UNIVERSITY OF CAPE COAST

INFLUENCE OF ADVERSE CHILDHOOD EXPERIENCES AND STRESSFUL LIFE EVENTS ON MARITAL SATISFACTION AND HEALTH-RELATED QUALITY OF LIFE AMONG MARRIED PERSONS IN GHANA

PAUL ASIEDU KUMI

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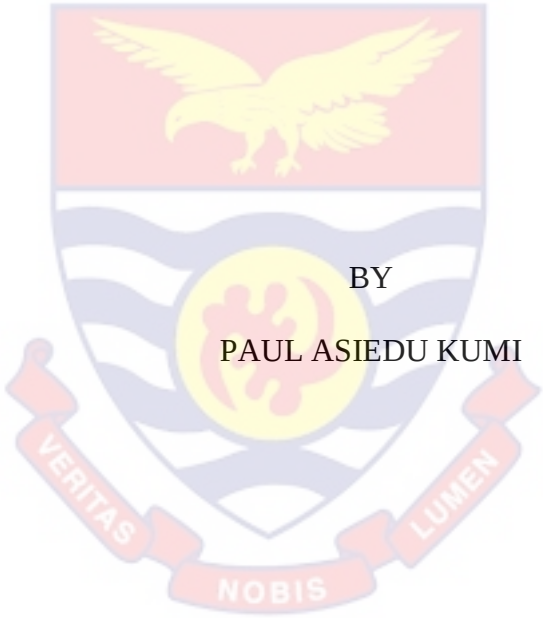

BY

PAUL ASIEDU KUMI

Thesis Submitted to the Department of Guidance and Counselling, of the Faculty of Educational Foundations, College Of Education Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Doctor of Philosophy Degree in Guidance and Counselling

FEBRUARY, 2024

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: ……..

Supervisor's Declaration

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

Supervisor's Signature…… Date: ……..

Name: ……..

Co-Supervisor's Signature…… Date: ……

Name: ……..

ABSTRACT

This study examined the influence of adverse childhood experiences (ACEs) and stressful life events (SLEs) on marital satisfaction and health-related quality of life among married persons in Greater Accra, Ghana. The concurrent mixed methods design was employed. A total of 400 married persons were involved in the quantitative phase of the study. Five of these participants were selected for the qualitative phase. The research instruments were standardised questionnaires and an interview guide. Frequencies and percentages, Pearson Product Moment Correlation, ANOVA, Multiple Regression and Multiple Logistic Regression were used for the quantitative data. The interpretative phenomenological approach was employed for the qualitative data. Adverse childhood experiences and stressful life events were found to significantly correlate negatively with marital satisfaction. There was a significant difference in marital satisfaction with respect to cumulative adverse childhood experiences. Married persons with more histories of ACEs experienced greater decline in marital satisfaction. Adverse childhood experiences and stressful life events significantly impacted marital satisfaction negatively. Similarly, adverse childhood experiences and stressful life events significantly impacted health-related quality of life negatively. However, marital satisfaction impacted health-related quality of life positively. The qualitative findings corroborated the quantitative findings. It is recommended that clinical psychologists and psychotherapists receive trauma informed care training. Also, single and married persons should be screened for and educated on the impact of childhood trauma and traumatic stress on marriage and HRQoL.

KEYWORDS

Adverse Childhood Experience (ACE)

Stressful Life Event (SLE)

Marital Satisfaction

Health-Related Quality of Life (HRQoL)

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DEDICATION

To my family, patients and beloved

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CHAPTER ONE

INTRODUCTION

Marital satisfaction has been a critical aspect of existence and has received considerable research attention over time. However, it appears the impact that adverse childhood experiences have on married persons' marital satisfaction and the health-related quality of life have not received much attention. Same can be said about the impact of potential life-changing stress often experienced in adulthood on marital satisfaction. According to Monnat and Chandler (2015), the childhood years, from the prenatal period to late adolescence, are the "building block" years that help set the stage for adult relationships, behaviour, health, and social outcomes throughout the lifespan.

This thesis examines the impact that adverse childhood experiences and stressful life experiences have on the marital satisfaction and health-related quality of life among married persons in the Ga Central Municipality of the Greater Accra Region of Ghana. With this in mind, the chapter provides an overview of the background surrounding the problem under investigation. It includes statement of the problem, purpose of the study, the research objectives, questions and hypotheses. The chapter also gives insight into what the significance of the study is, its limitations and delimitations, organisation of the entire research, and operational definition of key terms used in the study.

Background to the Study

Adverse Childhood Experiences (ACEs), broadly described as abuses, neglect and household disturbances are experiences which occur during the first 18 years of a person's life. They are typically characterized by exposure

to negative mental conditions, substance use, incarcerations, separation, divorce, violence, physical and sexual abuse (Campbell, Walker & Egede, 2016). These experiences have been classified into three subtypes: neglect, abuse, and household dysfunction. Abuse comprises physical, verbal and sexual abuse while neglect comprises physical and emotional absence of a parent or care-giver. Household dysfunction on the other hand comprises substance use, criminality, parental separation and mental health challenges of a household member (Parenting Fundamentals, 2012). Adverse Childhood Experience (ACE) has been used in place of terms such as childhood trauma, childhood adversity and childhood maltreatment (Kalmakis & Chandler, 2015). According to Cluver, Orkin, Boyes and Sherr (2015), a significant number of youth within the Sub-Saharan region of Africa have been exposed to ACEs and it is commonly evinced in physical and emotional abuse, domestic violence, parents suffering conditions such as AIDS and early death which usually results in multiple adversities.

ACEs have been shown to impact neuro-development, onset and progression of health-risk behaviours and poor health outcomes in later life, according to the first ACE study by the Centre for Disease Control (CDC)-Kaiser Permanente in 1995 (Chanlongbutra, Singh & Mueller, 2018). A greater risk of later medical and psychological conditions have also been associated with ACEs (Kalmakis & Chandler, 2015). Psychiatric challenges during childhood have also been associated with ACE with recent studies pointing to a number of ACE issues generating some mental health outcomes during adulthood (Schilling, Aseltine & Gore, 2007). ACE related mental health conditions have a tendency of disrupting normal developmental

pathways resulting in adjustment difficulties in adulthood (Schilling et al., 2007). Chronic traumatic experiences characterized by all forms of abuse and neglect have been indicated to cause an over-stimulation of the autonomic nervous system (Pervanidou & Chrousos, 2007) and a disruption in the regulation of the hypothalamic-pituitary-adrenal (HPA) axis (Trickett, 2010). A short-term disruption could cause a number of physical and psychological changes as the body adjusts to the stressor. A chronic stimulation of the HPA axis will further result in stress induced systemic disorders such as a shift from allostasis or homeostasis which is implicated in a number of psychiatric and physical health conditions across the lifespan (McEwen, 2007).

More specifically, ACEs have been shown to have the capacity to impact developmental pathways and influence a person's character and approach to later life (Monnat & Chandler, 2015). Furthermore, ACEs have been shown to lead to depression, post-traumatic stress disorder, poor health beliefs and attitudes, socioeconomic uncertainties, stressful home environments, poor health-behaviour choices in adulthood with consequential health challenges and inconsistencies over the life course (Monnat & Chandler, 2015). This accentuates the reason why early life environmental exposures and stressors have been strongly linked with the development of adult chronic diseases which ultimately decreases life span (Spencer-Hwang et al., 2018).

According to Carlson (2014), Stressful Life Events (SLEs) are unplanned, and or uncontrollable events which are distinct and observable in nature and usually results in a major life change. They have also been associated with significant negative physical and psychological repercussions.

Seyle's (1936) stress experiment indicated that repeated exposure to challenging conditions makes one vulnerable to illness and diseases (Carlson, 2014).

SLEs have been found to be strongly associated with mortality, whether natural death or suicide as well as the illness of a significant other including children, parents and or siblings and could increase the sufferer's risk of developing depression or anxiety (Dorji & Dunne, 2017). This suggests that SLEs just as ACEs, also negatively affect HRQoL.

According to Dorji and Dunne (2017), two experiences that significantly affect the physical as well as psychological health outcomes of older adults are SLEs and a significant other's morbidity due to chronic conditions. Randall and Bodenmann (2009) also indicated that an understanding of stress impact plays a causal role in enhancing physical health and emotional well-being, including resistance to depression. However, the influence of SLEs on a person has been indicated to be dependent on their perception of it as either a threat or a challenge (Dorji & Dunne, 2017). This suggests that people with a high susceptibility to stress such as persons with a history of ACEs, are more likely to bear the negative brunt of SLEs in more significant ways than those who do not.

Cleland et al. (2016) opined that, one pathway that connects SLEs and health outcomes is the adoption of health risk behaviours such as smoking, alcohol use, poor and inadequate dietary habits. These habits, usually developed as coping mechanisms in the face of stress aggravate an already declining health-related quality of life.

The concept of health-related quality of life represents an individual's overall well-being, encompassing various dimensions that have been demonstrated to impact both physical and mental health. It is said to encompass self-reported non-communicable chronic conditions such as depression, diabetes, hypertension and arthritis as well as the factors that put people at risk of these conditions, socioeconomic status, social support and functional status (Healthy Days Guide, 2019).

Apart from its impact on HRQoL, SLEs have been associated with lower marital satisfaction and daily life stressors or workload associated with daily fluctuations in marital satisfaction and functioning (Whisman, 2006).

According to Randall and Bodenmann (2009), stressors can be categorised into four; external stressors such as job stress, internal stressors such as anxiety regarding a partner's health and well-being, major stressors such as death of a significant other, acute stressors such as road traffic accident and chronic stressors such as prolonged unemployment. The interaction between external and internal stressors can increase the tendency of marital distress and poor marital outcomes (Karney, Story, & Bradbury, 2005). On the other hand, major stressors are normative or unnatural critical life events which have the potency to strain close relationships, whereas minor stressors such as frustration, irritations and distresses that emanate from daily interactions and demands have been found to have a debilitating impact on marital relationships (Randall & Bodenmann, 2009).

According to Samios and Baran (2018), married persons experience different kinds of stressors with each embedded with the capacity to disrupt their relationships. Two primary forms of stressors are stressful life events and

daily life stressors (Whisman, 2006). In periods when married persons are experiencing any of these forms of stressors, emotions are shared with partners and stressors are appraised on the basis of their value systems and meaning made out of the experience (Samios & Khatri, 2019). These stressors can have negative ramifications on marital satisfaction and partners' well-being (Samios & Khatri, 2019).

According to Randall and Bodenmann (2009), stressful environments affect marital satisfaction and interaction. Also, the personality and quality of marital interaction between married couples have been associated with divorce and rates of change in the trajectories of marriage (Randall & Bodenmann, 2009). The decrease in marital satisfaction during the initial four years of marriage has been linked to the influence of stress, specifically the challenges associated with adapting to multiple roles, transitioning into parenthood, and facing acute or chronic stressors. These factors can exert pressure on the marital relationship, leading to a decline in satisfaction (Woszidlo & Segrin, 2013).

A few longitudinal studies of newly married persons indicated that cumulative negative stressful life events were associated with lower marital quality over the life course (Umberson, Williams, Powers, Liu & Needham, 2005). To fully understand marital relationships, one needs to consider a number of factors in their specific context including the role of stress in marital relationships (Whisman, 2006). The stress universe as Whisman (2006) refers to it, varies on a life-course dimension as it could affect a person's life whether in childhood or adulthood at varied levels of discreteness and severity. A few studies have been done to foster comprehension regarding

how stress affects marital quality over the life course even though stress' effects on marriage have been indicated to be chronic or short lived (Umberson et al., 2005). According to Randal and Bodenmann (2009), a person's life satisfaction is strongly predicted by the stress associated with their marital relationship. In spite of all these, intimacy is a significant buffer between stress and marital satisfaction (Randall & Bodenmann, 2009).

ACEs have been said to impact marital quality in very unique ways. For instance, the pathway that connects ACEs to marital dissatisfaction or relationship dysfunction varies based on perspectives (DiLillo, Lewis & Loreta-Colgan, 2007). However, it has been established that ACEs may influence adult relationships including marriage by indirectly influencing adult interpersonal functioning by operating through a number of intervening problems that could potentially distort a married person's functioning. For instance, the psychological distresses associated with ACEs such as depression, anxiety and anger are believed to be routes by which they could possibly impact adult marital satisfaction (DiLillo et al., 2007).

ACEs characterized by psychological maltreatment have been shown to be particularly harmful as they usually involve a parent or caregiver directly sending negative information that highlights the child's perceived failures or inadequacies (Perry, DiLillo & Peugh, 2007). These messages, usually manipulative in content, tend to disrupt appropriate interpretation on the part of the child and disengages a child's ability to learn appropriate ways of interpreting and expressing emotions as well as engagement in adaptive self-care (Perry et al., 2007). Once internalized, children form negative schemas about themselves, others and the world, extending these concepts into

adulthood (Perry et al., 2007). This suggests that married persons who have been exposed to ACEs in the form of abuse are prone to poor self-esteem and its concomitant psychological and marital ramifications.

According to Covey, Menard and Franzese (2013), adults who have been exposed to ACEs were found to have low income and financial reserve after their family status and childhood socioeconomic statuses were controlled. Meanwhile, adult socioeconomic status has been established to fundamentally create health disparities, premature death, disease course and self-rated health concerns (Monnat & Chandler, 2015). Hence, adults with higher socioeconomic statuses are likely to have access to financial resources, knowledge and social networks that can insulate them against negative health issues that are attributable to ACEs (Monnat & Chandler, 2015).

The socioeconomic impact of childhood adversity has also been shown to be far-reaching (Monnat & Chandler, 2015) as ACEs have been found to be implicated in loss of employment, decrease in tax revenue, reduced adaptability and self-esteem, increased social withdrawal, anger and dissociation as well as health care expenditure which together affect national productivity (Zielinksi, 2009).

Regrettably, adverse childhood experiences (ACEs) have been shown to affect employability and, consequently, socioeconomic status. Furthermore, individuals belonging to minority groups with lower income levels are more susceptible to experiencing ACEs compared to the general population. Therefore, implementing targeted interventions is essential to mitigate the long-term effects of ACEs in adulthood for these specific groups. (Mosley-Johnson et al., 2019).

Again, social support has been shown to be a protective factor as it buffers against lower psychological HRQoL and enhances cognitive and emotional reprocessing of ACEs. It helps in facilitating adaptive appraisal of the ACEs which eventually results in healthy psychological adjustment to the experiences (Evans, Steel & DiLillo, 2013). Both military and civilian populations with a history of ACEs have been shown to adapt well to post traumatic stress symptoms once they are shown to have strong social support (Evans et al., 2013). This reaffirms the assertion of social support being the single strongest predictor of a decline in post-traumatic stress symptoms with both perceived and received social support having been found to positively impact outcomes where perceived social support provided significant protection against the pathogenic effects of SLEs (Cheong, Sinnott, Dahly, & Kearney 2017). It has also been implicated in enhancing stress reduction and improvement of mental and physical HRQoL even more than received social support. According to Cohen (2013), social support has been associated with better quality of life and reduced burden of illness. Thus, when sufferers of health conditions receive help from significant others, there is usually an improvement in their overall health outcome and general well-being.

Statement of the Problem

The pervasive decline in marital satisfaction, marked by frequent quarrels, partner violence, emotional abuse, and marital separations, presents a global crisis demanding urgent scientific scrutiny and evidence-based interventions. Studies, including research by Verbrugge and House (1981) at the University of Michigan, underscore the profound health consequences: individuals dissatisfied with their marriages face a staggering 35% increased

risk of illness and up to a 4-year reduction in life expectancy (Gottman & Silver, 2015). Furthermore, research by Shrout (2021) reveals that maritally distressed individuals suffer from compromised psychological, cardiovascular, and immune health compared to their happily married counterparts.

Gottman and Gottman (2014) argue that marital distress often escalates due to spouses' inability to regulate their physiological and emotional responses during communication, exacerbated by factors such as Adverse Childhood Experiences (ACEs). ACEs not only impair emotional and physiological regulation but also correlate significantly with diminished marital satisfaction, as highlighted by the findings of Solisa (2014). Stressful Life Events (SLEs), such as birth of a first child, adolescence of children, job loss, and infidelity, further compound these challenges, contributing to emotional and physiological dysregulation within marriages (American Association for Marriage and Family Therapy, 2016; Vaez & Juhari, 2017).

The consequences of marital dissatisfaction are stark, manifesting in physical and emotional distress, including high blood pressure, depression, violence, and substance use (Gottman & Silver, 2015). Notably, longitudinal studies indicate a sharp decline in marital satisfaction among individuals with histories of ACEs and SLEs, emphasizing the critical need for research to understand and mitigate these impacts (Donnelly et al., 2018; Nguyen et al., 2017).

In Greater Accra, where approximately 38.7% of married individuals report experiencing physical, psychological, or sexual abuse from their spouses (Institute of Development Studies, 2016), the prevalence of marital dissatisfaction is alarmingly high. Yet, there remains a significant gap in

literature concerning the specific impacts of ACEs and SLEs on marital satisfaction and subsequent health-related quality of life among married Ghanaians.

Given the protective role of marital satisfaction throughout the lifespan, urgent empirical investigation is warranted to elucidate the mechanisms through which ACEs and SLEs diminish marital bliss, particularly in contexts like Ghana, where research on these critical issues remains sparse.

Purpose of the Study

The aim of the study is to ascertain the impact that adverse childhood experiences and stressful life events will have on marital satisfaction and health-related quality of life among married persons in the Ga Central Municipality of the Greater Accra Region of Ghana. The study will focus on the following objectives. To;

1. unearth the adverse childhood experiences experienced by married persons in the Ga Central Municipality of the Greater Accra Region.
2. unearth stressful life events experienced by married persons in the Ga Central Municipality of the Greater Accra Region.
3. unveil the prevalence rate of cumulative number of adverse childhood experiences among married persons in the Ga Central Municipality of the Greater Accra Region.
4. determine the relationship among adverse childhood experiences, stressful life events and marital satisfaction among married persons in the Ga Central Municipality.
5. determine the cumulative number of adverse childhood experiences

that will significantly influence marital satisfaction among married persons in the Ga Central Municipality.

6. explore how adverse childhood experiences, stressful life events, marital satisfaction relate with health-related quality of life among married persons in the Ga Central Municipality.
7. examine the influence of adverse childhood experiences and stressful life events on marital satisfaction among married persons in the Ga Central Municipality.
8. examine the impact of adverse childhood experiences, stressful life events and marital satisfaction on health-related quality of life among married persons in the Ga Central Municipality.

Research Questions

The study aims to address the following research questions:

1. What are the common adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region?
2. What are the common stressful life events experienced by married persons in the Ga Central Municipality of the Greater Accra Region?
3. What is the prevalence rate of the cumulative number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region?
4. What influence do Adverse Childhood Experiences and Stressful Life Events have on marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region?
5. What influence do Adverse Childhood Experiences, Stressful Life

Events and marital satisfaction have on Health-Related Quality of Life among married persons in the Ga Central Municipality of the Greater Accra Region?

Hypotheses

The study proposed the following hypotheses to provide further guidance:

$H_0$1: There will be no statistically significant relationship among adverse childhood experiences, stressful life events and marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

$H_1$1$_A$: There will be a statistically significant relationship between adverse childhood experiences and marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region.

$H_1$1$_B$: There will be a statistically significant relationship between stressful life events and marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region.

H_0 2: There will be no statistically significant difference in marital satisfaction with respect to cumulative number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region.

H_1 2: There will be a statistically significant difference in marital satisfaction with respect to the cumulative number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region.

$H_0$3: Adverse childhood experiences, stressful life events and marital satisfaction will not predict health-related quality of life of married persons in the Ga Central Municipality of the Greater Accra Region.

$H_1$3: Adverse childhood experiences, stressful life events and marital satisfaction will predict health-related quality of life of married persons in the Ga Central Municipality of the Greater Accra Region.

$H_0$4: Adverse childhood experiences and stressful life events will not predict marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

$H_1$4: Adverse childhood experiences and stressful life events will predict marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

Significance of the Study

This study is significant in the following ways:

First of all, counsellors and therapists will appreciate the extent to which their clients' adverse childhood experiences could influence their interpersonal challenges and health difficulties. This could help counsellors and therapists put in interventions that avert the probable consequences.

Furthermore, the general populace, especially the married will become more aware of how their adverse childhood experiences and stressful life events could be impacting their marriages and health. This awareness could help all and sundry to leverage on their knowledge and internal resources to reduce or avert the impact by seeking help where need be.

Also, the outcome of this study will bring to the fore the impact that marital satisfaction could have on health-related quality of life. This may

inform the clergy, physicians and mental health professionals about the need not to overlook but refer persons or clients who may inform them about their marital challenges to professional counsellors.

Additionally, it could inform management of health-care facilities to include counselling psychologists in their health care teams in order for persons with psychosocial challenges that may not meet a diagnostic criterion but could grossly affect health-related quality of life to receive the needed professional support. This will help improve health outcomes.

Moreover, this study will inform parents, guardians and teachers about how much adverse childhood experiences could be detrimental to the well-being of their wards and pupils throughout their lifetime. This insight could help parents and teachers attach importance to their children's mental health and well-being and make efforts to protect them or seek early relevant assistance to avoid any severe future challenges.

Also, the outcome of the study may necessitate the need for health care seekers to be screened for any adverse childhood experiences and or stressful life events and obtain referrals to the appropriate mental health professional once clients' scores are significant enough to negatively affect their health outcomes.

This study promises to lead to the creation of new knowledge in the area of marriage counselling and health-care by unveiling the impact that childhood adversity and stressful life events have on marriage and health as well as inform decisions for policy making and interventions towards marriage and health.

This study may also inform religious leaders and marriage counsellors to include screening for adverse childhood experiences and stressful life events during premarital and marital counselling sessions. This could serve as a guide during these sessions. Significantly, this could help counsellors tailor their interventions to meet the needs of their clients and refer where a psychiatric or psychologically illness is plausible.

Delimitation

This study focused on married persons to ascertain the impact of this phenomena on marriages and health-related quality of life. This study did not include partners in relationships or persons who are cohabiting.

For the purpose of effective data collection which is usually facilitated by proximity and the time cap over this study, the study population considered was married persons, 18 years and above, within the Ga Central Municipality of the Greater Accra Region.

Limitations

Data was gathered from some localities within the Ga Central Municipality of the Greater Accra Region and not all. This was due to the vastness of the municipality and difficulty to access all localities.

Also, some of the items were one the adverse childhood questionnaire were quite sensitive and could be responded to in socially desirable ways. However, the assurance of anonymity and confidentiality mitigated that possibility.

Operational Definition of Terms

The concepts of adverse childhood experiences, stressful life events, marital satisfaction and health related quality of life was repeatedly referred to

throughout this study. It is therefore imperative that these concepts are defined to suit their use in this study.

Adverse Childhood Experiences (ACEs): ACEs refer to adverse experiences of participants within the first 18 years of their lives characterised by maltreatment (physical, emotional, sexual abuse or neglect), household adversity which implies the presence of an adult or adults in a household who suffered a mental health condition, used illicit substances or committed crimes and or the presence of domestic violence, parental separation or living in a foster home (Centres for Disease Control and Prevention, 2021). For example; rape, parental divorce, battering etc.

Stressful Life Events (SLEs): SLE refers to circumstances that participants may consider undesirable and uncontrollable events with a generally clear onset and offset that resulted in major life changes (Ouyang, Gui, Cai, Yin, Mao, Huang, Zeng & Wang, 2021). For example; loss of a job, going through a divorce, death of a child or close relative.

Marital satisfaction: This pertains to an individual's perspective regarding their own marriage. In the context of this study, this concept refers to the extent to which a married person feels understood, loved, appreciated and supported by their spouse.

