established. This study's scores ranged from 6 to 24, with higher scores suggesting a greater satisfaction level for help-seeking from the homeopathy clinics. Scores ranging from 6 to 11 represented lower satisfaction levels, 12 to 17 represented moderate satisfaction levels, and 18-24 represented higher satisfaction levels for BPH patients seeking help from homeopathic clinics in Accra. Details of the results are presented in Table 3.

Table 3: *Level of Satisfaction with Homeopathic Treatment among Men with BPH*

| **Satisfaction Level** | **Frequency** | **Percentage (%)** |
|---|---|---|
| Low | 1 | 0.7 |
| Moderate | 6 | 4.1 |
| High | 141 | 95.3 |
| Total | 148 | 100.0 |

Source: Field Survey, 2020

Table 3 indicates results on the level of satisfaction with homeopathic treatment among men with BPH. The majority of the respondents claimed to be highly satisfied with their services from the homeopathic centres. Approximately 95.3% (141) of respondents reported higher satisfaction with the consultation and treatment regimens received, compared with less than 1% (1) of patients who had other reasons not to comply with the consultation and treatment regimens given. However, the remaining respondents recorded 4.1 per cent (6), which indicated they were moderately pleased with the services they got concerning BPH management from homeopathy clinics, indicating how

efficient and effective homeopathy medications are in the management and treatment of BPH in Ghana.

**Research Hypothesis 1: Social support is a significant predictor of help-seeking behaviour in patients with BPH.**

Research hypothesis one aimed at testing if social support could predict or not predict the help-seeking behaviour of men experiencing BPH. Multiple regression was deemed appropriate to predict the extent to which social support predicts help-seeking behaviour, having explored other statistical tools, taking into consideration all the dimensions of social support (family, friends, and significant others). Before running the analysis, it was necessary to test the appropriate assumptions before running the regression tests. A visual analysis of standard Q-Q plots and box plots revealed that the help-seeking behaviour was normally distributed to males with BPH relatively. The assumption for multicollinearity was tested by comparing the predictor variables. Results showed that all the values were less than .7, indicating that none of the predictor variables is multicollinear.

Additionally, to test for linearity, the predictor variables are expected to correlate with the outcome variables with values greater than .3. Results rightly showed that values were greater than .3, which satisfies the assumption that the relationship modelled is linear. From the plots, it appears they all fall on the line even though few dots deviate, which are insignificantly noticed. Also, the data does not indicate autocorrelation, indicating that the data is good. Finally, a scatterplot of residuals versus predicted values was checked for homoscedasticity, where there was no clear pattern in the distribution. Figures

2 and 3 and Table 4 show the normality, multicollinearity, and homoscedasticity test for the test variables.

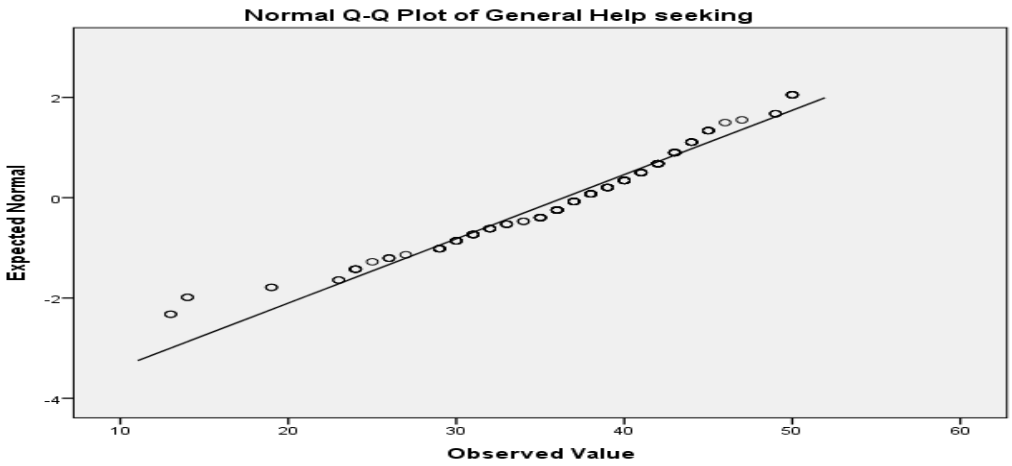


*Figure 2:* Normal Q-Q Plot

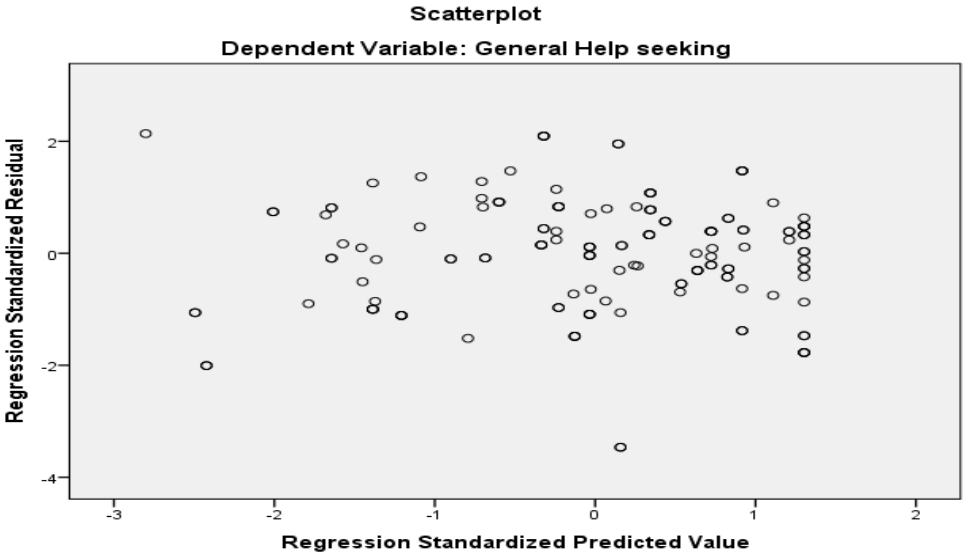


*Figure 3:* Linearity Graph

Table 4: *Correlations for the Sub-scales of Social Support*

| Pearson Correlation | | SO | FRDS | FAM |
|---|---|---|---|---|
| | SO | 1.000 | -.120 | .498 |
| | FRDS | -.120 | 1.000 | -.041 |
| | FAM | .498 | -.041 | 1.000 |
| Sig. (1-tailed) | SO | .000 | .073 | .000 |
| | FRDS | .145 | .073 | .310 |
| | FAM | .000 | .310 | .000 |

SO = Significant others FRDS= Friends FAM= Family

**Multiple Regression Analysis**

Multiple regression was calculated to predict men's help-seeking behaviour with BPH based on patients' social support. Tables 5 and 6 present the multiple regression results.

Table 5: *Multiple Regression between Social Support (Sub-scales) and Help-seeking Behaviour of Patients with BPH*

| Variables | B | $R^2$ | *SE B* | B | *T* | *P* |
|---|---|---|---|---|---|---|
| Constant | 5.76 | .299 | 4.020 | | 1.434 | .154 |
| Significant others | .417 | | .148 | .407 | 2.810 | .006 |
| Family | .794 | | .163 | .499 | 4.863 | .000 |
| Friends | .171 | | .092 | .088 | 1.864 | .064 |

Source: Field Survey, 2020 F=20.509 df= (3,144)

Table 6: *Multiple Regression between Social Support (Sub-scales) and Help-seeking Behaviour of Patients with BPH*

| Variables | B | $R^2$ | *SE B* | B | *T* | *P* |
|---|---|---|---|---|---|---|
| Constant | 8.588 | .282 | 3.755 | | 2.287 | .024 |
| Significant others | .385 | | .149 | .407 | 2.591 | .011 |
| Family | .801 | | .165 | .499 | 4.864 | .000 |

Source: Field survey, 2020 F=28.282 df= (2,145)

Table 5 and 6 indicates results on a multiple regression model calculated to predict help-seeking behaviour based on social support (significant others, family, and friends) of patients with BPH. Table 5 shows that a significant regression equation was found. The results indicate that $F$ (3, 144) = 20.509, $p$ < .01, with an $R^2$ of .299. The results suggest that social support is a significant and positive predictor of help-seeking behaviour. In the initial regression

analysis, friends as a subscale of social support were not a significant predictor hence its deletion; therefore, the prediction was based on significant others and family. Table 6 shows that a significant regression equation was found. The results indicate that $F$ (2, 145) = 28.282, $p < .01$, with an $R^2$ of .282. Here, $p <$ .01. The model explains 28.2 % of the variance. Thus 28% of the variation in one's help-seeking behaviour is predicted by the social support networks. Since there was a significantly positive association between social support and help-seeking behaviour, the null hypothesis is rejected.

**Research Hypothesis 2: Religious Faith is a significant predictor of help-seeking behaviour in patients with BPH.**

Research Hypothesis 2 aimed at establishing how religious faith predicted help-seeking behaviour in patients with BPH. In answering this research question, the hypothesis was tested by conducting a simple linear regression analysis to predict the extent to which religious faith influences help-seeking behaviour. In proceeding to perform the linear regression, certain assumptions might be met including, normality test, linearity, independence, and homoscedasticity test. The researcher checked these assumptions before conducting the regression test. Figures 3 and 4 show the normality and linearity test for the test variables.

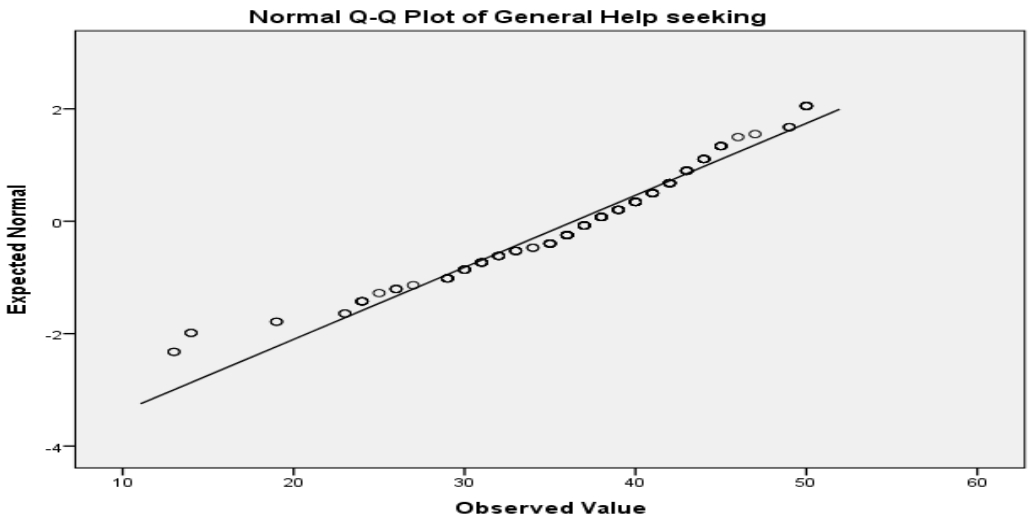


*Figure 4:* Normal Q-Q Plot

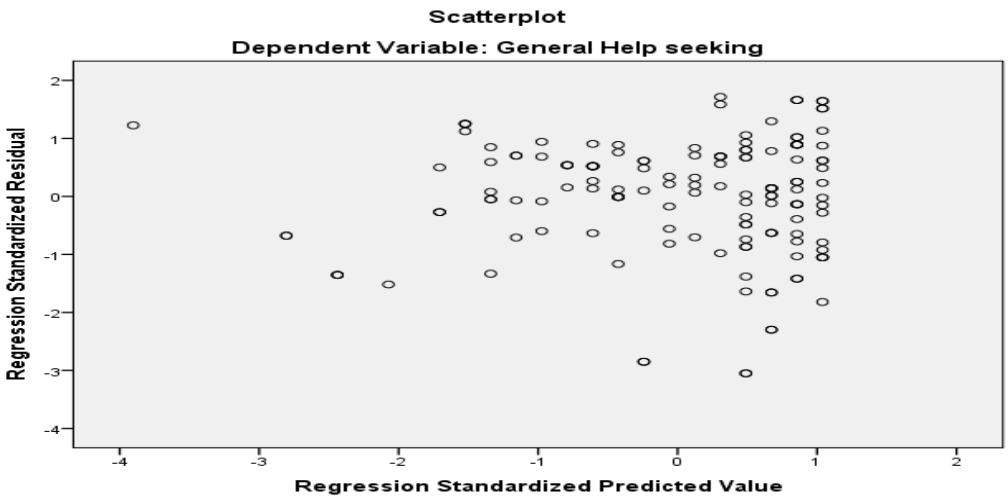


*Figure 5:* Linearity Graph

Figure 4 indicates the data was normal as the plots' points roughly form a straight diagonal line showing that the data met the regression analysis requirement. Figure 4, however, specifies there was little linearity present between the independent and the dependent variables, thus equally catering for homoscedasticity.

**Linear Regression Analysis**

A simple linear regression was calculated to predict men's help-seeking behaviour with BPH based on patients' religious faith.