Health-Related Quality of Life (HRQoL)**:** HRQoL refers to how well a participant functions in his or her life and his or her perceived well-being in physical, mental and social domains of health (Healthy Days Guide, 2019). For example; optimum function pertaining to activities of daily living.

Married person: This refers to a participant who is a Ghanaian citizen, above age 18, and is legally married either customarily or under ordinance.

Organisation of the Study

The study is structured into five chapters. Chapter One provides the study's background, offering an overview of the research topic and its context. The statement of the problem as well as the purpose of the study, research questions and hypotheses follow successively. The significance, delimitation and limitation of the study are detailed subsequently.

Chapter Two focuses on conducting a thorough review of related literature. This chapter delves into various theoretical frameworks, including Attachment theory, Trauma theory, Sound Relationship House theory, Transactional stress theory, and the Biopsychosocial Theory of Health. The aim is to provide a comprehensive examination of these theories in relation to the research topic. Chapter Three concentrates on the methodology, placing specific emphasis on the chosen research design, population selection, sampling procedures, and the instruments used for data collection. This chapter also addresses the validity and reliability of the instruments and outline the statistical tools that are employed for data analysis.

In Chapter Four, the results obtained from the analysed data are presented. This section aims to juxtapose the research outcomes with the research questions and hypotheses that are formulated.

Chapter Five details the summary, conclusions, and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter provides a comprehensive review of the literature related to the study, covering all relevant issues and variables. It encompasses a conceptual review, a theoretical framework, and an examination of empirical studies. The reviewed theories include Attachment theory, Trauma theory, Sound Relationship House theory, Transactional Stress theory, and the Biopsychosocial theory. The chapter concludes with a summary of the key findings and insights gathered from the literature review.

Conceptual Review

Adverse Childhood Experiences

Adverse childhood experiences are preventable, potentially traumatic events that occur in childhood (0-18 years) such as neglect, experiencing or witnessing violence, and having a family member attempt or die by suicide. Also included are aspects of a child's environment that can undermine their sense of safety, stability, and psychological attachment. Some examples of such environments are growing up in a household where illicit drugs are used, mental health problems, or instability due to parental separation or incarceration of a parent, sibling or another member of the household (Centres for Disease Control and Prevention, 2021). Importantly, these examples do not comprise an exhaustive list of all childhood adversities, as there are other potentially traumatic experiences, such as bullying, experiencing racism, and the death of a parent, that can also impact health and wellbeing (Centres for Disease Control and Prevention, 2021).

According to Bellis et al. (2015) ACEs have been found to have direct impact on children's health as a result of physical injury following physical abuse. However, present evidence indicates that ACEs alter brain, nervous, hormonal and immunological system development which in turn results in a persistent over-arousal of the nervous system in preparation for further trauma and subsequent physical and mental ill health. Bellis et al. (2015) further mentioned that children raised in violent environments are more susceptible to violent traits, perceiving them as normal while those exposed to other forms of ACEs such as emotional or sexual abuse as well as neglect have vulnerabilities to low self-worth and increased health risk behaviours such as smoking, harmful alcohol consumption, poor dieting and early sexual activity. They asserted that the cycle of violence which refers to the tendency for sufferers of ACEs to expose their children to ACEs is also a great susceptibility.

The life course perspective of ACEs, simplified in the Adverse Childhood Experiences pyramid below explained that adverse childhood experiences lead to disrupted neurodevelopment and allostatic load which eventually results in social, emotional and cognitive impairments, an adoption of high-risk behaviours and crime which are used as coping mechanism but eventually result in disease, disability, social problems and low productivity and then early death (Bellis et al., 2015). Figure 1 displays the Adverse Childhood Experience pyramid.

Figure 1: Adverse childhood experience pyramid (Centre for Disease Control and Prevention, 2021)

Stressful Life Experiences

The chronicity of strenuous daily stressful situations have potential health debilitating consequences just as much as personal stressful major life events may by resulting in acute and protracted physical and psychological ailment (Nezu, Nezu & Geller, 2003). Health risk behaviors, such as smoking, alcohol use, poor diets, and risky lifestyles, are often identified as significant contributors to various ailments. In addition, stressful life events play a role in impacting health outcomes. However, the relationship between stress and illness can be influenced by moderating factors such as social support and adaptive coping strategies. These factors can either mitigate or amplify the impact of stress on health, highlighting their importance in determining an individual's susceptibility to illness (Nezu, Nezu & Geller, 2003).

According to Nezu, Nezu and Geller (2003), there are three pathways that influence the stress illness interaction. The first is the physiological pathway which explains that physiological pathways such as changes in immune, endocrine and cardiovascular reactivity due to stress will result in

disease onset. The health compromising behaviour pathway also explains that people have a high propensity towards substance use in their attempt to relieve their stress especially when they are consumed by their stressors and begin to overlook their routine self-care. The third pathway explained that stress results in significant negative cognitive rumination, anxiety, anger, depression and pessimism which may have detrimental health consequences. An example of this is that optimism has been shown to be associated with positive health outcomes, while depression has been identified as a potential precursor to poor health (Carver, 2001).

Marital Satisfaction

Marital satisfaction is often defined as the attitude an individual has toward his or her marital relationship (Whisman, 2006). Whisman (2006) indicated that couples experience varying degrees of marital satisfaction over the duration of their relationship, although there are competing viewpoints on exactly how this occurs. One view suggests a general decline in marital satisfaction over time. Others suggest a decline in marital satisfaction in the early stages with a gradual increase later. Still others indicate no significant change in marital satisfaction.

Children may play a significant role in marital satisfaction. More specifically, whether children are planned, the presence of parental stress, and co-parenting behaviours may all impact marital satisfaction.

Communication skills have been noted as a significant contributor to marital satisfaction in its facilitation of relationship maintenance, enhancement of feelings of happiness, satisfaction and commitment with effective conflict management in couple relationships being a function of communication

efficacy (King, 2019). Nurhayati, Faturochman and Helmi (2019) expounded on the concept of marital satisfaction by indicating that couple's personality affects their marital quality. Specifically, couples who were highly neurotic and less agreeable, conscientious and expressive were more dissatisfied in their marriages. Also, they mentioned that affective attachment or relationship between two people, in this case a husband and wife, was found to be related to marital quality with satisfaction being predicted from one's attachment style, the couple's attachment style, as well as combination of both. A decrease in marital quality was attributed to anxious attachment style.

Apart from effective communication, conflict resolution, couples' personality and attachment, religiosity and attendance at services were also found to directly or indirectly influence marital quality, lower chance of infidelity, domestic violence, and divorce (Nurhayati, Faturochman & Helmi, 2019).

Health Related Quality of Life (HRQoL)

World Health Organisation defined health as a state of complete physical, mental, and social well-being, not merely the absence of disease, or infirmity (Centres for Disease Control and Prevention, 2000). Health is considered a multidimensional construct that encompasses premature mortality and life expectancy as well as an array of physical states, symptoms and functions, psychological functions, and perceptions about present and future health (Centres for Disease Control and Prevention, 2000).

The Centres for Disease Control and Prevention (2000) elaborated the concept of health-related quality of life by emphasizing that it encompasses the meaningfulness that individuals attribute to their overall well-being,

including their happiness and satisfaction with life. They further mentioned that the concept addresses the impact that quality of life has on health, whether physical or mental. Health in this respect also includes health risk behaviours and conditions, social support, socioeconomic status and social support. However, genetic predispositions, illnesses and conditions that may be unknown to a person and does not result in any symptoms are not considered as having a bearing on quality of life.

Hence, a person's health-related quality of life strongly hinges on their perception of their own health condition, whether acute or chronic. This helps to predict the future health burden on sufferers and the health care delivery system as most people generally seek health care only when they are suffering conditions they perceive as detrimental to their overall wellbeing (Centres for Disease Control and Prevention, 2000).

Theoretical Framework

Attachment theory

The Attachment theory was birth out of John Bowlby's observation of children who had been separated from their parents. According to Bowlby (1979), the proponent of the Attachment theory, the survival of an infant is strongly hinged on the bond that exist between their caregiver and themselves where there is a significant care-giving response from the caregiver which he termed affectional bond (Smith et al., 2016). Bowlby indicated that, the affectional bond makes two significant provisions. First, it gives children a "safe haven" which serves as a fortress they can return to in times of stress. The other is a "secure base" which serves as the psychological foundation of

secured space from which children are able to explore their world and gain autonomy and a sense of individuality (Smith et al., 2016).

The interaction between children and their caregivers during infancy and childhood fosters the creation of an "internal working model" of themselves as unique individuals in relation to those they interact with (Smith et al., 2016). This model is fundamental in facilitating the development of children's personality as it helps in the predictability and comprehension of the responses of others and to aid in emotional comprehension in the course of interpersonal association (Smith et al., 2016).

Adults with positive self-image, optimum distress management capacities and a strong sense of independence and interpersonal prowess are believed to have been securely attached as children. Secure attachment is developed when caregivers are emotionally responsive and sensitive to the needs of children (Smith et al., 2016). On the contrary, adults with anxiety-response characteristics to stress whose emotional responses are excessively pronounced with avoidant traits such as the suppression of negative emotions as well as withdrawal or poor help seeking behaviour are said to be insecurely-attached (Smith et al., 2016).

These styles of attachment are known to significantly influence adolescent and adult personality and relationships; romantic or marital relationships and people's choice of partners (Smith et al., 2016). Again, there is a transgenerational impact of attachment styles where persons who are raised by securely-attached parents are found to also raise securely-attached children while those who are raised by avoidant or disorganized attached parents also raise children with similar attachment styles (Smith et al., 2016).

The quality of a person's family relationship and functional parental psychosocial attitude has been implicated in this inter-generational impact (Smith et al., 2016).

Maladaptive attachment styles are evinced among adults who have a low threshold for stressful life events (Smith et al., 2016). Adults who are securely-attached have been said to be less susceptible to depression and physical health problems (Smith et al., 2016).

Against this backdrop, it is likely that participants who have histories of ACEs are likely to experience significant decline in marital satisfaction due to their susceptibility to dysfunctional social interaction as a result of the fracture in the internal working system created by their maladaptive attachment history.

Also, in this study, participants with histories of ACEs may be vulnerable to stress which is likely to make them prone to the ramifications of SLEs such as poor HRQoL. Hence, it will not be a surprise if participants of this study who have experienced ACEs appear to suffer more decline in marital satisfaction and HRQoL.

Marital Satisfaction Theory

Gottman (1999) sound relationship house theory posits that marital stability and satisfaction can be predicted over time on the basis of the positive interaction and friendship that exists between couples. According to Gottman (1999), if out of every 6 conversations, 5 are positive interactions and 1 a negative one, a person's marital stability is significantly assured. He further defined marital stability as a satisfying marital relationship devoid of separation or divorce. The longitudinal study that formed the crux of the

theory indicated that more positive affect such as happiness was the single most important factor that predicted marital stability.

Again, the study indicated that 69% of couple's challenges were perpetual in form and more likely to go unresolved throughout the marital relationship. Hence, a couple always needed to communicate well in order to find common ground or compromise in the face of their differences instead of always seeking solutions. Once communication gets stifled, couples begin to get agitated and emotionally disengaged. Communication indeed plays a crucial role in marital satisfaction (Gottman, 1999).

Given Gottman's theory, it appears a couple with a secure attachment base where there is a sense of security without adverse childhood experiences may do better in terms of their communication patterns and outcomes which will culminate in better marital outcomes as well as health. This suggests that adverse childhood experiences with its consequential disrupted attachment base, a shattering of the framework of meaning and its tantamount interpersonal relation ineptitude could result in marital dissatisfaction and an eventual poor health-related quality of life.

Again, Gottman's model posits that partner's adaptive response to negative emotions such as anger by processing their emotional and physiological reactivity to the negative stressor instead of trying to regulate the other partner's, yielded better communication outcomes compared to active listening techniques (Gottman, 1999).

Furthermore, four negative and destructive interaction styles of interaction referred to as the "Four Horsemen of the Apocalypse" were

implicated in the perpetuation of divorce or dissatisfying marriages (Gottman, 1999).

One of these styles is called criticism. This is characterised by blaming one's partner by attacking their person or character. The other is defensiveness style which is also characterised by a partner's refusal to accept responsibility for their actions and or acknowledge their fault by responding to comments with an attack or defending their innocence. Contempt is another detrimental style characterised by an addition of a sense of superiority, disgust or contempt to criticism. Stonewalling is where a partner stops responding to the other because they feel overwhelmed and find it difficult to respond due to heightened arousal state associated with stifled dyadic relationship. Data suggests that 85% of men use the stonewalling style. Some protective factors for marital satisfaction and stability included husbands' willingness to accept their wives' influence, humour, respect, positivity, affection as well as empathy due to the former's potential to soothe physiological arousal.

There are 3 components or systems of the sound relationships house theory; friendship system, conflict system and the meaning making system. The components comprise seven levels that result in marital satisfaction; building love maps, sharing fondness and admiration, turning toward each other instead of away, keeping a positive perspective, managing conflicts, working towards life dreams and creating shared meaning.

Love maps imply how vexed a partner is in their knowledge and interest of the other. Love maps are an indicative of a partner's understanding of the other's thought, hopes and feelings with the aim of enhancing

friendship. When the love map breaks, there is a sense of distance, lack of care and emotional disconnection which results in alienation.

Again, the sharing of fondness and admiration refers to partners' ability to notice and express their appreciation to the other with the aim of sharing care and value. Criticism and attacks expunges the sense of love partner has.

Keeping a positive perspective is birth after the first three levels have been fulfilled. The use of humour, affection and calmness are key features of this level as well as the capacity not to personalise things.

Another is the conflict management level which is the act of normalising conflict. This level impacts marital satisfaction as the partners show gentleness, accept influence, maintain calmness, repair, deescalate and offer compromise as marital conflict is a perpetual phenomenon given differences in personalities and preferences.

The sixth level involves couples' ability to enquire about each other's dreams, hopes, values aspirations and convictions with the aim of understanding and supporting in their achievement. The root of marital relationship distresses are stories associated with a partner's unmet core needs.

The final level of marital satisfaction, according to Gottman, is the creation of shared meaning which involves married persons' definition of meaningful roles, values and goals that culminates into establishing a future together as they create patterns of behaviour that enhance bonding and interpersonal intimacy.

Hence, participants who report experiencing marital satisfaction are likely to describe or indicate characteristics of fondness, appreciation and

acceptance as being evident in their marriages. However, for those who may be experiencing a decline in their marital satisfaction, they are more likely to experience elements of criticism, defensiveness, contempt or stonewalling during communication with their spouses. Hence, it would not be unexpected to discover that individuals who seem to have higher levels of marital satisfaction might communicate with their spouses in a more responsive and constructive manner.

Transactional Stress Theory

The transactional stress theory posits that in the face of loss, harm or challenging stressful life events, individuals employ appraisal styles and techniques which help them contain the emotional distresses associated with the life events as their appraisal styles alter their belief about the situation and reduce the impact of the probable impact of the experience (Dillard, 2019).

According to Lazarus (2012), how a person appraises stressful life events (SLE) or experiences significantly imparts the outcome of the experience on them. Lazarus preferred the word appraisal to perception due to the cognitive evaluative component associated with appraisal. Appraisal is defined as the making of meaning with respect to a life event or situation with the potential of change in belief systems, information or experiences happening as one continues to cognitively re-evaluate the situation or life event (Lazarus, 2012).

Within the transactional stress theory, appraisal is categorized into two forms, primary appraisal and secondary appraisal (Dillard, 2019). A person is said to appraise a situation through the primary process when they evaluate the SLE or experience in the light of its intrinsic relevance. As well as, the extent

of its influence on their personal values, drives, commitments and beliefs as well as the possible outcomes it promises, should one make a decision for or against it (Dillard, 2019). For instance, if a person should experience the loss of a spouse or child, job or funds, the impact of the loss on them, whether on their marriage or health or both will be determined by their primary appraisal of the event or experience. Thus, their belief about the relevance of the event or experience and what they believe about the probable outcomes of the event will determine how they are influenced by them. If their personal belief about loss is that it is an already determined or destined course and that though painful, still has significant existential relevance, the outcome may differ compared to a similar situation of loss which is appraised as a sign of a curse or bad omen. The idea of primary appraisal constitutes motivational relevance and motivational congruence. Motivational relevance refers to appraising one's experience on the basis of its commonality with their beliefs, personal values and commitments or drives. However, motivational congruence refers to appraising one's experience on the basis of its congruence with one's goals and desires (Dillard, 2019).

On the other hand, secondary appraisal is when a meaningful relationship exist between a person and their environment (Lazarus, 2012). In the process of secondary appraisal, there is a self-assessment of one's ability to and capacity to manage their stressful life event or experience. This is referred to as coping self-efficacy (Dillard, 2019). For secondary appraisal to be successful, one needs to identify their available options for dealing with their stressors. This consists of problem focused coping potential, emotion focused coping potential, accountability and future expectancy (Dillard, 2019).

Accountability implies one's opinion on who should be blamed or credited for the outcomes of the events or experiences whereas future expectancy has to do with the likelihood of the life event and its motivational congruence changing (Dillard).

Lazarus (2012) opined that in typical transactional stress situations, appraising the life event results in either harm and loss, threat or challenge. In the event that the stressor results in an irreversible damage is envisaged upon appraisal, harm and loss is implied. However, if the possibility of a future harm and loss is inferred, it is considered a threat. The stressful life event is considered a challenge when it has the potential to enhance psychological growth following appraisal and the needed adaption and attention. In situations where a person experiencing stressful life events relooks at their primary and secondary appraisal styles in order to evaluate their efficacy in dealing with the stressor or insufficient in addressing a challenge, it is referred to as reappraising (Lazarus, 2012).

For every transactional stress process, the variables involved are usually interdependent and can be categorized into antecedent, mediating process and outcome variables. The antecedent variables are typically the stressful life experiences or situational conditions as well as the personal constraining characteristics which require appraising (Dillard, 2019). Situational conditions or stressful life events are those demands and resources such as SLEs which may be novel, predictable or unpredictable, ambiguous, imminent, chronic and happening within a specific frame of time (Lazarus, 2012). Furthermore, a person's personal constraining variables include their self-worth and world view or beliefs and this is formed by their sense of self

as well as interactions with others and the ideas of personal meaning as framed within the web of their sociocultural belief systems (Lazarus, 2012).

The mediating process variables are one's appraising capacity, their action propensities and coping styles. In appraising, a person evaluates the importance of their options of actions which results in emotional dispositions characterized by a set of fundamental relational theme (Dillard, 2019). A person's core relational themes are formed by how they appraise themselves in the context of their environment as well as their personal meaning making. Lastly, a person's action tendencies are their physiological processes associated with their core relational themes (Dillard, 2019). Action tendencies function both as mediating process variables and outcomes. For instance, in the process of person-environment appraisal, there is a resultant threat perception which generates anxiety that leads to the development of various behavioural coping styles. Furthermore, this appraisal style creates the possibility of reappraisal of the threat or challenging stressful life event and these occurrences trigger the activation of the hypothalamic-pituitary-adrenal axis and the sympathetic-adrenal-medulla system that control physiological responses to stressors (Dillard, 2019). These physiological action tendencies have been indicated to be significantly associated with and corresponds with one's perception of the stressor and core relational themes of emotions. Furthermore, how persons cope with their stressful life events engineers changes in the SLE or the way they appraise the person-environment relationships (Dillard, 2019).

The outcome or effect of the SLE on the sufferer can be either proximal or distal. In the event that the outcome of the SLE impacts the

sufferer's immediate subjective emotions or affect and action tendencies, it is considered a proximal or short-term outcome. On the other hand, should the SLE impact the sufferers' patterns of appraisal and coping chronically to an extent that it affects their wellbeing, social functioning and somatic health, thus their health-related quality of life, it is considered a distal or long-term outcome (Dillard, 2019).

In the light of this study, the transactional stress theory points to the fact that married persons who experience similar stressful life events may not respond in similar ways to the events. Hence, it is likely that some participants may experience significant decline in their marital satisfaction and HRQoL upon experiencing certain SLEs or a number of SLEs. On the contrary, others may not report any significant impact on their marital satisfaction or HRQoL irrespective of the nature of SLE they may have experienced due to their appraisal of the situation.

Biopsychosocial Model of Health

The biopsychosocial model of health was developed by George Engel and was published in 1977 (Bolton & Gillet, 2019). This model was distinct from the existing biomedical model as it emphasised the need for cognisance to be given to the sufferer of the ill-health, how the person experiences the condition as well as his or her perspective and attitude towards the condition ((Bolton & Gillet, 2019). Also, how others within the social convoy of the person perceive or regard the condition and how the person is cared for. These affirm the role of other psychosocial contributory factors in determining the onset and recovery from diseases other than looking at health and illness onset and outcomes from the mere biomedical basis (Bolton & Gillet, 2019)..

Furthermore, the healthcare system and the extent of professionalism exuded by the medical and other allied staff form the social basis of the model from a healthcare perspective (Bolton & Gillet, 2019).

Again, most people's lifestyle choices which are cognitive and behavioural in nature but have significant impact on health are socially determined (Bolton & Gillet, 2019). For instance, for persons exposed to ACEs who try to cope with the aftermath by engaging in risky sexual behaviours, these behaviours are influenced by the social environment of such persons. Similarly, for persons exposed to stressful life events who try to deal with the emotional and economic strain by working long hours and using alcohol as a de-stressor, their use of alcohol or sexual behaviours will be determined by their social environment. Thus, the availability of sexual partners or alcohol, availability of the needed assistance within their social circles to overcome the traumatic stress or even the person's socialisation and orientation regarding alcohol use, sex, work or health seeking.

According to the biopsychosocial model, a person's lifestyle such as health risk behaviours and self-care habits can be considered as behavioural. Whereas their belief system, character and personal values are classified as mental and these two work in tandem (Bolton & Gillet, 2019). The model indicates that psychological factors significantly impact lifestyle choices and further emphasises the link between a person's mental space and his or her behaviour (Bolton & Gillet, 2019). The model seeks to affirm the reality that a person's experience of adverse childhood experiences and or stressful life events constitute the psychological factors which could be determinants of their lifestyle choices. Such lifestyle choices could be depriving themselves of

sleep, using illicit drugs or alcohol and other health risk behaviours as ways of coping with the experiences which result in poor health outcomes.

A person's psychological health hinges strongly on his or her developed sense of agency and once agency is compromised as a result of chronic traumatic stress, mental health hangs in the balance with a greater propensity to suffer and so does one's physical health through various biopsychosocial pathways (Bolton & Gillet, 2019). This suggests that, persons who have been exposed to traumatic stress such as ACEs and SLEs are likely to suffer poor Health Related Quality of Life (HRQoL) given the impact of these traumas on their agency.

Fundamentally, a person's health is pivoted on the various biological influences of health (Bolton & Gillet, 2019). These comprise cellular or biological system which comprise of neural systems and genetic mechanisms, the psychological factors such as their personality, temperament, quality of life and lifestyle as well as social determinants such as social inclusivity and exclusivity (Bolton & Gillet, 2019) sometimes evinced in social status. Bolton and Gillet indicated that subjective social status typically referred to as perceived social status is what determines a person's health outcome or HRQoL and not their objectively measured social status.

Hence, in the instance that some participants attribute the quality of their health to their SLEs and ACEs, these attributions may be considered factual even if there are no biological explanations to the state of their health. The biopsychosocial theory thoroughly explains that, psychological distresses such as SLEs and ACEs are just as potent as pathogens may be in altering a person's health. Again, it should not be a surprise if participants indicate that

their HRQoL has been influenced by their marriages since, though a social phenomenon, the biopsychosocial theory elaborates its role in determining health outcomes. Therefore, though ACEs, SLEs and marital satisfaction are psychosocial phenomena and not biological, the biopsychosocial theory accentuates their potency in altering HRQoL.

Empirical Review

Adverse Childhood Experiences and Marital Satisfaction

According to Roberts, McLaughlin, Conron and Koenen, (2011) who examined adulthood stressors, ACEs, and risk of perpetration of intimate partner violence, there is a greater risk of intimate partner violence perpetration among individuals who were exposed to stressful life events and adverse childhood experiences. Also, participants with high levels of adverse childhood experiences were more likely to perpetrate intimate partner violence in the event that they experience stressful life events. This suggests that the reactivity to stress experienced during childhood significantly influences adult mental health and behaviour, encompassing both internalised and externalised behaviours. The tendency for a person to perpetrate intimate partner violence regardless of how high or low their childhood adversity was, depended largely on the magnitude of their recent stressors or stressful life events. This outcome is likely attributable to their susceptibility to stress sensitisation or reactivity.

In spite of the participants' response being self-reported and the data taken in retrospect thereby causing a probable under-reporting and susceptibility to social desirability bias, the study outcome was significant for

the purpose of generalisation given the huge sample size of 34,653 and an 86.7% response rate.

In similar research by Perry et al., (2007) which focused on the impact that psychological distresses had in mediating the link between childhood psychological maltreatment or ACEs on marital satisfaction, however among 65 newlywed couples, a significant relationship was found to exist between ACEs and marital satisfaction once participants reported some form of psychological distress, hostility and depression. They indicated that once psychological distress, hostility and depression were controlled, the linkage became non-existent. This finding shed light on the probable antecedent to intimate partner violence and the consequent marital dissatisfaction. They also found that among the husbands, broad psychological distress and paranoia mediated the long-term correlates of emotional abuse. However, among the wives, the relationship between emotional abuse and emotional neglect and later marital satisfaction was mediated by obsessive compulsive propensities and hostile tendencies.

Even though the sample size is not as high as in the earlier mentioned study by Robert et al. (2011) to warrant generalisability, the uniqueness of the study in using newlyweds and the drive to test how psychological distresses may be mediating their perception of their marital satisfaction in the light of their respective ACEs make the study very useful especially as it also gives insight into the probable triggers of intimate partner violence.

Furthermore, Dugal et al. (2020) realised an association between cumulative childhood trauma or ACEs and psychological intimate partner violence in a sample of 501 heterosexual couples. Their study further revealed

that ACEs were associated with increased levels of negative urgency which also results in a higher tendency for demand-withdrawal and or demand-demand communication pattern and perpetration of psychological intimate partner violence. This also reveals that apart from psychological distresses, hostility and depression which Perry et al. (2007) found to mediate ACEs and marital satisfaction, couple communication patterns were also found to be precursors to intimate partner violence or marital satisfaction.

Though Dugal et al. (2020) study was quantitative and therefore unable to thoroughly detail what characterised the pattern of communication and how they must have been determined by a person's ACEs, the implication of the finding is relevant for this research as it unveils how ACEs impact intimate partner relationships which includes marriage though not exclusively. It did good by revealing the mediating role that negative urgency and communication patterns play in instigating intimate partner violence when a partner has a history of childhood trauma.

Whisman (2006) study was unique in its approach as it tilted from examining the relationship between ACEs in general and marital satisfaction as well as the probable mediating factors to examining the relationship between ACEs and marital outcomes in adulthood with a direction toward establishing the association between 7 specific ACEs and 2 marital outcomes; martial disruptions such as divorce and separation and marital satisfaction.

The study used a sample size of 5, 877. The study outcome from a univariate and multivariate analyses indicated that the probability of marital disruption was higher among participants with a history of childhood physical abuse, sexual abuse or physical attack or assault. Also, marital satisfaction was

lower among participants who had a history of sexual abuse or molestation. This study brings to fore the impact of ACEs in predicting marital satisfaction and disruption even though it did not give any idea as to which factors may be mediating these relationships. The sample was significant to warrant generalisability of the findings. However, a qualitative approach may have revealed more as it possesses the fortitude to give much insight into the nature of the relationship.

Having ascertained how specific ACEs may affect marital situations, it seems rather imperative to explore how much ACEs affect specific genders within the context of couple relationships. Larsen, Sandberg, Harper and Bean (2011) the study provided valuable insight by investigating the connection between childhood physical and sexual abuse, the quality of romantic relationships, and the potential gender-specific impacts of these experiences. Using a sample of 338 women and 296 men and analysing the data with structural equation modelling, the study outcome indicated that the impact of childhood physical abuse on relationship quality was no different for both men and women. Also, childhood sexual abuse was not found to impact relationship quality for either gender. Hence, a person's gender does not appear to insulate them against the impact that ACEs may have on their relationship. This study was not agile with respect to the sample size it employed and does not seem to share commonality regarding its focus. However, its outcome is eye-opening as it was able to establish that physical abuse as an aspect of ACEs significantly impacted relationship quality regardless of a person's gender. It was unable to determine the extent and direction of the impact. It also did not use married persons as participants and

leaves a gap for future research to determine the association to be tested among married persons.

In a similar study by DiLillo, Lewis and Loreta-Colgan (2007) which sought to unveil the influence that childhood maltreatment or ACEs has on romantic relationships, a total sample of 174 college students were engaged in their study. The outcome of the study indicated that females with a history of child maltreatment or ACEs reported greater psychological and relationship challenges than those without a history of ACEs. This contravenes the findings of Larsen et al., (2011) who indicated that there was a difference. However, psychological distresses were found to influence the relationship between ACEs and couple functioning even in the aspects of intimacy, sexuality and conflict management just as was found in Perry et al., (2007). No such associations were found among male participants. Interestingly, this study did not use a huge number of participants as previous ones, neither were the participants a married group. However, in spite of its contrast with this research with respect to the social demography of the participants, its outcomes cannot be overlooked. It evinces the impact that ACEs have on all categories of people regardless of the form of relationship they may be involved in. Even though the study was unable to emphasise the reasons behind males not reporting relationship difficulties with respect to their ACEs, it was able to unveil the aspects of couple functioning which were significantly affected by ACEs and psychological distress.

Adverse Childhood Experiences and Health Related Quality of Life

A study by Chanlongbutra, Singh and Mueller (2018) sought to determine whether a person with an exposure to ACEs who lived in rural areas

had a greater tendency of experiencing poor general health outcomes, chronic diseases, poor psychological health and adult activity challenges. The study considered a total of 982,154 persons as participants. These persons were reached through telephone interview within a 2-year period; 2011 and 2012. However, 29,521 were selected due to the purpose of the study which was to use only rural inhabitants as participants. The study outcome revealed that after controlling for sociodemographic covariates, compared to those who were urban inhabitants, participants who experienced 1 or more ACE had increased odds of experiencing poor general health, limited activity and heart disease. Those who experienced 2 or more than 4 ACEs had a higher tendency of suffering a heart attack. Participants were more likely to suffer diabetes if they had experienced 3 ACEs and asthma or mental health challenges if they experienced 3 or more ACEs. More than half of the participants had experienced at least one ACE. ACEs were found to be as prevalent in the rural areas just as it was in the urban areas. This study is important in putting the relationship between ACEs and HRQoL into perspective as it considered a very significant sample size which gives credence to its generalisability. It also did well by adjusting for some sociodemographic covariates and hence helped to reveal the actual impact ACEs may have on persons who have been exposed to them regardless of their places of habitation. Even though it was unable to unveil the extent to which a person's ACEs score affected their health, it was able to give an idea of the influence that ACEs have on health.

Bellis, Lowey, Leckenby, Hughes and Harrison (2013) study affirmed Chalongbutra et al., (2018), findings by indicating that after controlling for socio-demographics and deprivation, their study, which sought to examine the

extent to which ACEs could predict behavioural problems, health, criminal justice and educational outcomes among a sample of 1500 participants who had experienced significant material and childhood poverty, cumulative ACEs were found to be significantly associated with adverse behavioural, social and health outcomes with those who had experienced 4 ACEs having odds of about 4 for smoking, 4 for binge drinking, 9 for incarceration and 3 for morbid obesity compared to those with no ACE history.

Also, persons with 4 ACEs also had greater risk of a significant decline in mental wellbeing, life satisfaction and increased likelihood of violence, inpatient hospital care and chronic illnesses. Higher ACE scores were also significantly associated with unintentional pregnancy. ACEs were found to influence poor life course, health and social outcomes. Furthermore, there appears to be a vicious cycle where those with higher ACE scores are more likely to expose their children to ACEs given the associated risks. This study reveals how ACEs may have negative generational implications once it goes unmitigated. Given the generalisability of this study's outcome going by the sample size, it appears this is likely to be the narrative across populations where there is not deliberate attempt to mitigate its impact.

Kalmakis et al, (2015) study using a systematic review and meta-analysis procedure to synthesise a total of forty-two research articles gave credence to the relationship between adverse childhood experiences and health consequences by revealing that ACEs were associated with both physical and psychological conditions, developmental disruptions, health risk behaviours and increased healthcare use. ACEs were associated with a number of systemic conditions such as heart conditions, chronic lung conditions,

headaches, autoimmune conditions, sleep difficulties as well as early death. Obesity, smoking and general poor health outcomes were also implicated. Also, ACEs were found to have associations with chronic psychiatric and psychological conditions and addictions including clinical depression, post-traumatic stress disorder and substance use disorder. It was also established that there was a relationship between ACEs and suicidality.

Suicide was found to be about 50% prevalent among persons who had been sexually and physically abused as well as observed domestic violence recognising that if ACEs were prevented within this sample 50% and 33% of women and men respectively would not have attempted suicide. Again, persons who had experienced ACEs were found to abuse alcohol and drugs. They were also found to engage in health risk behaviours during vulnerable moments in their lives such as during pregnancy and adolescence.

Women who had experienced ACEs were also found to have repeated abortions and to experience intimate partner violence than women without a history of ACEs. Homeless people who had experienced ACEs were more likely to have an early onset use of substances than those who had experienced lesser childhood adversity. This systematic review also evinced a strong positive correlation between use of prescribed medications and ACEs. ACEs were also shown to lead to an increase in healthcare use, an increase in health care cost due to ACE related disability, economic losses, family dysfunction, financial burdens and a fall in perceived quality of life. Revealing and confirmatory as these findings are, the African picture has not yet been painted due to the absence of literature. Also, this study only painted a figurative

picture without giving a voice to the findings. Hence, the need for more Afrocentric literature.

However, Schiling, Aseltine and Gore (2007) study threw the spotlight on a specific relationship; Adverse childhood experiences and mental health in young adults. Being a longitudinal study and considering a sample of 1093 participants with the initial data gathered through face-to-face interview and the subsequent one done via telephone after a 2-year period, the outcome revealed a strong association between ACE and antisocial behaviour in young adulthood with the direction towards the male than females.

It was also evinced that there was a significant correlation between ACEs and the development of depressive symptoms and drug use during early transition into adulthood. Nine out of the ten ACEs items were associated with drug use while eight out of ten with antisocial behaviour. The study also revealed that whites suffered more with respect to their mental health compared to blacks and Hispanics. However, the impact is no less significant among blacks. Hence, the outcome of this study has relevance for persons of African descents. The sample size was significant in ensuring generalisability and the outcomes useful in enlightening all and sundry on the impact of ACEs and the mental health of adults and for that matter their psychological HRQoL.

Cheong et al. (2017) further narrowed the mental health enquiry by investigating ACEs and later-life depression with the aim of determining to what extent perceived social support may be serving as a potential protective factor. It used a sample of 2047 Irish participants between the ages of 50 and 69 years. They employed logistic regression analysis to ascertain the extent of association while controlling sociodemographic factors. Cheong et al. (2017)

discovered that ACE exposures whether overall score or subtype was associated with higher odds of depressive symptoms but solely among persons who reported poor perceived social support. Also, persons who had been exposed to any of the forms of ACE with poor perceived social support compared to those who had experienced none had almost three times the odds of depressive symptoms. On the other hand, individuals who reported moderate levels of perceived social support had approximately twice the odds of experiencing depressive symptoms, while those with strong perceived social support had about one times the odds of experiencing such symptoms. For participants who reported abuse, perceived social support significantly impacted their development of later-life depression. This study goes to reinforce the impact that social support has in mitigating the adverse effect of ACEs on the HRQoL of adults, under the circumstance, their depressive symptoms. In as much as this research is not focused on examining the moderating effect of social support on ACEs and depression, the outcome of this study highlights the probable impact that marital satisfaction will have on ACE victims once they perceive their marriages as a significant source of social support. It is also relevant in its delineation of the strength of perceived social support and their influence later-life depressive symptoms of persons with ACE history.

Another study that examined the relationship between adverse childhood experiences and long-term physical health consequences using an analytic sample of 52,250 adult Americans between the ages of 18 and 64 from 2009 to 2012 was conducted by Monnat and Chandler (2015). Their study, though not a longitudinal one, was unique in its focus on ACEs impact

on health across the lifespan. It was discovered that experiencing childhood physical, verbal or sexual abuse, witnessing parental domestic violence, divorce, living with someone who was depressed, used substances or alcohol and or incarcerated were associated with at least one of the following health outcomes: self-rated health, functional limitations, diabetes and heart attack. Also, these associations were significantly mediated by adult socioeconomic status, poor mental health and health behaviours. This study indicated that adult socioeconomic status and stress related coping mechanism were instrumental in buffering the link between ACEs and adult health outcomes or health related quality of life. Even though, this study was done in the US, hence may have used participants whose social demography may be largely different from those used in this research, the outcome is undoubtedly significant as it considers how each ACE may be impacting HRQoL across the lifespan. It was able to delineate the gravity of ACEs on HRQoL of adults and emphasis the impact that a person's socioeconomic status or coping strategies could have on their health outcomes.

Mosley-Johnson et al, (2019) brought a unique perspective to the association between ACEs and HRQoL by not measuring ACEs impact on specific health conditions as has been the pattern. Rather, they assessed health from a wellbeing perspective by examining the relationship between adverse childhood experiences and life satisfaction, psychological wellbeing and social wellbeing among 6323 participants domicile in the United States. They used a longitudinal cohort which span between 1995 and 2014 and employed repeated measures models to test the associations between ACEs and all three

psychosocial scales for measuring life satisfaction, psychological wellbeing and social wellbeing.

The outcome of their study indicated that after controlling for demographics covariables, participants who had suffered an ACE had significant low levels of life satisfaction compared with those who had not. However, those with higher ACE scores were associated with lower life satisfaction compared to those without an ACE. Abuse and household dysfunction were associated with significantly lower life satisfaction. ACEs have been shown to be significantly associated with lower sense of social wellbeing. It was revealed that ACEs were significantly linked with lower life satisfaction, psychological and social well-being especially among persons who reported abuse and household dysfunctions during childhood.

The study was able to adequately determine which aspects of ACEs impacted a person's life satisfaction and well-being. Since it used a longitudinal cohort study, it is also significant in examining the constructs; life satisfaction, psychological and social well-being as it measured participant's actual satisfaction over a significant period of time. In as much as qualitative research would have probably revealed participant's unique measures of life satisfaction and psychosocial well-being in respect of their ACEs, this study does not lose its significance.

Spencer-Hwang et al., (2018) took a preventive approach to understanding the concept of ACEs by studying its prevalence among a community of resilient centenarians and seniors in the region of Loma Linda Blue Zone, one of five worldwide longevity hotspots regarding their childhood experiences to inform chronic disease prevention framework. It employed a qualitative research design assessing ACEs and practices using a focused

group and semi-structured key informant interviews with open-ended questions on general hardships, lifestyle and resiliency factors. It used a total of 7 centenarians and 29 seniors as participants with their ages ranging from 65 years to 102 years.

It was revealed that all participants reported being exposed to ACEs characterised by economic deprivation, family dysfunction and community violence. However, practicing resiliency factors, each with anti-inflammatory properties appear to have mitigated ACE-related toxic stress which eventually alleviated chronic disease burden and promoted a culture of health.

This study is unique in its employment of a qualitative research design. More so is the choice of participants and its interventive orientation by examining a significant moderating variable that averted the impacted of ACEs on adults. It brings to the fore, a significant construct that can be enhanced in every individual especially victims of ACEs in order to reverse the impact. However, it seems quite difficult to ascertain whether the health outcomes of the participants in spite of their ACEs is also attributable to their faith as the participants were Seventh Day Adventist who are known to be a strict religious group with unique practices such as refraining from the use tobacco, alcohol and illicit substances as well as a majority being vegetarians. Again, since the study was unable to control for lifestyle, faith and social support, it is likely that ACEs did not have as much impact on this group of people due to their resilience factors which were listed as caring and supportive relationships and healthy life style practices such as diet, rest and life outdoors. Again, certain aspects of ACEs were not examined such as childhood history of abuse and neglect. Hence, the need for more qualitative studies and more so among seniors in order to ascertain determine the protective factors.

Stressful Life Events (SLEs) and Marital Satisfaction

In a study titled stressful life events, marital satisfaction, and marital management skills of Taiwanese couples by Li and Wickrama (2014) which aimed at examining the association between SLEs and marital satisfaction among 372 Taiwanese couples with a focus on how three marital management skills would moderate the association SLEs were found to reduce marital satisfaction of both husbands and wives. It also revealed that the marital management skills employed by spouses resulted in an increase in marital satisfaction except for husbands soothing and alleviation skills. However, husbands' tolerance and empathy skills were associated with an increase in the wife's marital satisfaction and interacted significantly with the relationship between the wife's stress and her marital satisfaction. Also, there was a significant interaction between SLEs and spouses' own marital satisfaction on account of their soothing skills.

This outcome buttresses the fact that SLEs are significant in disrupting marriages once couples are oblivious of its impact and how to leverage on their coping or marital management skills. Though this study did not use a comparatively high sample size, it highlights some marital management skills that may be useful in alleviating the impact of SLEs on marital satisfaction.

Harper, Schaalje and Sandburg (2000) examined the role of intimacy in buffering marital satisfaction in the face of daily stressors among a sample of about 472 couples who ranged between 55 and 75 years. Though the specific daily stressors were not mentioned, the findings of the study indicated that daily stressors negatively impacted marital quality for both husbands and wives. It also revealed that intimacy, operationalised in this study as sharing intimate experiences characterised by feeling of emotional, social, sexual, intellectual and recreational closeness and sharing mediated the interaction

between stress and marital satisfaction for both husbands and wives. This study is unique in its contribution as its outcome highlights the impact of daily stressors on marital quality among middle aged and persons in late adulthood. Even though it would have shared commonality with this research apart from the specific age range of the participants if it studied SLEs instead, it re-echoed the life course impact of stress on marriage. Furthermore, it highlighted the place of intimacy across the life course in sustaining marital bliss which adds to the two buffering factors of empathy and tolerance aforementioned by Li and Wickrama (2014).

Woszidlo and Segrin (2013) similarly investigated the role that stressful life events have on marital satisfaction, making an attempt to also consider how neuroticism may be directly and indirectly influencing mutual problem solving in newlywed couples. They used a sample size of about 186 couples in their first five years of marriage. Using a dyadic analyses and tests of indirect effects, the study revealed that work, job-home interference and family stress were significantly associated with lower marital satisfaction of both husbands and wives. Again, the family stress of both husbands and wives significantly affected their marital satisfaction. Problem-solving communication was found to influence the relationship between SLEs and marital satisfaction as well as neuroticism and marital satisfaction. Woszidlo and Segrin (2013) brought clarity but delineating specific SLEs which negatively affected marital stability and the impact that problem solving has in enhancing marital satisfaction. Though the sample size was quite abysmal for a quantitative study, they studied dyads which gives a two sided or couple perspective to the concepts instead of obtaining the perspective of just one of the couple. Though this research will not focus on dyads, it will add to the

body of knowledge by unveiling the extent to which SLEs could result in marital satisfaction using a much bigger sample from Ghana.

Though quite different from Li and Wickrama (2014) in design and approach, Umberson et al., (2005) study uniquely employed a longitudinal approach, qualitative in nature with a focus on SLEs in both childhood and adulthood and their impact in marital satisfaction. Even though secondary data was used and responses were retrospective in nature, the objectivity of participants' responses were not compromised as it has been established by Umberson et al., (2005) that subjected measures of stress compared to objective ones are not significantly distorted by changes in psychological distress over time.

The study outcome predicted positive marital experiences for participants who reported high childhood stress and those who reported low childhood stress once there was no change in adult stress burden. However, an increased rate of adult stress burden was associated with a decline in positive marital experiences for those who reported high childhood stress, whereas a decreased rate of adult stress burden resulted in an increase in positive marital experiences. These findings imply that, individuals who experience high levels of adverse childhood experiences may be more sensitive to fluctuations in adult stress burden in both positive and negative directions. Umberson et al. (2005) study sets a good tone for this research as it helps enhance understanding into how an experience of ACEs predisposes couples to marital dissatisfaction in the face of stress. This will be further studied in this research from both a qualitative and quantitative perspective.

Ledermann, Bodenmann, Rudaz and Bradbury (2010) study used 345 dyads as participants and employed the Actor-Partner Interdependence Model (APIM) and the Common Fate Model (CFM) to test the mediating hypotheses. The model makes up for the probable challenge posed by the low sample size since it was able to appropriately test the mediating hypotheses. The findings of the study indicated that a person's relationship stress is strongly related with their external stress than with their partner's external stress. It was also revealed that both low relationship stress and a high level of positive communication are important in relationships. This implies that, individuals within a dyad are more likely to experience relationship stress as a result of their own external stressors other than that of their partner's. Also, for couple relationships or marriages to thrive, there is the need for less stress and more positive interactions.

A thorough review of about 21 literatures with a focus on various types and dimensions of stress but not SLEs specifically by Randall and Bodenmann (2009) revealed that stress is pervasive in present day societies and it leads to so much personal, social and financial strain. It was also revealed that stress is associated with adverse dyadic development and outcomes with external stress having a spill over effect on the relationship and a deleterious impact on marital quality. Stress was found to disturb communication and lead to social withdrawal and a higher tendency of divorce (Bodenmann, 2005).

SLEs and Health Related Quality of Life

Cleland, Kearns, Tannahill and Ellaway (2016) conducted a longitudinal design using a sample of 1247 participants with the aim of determining the impact stressful life events have on mental and physical health

and wellbeing. The study revealed that experiencing five stressful life events had a statistically significant negative impact on mental health. The SLEs included a relationship breakdown, a health condition, being the victim of a crime, bereavement and moving to a new house. Also, physical well-being was negatively impacted by three stressful life events: the occurrence of a health condition, bereavement and housing improvements. This outcome gives the impression that there are fewer direct correlates between stressful life events and physical health compared to mental health. It was also revealed that as stressful life events accumulate, health outcomes deteriorate especially when people experience three or four stressful life events over a period of three years. Though the study was conducted in the UK, its outcome is significant to the Ghanaian population as the sample was drawn from Glasgow, which as compared to other parts of Scotland has high levels of socio-economic disadvantage, considerable health inequalities and low levels of life expectancy just it is for Ghana compared to other parts of the world. Cleland et al., (2012) findings reveal with specificity which SLEs and how many of them could impact either physical or mental health. This research will replicate their study to ascertain the facts as it pertains to Ghana though it will employ a mixed method approach.

The study did not only consider only positive life events but negative ones as well. This helps to put into perspective, how different life events may impact on health.