Table 7: *Linear Regression between Religious Faith and the Help-seeking Behaviour of men with BPH*

| Variables | B | $R^2$ | *SE B* | B | *T* | *P* |
|---|---|---|---|---|---|---|
| Constant | 30.259 | .009 | 5.254 | | 5.760 | .000 |
| Religious faith | .139 | | .118 | .097 | 1.177 | .241 |

Source: Field Survey, 2020 F= 1.386 df= (1,146)

Table 7 indicates a simple linear regression analysis conducted to analyse the data and test the hypothesis. A linear regression model was calculated to predict help-seeking behaviour based on patients' religious faith with BPH, the predictor variable. Results indicated that a non-significant regression equation was found. The results indicate that $F$ (1, 146) = 1.386, $p$ > .05, with an $R^2$ of .009. Here, $p$ = .241. The results suggest religious faith (β= .097, $p$> .05) is a not significant predictor of help-seeking behaviour. The model explains 0.9% of the variance. Thus, 1% of the variation in one's help-seeking behaviour is predicted by the individual's religious faith. Since there was no significant positive association between religious faith and help-seeking behaviour, the null hypothesis is not rejected.

**Research Hypothesis 3: Social support will mediate the relationship between religious faith and men's help-seeking behaviour with BPH.**

**Mediation Analysis**

Mediation analysis was carried out to examine social support's role in mediating the relationship between religious faith and one's help-seeking behaviour. The study evaluated the significance of the relationship between the initial independent variable and the dependent variable (X→Y), the significance of the relationship between the initial independent variable and the mediator (X→M), the significance of the relationship between the mediator and the dependent variable in the presence of the Independent Variable (M|X → Y) and the insignificance (or the meaningful reduction in effect) of the relationship between the initial independent variable and the dependent variable in the presence of the mediator (X|M → Y), to validate the mediating variable and its significance in the model. The result of the analysis is presented in Table 8.

Table 8: *Mediating Role of Social Support in the Relationship between Religious Faith and Help-seeking Behaviour*

| **($R^2$ = .2301)** | **Coeff** | **BootSE** | **t-value** | **P** | **BLLCI** | **BULCI** |
|---|---|---|---|---|---|---|
| X→ Y | .1385 | .1176 | 1.1774 | .2409 | -.0940 | .3710 |
| X→ M | .1309 | .1323 | .9897 | .3240 | -.1305 | .3924 |
| M/X→ Y | .4197 | .0651 | 6.4472 | .0000 | .2911 | .5484 |
| X\|M → Y | .0836 | .1044 | .8002 | .4249 | -.1228 | .2899 |
| **Effects** | | | | | | |
| Total effect of X on Y | .1385 | .1176 | 1.1774 | .2409 | -.0940 | .3710 |
| Direct effect of X on Y | .0836 | .1044 | .8002 | .4249 | -.1228 | .2899 |
| Indirect effect of X on Y | .0550 | .0551 | | | -.0567 | .1658 |

**Note:** X= Religious faith, Y= Help-seeking behaviour, M= Social Support

The results from Table 8 reveal that a total effect of religious faith on help-seeking behaviour was not significant after controlling for the mediator,

social support. Results show that social support does not fully mediate the relationship between religious faith and help-seeking behaviour. Approximately 23% of the variance in men's general help-seeking behaviour with BPH was accounted for by the predictors ($R^2$ = .2301). The results from Table 8 show that religious faith was not a significant predictor of help-seeking behaviour, b = .1385, $t$ (1,146) = 1.1774, $p$ > .001. Moreover, religious faith was not a significant predictor of the mediator (social support), $b$ = .1309, $t$ (1,146) = .9897, $p$ = .3240. The path (direct effect) from religious faith to social support is positive and not significant (β= .0836, SE=.1044, p= .4249, where $p$> .05, indicating that persons scoring on Religious faith are not likely to be affected by their social support.

However, social support's direct effect on general help-seeking behaviour is positive and significant (β= .4197, SE=.0651, p= .0000, where $p$<. 001, indicating that persons scoring higher on the social support scale are more likely to experience a more significant general help-seeking behaviour than those scoring lower on the measure. The indirect effect of religious faith through social support on the general help-seeking is positive but not significant; the indirect effect is statistically non-significant.

**Research Hypothesis 4: Level of education will predict help-seeking behaviour in patients with BPH.**

Research hypothesis four examined the role of level education on the help-seeking behaviour of men experiencing BPH. From Table 1, it is evident that most of the participants had some form of formal education, indicating that higher education could fuel the desire for people suffering (physical, behavioural, or emotional) to seek clinical support. However, a few respondents

had no formal education, likely since this study's participants come from a high socioeconomic status. If the study had been conducted in varying communities (urban, rural, suburban), there might have been a more exact representation of education level, which may have yielded different results.

**Multiple Regression Analysis**

Multiple regression was estimated considering all educational level categories (no formal education, primary, secondary and tertiary) to predict the extent to which level of education predicts help-seeking behaviour. In order to help in regression analysis, variables were dummy-coded. Table 9 presents the multiple regression results.

Table 9: *Mediating Role of Social Support in the Relationship between Religious Faith and Help-seeking Behaviour*

| Variables | B | $R^2$ | *SE B* | B | T | P |
|---|---|---|---|---|---|---|
| Constant | 33.250 | .058 | 3.826 | | 8.690 | .000 |
| Primary | -2.333 | | 4.418 | -.082 | 2.810 | .598 |
| Secondary | 4.477 | | 3.941 | .286 | 4.863 | .258 |
| Tertiary | 3.008 | | 3.941 | .192 | 1.864 | .447 |

Source: Field Survey, 2020 F=2.949 df= (3,144)

Table 9 indicates results on a multiple regression model calculated to predict the extent to which level of education predicts the help-seeking behaviour of patients with BPH. “No formal education” as a category of the educational level served as the reference group for the dummy coding analysis. The results indicate that $F$ (3, 144) = 2.949, with an $R^2$ of .058. The model explains 0.58 % of the variance. Thus, less than 1% of the variation in one’s help-seeking behaviour is predicted by the educational level. The slope for “primary education” is not significant (b= -2.333, SE=4.418, p=.598). In other

words, persons with “primary education” scored 2.333 points lower on average than those in “no formal” education category. However, the slope for “secondary education” is also not significant (b= 4.477, SE=3.941, p=.258). In other words, persons with “secondary education” scored 4.477 points higher on average than those in the “no formal” education category. similarly, the slope for “tertiary education” is also not significant (b= -3.008, SE=3.941, p=.447). In other words, persons with “tertiary education” scored 3.008 points higher on average than those in the “no formal” education category.

**Discussion of Research Findings**

In comparison to the empirical literature reviewed, the study's research conclusions are discussed. It outlines areas where other research findings are confirmed by this study's results and areas with contradictions.

**Demographic Characteristics**

The findings indicate that the highest age distribution was 60 years and over, while the lowest age distribution was less than 40, indicating that the essence of etiological growth is related to the ageing phase of the observed population. From this analysis, with the least age distribution below 40 years, it can be concluded that the disorder can no longer affect only the elderly but even those below 40 years of age. All men aged 50 and over are at a greater risk of developing BPH, according to Obu (2014). In the age group of 50 years and beyond, most participants diagnosed with BPH were confirmed to experience symptoms linked to BPH (Kirby, 2000). It is predicted that the prevalence of BPH observed in males will rise as age progresses. The prevalence of BPH was shown to have risen with age in this current study, with a higher proportion of subjects older than 50 years of age (Table 1). Such reports are similar to Akpo

and Akpo (2011) and Ali As-ghar (2012). The research findings thus revealed a precise distribution of all age ranges included in the study, which seems to be in line with other research (Mackenzie, Gekoski, & Knox, 2006; Bourne, 2009), which make the same point for men over the age of 40. These researchers found that older adults had more beneficial intentions than younger adults to seek primary care treatment.

More than half of the population is Christian, with Muslims being a small portion of the population, there was no evidence of any participant adhering to the traditional indigenous religions and any other faith not listed. The majority of the participants recorded higher levels of education. Symptom recognition and diagnosis have been generally shown to affect men seeking help, and a higher level of education serves as an essential mechanism for enhancing individuals' resilience to protect themselves against potential shocks to health (Mante, 2018; Barwick, de Man & McKelvie, 2009; Boafo, 2013). The study's findings imply a significant influence of higher education level towards BPH among the participants.

**Level of General Help-Seeking of men with Benign Prostatic Hyperplasia**

The help-seeking behaviour of men with BPH brings out an interesting picture. Knowing men's help-seeking behaviour with BPH will directly impact men's inability to seek medical attention and decrease the current disorder's aggravation. A person's help-seeking activity is often predicted by multiple determinants, including patients, service providers, and the available healthcare infrastructure (Azu et al., 2018). The findings suggested that an overwhelming majority of patients at the three homeopathy centres had positive help-seeking behaviour. Most respondents claimed to be seeking help at a moderate level

whenever they are faced with life-threatening conditions. However, a few recorded a low help-seeking behaviour whenever they were faced with such life-threatening conditions.

For any person, psychosocial services such as religious faith and social support are essential (Navarro-Abal et al., 2018). They are more commonly regarded and have widely emerged as influential outlets as determinants of help-seeking behaviour as they play a critical role in resolving how people cope with these uncomfortable life events such as BPH and other long-term illnesses (Åslund et al., 2014). In low- and middle-income countries such as Ghana, males' help-seeking activity linked to BPH is frequently delayed or deferred (Azu et al., 2018). There is a need for early treatment-seeking care for all prostate-related disorders and, more particularly, for BPH as it has a psychological toll on the individual, thereby impacting their quality of life (Azu et al., 2018).

This research has shown that the general help-seeking behaviour of men with BPH is moderate, suggesting that people with BPH continue to increase their quality of life by family members and significant others (Mante, 2018). Aspects that helped most people cope with BPH were their religious/spiritual beliefs and faith, the counselling services available, families and friends, and individuals' positive desire to seek assistance in managing the condition (Sharma et al., 2016). However, the study did not support the claim that one’s religious faith could influence BPH patients to seek help from homeopathy centres.

Similarly, the study's findings revealed that respondents received some support because they might have other people communicating feelings of value

to them and, to some extent, making them feel competent and in control over their prevailing condition.

**Level of satisfaction with homeopathy treatment among BPH patients**

Homeopathy as a form of Complementary and Alternative Medicine (CAM) in western and less developed countries is gaining interest in healthcare provision (Barbadoro et al., 2011). The study supported the claim that healthcare quality is measured using significant and universal metrics, with one such metric being patient satisfaction that can be used to assess the quality of healthcare offered by a specific facility (Brak, 2016). The study results imply that patient satisfaction is recognized as a significant consideration (Marian et al., 2008).

In the homeopathic care of BPH, average patient satisfaction was considerably high, obviously suggesting how effective and reliable health staff in homeopathy are in handling and treating BPH in Ghana. Moreover, results from the study are consistent with Raza's (2020) study, which found that patients were pleased with the services given by the homeopathic hospital, while patients who were not satisfied with the services provided by the medical staff opened up a window of change for the administration of the hospital. The researchers concluded that there would be a more significant net result for people who used homeopathy care and requested homeopathy consultations. In the treatment of BPH, the outcome of the research indicated that homeopathy has a significant role.

**Relationship between social support and help-seeking behaviour of men with BPH**

Studies have shown that after they have been diagnosed with BPH, there are so many causes that bother men and as such social relationship is crucial to improving the patient's quality of life (Hyeok et al., 2015). This discovery could be because they are more likely to have minimal distress as patients receive help since most respondents cannot take care of essential activities inside and outside the home. A significant factor affecting help-seeking is social support (Rothi & Leavey, 2006). To investigate whether the level of social support of BPH patients is significantly linked to BPH patients' help-seeking behaviour, the findings revealed that social support is significantly related to the BPH patients' help-seeking behaviour.

Although the study found that family support and significant others as social support aspects had a significant positive association with help-seeking behaviour, it also appeared that friends' support was not strongly connected to help-seeking behaviour. Even though the support from friends was not so high compared to the other subscales of social support, this finding revealed that respondents, to some extent, had some share of support from friends.

This conclusion is compatible with a Kenin (2018) analysis to establish if the aspects of social support (family and friends) were substantially linked to mental health. Although the study found that family support had a strong positive correlation with mental health, it also emerged that friends' support was not positively linked to mental health. Findings suggest that the more research subjects gain family care, the healthier their mental health would be. However,

the research results noted a significant association between family involvement and one's help-seeking behaviour.

The explanation that social networks diminish as individuals grow while family connections and relationships with significant others remain reasonably intact over time may be a possible cause for the non-existence of a significant connection between support and help from friends. This phenomenon suggests that older adults are in regular contact with their family relationships and significant others than peers, so they gain more physical, social, and therapeutic support from family members and their significant others than friends. Regarding the present research, this means that a person's attitude towards pursuing therapeutic assistance depends on the help provided in his or her life by significant others and family, but not by friends.

Ahwireng (2018) suggests that family support for patients with chronic disease is vital for survival. This argument is accurate because participants in this study recounted how family support was beneficial. One of the patterns revealed by this study reflects the excellent support interaction structure revealing that significant others and family were central to participants embracing and dealing with the BPH and had better chances of seeking care from homeopathy centres.