Though it did not consider other medical or psychological conditions which could be affected by life events nor investigate their direct impact on health-related quality of life, they did well to consider certain prevalent

physical and mental health conditions which have a bearing on health-related quality of life. They also did well to control for confounders and previous illness. Again, a qualitative approach may have given a broader and more detailed understanding of the connection being established, however, sample size was significantly high enough to drive home the magnitude of the problem considering that logistic regression was employed in establishing the relationship. The study indicated that participants were likely to develop depression or anxiety by 14%, asthma by 12.3% and the other conditions by less than 4%. Also, personal stress increased the tendency for the onset of depression or anxiety, diabetes mellitus 2 and circulatory diseases whereas family related stress, the onset of coronary heart disease and circulatory diseases. A positive correlation was observed between work-related stress and onset of anxiety or depression. This affirms Cleland et al., (2016) findings and the need for Afrocentric researches as the outcome will depict the African situation while giving insight into how detrimental SLEs could be to one's health.

Dorji and Dunne (2017) employed a cross sectional research design targeted at establishing the prevalence and association between SLEs and health conditions among older adults who lived in Bhutan. A convenient sampling technique was used in drawing the 337 participants comprising 189 make and 148 females who were mainly situated at temples, market places stupas and pagodas within four major commercial towns of Bhutan. Even though the sample was not as high as to warrant generalisability, it was good enough to represent persons within the age bracket of the participants used in the study, thus 60 or more-year-old people. In establishing the relationship

between SLEs and health conditions, it was made apparent that participants who had experienced between 8 to 14 SLEs were about two times likely to have poorer health outcome or health related quality of life compared to those who had experienced about 1 to 5 SLEs. Again, there was a significant difference in certain health conditions such as back pain, memory decline, depression, movement difficulties, sleeplessness and lung condition in respect of gender. An impressive aspect of their findings was their ability to establish how many SLEs could influence the onset of health conditions as well as the associated physical conditions.

Villalonga-Olives, Rojas-Farreras, Vilagut, Palacio-Vieira, Valderas, Herdman, Ferrer, Rajmil and Alonso, (2010). This study contrasted the one by Dorji and Dunne (2017) as it focused rather on adolescents and youths even though it was tilted towards establishing a similar outcome; whether SLEs were related to HRQoL. A total of 840 participants were used as the study's sample using telephone sampling. This study revealed that the greatest impact of SLEs on HRQoL was more observable in the boys who reported more stress in their livelihood than girls even though the difference was not significant. Girls tended to be less impacted in their HRQoL compared to boys going by their life change units.

This study was unable to elucidate which particular SLEs were involved in lowering the HRQoL of its participants. It was also unable to indicate which aspects of the participants HRQoL were being considered. This makes the outcome quite indistinct in terms of what is being measured. Even though it did well to consider a significantly high sample size, it did not do so well in particularly raising consciousness to the impact of SLEs on the

physical or psychological wellbeing of participants. It is however important to recognise that, it brought to the fore, the impact that SLEs have on gender even in the formative years of both boys and girls especially when SLEs have been evinced to be associated with worse HRQoL, paediatric psychosomatic conditions, poor physical health, increased risk of disabilities and increased health care use.

Sherien and Kader (2016) study used a rather unique sample comprising participants who were already suffering some mental health conditions. In their attempt to understand how stressful life events impact quality of life of adolescent patients, they sampled a clinical group by employing the convenient sampling technique. The study uncovered a notable and adverse correlation between stressful life events (SLEs) and the quality of life of the patients. A majority of the patients were found to have encountered multiple SLEs, which had a detrimental effect on their overall quality of life.

Coker et al. (2011) were specific by investigating the association between family-related stressful life-change events (SLEs) with health-related quality of life (HRQOL) in fifth graders. They also used a crossed sectional survey design to solicit responses from a total of 5147 school children and their parents. Children who had experienced more SLEs were shown to have greater odds of HRQoL compared to those who had none. Also, participants psychosocial HRQoL was found to mediate the relationship between SLEs and HRQoL associated with physical health. Even though this study did not consider an adult population, the outcome still holds relevance to this research as it aptly unveils the impact that SLEs have on children just as it does on adults. It goes to reinforce the need for health care practitioners, institutions

and school counsellors as well as administrators to give particular attention to children and adult clients who may be experiencing stressors of all kinds. This buttresses the essence of this research in spite of the difference in the type of SLE being investigated and the population of interest.

Conceptual Framework

According to Miles and Huberman (1994), a conceptual framework is described as a visual or written output that effectively illustrates or describes the main elements to be investigated. It includes key factors, concepts, or variables, along with their presumed relationships, either in a graphical or narrative form.

This study examines adverse childhood experiences as an independent variable and marital satisfaction and health related quality of life as the dependent variable. The conceptual framework of this study depicts that adverse childhood experiences predict marital satisfaction as well as health-related quality of life. It further predicts that stressful life events also predict marital satisfaction and health-related quality of life.

It is believed that married persons with histories of adverse childhood experiences are likely to experience marital dissatisfaction due to their ineptitude in interpersonal relationships encrypted by their attachment challenges and stress sensitivity. This is because marriage requires good interpersonal relationship and given that it comes with its own stressors as well as some daily stressors, it is much likely for persons with adverse childhood experiences to experience dissatisfaction in their marriages due to their ACEs. Also, stressful life experiences may lead to marital dissatisfaction among persons with histories of ACEs due to the impact that acute stressors

have on interpersonal relationships, communication and a person's stress threshold.

Stressful life events, on their own, may also predict marital dissatisfaction. Stressful life events such as loss of a job, financial demands and changing of places of residences as well as childbirth as very common and sometimes unimaginably strenuous with their impact almost unnoticeable. These could have a cascading effect on the marital relationship as they could deprive couples of quality time, shift the focus of their intimate communication and heighten irritability tendencies. Hence, couples without an appropriate coping strategy, social support and an awareness of the impact of ACEs and SLEs on their relationships are likely to fall prey to marital dissatisfaction.

Furthermore, ACEs have been shown to independently impact health related quality of life independently just as SLEs do. Therefore, health related quality of life is likely to be grossly affected when persons exposed to ACEs also experience SLEs along their life trajectory.

In essence, the conceptual framework depicts the relationship between adverse childhood experiences and marital satisfaction. It also evinces the impact of adverse childhood experiences on health-related quality of life. Furthermore, stressful life events also predict marital satisfaction and health-related quality of life. This suggests that, when a person is exposed to ACEs without being exposed to SLEs, their marriages and health related quality of life are likely to be negatively impacted. Moreover, when they are exposed to ACEs and SLEs, their marriages and health related quality will still be impacted negatively. Given that marriage is a stressful life event just as poor health outcomes are, it is expected that once a person suffers marital problems

and or health challenges which go unabated or treated, these experiences will impact their stress sensitivity which will eventually increase their SLE threshold and inadvertently worsen their marital satisfaction and health related quality of life. In the event that the person experiencing these vicious cycles also has a history of ACEs, their stress sensitivity further heightens and further distorts their marital satisfaction and health related quality of life.

This framework explains the likely vicious cycle associated with ACEs and marital dissatisfaction, ACEs and HRQoL, SLEs and marital satisfaction, SLEs and HRQoL as well as marital satisfaction and HRQoL once a timely intervention is not instituted.

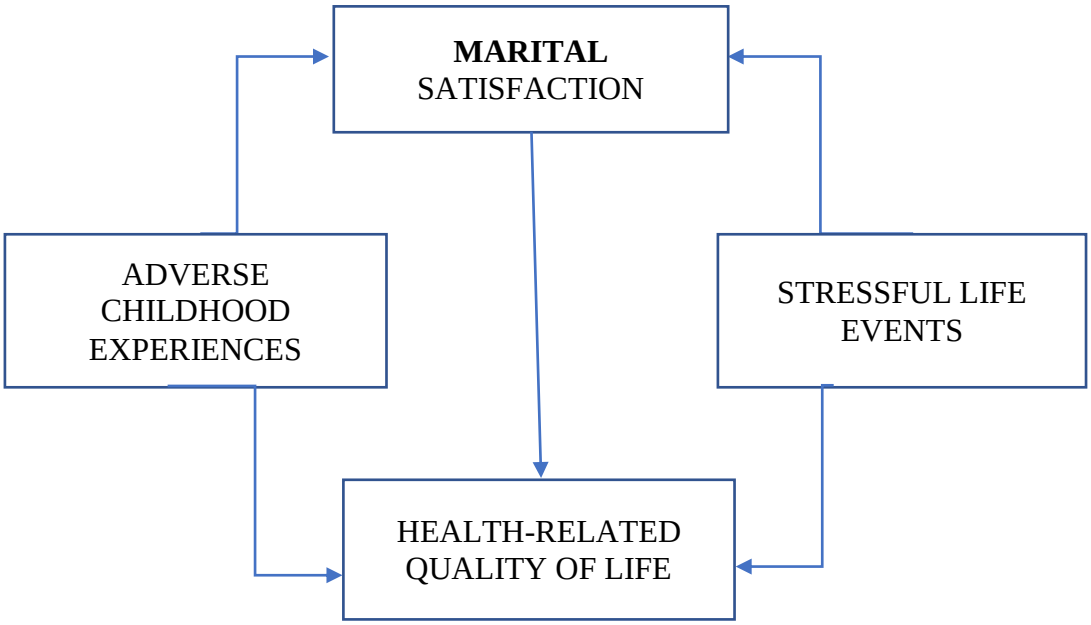


Figure 2: Conceptual Framework

Figure 2 is a conceptual framework showing the relationship among adverse childhood experiences, stressful life events, marital satisfaction, and health-related quality of life.

Summary of Review of Literature

The literature review reveals how ACEs and SLEs impact marital satisfaction and health related quality of life. They suggest that a person's exposure to ACEs may have dire consequences on a person's marital satisfaction and stability as well as both physical and mental health outcomes and health related quality of life.

A number of theories that explain ACEs, SLEs, marital satisfaction and HRQoL were expounded to give meaning to the constructs in the light of the study. The literature reviewed theories such as Trauma theory, Attachment theory, Cognitive Transactional Stress theory and Gottman's theory of marital satisfaction.

The literature review revealed that with appropriate coping strategies, psychological interventions and marital counselling, the impact of ACEs as well as SLEs on marital satisfaction could be significantly reduced. Also, it was revealed that tailored psychological and medical intervention can reduce the repercussions of ACEs and SLEs on HRQoL with prevention being the epicentre of all recommendations.

The current study focused on the aforementioned predictors of marital satisfaction and HRQoL. Theoretical bases, conceptual framework as well as empirical reviews give credence to the fact that ACEs and SLEs significantly influence marital satisfaction and HRQoL. However, there appears to be no evidence to these findings locally or in Africa and the significance of the outcomes towards enhancing public insight into some of the most instrumental constructs that influence marital satisfaction and HRQoL drive the need for this research.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter provides an overview of the methods and techniques used to collect data pertaining to Adverse Childhood Experiences (ACEs), Stressful Life Events (SLEs), and their impact on participants' marital satisfaction and health-related quality of life. The chapter delves into the research design, outlining the specific area of study, the target population, the sample selection process, and the data collection instruments utilised. It also discusses the reliability and validity of the scales employed and provides details on the procedures for data collection and analysis used to accomplish this research.

Research Philosophy

Experts who adhere to the mixed methods approach postulate that multiple paradigms can be employed as the philosophical basis for the approach (Teddlie & Tashakkari, 2012) emphasising pragmatism as the main philosophy that undergirds the approach. Pole (2007) indicated that the stance to be more inclined to addressing research questions instead of following a particular methodology forms the core of pragmatist philosophy. Hence, the study was conducted within the context of the pragmatic philosophical standpoint as it sought to gain insight into the phenomenon of marital satisfaction and health-related quality of life from diverse theoretical perspectives.

Pragmatism holds the view that social scientists are free to make the choice of employing both quantitative and qualitative research designs,

procedure and methods that best help them answer the questions that form the bedrock of their scientific enquiry (Creswell & Creswell, 2018).

From an ontological perspective, pragmatism as a philosophical foundation of mixed method scientific research methodology holds the assumption that knowledge is produced by the interaction between people and their environment and is constructed and founded on the mind-independent reality with an emphasis on the influence of theory in inquiry (Creswell & Creswell, 2018). Hence, the study was approached by initially establishing an interaction between the researcher and the participants. The focus was to examine the unique experiential perspective of the participants regarding how their marriages and health-related quality of life have been impacted by their ACEs and SLEs. These unique experiences helped bring to the fore, multiple realities regarding the phenomenon under study while establishing peculiar knowledge, detailed enough to enhance in-depth understanding of the phenomenon. The phenomenon also enhanced understanding of the unique relationship that exist among the constructs being studied. By implication, participants' experiential perspective of the phenomenon under study coupled with an understanding of the measured extent of relation between the constructs helped to establish knowledge and further deepen understanding of the phenomenon; which was the aim of this study.

Also, the epistemological assumption holds that the researcher is not bound by a specific method of interaction with participants and is free to choose a method that will help the researcher achieve the purpose and needs of the research (Creswell & Creswell, 2018). This was evinced in this study as data was gathered through an interaction between researcher and participants

as well as a mutually exclusive process of data collection by means of questionnaires in the qualitative and quantitative phases of the study respectively. Hence, the quest to achieve in-depth understanding of the phenomenon under study and to determine an objective measurement of the relationship between the constructs experienced by the participants resulted in the achievement of the aim of this study.

Furthermore, the axiological assumption of the pragmatist perspective holds that scientific research is value-oriented with the aim to solve problems (Creswell & Creswell, 2018). The choice of this topic accentuated the axiological assumption by presenting the potential opportunity to implement the outcomes of the study in both clinical practice and counselling sessions. It also enhanced insight into people's experiences and to specifically determine the impact of the multiple constructs on them. These insights deepened practitioner understanding and promised and enrichment of the therapeutic process.

Research Paradigm

The mixed methods approach offered a broader and more comprehensive understanding of the phenomenon studied. According to Dawadi et al. (2021), incorporating both qualitative and quantitative methods in research enabled researchers to gain a more comprehensive understanding of the phenomenon under study, which could be valuable for informing practice.

The merit of employing the mixed method approach was that the strength of the quantitative method made up for the weaknesses of the qualitative method and vice versa resulting in a comprehensive result as

advocated by Dawadi et al. (2021). For instance, in the researcher's attempt to make meaning of the phenomenon, the qualitative study helped to identify significant processes, factors and patterns that a quantitative study could not have unearth.

Research design

This research was designed within the framework of the concurrent triangulation mixed methods paradigm. Due to the adopted mixed methods approach, both quantitative and qualitative approaches were employed in this research. The quantitative phase used the cross-sectional survey design while the qualitative used the interpretative phenomenological analysis design.

With respect to the cross-sectional survey design, the researcher observed the phenomenon under study in a procedural and organised way as data was collected, analysed and described without influencing the phenomenon under study. This generated credible data that made it more likely to generate robust outcomes and form novel hypotheses relevant for further research (Zangirolami-Raimundo et al., 2018).

However, cross-sectional survey design engaged within the quantitative approach, though useful, did not allow an elucidation of a detailed, contextual and experiential perspective of participants in respect of the phenomenon under study as Johnson and Onwuegbuzie (2004) affirmed. Hence, the need for an interpretative phenomenological (IPA) design for the qualitative phase of the study**.**

The interpretative phenomenological approach (Reid, Flowers & Larkin, 2005) was a "bottom-up" approach, which allowed the researcher

understand how participants made sense of their experiences and the world around them.

Going by the interpretative phenomenological approach, the participants were considered the experts who shared their unique story and personal understanding of the phenomenon of interest, such as lived experiences, events, or situations as prescribed by Finlay (2012). The researcher aimed to provide a detailed and well-organized account of individuals' meaning-making within their "lifeworld," focusing on plausibility and transparency (Reid et al., 2005). Due to the depth of analysis involved, interpretative phenomenological approach studies typically have small sample sizes, with Smith et al. (2009) advocating for a range of three to six participants.

Given that the phenomenon researched into had health implications, it benefited from combining phenomenological and quantitative approaches, as the subject matter often spanned both psychological and sociological domains as advocated by Smith (2011).

Area of the Study

The data was gathered from married persons who live within the Ga Central Municipality of the Greater Accra region. According to the Ghana Statistical Service (2021), the Ga Central Municipal Assembly (GCMA) lies within latitudes 5º 48´ North and within longitudes 0º 8´ East and 0º 3´ West. The Municipality constitutes one of the sixteen (16) Metropolitan/ Municipal/District Assemblies within the Greater Accra Region.

According to Ghana Statistical Service (2021) the total population of the municipality stood at 117,220 inhabitants with females constituting 51.1%

and males 48.9%. A good majority of the populace constituted the youth with 34.4 % below 15 years and 3.9% being 60 years and older. With respect to marriage, 44.2% of the populace had never been married and 2.6% being either divorced or widowed and 1.7 % having separated. However, 43.5% had been married with 5.2% in consensual relationships. Among the married populace, 9.2 % had no formal education but 55.7% had received basic education. Also, among the married population, 80.4% were employed with 4% being unemployed and 15.6% being economically inactive.

Persons who profess Christianity constituted 86.9% of the population with pentecostal/charismatic constituting 50.5% and 19.1% being Protestants. About 88.5% of the population constituted Christian females and about 85.3% being males. Persons who belonged to the Islamic faith constituted 9.4 %. However, those who had no religion constituted 2.5% of the populace with a greater proportion of males (3.6%) not affiliated to any religion as against 1.4% of the females.

As one of the population dynamics, marriage appears to affect the processes and levels of fertility and minimally but not insignificantly, mortality and migration.

Population

The target population for the research was 56, 851 married persons within the Ga Central Municipal Assembly. This population was relevant for the research due to its peculiarity evinced in the distribution of its populace. The Ga Central Municipal Assembly has about 43.5% of its populace married, representing about 56, 851 married persons according to Ghana Statistical Service (2021). This percentage appear to be significant and grants an

opportunity for generalisability of the quantitative research findings as well as a good basis for the qualitative aspect of the study.

Sampling and Sampling Procedures

In certain study areas where there was a significant number of potential participants, purposive and convenience sampling were used, where participants were purposively sampled and then conveniently sampled for the data collection process. However, participants for the qualitative phase of the study were purposively sampled after they had met the eligibility criteria of being above 18 years and legally married for the study. These participants also participated in the quantitative study.

The quantitative methods relied on established formulae in order to avoid Type I and Type II errors (Palinkas et al., 2015). Hence, in respect of this study which drew its sample for the quantitative phase from a population size of 56,851 married persons, Yamane's formula was employed in determination of the ideal sample size. Going by Yamane (1967) formula for determining minimum sample size which is denoted as n= N/ (1+N (e) 2) where "n" is the sample size, "N" is the target population size and "e" is the level of precision where confidence interval is 95%. The estimated sample from this population of married persons that ensured a good representation of the target population was 400 married persons.

Palinkas et al. (2015) indicated that qualitative methods often rely on precedents for determining number of participants based on type of analysis proposed. According to Palinkas et al. (2015) an IPA study where participants may be interviewed multiple times, three to six participants are considered as ideal sample size for a mixed method study. In view of this, five participants

were used as sample for the qualitative phase of this study. These participants were selected using purposive sampling by ascertaining their eligibility and confirming their willingness to provide a more detailed account of their experiences through semi structured interviewing.

Data Collection Instrument

The instruments used in gathering the quantitative data for this study were examined by my supervisors in order to ensure content validity and adapted for data collection. However, a confirmatory factor analysis of the instruments was not done.

The Cronbach's Alpha formula was utilised to determine each instrument's reliability coefficient (Tavakol & Dennick, 2011) which was considered to be ideal once a coefficient of .70 or above was obtained (Pallant, 2016). Each of the instruments used in this study was subjected to the Cronbach's Alpha formula to ascertain their reliability before they were utilised in data collection.

Section A of the questionnaires solicited demographic information of the participants. The questionnaire encompassed a total of 87 items, which were divided into four sections labelled as B, C, D, and E.

Section A: This section was aimed at gathering data on various aspects including age, gender, duration of marriage and age difference between spouses.

Section B: This section was targeted at collecting data pertaining to the adverse child experiences of married persons. The adverse childhood experiences scale was originally developed by Dr. Felitti and colleagues (Chanlongbutra, Singh, & Mueller,

2018). It is a 10-item measure intended to assess 10 types of childhood adversity in three different areas of abuse, including emotional and physical abuse, physical neglect, and abuse associated with living in a dysfunctional household. Adverse childhood experiences include emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, mother treated violently, household substance abuse, household mental illness, parental separation or divorce and incarcerated household member. This questionnaire was designed to measure the occurrence of adverse experiences an individual experienced before the age of 18 years. The ACE is a reliable, valid and economic screen for retrospective assessment of adverse childhood experiences (Wingenfeld et al., 2010). It has adequate internal consistency (Cronbach's alpha =.88) (Murphy et al., 2014). An ACE Score of 0 suggest that the person reported no exposure to childhood trauma. An ACE Score of 1 suggests that the person reported exposure to childhood trauma. The higher the total ACE Score, the greater the likelihood that a person will develop some health problems (Felitti et al., 1998). The items were measured on a dichotomous scale where 1= Yes and 2= No.

Section C: The ENRICH Marital Satisfaction Scale **(**EMS Scale) is a 15-item scale that consisted of the 5 items that make up the Idealistic Distortion and 10 items that solicited data on Marital Satisfaction. Each of the 10 Marital Satisfaction items

represented one of the areas of the marital relationship assessed by the full-length ENRICH Inventory (Fowers & Olson, 1993). The EMS Scale was evaluated for internal consistency and test-retest reliability and its Cronbach's alpha revealed an internal reliability of .86 (Fowers & Olson, 1993). The items were measured using a scale of 1 to 5 where 1= strongly disagree, 2= moderately disagree, 3= neither agree nor disagree, 4= moderately agree, 5= strongly agree.

Section D: The Stressful Life Events Scale (SLE scale) also referred to as the social readjustment rating scale or Holmes and Rahe Stress Scale is a 43-item scale that was intended to establish the relationship between stressful life events and health outcomes. The SLE's had a significant internal consistency (Cronbach's alpha= .89). A score ≥ 300 suggested about an 80% chance of a person falling sick after 2 years while a score ≥ 150 and ≤ 299 implied a 50% chance of illness. However, a score < 150 was suggestive of a decreased likelihood of illness (Noone, 2017). The items were measured on a dichotomous scale where 1= Yes and 2= No.

Section E: The Health-Related Quality of Life Scale (HRQoL-14 Scale).

The CDC HRQOL-14 comprised 14 questions which included health status measure (self-rated health) and HRQOL measures; recent physical health, recent mental health, and recent limitations in activities of daily living. The items included the CDC HRQOL-4 core measures, five activity limitation

questions, and five additional Healthy Days HRQOL questions that measure recent symptoms of pain, depression, anxiety, sleeplessness, and vitality. The activity limitation questions measure the presence of any self-reported current limitation. If present, its main cause and duration, as well as whether the help of another person is needed to perform basic activities of daily living (ADLs) or other routine instrumental activities of daily living (IADLs) (Moriarty et al., 2003). The HRQoL-14 scale was evaluated for internal consistency and test-retest reliability and its Cronbach's alpha revealed an internal reliability of .89. The core items were measured on a dichotomous scale where 1= Optimum HRQoL and 2= Poor HRQoL (Moriarty et al., 2003).

The Interview Guide

The qualitative data was gathered by employing a self-designed semi-structured interview guide open-ended questions that allowed for further probing into the issues. The interview guide was developed across 5 areas: experiences of ACEs and marriage, experiences of ACEs and HRQoL, experiences of SLEs and marital satisfaction, experiences of SLEs and HRQoL and experiences of marriage and HRQoL. The interview guide enabled the researcher and participants have a flexible, in-depth discourse pertaining to the subject under study without digressing into other areas of the participant's life which did not meet the aim of the study. Some of the open-ended questions that were asked include:

- How has your childhood adversities impacted the quality of your mental health?
- How has these stressful life events influenced your marital satisfaction?
- Share with me, how your marriage has influenced the quality of your health.