Moreover, the study results are consistent with research published by others (Emberton & Martorana 2006, Burns & Machin, 2013), who observed that patients who received regular care were more likely than those with less support to achieve a positive attitude towards seeking and receiving help. In addition to the treatment provided at health facilities, social support and its impact play a critical role in health outcomes. It should be noted that the

research results give credence to the biopsychosocial paradigm to the degree that social influences such as social support, level of education, and marital status may have some impact on the actions of an individual's help-seeking behaviour. The biopsychosocial paradigm suggests that biological causes are not the only potential factors that will influence individuals' health problems, but other psychological and social factors often contribute significantly to individuals' health outcomes. Since the Ghanaian socio-cultural system is socially collectivist, the population surveyed socio-cultural orientation may also have accounted for the current result, so the involvement of parents, brothers, aunties, uncles, and grandparents could help respondents more readily express their grievances and pain.

**Relationship between Religious faith and Help-seeking behaviour of men with BPH**

One of the most relevant factors affecting help-seeking is religious faith (Benjamins, 2007). People find support to fix their issues, so one 's religion has a significant influence on where to take advice (Nagai, 2010). The support provided by religious faith, which is capable of taking many forms, including material, emotional and psychological support, is one of the essential resources for coping people depend on (Nuworza, 2013). Based on this current study's results, a significant negative relationship between religious faith and help-seeking behaviour has been established. The absence of a major connection between the levels of BPH patients' religious faith and their help-seeking behaviour is possible as this study (persons with BPH) differs in comparison to other samples that have reported substantial correlations between religiosity and help-seeking behaviour.

The confirmation that is worldly accepted reflects the assumption that women are more religious than men (Leondari & Gialamas 2009, Herstad, 2009), which readily affects their decisions to seek help or not as they hold on to their beliefs with resolute determination. This may explain why, when faced with a debilitating illness such as BPH, religious faith was not established as a significant indicator of support seeking behaviour among men with BPH. In comparison, most participants spend more time with relatives, friends and significant others and discuss their concerns with the peer support network than with religious group members. Although most research in this area suggests a significant positive association between religiosity and health effects, some often show no correlation or a significant negative relationship. This result is in line with what Aukst-Margetic and Margetic (2005) stated. They suggest that very few observational research shows either a negative or no relationship between religiosity and help-seeking behaviour. Consequently, a significant association between the two is not unanimously confirmed by the findings.

While there was no clear evidence in the present observation literature, some research linked high religiosity to the preference for religious help-seeking rather than clinical mental wellbeing (Abe-Kim et al., 2004). For example, Abe-Kim et al. (2004) found a significant variation in help-seeking rates from religious clergy and mental health professionals. However, their study showed that high religiosity was correlated with more help-seeking from religious clergy than mental health professionals.

However, the non-significant effect of the degree of religious faith on BPH patients' help-seeking behaviour is compatible with some previous works (Herstad, 2009). Interestingly, they find no good evidence for mainstream

claims that religious faith and spirituality positively impact well-being in their research of religiosity and physical health. While the present analysis revealed the reverse, another study found that high religiosity was correlated with more religious clergy needing support (Gambrah, 2014), particularly among disadvantaged communities. It is also possible that the popular perception triggered the present result that very high religiosity was reflected by Ghanaian culture. Each member of the studied population belonged to a single religious group and therefore shared same views regarding help-seeking, thus contributing to the non-significant prediction between religious faith and help-seeking actions in BPH patients.

In effect, religious faith can be connected to BPH patients' help-seeking behaviour, but through the mechanisms of other psychosocial influences that need to be systematically investigated. Again, religiosity's one-dimensional nature could be a constraint in capturing the different aspects of religious faith that could be substantially related to help-seeking behaviour among BPH individuals. In comparison, while religious faith was not significantly associated with help-seeking behaviour, it was significantly correlated with social support, impacting patients' help-seeking behaviour. Thus, religious faith's effect on help-seeking behaviour could be through social support (Koenig et al., 2012). Therefore, this revealed that the effect of religiosity among BPH patients in help-seeking behaviour is relative and not always as defensive as some studies indicated. However, religious attendance does not reflect the patients' true religious faith, as attendance is not an assurance of religiousness. and religious faith.

The proof of a correlation between religious faith and wellbeing is limited and contradictory, even in the finest research. However, a vast unexplored territory lies between the extremes of denying the notion that religious faith can provide relief to specific individuals struggling with disease and embracing the belief that religious faith can actively encourage religious practice to patients, under which even the presence of persuasive proof of a connection between religious activity and beneficial health effects is desperately required. Nevertheless, caution is essential (Sherman et al., 2001; Sloan, Bagiella, & Powell, 1999).

**Social support and the mediating relationship between Religious faith on Help-seeking behaviour of men with BPH**

The results indicated that social support does not explain religious faith's effect on patients' help-seeking behaviour. Findings support the fact that when a patient does not present a positive help-seeking behaviour, it could mean that the patient is less religious but not because of a lack of social support. Again, when a patient exhibits convincing help-seeking behaviour towards BPH management, it may solely be because of being more religious but not having good social support.

For many people predominantly helped by social, personal, and situational influences, help-seeking behaviour that adopts the religious component as a process of coping with a health problem is expected. However, religiosity and one's religious faith have proven their usefulness as a resource for those who suffer from health illnesses and other life-threatening circumstances.

In their effort to live a life of integrity and resolve life's problems, most people in Ghana tap religious resources. Thus, religion holds a central role in people's minds and has shaped the way people attempt to view and react to the world around them. Religion is so widespread in people's lives that we can understand both the expression and manifestation of one's religious faith at the casual, unofficial level. It virtually flows through faiths and religions, meaning that there is no end when people seek support in crisis times. This finding may explain why there was no substantial correlation between religious faith and receiving care from homeopathy centres. Nevertheless, men from numerous religious groups considered more religiously inclined (like Christians / Muslims) were more likely than those thought to be less spiritually inclined (like non-believers and traditionalists) to undergo homeopathic therapy and its treatment modalities.

Conversely, it has been suggested that religious people's improved health is most likely due to their lifestyle patterns, the increased social support that religious congregations usually have and a supportive worldview that encourages well-being. Consequently, this can create a trend that eventually leads to better emotional or general well-being in society. Social support is also recommended to clarify the correlation between religiosity and separate health effects as a significant mediating factor (Koenig et al., 2012).

Assessing whether BPH patients' social support substantially influences the associations between religiosity and help-seeking behaviour, it was found that social support did not necessarily mediate the relationship significantly. Results suggest that social support does not improve the religious faith bond and help-seeking behaviours of men with BPH. This finding is not unexpected

because religious faith was not a significant predictor, making sense for social support not to be a mediator. After all, for many people mainly supported by psychological, personal, and situational influences, help-seeking behaviour that adopts the religious context to cope with a health problem is common. However, religiosity has proven its usefulness as a resource for those dealing with health illnesses and other life-threatening circumstances.

Chokkanathan (2013) found that psychosocial instruments (social support and mastery) mediate the relationship between religiosity and psychological wellbeing. Religious organizations' routines can serve to divert people from their difficulties and thereby promote better therapeutic effects. In periods of tension and distress, faith also creates social ties and connections that go far deeper than family relationships and play a supporting role (Chokkanathan, 2013; Koenig & Larson, 2001). Although findings did not see social support as a mediator between religious faith and help-seeking behaviour, research on social support mostly centred on family relationships or partnerships or both but seldom focused on the impact of religious faith. Furthermore, this explains that an individual's religious devotion offers resources and assistance to cope with traumatic incidents. Therefore, it is not unusual for stressed individuals to look to God to deal with traumatic events. It logically follows that persons will be more likely to turn to God for support if they expect to receive such support or have in the past. Congregations are potential sources of companionship, fellowship, and encouragement for those holding common beliefs and priorities. The church has been theorized to have coping mechanisms for its members and an increased feeling of belongingness.

**Level of Education and Help-Seeking of men with Benign Prostatic Hyperplasia**

Individuals with tertiary and higher school experience displayed more favourable views toward seeking help than those with a basic primary education history. There is the assertion that people with tertiary qualifications and post-graduate degrees are more likely to realize their physical and mental health challenges and thus be more likely to seek support than those with basic educational backgrounds (Asamoah-Adjepong, 2018). This outcome is consistent with a previous study that found that patients with a high level of education will have more insight into their situation and are more likely to have expectations of getting better, positively affecting their quality of life (Parslow & Jorm, 2000). Another survey showed that people were 15 per cent more likely to see a therapist at each different stage of education, 12 per cent more likely to see a family doctor, 16 per cent more likely to see a counsellor, and 16 per cent more likely to see a social worker (Steele, Dewa, Lin, & Lee, 2007). One potential reason for the present result may be that tertiary/higher education adds substantially to human resources by improving several skills and attributes, such as cognitive ability, problem-solving skills, learning performance, and personal control (Mirowsky & Ross, 2005). Thus, as a person acquires greater cognitive and problem-solving capacity, he becomes more empowered to think more objectively based on factual data through events seeking solutions to questions, including health challenges. Consequently, this will develop problem-solving capabilities that do not make people feel less knowledgeable, and they can tackle challenges by seeking help to resolve a challenge rather than allowing people to be more optimistic.

Although much of the literature reviewed in this study supported the idea that higher education is linked to increased help-seeking (Naved et al., 2006; Vasiliadis et al., 2005), respondents with lower levels of formal education may have felt compelled to explain their problems and challenges because they couldn't understand what was going on. The outcome of this research question suggests that when coping with persons undergoing BPH, the level of education is not a significant aspect to remember, although a higher level of education seems to impact individual decisions.

# CHAPTER FIVE

# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter consists of the summary, conclusions, and recommendations. The purpose of the summary segment is to identify the processes used in this research. The researchers' ideas about how social support and religious faith affect the help-seeking behaviour of patients living with BPH will be briefly addressed in the conclusions and recommendations.

## Overview

This research sought to explore how social support and religious faith influences the help-seeking behaviour of patients living with BPH in the Greater Accra Region of Ghana. The study was a quantitative study that utilized a cross-sectional descriptive survey. The required data for the study was collected using a questionnaire. Approval to conduct the research was received from the Institutional Review Board of the University of Cape Coast. Pre-testing of the research instrument was done at Nature's Cure Homeopathy Centre in Accra. Participants were purposively selected before partaking in the study. The result of demographic data was analysed descriptively and inferentially using frequencies and percentages, multiple linear regression, simple linear regression, and Hayes Mediation Process.

**Summary of Key Findings**

Several participants were within the age range of 41-60 years and above. The study population was predominantly made up of married men, and results indicated that Christians constituted the largest proportion of respondents. Based on the analysis, the following inference was reached:

1. The general help-seeking behaviour of men was neither poor nor good but was moderate.
2. The satisfaction of homeopathy service and treatment, as indicated by most of the respondents, was high.
3. Social support significantly predicted help-seeking behaviour among homeopathy patients with BPH in Accra, Ghana.
4. Religious faith did not significantly predict help-seeking behaviour among homeopathy patients with BPH in Accra, Ghana.
5. Social support as a mediator could not strengthen the relationship between religious faith and help-seeking behaviour.
6. The level of education did not significantly predict help-seeking behaviour among homeopathy patients with BPH in Accra, Ghana.

**Conclusions**

This study's findings provide several important implications for understanding the impact of social support and religious faith on BPH patients' help-seeking behaviour. Without question, social support and religious faith can be positive factors in benefiting BPH patients. Findings concluded that the better a BPH patients social support network, the better their help-seeking behaviour, thus, improving their health tremendously.

There is also a need to advocate that voluntary annual PSA screening should be prescribed for males aged 40 years and over for those in the high-risk bracket. Increased knowledge of the factors predisposing individuals to the disease is also required, even though this study did not look at factors that predispose people to the condition as this is one of the significant limitations of the current study.

**Recommendations**

The recommendations are indexed under (i) Future Studies, (ii) Homeopathy Health Professionals, (iii) Health Sector.

**Future Studies**

The study mainly covered patients with BPH of 3 homeopathic clinics in Accra, Ghana. Additional studies can involve patients with other conditions from other fields of health. The analysis may be applied to other parts of the world, and patient comparisons can be considered in various geographical areas. In future studies, community-dwelling older adults in urban areas can be compared with those living in rural areas seeking help to ascertain whether significant differences exist between them.

Future studies should use qualitative methods to explore the relationship between religious faith, help-seeking behaviour, and social support and help-seeking behaviour. Moreover, this will lead to an in-depth understanding of help-seeking behaviour outcomes among older adults concerning religious faith and social support.

More research should be done to expand the sample size to include other social categories and married people living outside of Accra and other parts of Ghana. Future research should look into other factors related to help-seeking,

such as respondents' ethnic backgrounds, the helpers' cultural backgrounds, the sort of help provided, and unique cultural characteristics.

**Health Professionals**

For homeopathy health practitioners, the conclusions of this report also have real consequences. Therefore, apart from other variables, adequate attention should be given to the BPH patient's cognitive evaluation of their condition. This is because the sense of comprehension of BPH substantially decreased the health issues of much of the help-seeking actions of patients with BPH, and conscientious attempts must be taken to ensure that patients accept BPH and minimize the uncertainties around the condition.