Pilot testing of Questionnaires

To effectively determine the internal consistency of the instruments used in the study, a pilot test was conducted involving 10 married individuals. This pilot test ensured that the instruments were adequately validated and suitable for data collection. Fink (2009) alluded to 10 participants being an adequate sample for a pilot test. These married persons were selected from the Ga Central municipality upon meeting the inclusion criteria for this study. Gay, Mills and Airasian (2009) indicated that one essence of conducting pilot studies is the advantage it offers in raising the researcher's awareness to areas of possible improvement. This process enhanced attention to the wording of the items of the instrument. Also, it resulted in correction of these items even before the actual data was gathered. The Cronbach's Alpha coefficient of the various instruments (adverse childhood experience, stressful life events, enrich marital satisfaction and health-related quality of life) were analysed.

A Cronbach's Alpha coefficient of .70 or higher is considered sufficient (Pallant, 2016). Consequently, these instruments were deemed internally consistent for collecting data in relation to this study. Table 1 shows the results for the pilot testing.

Table 1: ***Cronbach Alpha (α) coefficients of Variables***

Scales	Number of items	A
Adverse childhood experience	7	.709
Stressful life event	43	.848
ENRICH marital satisfaction	15	.924
Health-related quality of life	14	.988

Source: Field Survey (2022)

Methodological Rigour and Pilot Testing of Interview Guide

The quality of the qualitative research lay in its methodological rigour (Löblich, 2017). The rigour referred to methods that ensured accuracy and authenticity of interview guide and research process validated by trustworthy research outcomes. This paradigm addressed emergent issues based on the interpretations drawn from participant's experiences in the most trustworthy manner as practicable. To test rigour, 4 relevant factors were considered: credibility, auditability, confirmability and reflexivity (Löblich, 2017).

Credibility

Credibility of the study (Löblich, 2017) was achieved by reviewing the pilot interviews in order to ascertain the viability of the interview guide, skills and process. This helped ascertain all possible biases, emotional attachment to subject, beliefs and values.

Auditability

Auditability was achieved by systematically collecting and documenting the decisions or audit trail employed by the researcher. This helped to ascertain the possibility of arriving at a conclusion that was similar

to those of the researcher, having reviewed the data. (Löblich, 2017). Also, the method of coding, data segmentation, thematic formation and field and personal notes were preserved and shared with peer reviewers with the aim of aiding them critically assess the data and ascertain whether or not they will arrive at similar conclusions. Apart from the research assistants aiding in the process of reaching an agreement on the codes and themes, two post-doctoral fellows were enlisted as inter-raters.

Confirmability

Data was confirmed through an objective affirmation of its relevance by two independent and credible persons (Löblich, 2017). Confirmability was further ensured by including a copiously documented audit trail, comments from experienced researchers, deductions made from interaction with research assistants, and documentation of information gathered during participant follow-up sessions.

Reflexivity

Reflexivity allowed the researcher to introspectively consider himself and his experiences in order to determine what he desired to write about (Creswell, 2013). Reflexivity is a fundamental part of qualitative research as it allowed the researcher to act both as a data collection instrument and a research analyst (Creswell, 2013), hence, facilitating the researcher's interaction with and interpretation of the data in a continuous manner. This allowed the researcher to come to a meaningful understanding and interpretation of the research. This meaning-making interaction on the basis of the researcher's varied prior experiences and beliefs as well as participants'

story in respect of the phenomenon under investigation equipped the researcher with the appropriate perspective and ideas about the work (Creswell, 2013).

The researcher, being a medical psychologist with specialist training in psychological trauma and traumatic stress observed how a good number of clients traced the beginning and persistent marital problems and health challenges to certain stressful periods in their lives, their childhood experiences or both. In some cases, it was the loss of a job and in others, the birth of another child among others. For those who connected their marital problems to their childhood, it was the absence of the image of an ideal father. For others, the sheer weakness to control their extreme emotions or addictions or both developed as a result of their childhood adversity that weakened the marital fabric. Again, the researcher being a married person bedevilled with numerous stressors, while observing others, also noticed the reality of the observation in his own life. The research answered important questions and enhanced insight into a pertinent societal and health problem. Hence, the research topic provided significant empirical information that was potent enough to shape marriage and family counselling, health care interventions for both children and adults as well as societal ideology of marital satisfaction.

The possibility for the researcher's professional training and keen interest in the phenomenon under investigation to influence thorough data collection was very high. However, the tendency to over-indulge the participants as a result of passion and empathy was also possible. This tendency was averted by constantly evaluating the interview process, making notes after each interview and following through with the interview guide. By

so doing, the researcher was able to maintain focus and improve on the data gathering process.

Ethical Considerations for both Qualitative and Quantitative Phases of Study

In order to avoid ethical mishaps in research, it was imperative that the research was designed within an ethically sound framework. The researcher sought ethical clearance from the Ethical Review Board of the College of Education Studies of the University of Cape Coast.

Participants' privacy was ensured by seeking their consent with respect to their participation in the research. The essence of the research was thoroughly explained to ensure participants' comprehension of the need for the research and voluntary participation as well as volunteering of information. Again, participants were not required to provide their names or other personal details that could potentially affect the assurance of anonymity and confidentiality. Participants were assured of their right to withdraw from the study at any point in time if they deemed fit even after the purpose of the research had been explained as stipulated in the consent form and their informed consent had been sort by signing or thumb printing.

It was also ensured that every idea or information employed in the process of writing was duly acknowledged and referenced in order to avoid plagiarism.

Training of Field Assistants

Given the demanding nature of data collection in mixed methods research, it was appropriate for some research assistants to be trained in order

to expedite the data collection process. The research assistants were 5 university graduates with bachelor's degree in psychology and an interest in research. They were given training regarding quantitative data gathering using questionnaires in order to enhance appropriate data collection in an atmosphere of absolute confidentiality, anonymity, informed consent and a thorough explanation of the purpose of the study.

The research assistants were trained to establish rapport with prospective participants, to ensure privacy and still remain available for clarification. They were also trained to respond to and assure participants who may request to withdraw from the study and to receive a completed questionnaire in a manner that assured participants of confidentiality.

The research assistants were not paid any allowance.

Data Collection Procedure

In this mixed methods research, data was collected both quantitatively and qualitatively (Creswell, 2003) by use of a set of standardised questionnaires and through an interview guide respectively. For studies such as this, where a convergent design was adopted, and the focus was to triangulate the data gathered, with the sole aim of arriving at a corroborated and valid conclusions about the phenomenon under study as recommended by Creswell (2009), the use of two independent sources of data collection to ensure a robust and unique database resulted in a meaningful research outcome. Quantitative data was collected in order to confirm or debunk the hypotheses as well as deepened insight into the phenomenon through the gathering and exploration of qualitative data. This established the approach taken in this study to firstly ascertain the hypothesised predictions and

subsequently expatiate on the phenomenon qualitatively through semi-structured interviews.

The semi-structured interview was preferred due to the flexibility it offered in terms of the use of open-ended questions and flow of questions (DiCicco-Bloom & Crabtree, 2006) as well as the freedom to exclude certain questions while other questions which may not have been included in the structure were asked as recommended by Runswick-Cole (2011).

Against this backdrop, the Ga Central Municipal Assembly was duly furnished with a copy of the ethics review board's letter of approval in order to keep them informed. All the participants consented by signing the consent forms. The quantitative data collection phase started with the distribution of questionnaires to married persons who lived within the Ga Central Municipality of the Greater Accra Region of Ghana. In areas where married persons were available, eligible participants were purposively sampled to make available all eligible married person. Furthermore, in cases where eligible married persons were quite many and available, they were conveniently sampled for data collection after purposively determined.

During the qualitative data collection phase which started concurrently with the quantitative phase, the researcher solicited qualitative data from eligible participants who were willing to grant interview with respect to the research following their completion of the research questionnaires. Participants who gave their consent following their meeting of the eligibility criteria were interviewed at a place and time they found convenient. This enhanced confidentiality and privacy during the interview.

Data Processing and Analysis

Creswell and Plano (2018) opined that in mixed methods data analysis, qualitative and quantitative data are analysed separately using unique and appropriate qualitative and quantitative methods. This resulted in the mixing or integration of both data sets referred to as mixed method analysis.

Following mixed methods analysis, the data was interpreted on the basis of both the quantitative and qualitative findings in respect of the study's purpose (Creswell & Plano, 2018). Mixed method data was interpreted based on the results and inferences and meta-inferences were drawn as suggested by Teddlie and Tashakkori (2009). This implies that conclusions and interpretations were made from the independent quantitative and qualitative phases of the study as well as across both quantitative and qualitative strands of the study.

Quantitative Data Processing

The quantitative phase of the study gathered demographic information of the participant with the aim of making meaning of the frequency and percentage of occurrence in order to enhance insight into the nature and uniqueness of the participants being studied. To buttress this need, Dane (2011), indicated that it would serve the interest of the researcher if they knew the frequency of occurrence of the phenomenon under study as well as extent to which the variables varied. The idea behind descriptive analysis was to facilitate a thorough description of the phenomenon being studied (Sekaran, 2003).

Research questions 1, 2, and 3 were examined using frequency and percentage analysis. As part of the quantitative phase of the study some

inferential statistical analyses such as regression analysis, one way analysis of variance and correlational analysis were done.

The Pearson Product-Moment Correlation (Sekaran, 2003), measured the association between two variables and indicated the strength of their linear relationship, which can be either perfectly positive or negative. This analysis was used for hypothesis 1 which sought to determine the relationship that existed among ACEs, SLEs and marital satisfaction of married persons. The Alpha level used for all statistical tests was .05.

Hypothesis 2 was tested using the One-way Analysis of Variance (ANOVA) to determine the difference that may be observed in marital satisfaction with respect to the cumulative number of ACEs experienced by married persons in the Ga Central Municipality of the Greater Accra Region.

For testing research hypothesis 3, the multiple logistic regression analysis was employed. This analysis aimed to examine the relationship between ACEs, SLEs, marital satisfaction, and Health-Related Quality of Life (HRQoL). This logistic regression was deemed appropriate because the response variable (HRQoL) was binary in nature and its impact could be appropriately measured using the multiple logistic regression analysis. As Sperandei (2013) mentioned, the multiple logistic regression was employed when the researcher wanted to obtain odds ratio while examining the influence of one or more independent variables on a response variable which was binomial in nature.

The multiple regression analysis was used to analyse hypotheses 4 because the researcher sought to determine how much ACEs and SLEs

predicted marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

Qualitative Data Processing

According to the recommendation made by Smith et al. (2009) regarding the appropriate analysis for the qualitative phase of the study, the transcripts were individually analysed in a stepwise manner. The analysis process commenced with a thorough reading of the transcripts and making initial notes. This step was repeated multiple times for each transcript, focusing on identifying statements of interest, language usage, patterns, and contradictions. Additionally, the researcher took note of the key issues expressed by the interviewees and the context in which these issues were framed. The emerging themes were identified and documented as initial interpretations of the interviewees' accounts. These themes were further grouped together to form broader super-ordinate themes. After analysing all the transcripts through consistent re-reading and seeking clarity in the accounts, connections were established across the transcripts to identify overarching master themes. These master themes, along with the corresponding narratives from each participant, were recorded in a spreadsheet. Based on these master themes and narratives, a final report was generated, and conclusions were drawn.

The development of themes were done *posteriori* or inductively. This implies that all themes or codes were generated post-analysis of the data as Pietkiewicz and Smith (2014) opined that themes should not be predetermined before data analysis is done. The Interpretative Phenomenological Analysis (IPA) was used to answer research questions four and five.

Summary of Research Methods

In this chapter, the research design and methodology for a mixed method research approach were discussed. The quantitative study employed a cross-sectional survey, while the qualitative phase utilised interpretative phenomenological analysis. The chapter provided an overview of the data collection and analysis procedures, as well as the selection of appropriate statistical tools and scales for data collection. The ethical considerations within which the study was framed was also discussed.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The aim of the study was to investigate the impact that adverse childhood experiences and stressful life events have on marital satisfaction and health-related quality of life in the Ga Central Municipality. Specifically, the study sought to find out (1) the forms of adverse childhood experiences and stressful life events experienced by married people; (2) the impact that adverse childhood experiences and stressful life events have on marital satisfaction and health-related quality of life; (3) the extent to which adverse childhood experiences and stressful life events predict marital satisfaction and health-related quality of life; (4) the relationship between marital satisfaction and health-related quality of life; (5) the difference that abuse, household dysfunction and neglect make in determining marital satisfaction of married person in the Ga central municipality.

This chapter focused on presenting the results of the data analyses and discussing the findings of the study. The first part of the chapter specifically focuses on the quantitative research results. The data were analysed using various statistical techniques, including percentages, frequencies, computation of means, standard deviations, Pearson's product moment correlation coefficient, multiple regression analysis, logistic regression analysis, and one-way analysis of variance. These analytical methods were mentioned in the preceding chapter as appropriate for the study.

Socio-demographic data of Participants

The study was conducted within the Ga central municipality with a

total of 400 married persons. The initial phase of the analysis focused on examining socio-demographic information of the married individuals participating in the study. Specifically, the analysis included variables such as gender, age, age difference between partners, and duration of marriage.

Table 2 presents the gender distribution of the Research Participants

Table 2: *Distribution of participants by Gender*

Gender	Frequency	Percent (%)
Male	167	41.8
Female	233	58.3
Total	400	100

Source: Field survey (2022)

The results in Table 2 indicates that 167 (41.8%) were males while 233 (58.3%) were females. It is therefore conclusive that women were the greater of the participants.

Table 3 presents the age distribution of the participants involved in the study.

Table 3*: Distribution of participants by Age*

Age	Frequency	Percent (%)
18-23years	1	.3
24-29years	36	9.0
30-35years	170	42.5
36-40years	107	26.8
41-45years	44	11.0
46-50years	15	3.8
>50years	27	6.8
Total	400	100

Source: Field survey (2022)

Results displayed on Table 3 shows a majority of 170 participants within the age range of 30-35 years. They were followed by the group of 36-40 years, with a total of 107 participants. The age range with the least number of participants, on the other hand was 18-23 years.

Table 4 presents the age difference between participants involved in this study and their spouses.

Table 4*: Distribution of participants by Age Difference between participant and spouse*

Age difference between participant and spouse	Frequency	Percent (%)
1day- 2 years	188	47.0
3-5 years	123	30.8
6-8 years	50	12.5
9-10 years	25	6.3
>10 years	14	3.5
Total	400	100

Source: Field survey (2022)

The findings presented on Table 4 showed that the maximum number of the participants were between a day and 2 years older or younger than their spouses. Participants whose age difference with their spouses was above 10 years were the least in number. It was found that participants with wider age difference were lesser in number across the age ranges.

Table 5 presents the age difference between participants involved in this study and their spouses.

Table 5: *Distribution of participants by duration of marriage*

Duration of marriage	Frequency	Percent (%)
1day- 2 years	88	22.0
3-5 years	100	25.0
6-8 years	70	17.5
9-10 years	43	10.8
>10 years	99	24.8
Total	400	100

Source: Field survey (2022)

Results displayed on table five showed that participants who had been married for three to five years were the most represented while those who had been married for about a decade were the least represented. Participants who

had been married for more than five years were just as many as those who had been married for less than five years.

Presentation of Results

This section of the study revealed the primary findings related to the research questions and hypotheses formulated to guide the study. It provided an overview of the main results obtained through the research process.

Research Question One

What are the common adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region?

Table 6 presents the data analysis of participants' responses with respect to their adverse childhood experiences.

Table 6*: Results on the distribution of Participants' Adverse Childhood Experiences*

ACEs `	Frequency	Percentage Yes	No
1. Verbal abuse	80	20.0	80.0
2. Physical abuse	53	13.3	86.7
3. Sexual abuse	65	16.3	83.7
4. Emotional neglect	73	18.3	81.7
5. Parental Divorce	101	25.3	74.7
6. Domestic violence	36	9.0	91.0
7. Relative Drug addiction	42	10.5	89.5

Source: Field survey (2022)

The results in Table 6 showed that participants who experienced verbal abuse in childhood were 80 (20.0%) while those who experienced physical abuse were 53 (13.3%) and 65 (16.3%) had experienced sexual abuse.

Participants who had experienced emotional neglect were 73 (18.3%) while those who experienced parental divorce or separation were 101 (25.3%). Also, those who experienced violence perpetrated against their mother were 36 (9.0%) while those who experienced drug or alcohol use by a household member were 42 (10.5%).

Research Question Two

What are the stressful life events experienced by married persons in the Ga Central Municipality of the Greater Accra Region?

Table 7 displays the data analysis of the participants' responses regarding their experiences of stressful life events.

Table 7: *Results on the distribution of Participants' Stressful Life Events*

	SLEs		**Percentage**	
s/n	**Items**	**Frequency**	Yes	No
1.	Death of spouse	5	1.2	98.8
2.	Divorce	5	1.2	98.8
3.	Marital Separation from spouse	28	7.1	92.9
4.	Detention in prison or other institution	2	0.4	99.6
5.	Death of a close family member	175	43.7	56.3
6.	Major personal injury or illness	65	16.2	83.8
7.	Marriage	293	73.3	26.7
8.	Being fired at work	22	5.4	94.6
9.	Marital reconciliation with spouse	40	10.0	90.0
10.	Retirement from work	10	2.5	97.5
11.	Major change in the health or behavior of a family member	142	35.4	64.6

12.	Pregnancy	137	34.2	65.8
13.	Sexual Difficulties	73	18.3	81.7
14.	Gaining a new family member (i.e. birth, older adult moving in, etc.)	177	44.2	55.8
15.	Major business adjustment	135	33.7	66.3
16.	Major change in financial state (i.e. a lot worse or better than usual)	255	63.7	36.3
17.	Death of a close friend	85	21.2	78.8
18.	Changing to a different line of work	132	32.9	67.1
19.	Major change in number of arguments with spouse (i.e. a lot more or less)	152	37.9	62.1
20.	Taking on a loan (for home, business, etc.)	137	34.2	65.8
21.	Ejection from a rented apartment	20	5.0	95.0
22.	Major change in responsibilities at work (i.e. promotion, demotion, etc)	133	33.3	66.7
23.	Son or daughter leaving home (due to marriage, school, etc.)	23	5.8	94.2
24.	In-law troubles	63	15.8	84.2
25.	Outstanding personal achievement	175	43.8	56.2
26.	Spouse beginning or ceasing work outside the home	160	40.0	60.0
27.	Beginning or ceasing formal schooling	97	24.2	75.8
28.	Major change in living condition (i.e. new home, remodeling, deterioration, etc.)	150	37.5	62.5
29.	Revision of personal habits (i.e. dress, associations, quit smoking or alcohol use, etc.)	88	22.1	77.9
30.	Troubles with your boss or superior.	78	19.6	80.4
31.	Major changes in working hours or conditions	155	38.8	61.2

32.	Changes in residence	155	38.8	61.2
33.	Changing to a new school	50	12.5	87.5
34.	Major change in usual type and/or amount of recreation	78	19.6	80.4
35.	Major change in church activity (i.e. a lot more or less)	148	37.1	62.9
36.	Major change in social activities (i.e. clubs, movies, visiting, etc.)	108	27.1	72.9
37.	Taking on a loan (i.e. car, rent, funeral etc.)	80	20.0	80.0
38.	Major change in sleeping habits (i.e. a lot more or less)	250	62.5	37.5
39.	Major change in number of family get-togethers (i.e. a lot more or less)	110	27.5	72.5
40.	Major change in eating habits (i.e. a lot more or less, eating hours, surroundings, etc)	209	52.5	47.5
41.	Vacation or travels	82	20.4	79.6
42.	Major holidays or breaks	95	23.8	76.3
43.	Minor violations of law (i.e crossing red light etc.)	40	10.0	90.0

Source: Field survey (2022)

The results in Table 7 showed that the most prevalent SLEs among married persons were major changes in finances, marriage related issues, sleep habits and eating habits. More than 50% of participants indicated these as their SLEs. This suggests that at least five out of ten married persons were distressed by their marriage, sleep, eating habits and financial situation. Also, about four out of ten (approx.40%) of married persons experienced the death of a close relative, presence of a new child or household member, outstanding personal achievement and a change in their spouse's work situation. Furthermore, at least three out of ten married persons (approx. 30%) experienced major changes in church activities, residence, working hours,

working conditions, work demands, new work roles, new line of work, living conditions and frequency of arguments with spouse.

Research Question Three

What is the prevalence rate of the cumulative number of adverse childhood experiences among married persons in the Ga Central Municipality of the Greater Accra Region?

Table 8 presents the data analysis of the cumulative adverse childhood experiences scores that helped to measure participants' level of childhood adversity.

Table 8*: Results on the cumulative number of Adverse Childhood Experiences among Participants.*

Number of ACEs	Frequency	Percentage
0ACE	195	48.8
1ACE	85	21.3
2ACE	58	14.5
3ACE	28	7.0
4+ACE	34	8.5
Total	400	100.0

Source: Field survey (2022)

The results in Table 8 indicated that participants who never experienced any adverse childhood experiences were 195 (48.8%) while those who experienced one (1) were 85 (21.3%) and 58 (14.5%) had experienced a total of two (2). Participants who had experienced a total of three (3) ACEs were 28 (7.0%) while those who experienced four or more (4+) were 34 (8.5%). This suggests that about 51.2% of the participants had experienced at least one adverse childhood experience.

Hypothesis Testing

Hypothesis One

$H_0$1: There will be no statistically significant relationship among adverse childhood experiences, stressful life events and marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

H_A1: There will be a statistically significant relationship among adverse childhood experiences, stressful life events and marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region.

The purpose of hypothesis one was to find out the relationship among adverse childhood experiences, stressful life events and marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region. Pearson's product moment correlation coefficient was employed to test this hypothesis. The result is presented in Table 9.

Table 9*: Pearson's Product Moment Correlation Coefficient of adverse childhood experience, stressful life events and marital satisfaction.*

Variables	Mean	Adverse Childhood Experiences	Marital satisfaction
ACE	8.1250	1	
MS	53.3325	-.228*	
SLE	54.1125	.337***	-.206**

Source: Field survey (2022) *Note.* *** p = .000; ** p = .01; * p = .05

Finding from Table 9 indicates a significant negative relationship between adverse childhood experiences and marital satisfaction of participants (r= -.228, p < .05). This implies that the greater a participant's adverse

childhood experiences, the poorer their marital satisfaction.

It was also found that a significant negative relationship existed between stressful life events and marital satisfaction (r= -.206, p < .05) which suggests that an increase in stressful life experiences tends to result in a decline in marital satisfaction.

Hypothesis Two

$H_0$2: There will be no statistically significant difference in marital satisfaction with respect to number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region.

H_A2: There will be a statistically significant difference in marital satisfaction with respect to number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region.

The purpose of hypothesis two was to find out if there were significant differences in marital satisfaction with respect to number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region. One-way Analysis of Variance was used to test this hypothesis and the result is presented in Table 10.

Table 10*: One-way Analysis of Variance of number of ACEs*

	M	SD	df	F	Sig
0ACE	56.0615	12.60119			
1ACE	53.2588	13.28636			
2ACE	49.8966	14.13306			
3ACE	49.6429	12.97352			
4+ACE	46.7647	15.90704			
	53.3325	13.60919	395	5.629	.000

Source: Field survey (2022) *Significant, p< .05

The Null Hypothesis 2 was tested at significant level of .05 and the results showed that at df = 395, F = 5.629, p = .000 is less than .05. Therefore, Null Hypothesis is rejected. This implies that there was a significant difference in marital satisfaction among participants who had suffered no ACE, 1 ACE, 2 ACEs, 3 ACEs and 4 or more ACEs. An observation of the means suggest that participants who had no history of ACEs (M = 56.0615, SD = 12.60119) experienced greater marital satisfaction compared to those who had experienced at least one ACE (M = 53.2588, SD = 13.28636). Also, participants who had experienced four or more ACEs (M = 46.7647, SD = 15.90704) appeared to have experienced the least satisfaction in their marriage.