The Homeopathy Clinic administration should ensure that patients are thoroughly and adequately counselled by nurses or clinical health psychologists before and after consultations and treatment. Patients should also be counselled, especially on sexual and emotional needs, which may help alleviate frustration feelings.

Lastly, the public and family and significant others of patients living with BPH need to be sensitized and appropriately educated by practitioners on the BPH related complications to curb patients fear of being stigmatized.

There is a need for homeopathy health practitioners and Clinical Health Psychologists to educate the men on the effectiveness of their social support network systems in helping them cope with their conditions during their radio outreaches and programmes.

**Health Sector**

The first recommendation for Ghana's health sector is that a systematic approach to BPH management should be adopted. A health care approach known as the bio-psychosocial approach includes healthcare providers of diverse experience, including homeopaths, physicians, nurses, therapists, clinical health psychologists, and dieticians.

Furthermore, in the management (treatment) regimen for BPH patients, it is recommended that access to homeopathy healthcare should be provided for health policy development. This will encourage patients to access complete care and reduce the pressure on the few medical services. The following steps are recommended to intensify the phenomena of general help-seeking behaviour globally and in Ghana in particular, based on the results obtained in this study:

1. It should be the duty of government, non-governmental organizations, social and religious associations at all levels to engage psychologists in training/advising persons about how to live a safe and right help-seeking attitude.
2. General information on the side effects of BPH and how it impacts help-seeking behaviour should be delivered by the media.
3. Homeopathy Medical practitioners are in a role to support people, so they can refer them to psychologists and counsellors following clinical therapy to take care of other social and psychological issues that cause or may precipitate their help-seeking behaviour.
4. Religious centres should introduce clinical expertise into their clergy's curriculum to better understand individual nature and learn how to inspire, promote, and encourage help-seeking rather than relying on a

spiritual approach alone. This message would be easily distributed across the religious world if there were greater cooperation between church leaders and homeopathy health practitioners. To that end, homeopathy clinics in Ghana that support the elderly need to partner with religious bodies and informal social networks to produce holistic approaches.

5. There is also the need to inspire Ghanaians to seek higher education, which would impact their search for help. This recommendation is particularly relevant in Ghana and Africa because the study's results found that people with educational backgrounds indicated substantially more readiness to seek health practitioners than those without experience registered across education levels.

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# APPENDICES

## A: Questionnaire

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF EDUCATIONAL FOUNDATIONS

DEPARTMENT OF EDUCATION AND PSYCHOLOGY

I am a final year Clinical health Psychology student at the University of Cape Coast. I am writing on the thesis topic: **Social support and Religious Faith as determinants of help-seeking behaviour among men with benign prostatic hyperplasia.** This survey is for academic purpose. Your participation is voluntary. The highest confidentiality will be maintained; the questionnaire is anonymous, and no name or address (s) are needed.

### SECTION A

### Demographic data of respondents

Please tick (√) the appropriate box

Age: 18-30 [ ] 31-40 [ ] 41-50 [ ] 51-60[ ] 60 + [ ]

Religion: Christianity [ ] Islam [ ] Traditionalist [ ] other (specify)

……..

Educational level: [ ] No Education [ ] Primary [ ] Secondary [ ] Tertiary

## SECTION B

### Santa Clara Strength of Religious Faith

**Please answer the following questions about religious faith using the scale below. Indicate the level of agreement or disagreement for each statement by ticking the appropriate box.**

**1= strongly disagree; 2= disagree; 3= Neutral; 4= agree; 5 = strongly agree**

| | ***Statements*** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| 1 | My religious faith is extremely important to me. | | | | | |
| 2 | I pray daily. | | | | | |
| 3 | I look to my faith as a source of inspiration. | | | | | |
| 4 | I look to my faith as providing meaning and purpose in my life. | | | | | |
| 5 | I consider myself active in my faith or church. | | | | | |
| 6 | My faith is an important part of who I am as a person. | | | | | |
| 7 | My relationship with God is extremely important to me. | | | | | |
| 8 | I enjoy being around others who share my faith. | | | | | |
| 9 | I look to my faith as a source of comfort. | | | | | |
| 10 | My faith impacts many of my decisions. | | | | | |

## SECTION C

## GENERAL HELP-SEEKING

Personal or emotional problems

If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?

Please indicate your response by ticking the appropriate box that best describes your intention to seek help from each help source that is listed.

**1 = extremely unlikely; 2= quite Unlikely; 3= unlikely; 4= Neutral; 5= likely; 6= quite likely; 7= extremely likely**

| | ***Statements*** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|---|---|---|---|---|---|---|---|---|
| 1 | Intimate partner (e.g., girlfriend, boyfriend, husband, wife, | | | | | | | |
| 2 | Friend (not related to you) | | | | | | | |
| 3 | Parent | | | | | | | |
| 4 | Other relative/family member | | | | | | | |
| 5 | Mental health professional (e.g. psychologist, social worker, counselor) | | | | | | | |
| 6 | Phone helpline (e.g. Lifeline) | | | | | | | |
| 7 | Doctor/GP | | | | | | | |
| 8 | Minister or religious leader (e.g. Priest, Rabbi, Chaplain) | | | | | | | |
| 9 | I would not seek help from anyone | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 10 | I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)_____ _____ | | | | | | | |

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## SECTION D

## SOCIAL SUPPORT

**Please indicate your response by ticking the appropriate box.**

**1= Very Strongly Disagree; 2= Strongly Disagree; 3= Mildly Disagree; 4= Neutral;**

**5= Mildly Agree; 6= Strongly Agree ; 7= Very Strongly Agree**

| | ***Statements*** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|---|---|---|---|---|---|---|---|---|
| 1 | There is a special person around me when I am in need | | | | | | | |
| 2 | There is a special person I can share my joys and sorrows with | | | | | | | |
| 3 | My family really tries to help me | | | | | | | |
| 4 | I get the emotional help and support I need from my family | | | | | | | |
| 5 | I have a special person who is a real source of comfort to me | | | | | | | |
| 6 | My friends really try to help me | | | | | | | |
| 7 | I can count on my friends when things go wrong | | | | | | | |
| 8 | I can talk about my problems with family | | | | | | | |
| 9 | I have friends with whom I can share my joys and sorrows | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 10 | There is a special person in my life who cares about my feeling | | | | | | | |
| 11 | My family is willing to help me make decision | | | | | | | |
| 12 | I can talk about my problems with my friends | | | | | | | |