Table 11: *Multiple Comparisons- Tukey HSD*

ACE	ACE	M	S.E	Sig.	95% C.I Lower Bound	Upper Bound
0ACE	1ACE	2.80271	1.72916	.485	-1.9359	7.5413
	2ACE	6.16499*	1.98981	.018	.7121	11.6179
	3ACE	6.41868	2.68867	.121	-.9494	13.7868
	4+ACE	9.29683*	2.47254	.002	2.5210	16.0726
1 ACE	2ACE	3.36227	2.26583	.574	-2.8470	9.5716
	3ACE	3.61597	2.89890	.723	-4.3282	11.5602
	4+ACE	6.49412	2.69964	.116	-.9040	13.8923
2 ACE	3ACE	.25369	3.06153	1.000	-8.1362	8.6436
	4+ACE	3.13185	2.87357	.812	-4.7430	11.0066
3 ACE	4+ACE	2.87815	3.39515	.915	-6.4260	12.1823

Source: Field survey (2022) *Significant, p< .05

Table 11 revealed that participants who had no history of ACEs experienced a significantly higher marital satisfaction compared to those who experienced two ACEs (M = 6.16499, p < .05). Also, participants who had no history of ACEs experienced a significantly higher marital satisfaction

compared to those who had experienced four or more ACEs (M = 9.29683, p < .05). This implies that participants who had experienced at least one ACE suffered a decline in marital satisfaction compared to those who had no history of ACE. The findings further revealed that participants who had more ACEs suffered greater decline in marital satisfaction.

Hypothesis Three

$H_0$3: Adverse childhood experiences, stressful life events and marital satisfaction will not predict health-related quality of life of married persons in the Ga Central Municipality of the Greater Accra Region.

$H_1$3: Adverse childhood experiences, stressful life events and marital satisfaction will predict health-related quality of life of married persons in the Ga Central Municipality of the Greater Accra Region.

The purpose of hypothesis three was to find out the relationship among adverse childhood experiences, stressful life events, marital satisfaction and health-related quality of life among married persons in the Ga Central Municipality of the Greater Accra Region. Multiple Logistic Regression Analysis was used to test the hypothesis and the result is presented in Table 11.

Table 12: *Logistic Regression Analysis of adverse childhood experience, stressful life events, marital satisfaction and health-related quality of life.*

		15 or more healthy days				
					95% C.I.	
		B	S.E.	O.R.	Lower	Upper
Step 1[a]	ACE	-.772	.350	.462	.233	.918
	SLE	-.039	.019	.962	.927	.998
	EMSS	.038	.009	1.039	1.021	1.057
	Nagelker R^2	.168				

Source: Field survey (2022)

Findings from Table 11 indicate a significant negative relationship between the independent variable (ACEs) and dependent variable (HRQoL) of participants. ACEs predicted a negative relationship with HRQoL (B = -. 772, O.R = .462, p< .05). This suggests that for every extra experience of ACEs among married persons, there will be a .462 odd of experiencing a decline in HRQoL compared to them not experiencing any decline in HRQoL. This implies that married persons who have experienced any form of ACE are more likely to experience a decline in HRQoL, with those with more experiences of ACEs being more liable to experiencing poorer HRQoL than not.

The study also revealed a significant negative relationship between stressful life events and health-related quality of life (B = -.039, O.R = .962, p< .05). This suggests that for every additional increase in experiences of SLEs among married persons, there will be a .962 chance of experiencing a decline in HRQoL compared to them not experiencing any decline in HRQoL. This implies that married persons who experience any form of SLEs are more likely to experience a decline in HRQoL, with those with more experiences of

SLEs being more susceptible to experiencing poorer HRQoL than not.

Finally, the study revealed a positive correlation between marital satisfaction and Health-Related Quality of Life (HRQoL), indicating that an increase in marital satisfaction was associated with a corresponding increase in HRQoL (B = .038, O.R = 1.039, p< .05) which suggests that as a participant's marital satisfaction increased, there was a corresponding equal increase in their HRQoL.

$H_0$4: Adverse childhood experiences and stressful life events will not predict marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

$H_1$4: Adverse childhood experiences and stressful life events will predict marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

Hypothesis four sought to establish the extent to which adverse childhood experiences and stressful life events impact marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region. The independent variables are adverse childhood experiences and stressful life events. The dependent variable is marital satisfaction. To test this hypothesis, the multiple regression analysis was employed. This statistical analysis technique was used to assess the extent of influence and impact of the independent variables on the dependent variable, which in this case is the participants' marital satisfaction. By using multiple regression analysis, it was possible to determine the impact of the predictor variables on the outcome variable. Prior to running the multiple regression analysis, assumptions such as normality (tested using a P-P plot) and multicollinearity were evaluated.

Figure 3 displays the P-P plot normality test results for the study variables.

Normal P-P Plot of Regression Standardised Residual

Dependent Variable: Marital Satisfaction

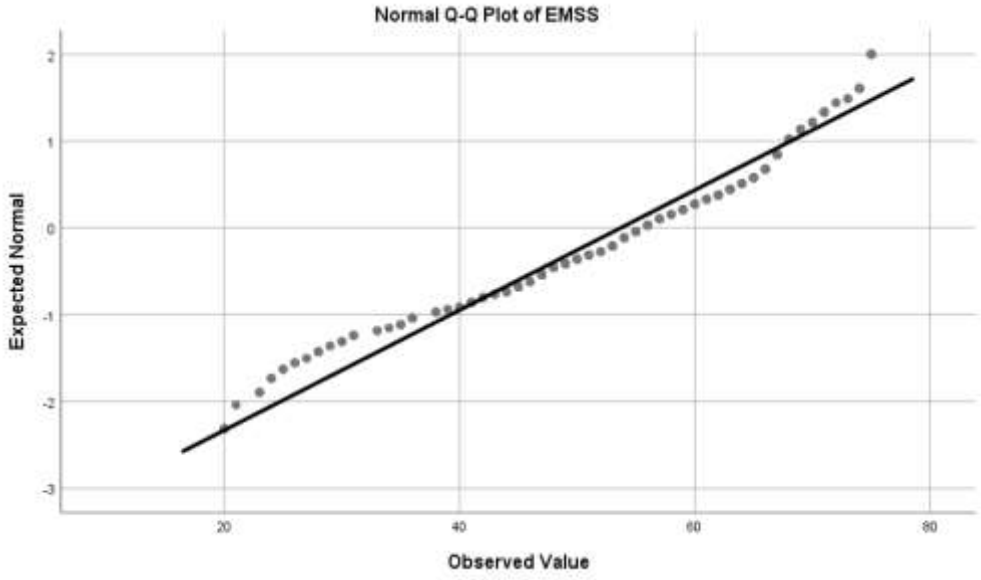


Figure 3: P-P plot of normality

Source: Field Survey (2022)

Figure 2 demonstrates that the majority of the scores are relatively close to the central diagonal line. When a significant portion of the scores align closely with the diagonal line, it indicates a normal distribution of the data (Pallant, 2016). In order to further validate the assumption of normality based on the P-P plot, a multicollinearity test was conducted using tolerance and variance inflation factor (VIF). Table 12 provides the results of the multicollinearity analysis, which assesses the presence of collinearity among the variables.

Table 13: Multicollinearity Test

Variables	Correlations	Multicollinearity	
	Marital Satisfaction	Tolerance	VIF
ACEs SLEs	.231	.887	1.128

Source: Field survey (2022)

Multicollinearity testing is where the researcher tests the correlation between the independent variables in a regression analysis (Vatcheva, Lee & McCormick, 2016). However, multicollinearity does not influence the predictive outcome of the variable even though it could cause a misidentification and obscure the computation of the exclusive influence of collinear independent variables on dependent variables and this could result in drawing a wrong conclusion in determining how each independent variable may be predicting the dependent variable (Vatcheva et al., 2016). Interestingly, in spite of these, multicollinearity holds potential in facilitating a more accurate interpretation of the data (Vatcheva et al., 2016). Tanko, Kang and Islam (2019) indicated that in testing multicollinearity issues in research, the tolerance and variance inflation factor will be used with a cut-off point of .1 as well as a tolerance 10 (Tanko et al., 2019).

Table 14: *ANOVA of ACEs, SLEs and Marital Satisfaction*

Model	**SS**	**df**	**MS**	**R^2 Change**	**F**	**Sig.**
Regression	5225.086	2	2612.543	.071	15.103	.000[b]
Residual	68673.691	397	172.982			
Total	73898.778	399				

Source: Field Survey (2022)

According to Table 13, the variance in the dependent variable, marital satisfaction, is accounted for by 7.1% (.071) of the independent variables, adverse childhood experiences (ACEs) and stressful life events (SLEs). The statistical analysis revealed a significant relationship at F (15.103) = .000, with a significance level of p < .05. This suggests that ACEs and SLEs have a statistically significant impact on the marital satisfaction of the participants. Consequently, a standard multiple regression analysis was conducted to determine the extent of the influence of the independent variables on the dependent variable.

Table 15*: Standard Multiple Regression Analysis of ACEs, SLEs and Marital Satisfaction*

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	S.E	Beta	t	Sig.
1	(Constant)	83.034	5.766		14.399	.000
	ACE	-1.655	.476	-.179	-3.475	.001
	SLE	-.300	.106	-.146	-2.840	.005

Source: Field survey Dependent variable = Marital satisfaction

According to the data presented in Table 14, the analysis indicates that adverse childhood experiences (ACEs) are statistically significant at a .05 confidence level, with a significant value (*p* = .001), which is less than .05. Also, stressful life events (SLEs) are statistically significant at the same confidence level, with a significant value (*p* = .005), which is less than .05. In terms of the standardized beta values, the results suggest that ACEs (independent variable) have a significant predictive effect on marital satisfaction (dependent variable), indicated by (beta = -.179 or 17.9%).

Similarly, SLEs (independent variable) have a significant predictive effect on marital satisfaction, as reflected by a beta value (beta = -.146 or 14.6%).

These findings imply that while both ACEs and SLEs significantly contributed to the prediction of marital satisfaction, ACEs had a stronger and more significant impact compared to SLEs in this particular study.

Results for the Qualitative aspect of the Study

The qualitative findings of the study were presented in the form of superordinate themes, sub-themes and basic themes. However, a detailed presentation of the qualitative findings based on thematic analysis is also presented below.

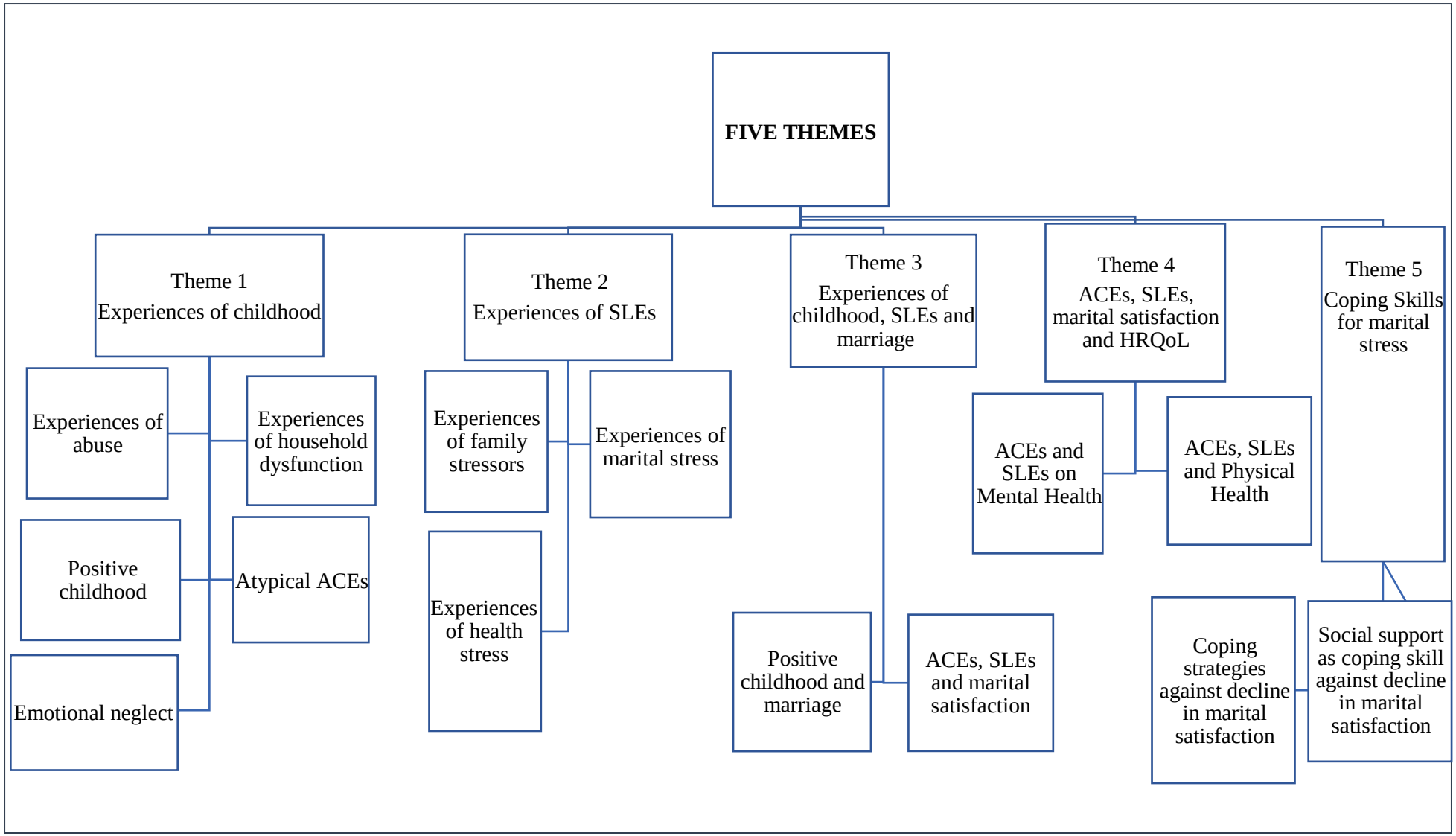


Figure 4: Summary of Qualitative study findings

Characteristics of Interview Participants

Summary of relevant characteristics of Study 2 participants.

Table 16: *Background Characteristics of Interview Participants*

Participant ID	Age	Gender	Duration of Marriage *(in years)*	Number of children	Social Status
Participant 1	28	Female	3	0	Environmental Scientist
Participant 2	44	Female	17	1	Entrepreneur
Participant 3	32	Female	4	3	Nutritionist/ Beautician
Participant 4	37	Male	5	0	Quantity Surveyor
Participant 5	38	Male	7	1	Businessman

Table 17 *: Summary of Emerging Themes from Qualitative Interviews*

Superordinate themes	Sub-themes
Married persons' experiences of positive and adverse childhood experiences	Physical abuse Verbal and emotional abuse Sexual abuse Domestic violence Extramarital affairs Discipline Communal living Restricted social interaction Restricted verbal expression Over-protection Emotional neglect
Married persons' experiences of stressful life events; family, marital and health stress.	Financial Challenges Spousal Job Stress Child Care Third Parties Miscarriages
Childhood experiences and stressful life events impact marital satisfaction of married persons.	Nature of marriage Positive childhood experiences ACEs and marriage SLEs and marriage Spousal negative responses
Childhood experiences, stressful life events and marital satisfaction influence HRQoL of married persons.	Suicide Depression Anger Anxiety Mood Pain Hospital visitations
Adaptive responses provide psychological buffer for SLEs and	Prayer Walk away Audiovisuals

decline in marital satisfaction.	Communication Social engagement Common interest Acceptance of weakness Externalisation Forgiveness Scrutiny Diet Friends

Five (5) major themes emerged from the gathered data, namely "Childhood experiences", "Experiences of stress", "Experiences of marriage", "Experiences of health" and "Coping techniques". Sub-themes revealed more about participants' experiences of marriage and the meaning they attached to the phenomenon primarily in the light of their childhood experiences, life stressors and health. Specific quotes that elucidated participant's unique experiences were used in this report. A summary of superordinate and sub-themes that emerged from the data are reported in Table 16.

Table 18: *Summary of Qualitative Findings*

RQ1: What are the common ACEs encountered by married persons in the Ga Central Municipality of the Greater Accra Region		
Themes	Basic Themes	Sample Quotes
Abuse	Physical abuse	*When you do something wrong and he comes around, he beats you, locks you in the room or he locks you in his room for hours or puts you under his bed and*

			locks the room … he will cane you with like the head of the belt or like a charger wire or like those wires (P1, F28).
		Verbal and Emotional Abuse	*I was in class four, that should be around age 10. That was when I moved in with my uncle. I moved into quite a hostile environment. Not hostile in the sense of physical of course. Yes, emotionally, psychologically hostile (P4, M37).*
		Sexual Abuse	*Sexual abuse was with my cousins and a neighbor. I can't count. Some I think my, my mind has blocked. It's when I hear someone say something or when I smell something then I get a kind of, like I get scared; why am I feeling so. I remember, like I know this smell, then I remember. Not one person but one person was more consistent because he was living around. He was our next door neighbor (P1, F28).*
	Household Dysfunction	Domestic Violence	*A lot more times, even physical. That's why I said my parent's marriage wasn't something I looked up to (P3, F32).*

		Extra-marital affairs	*My dad, unfortunately was a womanizer, yes I never looked up to my parent's marriage. I always said I will never marry someone like my dad (P3, F32).*
	Positive Childhood Experiences	Discipline	*So if you hear your auntie shouting, like go and bath, its five ;'clock, your father will come home soon. It's a form of the training but not hatred as in the person hates you and is abusing you (P2, F44).*
		Provision	*My dad made sure we had everything… he made sure we enjoyed life very much. He takes you out, you know… our fridge was always stocked with ice cream. You know, we didn't lack. We didn't lack anything (P3, F32)*
		Exciting communal living	*You come to the house and everybody is cooking and we are all sharing jokes and everything. So I came from that jovial, exciting home. I didn't see more conflicts even between like spouses of my aunties or my uncles (P2, F44).*

	Limited Social Engagement	Restricted social interaction	*The only thing we lacked was not getting the opportunity to mingle with your colleagues… We didn't have to mingle with other kids, like playing those kind of you know. We were always indoors when he was around, unless he's not around, then we sneak. It was just us. Even SHS, he doesn't want you to go to a boarding house (P3, F32).*
		Restricted Verbal Expression	*Just like the typical Ghanaian home, you don't have that liberty to express yourself (P4, M37).*
		Over-protection	*… we didn't have the opportunity to go out, explore, yeah, it was school, home, church basically … the environment was not too safe, not too welcoming and there was much robbery, chaos, children getting missing … parents are very protective (P4, M37).*
	Neglect	Emotional Neglect	*We don't talk, we don't go to his room. He's just in his room and we take food to him. He goes out in the morning, comes back in the evening. … you couldn't talk to him. (P1, F28).*
RQ 2: What are the common SLEs encountered by married persons in the Ga			

Central Municipality of the Greater Accra Region			
	Superordinate Theme 2: Married persons' experiences of stressful life events; family, marital and health stress.		
	Family Stressors	Financial challenges	*We lived hand to mouth, you know. He gives you money for the house, the rest of the money you don't know where he spends it. So it became like a whole issue, he's spending his money and then I'm questioning it. It's my money, he's working for the money so he can spend it anyhow he wants it and I didn't feel safe (P1, F28).*
		Spousal Job Stress	*The first one was his boss giving him a lot of stress. He feels that people wanted to work with the subordinate than the boss. If they want to get to his boss, he's not straight forward, he's that fishy … person like he is "kululu". So he felt that his position was being threatened (P2, F44).*
		Child Care	*Taking care of kids without help because most of the time I'm tired and my back pain has come in so instead of sitting I always want to be lying down because of my back and it's all because*

			of taking care of kids, you know, giving birth, raising kids. It's just the kids (P3, F32).
	Marriage	Third Parties	*One of the stressors was the shock of the email. That thing shuttered me err… honestly, that email was the deal breaker… He had already said that even if I go ahead and get married, he can have her anytime… That was it. In the process of trying to heal, singlehandedly, then another issue comes up. That was the issue of her ex. So now it doubles (P4, M37).*
	Health	Miscarriages	*… and having miscarriages (P2, F44).*
RQ 3: What influence do ACEs and SLEs have on marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region			
	Superordinate Theme 3: Childhood experiences and stressful life events impact marital satisfaction of married persons.		
	Marital Satisfaction	Nature of Marriage	*He's beginning to appreciate that oh everything is not like serious, serious. You don't have to take everything to heart and at times it's a joke. Initially things that I said, that seems like a joke, for him was a serious thing, but now we are beginning to realise that oh it's a*

			joke. So it has been friendship (P2, F44).
		Positive Childhood Experiences	*So I think growing up and seeing my parent's marriage, it's a good place to be so may be the training we had from my parent (P2, F44).*
	Marital Dissatisfaction	Nature of marriage	*Now we don't chat, we are always with our phones. … social media, he's always on his phone, I'm always on my phone. I think we're not making the effort because we're stuck to our phones (P3, F32).*
		ACEs and Marriage	*I never saw the effect it had on me until I got married and then I realized I was afraid of my husband … I feel like if I didn't go through that with my father, I wouldn't have found that so upsetting (P1, F28).*
		SLEs and Marriage	*You want to have your privacy, small time mummy this, someone is knocking on the door, you can't have that privacy anymore ... so it's like endless, unlimited complains all day (P3, F32).*

		Spousal negative responses	*In fact, when the ex's issue came, instead of being remorseful and apologetic, she kept being defensive. Like you know, it puts pressure on me (P4, M37).*
RQ 4: What influence do ACEs, SLEs and marital satisfaction have on married persons in the Ga Central Municipality of the Greater Accra Region			
	Superordinate theme 4: Childhood experiences, stressful life events and marital satisfaction influence HRQoL of married persons.		
	Mental Health	Suicide	*Sometimes when I start crying and he asks me what the problem is, I say I'm just having suicidal thoughts, I just want to end my life. Then he's like why, why do you want to end your life (P1, F28).*
		Depression	*Depression, yes. I was going through it, I went through depression. (P4, M37).*
		Anger	*I've bitten my husband before ... I could feel his flesh in my mouth. I had to wash it because I was so angry (P3, F32).*
		Anxiety	*There was a time he would confess that he's afraid. He will tell me that "pray for me, I'm afraid". Then I will hold him and pray for him even though I had my fears (P2, F44).*

		Mood	*It didn't affect our relationship but it affected our mood (P2, F44).*
	Physical Health	Sudden Collapse	*I passed out once in the middle of the night…when I went to the hospital in a couple of days after, the first question the doctor asked was what is wrong with you. Why are you thinking so much (P4, M37)*
		Pain	*I'm always doing something and my back especially my back is always hurting … I've done physio for more than a year ... taking care of children has always been stressful for me (P3, F32).*
		Hospital Visitation	*I use to go to the hospital almost all the time. They gave me the medication but still (P1, 28).*

Presentation of Thematic Analysis of Qualitative Findings

Superordinate theme 1: *Married persons' experiences of positive and adverse childhood experiences*

The theme "Experiences of childhood" is the superordinate theme from which emerged two categories of childhood experiences; positive childhood experiences and adverse childhood experiences. From these categories, five main themes were derived "Abuse", "Household dysfunction", "Limited social engagement" and "Neglect". These themes had 11 sub-themes, namely,

"Physical abuse", "Verbal and emotional abuse", "Sexual abuse", "Domestic violence", "Extramarital affairs", "Discipline", "Communal living", "Restricted social interaction", "Restricted verbal expression", "Over-protection" and "Emotional neglect", explaining participants' experiences of childhood.

The majority of participants in this study indicated that they had experienced various forms of abuse. Others recounted experiences of observing domestic violence while some others experienced significant emotional neglect and restriction. Participants who experienced domestic violence recalled instances of grave assault of their mothers by their fathers, right in their presence. Also, those who experienced sexual abuse alluded to it being perpetuated by close family relations or neighbours. Participants whose parents appeared to have been materially and emotionally supportive indicated that their parents were rather too over-protective of them which they believed must have affected their capacity to aptly assert themselves in their relationships. However, these participants indicated that their parents did well by disciplining them and thus did not attribute being caned or shouted at as physical or verbal abuse but rather, as being disciplined.

Married persons' experiences of various forms of abuse; physical, emotional and sexual abuse

Physical abuse

A finding of this study was the physical assault of participants by their parents for what they believe their parents perceived as wrong-doing but was not the case in some instances … this was evident from participants' account

of the phenomenon:

> *When you do something wrong and he comes around, he beats you, locks you in the room or he locks you in his room for hours or puts you under his bed and locks the room … he will cane you with like the head of the belt or like a charger wire or like those wires. (P1, F28)*

Another participant who experienced physical abuse perpetuated by her mother recounted her experience:

> *My sister asked her why she's always beating me. Like you're sitting with my mum, the next minute there's blood coming out of your mouth. Like the next minute, if you're to check your mouth and there's blood and you're crying and then she just opposite you. (P1, F28)*

Verbal and emotional abuse

Apart from physical abuse, some participants also reported experiencing verbal and emotional abuse from their parents. Some reported these experiences of abuse characterised by use of derogatory words and emotional detachment:

> *So she told me like with any opportunity she gets, she's telling you about something that she doesn't like about you. She still makes those utterances… She use to say things like she doesn't know which man will marry me or like me, you know, she is scared that I would not get married, you know that kind of thing (P1, F28).*
>
> *We didn't know when he's coming but once you are home and you hear his voice, everybody runs inside. You just don't want to be in plain sight (P1, F28).*
>
> *I was in class four, that should be around age 10. That was when I*

moved in with my uncle. I moved into quite a hostile environment. Not hostile in the sense of physical of course. Yes, emotionally, psychologically hostile (P4, M37).

Sexual abuse

A female participant experienced sexual abuse before turning 18 years. The participant was sexually assaulted by some of her cousins and more consistently by an older neighbour which she reported as:

My cousins and a neighbour sexually abused me. I can't count. Some, I think my, my mind has blocked. It's when I hear someone say something or when I smell something then I get a kind of, like I get scared; why am I feeling so, I remember, like I know this smell, then I remember. Not one person but one person was more consistent because he was living around. Because he was our next door neighbour (P1, F28).

A male participant who had been sexually abused by his elder step-brother between age four and seven years reported the experience as:

I was sexually abused by my older brother from 4 to 7. I think my mum knew. She's like there was a day when they were leaving me in the house and I started crying as they were driving away (P5, M38).

Married persons' experiences of household dysfunction; domestic violence and extramarital affairs

Domestic violence

Apart from participants being directly impacted by abuse from their parents, some also mentioned being distressed by physical abuse being

perpetuated against their mothers. According to some participants, they saw their mothers being beaten by their fathers on several occasions:

> *A lot more times, even physical. That's why I said my parent's marriage wasn't something I looked up to (P3, F32).*

Another participant recounted a similar experience as:

> *My home, very unstable home… by unstable I mean there were fights, physical fights. They were always shouting (P5, M38).*

Extramarital affairs

Also, some participants reported not only domestic violence but emotional abuse of their mothers in the form of their fathers engaging in extramarital affairs. As a result, they vowed to themselves never to allow themselves to be disrespected by anyone, including their husbands:

> *My dad, unfortunately was a womanizer, yes I never looked up to my parent's marriage. I always said I will never marry someone like my dad (P3, F32).*

Another participant who described his home severely distressing indicated that:

> *There was no joy at home. There was no peace. He was never really home. He was highly promiscuous. He spiraled out of control (P5, M38).*

Married persons experiences of emotional neglect and atypical ACEs; Emotional neglect and restricted social interaction

Emotional neglect

Some participants experienced emotional neglect characterised by

parental disinterest in their emotional needs. They described their parents as being emotionally unavailable:

> *We are not close, most of the time, he just calls and gives you orders to respond basically. We don't talk, we don't go to his room. He's just in his room and we take food to him. He goes out in the morning, comes back in the evening. … you couldn't talk to him. (P1, F28).*

Also, another participant narrated a similar experience suggestive of emotional neglect as:

My father was a teacher. At some point I was in the same school he was teaching in but we never spoke, for two years. I use to ran into him on the corridor and I will just change direction (P5, M38).

Restricted social interaction

The study however revealed that some participants experience some adverse childhood experiences which may not have been considered as adverse but participants found to have adversely affected them. The participants reported some of these experiences:

> *The only thing we lacked was not getting the opportunity to mingle with your colleagues… We didn't have to mingle with other kids, like playing those kind of you know. We were always indoors when he was around, unless he's not around, then we sneak. My dad never wanted us to go stay with anybody. It was just us. Even SS, he doesn't want you to go to a boarding house. So we were always day students. It only our last brother who went to SHS in a boarding school. (P3, F32)*
>
> *Because of the environment that I was born into, we didn't have the opportunity to go out, explore, yeah, it was school, home, church*

basically. I spent a few of my lifetime with my parents. For the few that I spent with my parents, it was good. But because the environment was not too safe, not too welcoming and there was much robbery, chaos, children getting missing ... parents are very protective. (P4, 37)

It was comfortable. Just like the typical Ghanaian home, you don't have that liberty to express yourself. (P4, M37)

One participant reported how his mother was constantly overprotective of him and literally made him play elderly roles at a tender age:

This is how I grew up. I always solve people's problem. I've been solving my mother's problem since childhood. And also the issue of overprotection, she doesn't want you out of her sight. You're the only person I have. So you just don't have that freedom. My whole move to Ghana was just to get away from her because I find her overbearing. You know there are certain people that when they talk, you immediately get defensive and you're ready to attack. That's the training I got with my mum. So when she begins to talk I'm ready to defending myself (P5, M38).

Married persons' encounters with positive childhood experiences; communal living, discipline and provision

Communal living

A few participants however reported positive experiences of their childhood which they believe has significantly favoured their marriages. A few others who experienced these positive childhood events were not insulated from other forms of ACEs. These participants appeared to have parents who prioritized certain aspects of

their children's wellbeing such as providing them with material and academic needs, as well as moral uprightness over other aspects such as emotional presence:

It was a family… it was fun. If I say it was fun. I grew up in a family house, let me say. I stayed with aunties. That old traditional family house, big family. All my aunties, uncles with their kids, husbands, wives we were all in that big house. You come to the house and everybody is cooking and we are all sharing jokes and everything. So I came from that jovial, exciting home. I didn't see more conflicts even between errmm, like spouses of my aunties or my uncles (P2, F44).

Discipline

Some participants also interpreted shouting and caning as forms of being disciplined by an adult figure or parent in the study. They believed that once these correctional measures were meted out to a child without any form of malice or intent to harm, it was appropriate and has helped in their upbringing:

So if you hear your auntie shouting, like go and bath, it's 5'o clock, your father will come home soon. It's a form of the training but not hatred as in the person hates you and is abusing you (P2, F44).

He disciplined us very well (P3. F32)

Provision

Majority of the participants indicated that they had no significant material needs. They for example reported:

He was there financially. Yes, like I mean when your fees, like you know, you don't have issues with your fees being paid. (P1, F28)

My dad made sure we had everything… he made sure we enjoyed life very much. He takes you out, you know… he made sure, our fridge was always stocked with ice cream. You know, we didn't lack. We didn't lack anything. (P3, F32)

Superordinate theme 2: Married persons' experiences of stressful life events; family, marital and health stress.

The second theme revolved around participants' experiences of stressful life events including financial challenges, spousal job stressors, child care and miscarriages. Financial challenges for instance, was experienced by some of the participants as well as challenges of child care. Some participants were also stressed by recurrent miscarriages and its associated pain and intrusion by third parties who negatively influenced some spouses.

Married persons experiences of family stressors; financial challenges, spousal job loss and demands of child care.

Financial challenges

Some participants experienced domestic challenges which comprised of financial challenges, spousal job loss and demands of childcare which they described as very difficult circumstances with devastating impact on their marriages and wellbeing. Regarding financial challenges, some participants recounted some experiences:

We lived hand to mouth, you know. He gives you money for the house, the rest of the money you don't know where he spends it. So it became like a whole issue, he's spending his money and then I'm questioning it. It's my money, he's working for the money so he can spend it

anyhow he wants it and I didn't feel safe. (P1, F28)

Financially, now we are even drained than (before) if you don't have money, Charley it's annoying, almost everything annoys you. Because you pay a child's school, just one you paying over 2,500 cedis and you calculate three kids. That's a lot. It's stressful, I mean kids, so kids play a big role. When we had one, you know we didn't feel it like that, then two, now, you know. I've always said I wanted more kids but right now me "Naa" I said I won't have kids again. Kids is a lot. You get stressed. (P3, F32)

Spousal job loss

Some participants also reported experiencing significant stressors when their spouses faced challenges at work. They described its impact on their health and marital interaction:

The first one was his boss giving him a lot of stress. He feels that people wanted to work with the subordinate than the boss. If they want to get to his boss, he's not straight forward, he's that fishy … person like he is "kululu". So he felt that his position was being threatened (P2, F44).

Demands of child care

A few participants indicated that raising children was an extremely stressful experience particularly when there was no assistance from their spouses, relative or house help. They mentioned that it posed both physical and emotional strain on them:

Taking care of kids without help because most of the time I'm tired and my back pain has come in so instead of sitting I always want to be

lying down because of my back and it's all because of taking care of kids, you know, giving birth, raising kids. It's just the kids. (P3, F32)

Married persons' experiences of marital stressors

Third party influence

The influence of third parties such as friends, in-laws and ex-relationship partners was mentioned as one of the major stressors participants endure in their marital relationship. Some of the participants indicated that some third parties almost held their marriage and life hostage by their influence on their spouses:

One of the stressors was the shock of the email. That thing shuttered me err… honestly, that email was the like the deal breaker… He had already said that even if I go ahead and get married, he can have her anytime… That was it. In the process of trying to heal, singlehandedly, then another issue comes up. That was the issue of her ex. So now it doubles. (P4, M37)

Spousal Disagreements

Others attributed their marital stressors to their spouse's behaviour which they found overbearing;

I'm stressed right now by my wife because there's a problem with our toilet, if you don't flash and hold everything won't go, so I'll pee and I'll press quickly; two, three days ago I was on the phone, I used the toilet, I pressed quickly and I left. I actually had to close it and I didn't want it to make too noise so I pressed quickly and I ran out of the toilet, you know. So it probably didn't flash well. My wife took pictures, then she said, on such and such a day

this is how you left the toilet, the following day, this is how you left the toilet, the day after, this is a picture of how you left the toilet. And I'm like eiii, so somebody is busy taking pictures of how I left the toilet. If you come and there's something in the toilet, flash it. Would you believe that I was out, this is around 7pm, I came home like 9pm, when I walked into the room the first thing she told me was that I should go and flash the toilet. So from afternoon when you saw it like that you couldn't flash it. You left it till 9pm. So anyway, my stressors are external factors. What other people do and situations that other people find themselves in then they tell me to find solutions to them like my mum (P5, M38).

My wife is just not understanding. I don't know what she wants. I don't know whether he (son diagnosed with autism) will be able to fit into society. When I think about the future, will this boy be able to marry. My wife doesn't want to give me other children. These are the things that are bothering me. I'm not going to be happy with this kind of situation from her (P5, M38).

Married persons experiences of health stressors

Health challenges

Some participants also indicated that they were challenged with their health and this stressed them quite significantly. According to some participants, the medical diagnosis and the demands of the management of the condition are sometimes very stressful:

It has been difficulties at his work which we even felt was spiritual than physical… and having miscarriages (P2, F44).

Superordinate theme 3: Childhood experiences and stressful life events impact marital satisfaction of married persons.

The third superordinate theme unveils participants' unique experiences of marriage by revealing the nature of participants' marital experiences and how ACEs and SLEs have influenced the marital experience of the participants. Majority of the participants explained that their marriages were blissful from the beginning but as the years went along, their marriage became quite challenging and less satisfactory. Some participants recounted how their childhood experiences had influenced their marriages and others, how various stressful life events had impacted their marriages. A few of the participants also described how their spouses' response to their stressors played on their marital satisfaction.

Married persons experiences of the nature of their marital experiences

A few of the participants indicated that their marriages have been almost uneventful irrespective of some of the challenges they had faced over the period. However, majority mentioned that their marriages have suffered significant changes over the period:

> *I think we have really come to understand each other more. Now we wouldn't fight over certain things. He's becoming to appreciate that everything is not like serious, serious. You don't have to take everything to heart and at times it's a joke. Initially things that I said that seems like a joke for him was a serious thing but now we are beginning to realise that oh these things he says it and it's a joke we'll let it pass and we all crack it around. So, it has been friendship (P2, F44).*

On the contrary, some participants recounted their marital experiences as:

> *Now we don't chat, we are always with our phones. ... social media, he's always on his phone, I'm always on my phone. We are all on our phones. The only time we bond is when we're watching football together. That's the only thing I watch on Tv. I think we're not making the effort because we're stuck to our phones and even when we're not working, the kids are disturbing. That free time is with our phones (P3, F32)*
>
> *So, communication was erm, was an issue. You try to communicate and she's like no, mine is right. So, she is very defensive, and I am the kind who once you start like that and I give you time to process. (P4, M37)*

Married persons experiences of the impact of childhood experiences, stressful life events and negative spousal response on marital satisfaction

Impact of adverse childhood experiences on marital satisfaction of married persons

Some of the participants described their childhood as relatively adverse. For some, there was apparent abuse, neglect and household dysfunction. Others had experiences which did not evince childhood adversity, but which participants believed has had an impact on their marriages. However, a few recounted positive childhood experiences which they alluded to having a good influence on their marriage:

A participant who experienced physical abuse and emotional neglect recounted her experience of ACEs:

> *I never saw the effect it had on me until I got married and then I*

realised I was afraid of my husband. I couldn't talk to him. I couldn't confide in him, you know. And then he also came with his own you know, like my dad. All this kind of erm, like you know, you wouldn't know, he will just shout at you, you don't have a say, you know. He just always wants to be like an authority figure… like he's asking you to do something, and you shouldn't question it. I feel like if I didn't go through that with my father, I wouldn't have found that so upsetting. I could have been able to talk to him like nicely about it compared to how I handle it (P1, F28).

Another participant who recounted experiences of childhood emotional neglect and restrictions in verbalising his desires described his experience:

More like I went back to my default mode. Like everybody should be okay. So I created my space and lived in it. I left you, I'm there but… it annoyed her a lot erm because it annoyed her a way that now she became more hostile, physical sometimes. She was more attacking, you don't know where it is coming from and then the annoying thing is that I won't defend it. I won't say what I have to say, if because I know that even when I defend it, you will still insist that this is it, what's the point. Most of the time, I realise that the communication, because I start and she's defensive… I don't want this chaotic environment so hold and then revisit it. So one issue will linger over and over and over. By the time we resolve it, then it has caused a lot of damage. So yeah, it's the upbringing effect. It's very necessary, rather the parents should teach us more (P4, M37).

A participant who had developed a defensiveness and withdrawal

approach following his exposure to persistent emotional neglect and domestic violence narrated his fall back to such defenses in his interaction with his spouse as:

Everything must be the way she wants it, the way she imagines it, the way she sees it. If it's not how she said it or sees it, then it's wrong. We could be saying the same thing but she wants you to say it the way she says it. That shows that you agree. If you don't, then she'll be arguing with you. So me, nowadays when she say something's and I don't even agree with her, I walk away. I don't have time for that. That's my approach now. I don't want to talk to you and argue with you because if my mind has told me that you are coming and you're coming to give me a problem, I'll be defensive and i won't talk to you (P5, M38).

Impact of positive childhood experiences on marital satisfaction of married persons

One other participant who did not experience any childhood adversity said:

> *So I think growing up and seeing my parent's marriage, it's a good place to be so and may be the training we have from my parent (P2, F44).*

Impact of stressful life events on marital satisfaction of married persons

Majority of the participants alluded to financial challenges negatively influencing their satisfaction in marriage. Apart from finances, other participants indicated that raising children also had a significant toll on their marital satisfaction.

A participant described how financial constraints influenced her marital satisfaction:

> *Sometimes when he doesn't have money, he comes, and you can see that he's upset because he's broke, he's just moody or he just respond to you in a way that you ... you ask him what the problem is, and he doesn't have a reason (P1, F28).*

Another participant who attributed her major stressor to child care recounted her experience:

> *You want to have your privacy, small time mummy this, someone is knocking on the door, you can't have that privacy anymore. You're in the bedroom with your husband and this one finishes complaining and he's walking away, another person is coming. So it's like endless, unlimited complains all day. sometimes you want to do your own thing in the bedroom and knock knock Charley, it vanishes, the feeling has gone (P3, F32).*

Impact of spousal responses on marital satisfaction of married persons

A significant number of the participants indicated that their spouses' response to them especially in the face of stress significantly influenced their marital satisfaction.

Some participants described the distress associated with their spouse's defensive response to some of their complaints:

> *Sometimes he's like no, you are just making it up. Because I know this happened, you said this to me and he's like he just goes all accusing you and you are the same. You're back to the same point so because of that I didn't like complaining about the same thing he did because once you complain, he will deny it. He will make it look like it's your fault because you did this, that's why I did that. So, the next thing I'm*

crying. We start talking and I just start, and I hate it. I hate the crying. I don't like crying. And he's like why are you crying and I'm like I hate the crying, I don't know why, the tears won't stop, like the tears, I don't know how to stop it. You did this to me, you haven't apologised to me, you haven't said anything, and you just want sex, and we continue, and he says sex fixes all problems. We should forget about it (P1, F28).

In fact, when the ex's issue came, instead of being remorseful and apologetic, she kept being defensive. Like you know, it puts pressure on me. (P4, M37).

Another participant indicated that in her attempt to avoid confrontations, she developed a number of coping strategies like walking away so she can avoid making any form of offensive remarks but her husband's response to it aggravates the situation:

I just walk away, and he mistakes that for disrespect; like he's talking and I'm walking away (P3, F32).

Some participants indicated that their spouse's nonchalant behaviour posed a real challenge to their marital satisfaction:

So I'm fixing Children's breakfast, he's doing his own thing. When I finish, I'll also do my thing, I go to my bedroom (P3, F32).

Sometimes I just get angry because I feel like, yes, I feel like the help for instance, we could have had help, you are not pushing hard enough and I'm doing most of the things (P3, F32).

Superordinate theme 4: Childhood experiences, stressful life events and marital satisfaction influence on HRQoL of married persons.

The fourth superordinate theme revealed the nature of participants' HRQoL with respect to their experiences of marriage, ACE and SLE. Majority of the participants recounted how their physical and mental health were impacted by the decline in their marital satisfaction as well as the various stressful life events and childhood adversity they had to deal with. Some participants narrated how their childhood adversity made them vulnerable to being triggered by certain stressors within their marital relationship and its consequence on their HRQoL.

Mental health domains of HRQoL characterised by suicidality, depression, anger, anxiety and mood problems are impacted by ACEs, SLEs and marital satisfaction.

Impact of ACEs on mental HRQoL of married persons

A few participants described how they felt suicidal sometimes owing to the way their spouses spoke with them and how much it triggered them:

> *Sometimes when I start crying and he ask me what the problem is, I say I'm just having suicidal thoughts, I just want to end my life. Then he's like why, why do you want to end your life and he's just raising his voice at me and I just cry more and why is he shouting at me, why are you shouting at me like that, why don't you just calm down and talk to me (P1, F28).*

Another participant recounted how his feelings of emotional neglect plunged him into substance use:

My environment was strenuous, it was one of those situations where you had to throw yourself into something so that you can forget about everything. I threw myself into marijuana; Mary Jane… Euphoria is an escape. Only for an hour or two but you'd go and come back and face reality (P5, M38).

Mine started as wanting to belong… I was trying to find where I belong. I tried everything. In high school I was part of everything. Unfortunately I ended up in a group. It started out as a peer pressure thing. So what started out as peer pressure, you will end up finding out that hey, I actually like it and before you know, now you're escaping, before you know it you're addicted, before you know it, it take you out of control, you can't control it (P5, M38).

Impact of decline in marital satisfaction on mental HRQoL among married persons

Another participant shared how the decline in her marital satisfaction characterised by recurrent arguments made her contemplate suicide:

> *I used to want to just, something should happen to me. I felt I didn't want to exist anymore. But my kids have always been my saviour. Yes, because when I think about them and I think that I will just die and not witness them grow, they not having to have a mother while growing, it always takes away that. As for suicidal thoughts, I use to have them in the past, several times (P3, F32).*

Some client also mentioned that instances where they experienced depression or some depressive symptoms due to challenges in their marriages:

> *You know and we just going back and forth, just go into the room, lock*

myself in and cry, cry, cry, cry and he comes knocking and you know. It can happen for like a week continuously, I will be okay for some time, then it will happen again … I lost a lot of weight for some time. For like a period of time because after I got married, I think I was weighing 70 thereabout … at a point I was weighing around 59 (P1, F28).

Depression, yes. I was going through it, I went through depression. Should I say the initial stages but like, because I was aware of things like that, let me put it that way… My thinking ability was slow and I realised that I started making a lot of mistakes at work (P4, M37).

I cry a lot, I cry a lot when I'm really down. Sometimes I want to cry out so loud. If I want to scream and let everything out because when you scream, that energy in you… you finish and breathe, you breathe. It helps me, it help a lot. Yeah, so sometimes yeah that is what I do. If I don't, sometimes I feel I'm choking and I'm actually choking, not that I feel like I'm choking (P3, F32).

A few participants indicated that they sometimes couldn't help but expressed their displeasure with anger and in some instances their anger was coupled with aggression:

Like, I just cry and then I get angry. Usually, 90% of the time, I react to it with anger and that is the only time he will just keep quiet and then he will listen to you (P1, F28).

I just get angry when I see him. Sometimes I just get angry because I feel like, yes I feel like the help for instance, we could have had help, you are not pushing hard enough and I'm doing most of the things.

Yes, he helps but you know, you also get angry sometimes and you complain, you're doing too much, you doing, as if I'm using you too much ... I've bitten my husband before. Yeah, the mark is still there. The wound was bad. I could feel his flesh in my mouth. I had to wash it because I was so angry. I'm filled with some kind of strength, that's why I throw things ... If I don't do all of that, I feel terrible (P3, F32).

Impact of SLEs on mental HRQoL of married persons

One other participant associated her depressive symptoms to the SLE of job stress her spouse was experiencing:

It didn't affect our relationship but it affected our mood. When he's so down and low, you could, you could feel it, he may not eat much, even not him, all of us (P2, F44).

Another participant associated his clinical depressive symptoms to financial stress:

Two years ago I had to pay my rent. It's always money related. I was due to pay my rent and I didn't know where the money was going to come from and I coiled up and I ended up in bed, depressed…I felt a tonne of weight ... so I think I had about 1 year period that I didn't know what was going on. If it's not one year, then it's about 9 months. I didn't know where my left was from my right. I felt dirty. No haircut, no shaving, nothing will make me look in the mirror (P5, M38).