**SECTION E**

**Please answer the following questions about homeopathy service satisfaction by ticking the appropriate box. 1= very satisfied; 2= satisfied; 3 = slightly satisfied; 4 = very dissatisfied.**

| | **Statements** | **1** | **2** | **3** | **4** |
|---|---|---|---|---|---|
| 1 | I am very satisfied with the homeopathy consultation I had today. | | | | |
| 2 | The doctor examined me carefully and completely | | | | |
| 3 | The doctor knows almost everything about my condition. | | | | |
| 4 | I think that the doctor really knows how I think. | | | | |
| 5 | The time for the homeopathy consultation with me was not long enough to deal with everything I wanted. | | | | |
| 6 | The doctor listened to my ideas. | | | | |

## B: Introductory Letter

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
**DEPARTMENT OF EDUCATION AND PSYCHOLOGY**

Telephone: 233-3321-32440/4 & 32480/3
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Telex: 2552, UCC, GH
Telegram & Cables: University, Cape Coast
Email: nfofoand@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref:

Your Ref:

4th November, 2019

**TO WHOM IT MAY CONCERN**

Dear Sir/Madam,

**THESIS WORK**
**LETTER OF INTRODUCTION**
**MR. FELIX TETTEY ANSAH**

We introduce to you Mr. Ansah, a student from the University of Cape Coast, Department of Education and Psychology. He is pursuing Master of Philosophy degree in Clinical Health Psychology and he is currently at the thesis stage.

Mr. Ansah is researching on the topic:

**"PSYCHOSOCIAL DETERMINANTS OF HELP-SEEKING BEHAVIOUR: THE CASE OF MEN WITH BENIGN PROSTATIC HYPERPLASIA WHO OPT FOR HOMEOPATHY."**

He has opted to collect or gather data at your institution/establishment for his Thesis work. We would be most grateful if you could provide him the opportunity and assistance for the study. Any information provided would be treated strictly as confidential.

We sincerely appreciate your co-operation and assistance in this direction.

Thank you.

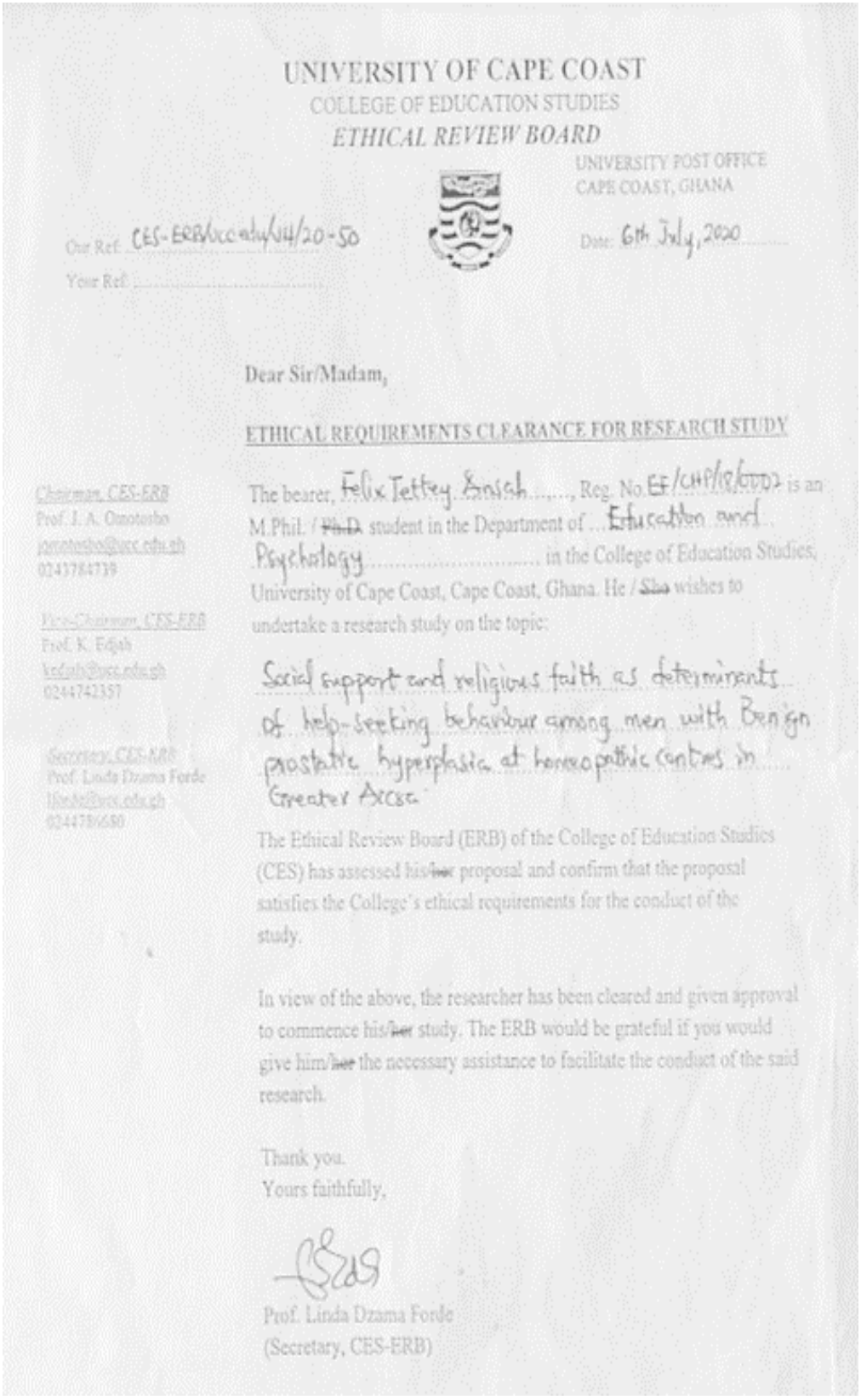
Yours faithfully

Theophilus A. Fiadzomor
***Principal Administrative Assistant***

For:

**(Dr. Irene Vanderpuye)**
**Head**

## C: Ethical Clearance



UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
*ETHICAL REVIEW BOARD*

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: CES-ERB/ucc-edu/34/20-50
Your Ref:
Date: 6th July, 2020

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

The bearer, Felix Tettey Anish, Reg. No. EF/CHP/18/0002 is an M.Phil. / ~~Ph.D~~ student in the Department of Education and Psychology in the College of Education Studies, University of Cape Coast, Cape Coast, Ghana. He / ~~She~~ wishes to undertake a research study on the topic:

Social support and religious faith as determinants of help-seeking behaviour among men with Benign prostatic hyperplasia at homeopathic centres in Greater Accra.

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed his/~~her~~ proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

In view of the above, the researcher has been cleared and given approval to commence his/~~her~~ study. The ERB would be grateful if you would give him/~~her~~ the necessary assistance to facilitate the conduct of the said research.

Thank you.
Yours faithfully,

Prof. Linda Dzama Forde
(Secretary, CES-ERB)

Chairman, CES-ERB
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