A participant associated her anxiety symptoms to a significant stressor in her life where her husband was being incessantly threatened and wrongly accused by his boss:

We were worried what is happening. There was a time he would

confess that he's afraid. He will tell me that "pray for me, I'm afraid". Then I will hold him and pray for him. Even though I had my fears (P2, F44).

A participant also recounted feeling very angry whenever she was faced with the challenge of handling the stress of caring for her children without any form of assistance:

Sometimes, you get angry with the crying. Sometimes I just hate noise, yeah, and when they are always complaining, mummy mummy, sometimes like I always say I want to crush their heads together. Yeah, Sometimes, it's not a joke, I just want to crush their heads. I just want to push them away, you know. When I'm in that state, I want to do something. I feel if I do that, I will release the pressure. I'll release the pain. So yeah, mentally, I just don't want noise and they can be very noisy most of the time (P3, F32).

Regarding physical health, some participants indicated that they experienced significant physical health challenges such as physical pain, sudden collapse and insomnia owing to the SLE they had to endure as well as decline in marital satisfaction.

Physical health domains of HRQoL characterised by sudden collapse, pain and hospitalisations are impacted by ACEs, SLE and marital satisfaction.

Impact of decline in marital satisfaction on physical HRQoL of married persons

A participant recounted collapsing one day after a prolonged period of marital challenges:

I passed out once in the middle of the night. I just woke up to ease

myself, before I realise I was on the floor for about 30 minutes. When I went to the hospital in a couple of days after, the first question the doctor asked was what is wrong with you. Why are you thinking so much … At the point he said my heart was enlarging and something about lipids and some other thing that he said but he told me to relax, yes, slow down a bit. (P4, M37)

I use to go to the hospital almost all the time. They gave me the medication but still. (P1, F28)

Impact of SLEs on physical HRQoL of married persons

Another described how the stress of raising her children affected her physical health:

I'm always up doing one or two things. I'm always doing something and my back especially my back is always hurting. It's become chronic now. I said I used to do physio, I've done physio for more than a year. Yeah, most of the time I have to sit with pillows. So taking care of children has always been stressful for me (P3, F32).

Summary of Qualitative Findings

Childhood adversity was a common phenomenon among married persons in Ghana, generally. Emotional abuse and emotion neglect were found to be the most prevalent among the lot. However, some participants experienced multiple childhood adversities such as a combination of physical, emotional and sexual abuse as well as emotional neglect and household dysfunction, characterised by physical and or emotional abuse from their mothers. The combined effects of such adverse experiences were often more

severe than it was on those who encountered single experiences. On the contrary some participants experienced no form of childhood adversity while others experienced unconventional forms of childhood adversity such as being raised in adverse childhood environments where there was a lot of crime. Participants who experienced such environmental adversities believe it made them less resilient to the hardships of life, as a result of the over-protective and restrictive parental upbringing they received as children. Both male and female participants experienced diverse forms of stressful life events such as financial challenges and the stress of child care. Participants' most predominant stressor was their spouses' inappropriate response to their needs or stressors. Thus, both male and female participants indicated that their spouses were mostly dismissive of their needs and this they believed was a significant stressor to them. They appeared to respond to their spouses' behaviour with anger, withdrawal or stonewalling which they indicated aggravated the situation most often than not, resulting in increasing the stress.

Participants also alluded to their experiences of childhood adversity influencing their marital satisfaction. For some, the experiences of being consistently restricted by their parents in expressing themselves appeared to have conditioned them to stonewall in the face of marital differences. While for others, these restrictions made them prone to anger and periodically, intense sadness because they usually felt being dictated to and somewhat oppressed and disregarded by their spouses just as they felt when their parents restricted them. Furthermore, other participants who witnessed household dysfunctions characterised by physical, verbal and emotional abuse from their mothers indicated that these experiences made them significantly sensitive to

raised voice tones, shouting and the least act of disrespect. They indicated that they found these experiences extremely triggering and could not help but respond with rage and sometimes intense sadness.

Apart from ACEs, participants also attributed declines in their marital satisfaction to certain stressful life events. One of such significant stressors was third party influence which the participant appeared to perceive as spousal infidelity. It seemed as though the presence or influence of the third party was in and of itself not the challenge but their spouses' denial of its happening and dismissal of its impact on the marital relationship was the most critical stress causing factor. For others, their spouses' nonchalant behaviour about the need for a house help or some form of domestic assistance as they appeared to be solely involved in caring for their toddlers and infants, while still playing wifely duties and at the same time shouldering the stress of regular work schedules was extremely heart-breaking. Besides this, some participants indicated that financial constraints also placed a significant toll on their marriage as it often became an issue of contention between married persons. For some, their spouses' recurrent criticism whenever there was a family need that had to be financially met upset them and this resulted in their withdrawal from their spouses. They alluded to being extremely enraged whenever this happened. However, some participants experienced the stress of miscarriage and the associated pain but these SLEs did not negatively affect their marital satisfaction because they received utmost support from their spouse.

Some participants reported experiencing significant physical health challenges such as physical pain, sudden collapse and recurrent hospital visitations without any significant medical findings. Others reported

experiencing a significant strain on their mental health and this includes suicidal thoughts, depression, anger and anxiety. Some participants attributed their mental health challenges to their childhood adversities where they were mostly angry about the way their father treated their mother and have found themselves significantly enraged by the least provocation since childhood.

Also, some participants reported experiencing severe back pain and insomnia which they attributed to the stress of constantly taking care of their children without assistance. While others experienced anxiety and low mood when they had to endure the SLE of their spouse losing his job and being implicated in a crime a superior set up.

Also, a decline in marital satisfaction appeared to significantly influence mental wellbeing by leading to suicidal ideation. For some participants, the idea of committing suicide was fuelled by the perceived lack of support from their spouses in the care of their children. For others, it was due to the constant dismissal of their comments and emotions by their spouses whenever they needed emotional support the most. To them, their spouses' emotional disconnect and disregard began to overwhelm them so much that they began to think of death as a way of finding peace. Others sank into depression and would not engage for weeks amidst constant crying spells while some were so enraged that they would become extremely angry and sometime physically aggressive.

Majority of the participants employed emotion-focused coping strategies which appeared to help them regulate their negative emotions as a result of the decrease in their marital satisfaction. For some, it served them well when they distracted themselves with movies, music or withdrew from

their spouses emotionally and sometimes physically. However, others coped by addressing the SLEs through prayer and spiritual or religious social engagements. It appears for persons who were challenged by SLEs which did not have any impact on their marital satisfaction, a problem-focused approach such as open and honest conversation about the situation was usually used.

Discussion of Key Findings of the Study

In the ensuing paragraphs, the researcher intricately discusses the afore-mentioned research results for both aspects. Equally central in the presentation is the relevance of the underpinning theories that anchored the entire research.

Common Forms of Adverse Childhood Experiences among Married Persons

The first research question sought to find out the common ACEs that were encountered by married persons in the Ga Central Municipality of the Greater Accra Region of Ghana. This research question was answered by both the quantitative and qualitative findings of the study. The quantitative results of this study indicated that the most common ACEs among married persons was parental separation or divorce, occurring in about three out of every ten participants. Emotional neglect and verbal abuse were the next in prevalence occurring among an average of two out of every ten participants. An average of one in every ten participants reported an experience of sexual abuse, physical abuse or relative's use of drugs. The least prevalent ACEs reported by participants was domestic violence perpetrated against their mothers by their fathers. In spite of its prevalence rate being lower than the others, the

percentage suggests a significant prevalence rate, as an average of about one in every ten of the participants also witnessed their mothers being violated. The incidence of one in every ten participants experiencing one ACE or another suggests a considerably significant prevalence of each of the forms of ACEs among married persons.

The qualitative findings on the same research question revealed that, household dysfunction, characterised by domestic violence against mothers, and emotional neglect were the most prevalent ACEs encountered by married persons. However, emotional neglect was the most prevalent direct childhood adversity, though subtly perpetuated and largely on the blind-side of parents. Emotional neglect was common among participants whose parents seemed to have been experiencing significant decline in marital satisfaction but not separated and were also highly culturally conservative without the slightest hint of how their emotional detachment from their children could be debilitating.

Furthermore, emotional neglect was evinced in some atypical forms of childhood adversity such as parental restriction of social and peer interactions and engagement. Some participants reported social engagement restrictions as adverse, as a result of its negative ramifications on their self-worth and interpersonal relationships. Harris and Orth (2019) confirmed this by indicating that persons who had experienced restrictions in social interactions also suffered lower self-esteem. The attachment theory explained such ramifications by positing that, people who had experienced ACEs such as emotional abuse and neglect were likely to have been insecurely attached. Persons with insecure attachment styles were predisposed to negative self-

esteem, difficulty in building trusted relationship, sudden shifts in mood among others (Smith et al., 2016). These attachment after-effects of ACEs could spiral into marital distress and health problems given how stressful and inimical they could be over a protracted period of time.

Going by these reports, it is clear that married persons experience diverse childhood adversity of varying degrees of severity ranging from vicarious, to in-vivo and sometimes covert types, largely perpetrated by parents and or close relatives and neighbours. Incidentally, these experiences are endured without a reason to seek redress from anyone due to the sociocultural environment within which they happen, where children are normatively required "to be seen and not heard" as well as detached from the experiences of their parents**.** The aftermath is usually the occurrence of multiple adverse childhood experiences whose impact across victim's lifespan largely go unnoticed by parents especially those who appear to have been materially responsible. Incidentally, regardless of the form of the ACEs, going by the postulation of transactional stress theory by Lazarus (2012), there is the propensity for married persons who experienced them to be physiologically and psychologically overwhelmed by them taking cognisance of the fact that these persons had to bear the stress of these childhood adversities unless remedied at a point. Such experiences have been opined to cause a significant decline in life satisfaction and overall health when victims have no adaptive appraisal and coping strategies to serve as buffers against them (Dillard, 2019). Hence the possibility of decline in HRQoL and marital satisfaction among persons with histories of ACEs.

ACEs were also experienced vicariously under certain circumstances. Vicarious adversity was characterised by physical abuse perpetrated against mothers as well as emotional abuse of mothers characterised by father's open extramarital affairs. However, others experienced direct childhood adversity. Direct ACEs were also evinced as physical, emotional and sexual abuse of the participant. A study conducted in Hungary and across Central-Eastern Europe by Ujhelyi Nagy, Kuritár Szabó, Hann and Kósa (2019) confirmed this study's outcome as it indicated that the most prevalent forms of ACEs in order of prevalence were parental divorce or separation, emotional abuse, emotional neglect and physical abuse. Sexual abuse was the least prevalent. However, though relative drug use was among the least prevalent in this research, it was just as highly prevalent in the study as parental separation or divorce. Within the African context, a South African rural survey also confirmed the findings of this research and affirmed the aforementioned study by indicating that, the most prevalent ACEs was emotional abuse and emotional neglect followed by sexual abuse (Manyema & Richter, 2018).

The study also showed that, participants whose parents' marriage was bedevilled with abuse and quarrels suffered multiple adversities. There is a high susceptibility to multiple and severe childhood adversity among persons raised in dysfunctional homes characterised by domestic violence or parental absence (Ujhelyi Nagy, Kuritár Szabó, Hann & Kósa, 2019). It seems quite obvious that experiences of ACEs are significantly prevalent among married persons in Ghana, and they vary in their nature and form. Given its prevalence rate, impact on victims and dynamic presentation especially among married

persons, it seems critical that it is given careful attention if any significant positive changes in marriage, health and overall well-being are to be made.

Moreover, it seems crucial that parents and married persons receive relevant education regarding the impact of their sociocultural orientation, child rearing styles and how their personal ACEs could result in significant interpersonal, health and family challenges.

Common Forms of Stressful Life Events among Married Persons

The second research question aimed to identify the common SLEs that were encountered by married persons in the Ga Central Municipality. The research question was answered by both the quantitative and qualitative findings of the study. On the quantitative front, findings revealed that the most prevalent SLEs were major changes in finances, marriage related issues, sleep and eating habits. These SLEs were reported by over 50% of the participants. This implies that about five out of ten married persons were distressed by their sleep challenges, eating habits, marital relationship and financial situation. In essence, the most prevalent SLEs were stressors which appeared to levy personal agency even if they are not the most distressing of their SLEs. They appear to be chronic in nature, spanning a significant period of time even though they do not seem to have the potency of causing immediate damage to the bearer (Patel-Davis & Rhodes, 2017).

Also, about four out of ten of the participants had experienced the stress of death of a close relative, presence of a new child or household member, outstanding personal achievement and a change in their spouse's work situation. These SLEs also seem to be ones which are almost outside of participants' control. They also appear to happen at specific unsuspecting

times of participants' life, with inherent potential of causing significant distress akin to episodic acute SLEs. According to Patel-Davis and Rhodes (2017) episodic acute stress is severe stress which recur from time to time. Furthermore, at least three out of ten married persons experienced major changes in church activities, residence, working hours, working conditions, work demands, new work roles, new line of work, living conditions and frequency of arguments with spouse. These forms of SLEs are suggestive of acute stress due to their capacity to have significant impact on participants' physical and emotional well-being though they may span short periods (Patel-Davis & Rhodes, 2017).

These prevalent SLEs can therefore be categorised into three forms of stressors: chronic stress, episodic acute stress and acute stress with chronic stress being the most prevalent. This finding is further corroborated by the qualitative findings. Participants reported SLEs such as financial challenges and childcare as some of the distressing chronic stressors. While a few others mentioned acute stressors such as third-party influence and spousal threatened job loss as SLEs they faced. The American Association for Marriage and Family Therapy (2016) reported that, some of the common SLEs married persons experienced which have potential to cause significant marital distress and divorce were financial constraints, birth of a child, loss of a child, infidelity, job loss, untreated mental conditions, substance use, gambling and providing care for a child with special needs.

It is rather worrying to find that, one in two participants of this study experienced chronic stress given how devastating such SLEs could be. The transactional stress theory (Dillard, 2019) explains the possible impact of these

forms of stress on the HRQoL and marital satisfaction of persons as it indicates that, whether or not SLE is acute, episodic acute or chronic in nature, it places significant strain on the biological and psychological make-up of its victims. The biopsychosocial theory (Bolton & Gillet, 2019) enhances comprehension of the chronic and vicious nature of these SLEs in perpetuating decline in HRQoL and marital satisfaction by indicating that, even though SLEs as revealed by the findings of this study are social factors, they impact health by over activating the nervous system, inciting the stress hormones, thereby reducing immunity to disease while disturbing positive adaptation. Unfortunately, the onset of disease further increases the victim's stress and impair their general well-being and functioning. Unless, remedied through appropriate care and stress inoculation techniques, this cycle may continue. Furthermore, the influence of SLEs on marital satisfaction is explained by Gottman (1999) marital satisfaction theory as it postulates that, an over activation of stress hormones causes a significant decline in marital satisfaction as it leads to poor emotional regulation and an eventual disruption of interpersonal relation among married persons in the face of SLEs. This finding, coupled with the various theoretical explanations of various possibilities unveils the critical need for public sensitisation activities on stress awareness and management strategies for married persons owing to the devastating impact of stress on marriage and health.

Prevalent Rates of Cumulative Number of Adverse Childhood Experiences among Married Persons

The third research question focused on unveiling the prevalence rate of cumulative number of ACEs of married persons within the Ga Central

Municipality of the Greater Accra Region. Both quantitative and qualitative findings of the study responded to this research question. The quantitative findings revealed that some participants suffered multiple ACEs while others had no such experiences. The results indicated that about six out of ten of the participants had experienced at least one ACE. Also, at least one out of every ten of the participants had experienced four or more ACEs. The qualitative study also affirmed this finding as it showed that, all participants but one experienced at least one ACE. Also, all forms of ACEs were reported with emotional neglect being the most prevalent, occurring among all victims of ACEs. In spite of the high prevalence of ACEs among married persons, a participant reported exciting childhood they sorely relished and desired to relive if they could.

This finding is similar to that reported by Manyema and Richter (2018) who mentioned that ACEs appear to be common in both high income and lower middle-income countries. For instance, in the first ACE study conducted in the US, at least one in six of the participants had a history of ACE. Also, in the same study, one in ten of the participants had experienced at least 5 or more ACEs (Manyema & Richter, 2018). This finding is confirmed by a few African studies which reported that about five out of ten Nigerian adults had experienced at least one ACE as well as nine out of ten rural Ugandan adults (Muwanguzi et al., 2023). Hence, apart from being prevalent, it appears extremely severe forms of ACEs are also significantly prevalent among married persons in Ghana. This degree of prevalence and severity gives an indication that, a significant number of married persons may have deep unresolved attachment needs which have the potential of turning their marital

dreams into nightmares given Bowlby's attachment theory's explanation of the relational and self-worth challenges of persons with histories of insecure attachment owing to emotional neglect and abuse among other childhood adversities reported in this study. Also, the findings seem to suggest that, majority of married persons may be bearers of chronic stress as a result of the multiple childhood adversities they may have been exposed to particularly at a time in their lives where they may not have developed strong appraisal and coping skills which could insulate them against the complications of stressors of such nature including lower life satisfaction and health challenges as explained by the transactional stress theory.

These findings seem to imply that irrespective of the form of ACEs experienced, a significant number of married persons are at risk of the complications associated with ACEs. This signals the need for more preventive strategies in curbing the incidences of ACEs while making integrated efforts at reducing its impact among the populace. Thankfully, this study's revelation of the most prevalent form, being family dysfunction characterised by parental separation or divorce, makes it necessary that, a more concerted effort be made at strengthening marriages in order to make it a buoyant buffer for averting all the other forms of ACEs, thereby reducing the overall prevalence rate. Therefore, for most married persons, the lived experiences of childhood seem to have been quite turbulent but was bore with resilience. For some, the impact has been unprintable memories which appear to have marred their psyche as its impact on their relationships and health has been telling.

Triangulated Discussion of Key Findings of the Study

Relationships that Exist Among Adverse Childhood Experiences, Stressful Life Event and Marital Satisfaction.

The research hypothesis one was intended to determine the relationship that existed between ACEs and marital satisfaction as well as SLEs and marital satisfaction among married persons within the Ga Central Municipality of the Greater Accra Region. This hypothesis was responded to by the quantitative findings only. The results suggested that ACEs negatively correlated marital satisfaction significantly. This implies that the greater a person's experiences of ACEs, the lower their marital satisfaction. Hence, married persons who report more experiences of ACEs will also report a lesser satisfaction with their marriages. This finding was affirmed by DiLillo et al. (2007) who reported a significant decline in marital satisfaction among married persons who had experienced ACEs compared to those who had not. Interestingly, the attachment theory sufficiently explains the probable reasons for this finding as it posits that, experiences of ACEs are a precursor to insecure attachment styles which have also been shown to result in behavioural tendencies such as mistrust, alienation, emotional disconnection and tantrums (Smith et al., 2016) among others, inimical to high marital satisfaction.

Similarly, it was also found that experiences of SLEs negatively correlated with marital satisfaction significantly. The findings suggest that the greater the number of SLEs experienced by a married person, the lower their marital satisfaction. Hence, married persons who report more experiences of SLEs are also expected to report lesser marital satisfaction. Randall and

Bodenmann (2009) confirmed this as they indicated a decline in marital satisfaction as stressful life events increased among couples. The transactional stress theory further confirms and explains this finding as it posits that, unmitigated stress has the potential to cause maladaptive thinking patterns and distort self-regulatory abilities which are fundamental for constructive interpersonal relationships (Dillard, 2019) as may be required to achieve high marital satisfaction.

These findings and theoretical underpinnings point to the need for married persons to be made aware and empowered to recognise and deal with the ramifications of their adult attachment needs birth from their ACEs. The same awareness and empowerment regarding their management of SLEs is needed since the findings revealed that, a decline and by extension, control of the consequences of ACEs and SLEs could result in an increase in marital satisfaction.

Difference in Marital Satisfaction with Respect to Cumulative Number of Adverse Childhood Experiences.

The research hypothesis two sought to find out the difference there will be in participants' marital satisfaction on account of the number of ACEs they had experienced. This hypothesis was discussed using both quantitative and qualitative findings. The quantitative study's findings indicated that the number of adverse childhood experiences (ACEs) a married individual had experienced significantly impacted their level of marital satisfaction. This implies that, participants' sense of marital satisfaction significantly varied when they reported single, multiple or no exposures to ACEs. The reported mean scores of marital satisfaction showed that there was an obvious

difference in marital satisfaction as the number of ACEs endured increased from person to person. Further analysis revealed marked difference in marital satisfaction between married persons who had no exposure to ACEs compared to those who had experienced four or more ACEs. The qualitative study's findings support the notion that ACEs, regardless of their type or number, have an impact on marital satisfaction. For instance, it was found that married persons with histories of multiple ACEs suffered significant decline in marital satisfaction even to the point of desiring divorce just as participants who reported only one ACE. Incidentally, high marital satisfaction was reported among participants with no history of ACE.

The attachment theory explained the possible reasons behind this finding as it postulates that, persons who formed insecure attachments due to abuse and emotional neglect suffer significant deficits in social interaction, emotional regulation and bonding which are fundamental to marital relationships (Smith, 2016). Beyond this, the marital satisfaction theory (Gottman, 1999) explained that these deficits are due to heightened physiological activities which offset emotional regulatory tendencies. The theory further expounds that, for positive marital satisfaction to occur, the capacity for married persons to aptly and promptly regulate their emotions in response to their spouses' emotional needs form the bedrock of marital bliss. Hence, the findings of the study.

It therefore goes to emphasise the idea that childhood adversity does influence marital satisfaction no matter the cumulative number experienced by victims. This finding further emphasises the need for public sensitisation on the essence for married persons to be aware of what constitutes ACEs and how

such experiences may play on their marriages. The finding also highlights the need for a more preventive than curative approach to the phenomenon given that, it could influence the marital satisfaction of persons who may have experienced them regardless of the extent of their exposure to such experiences and awareness of them, going by this study's findings.

Impact of Adverse Childhood Experiences and Stressful Life Events on Marital Satisfaction

The fourth hypothesis and fourth research question aimed at determining the impact of ACEs on marital satisfaction as well as the impact of SLEs on marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region. These findings were discussed using both quantitative and qualitative findings.

Firstly, with respect to examining the impact of ACEs on marital satisfaction, the quantitative findings revealed that ACEs have a statistically significant impact on marital satisfaction of married persons. It was found that a decrease in ACEs by one event predicted a significant increase in marital satisfaction by about 18% among married persons. Hence, for married persons with fewer histories of childhood adversity, there was a greater possibility of better marital satisfaction.

The qualitative findings which accentuated the quantitative findings revealed that participants with multiple direct forms of ACEs showed significant decline in marital satisfaction characterised by significantly disturbed patterns of communication such as intense crying while communicating their unmet needs, locking themselves up in their rooms in their attempt to communicate their marital distresses and prolonged periods of

silence and withdrawal in their attempt to communicate their disapproval of their spouse's behaviour. This is highlighted by the anecdotes of participants who recounted how their experiences of multiple childhood adversity characterised by direct perpetration of abuse against them as well as their observation of the marital distress their mothers endured impacted their own marriages negatively. Those who had lesser number of multiple ACEs which were also vicarious in nature appeared to be more aggressive in their communication and also quite defensive whenever they were confronted by their spouses about situations. Interestingly, participants without a history ACEs were rather constructive in their communication pattern and this was characterised by their ability to intentionally defer their grievances as well as recognise their shortcomings and accept correction from their spouses.

Communication challenges appeared to be the primary indicator of decline in marital satisfaction showing up across all narrations done by participants. These findings appear to purport that, married persons with experiences of multiple ACEs have a proclivity for communication challenges than those without histories of ACE with those with greater number of ACEs showing more profound forms of communication challenges. The attachment theory explains the veracity of these findings as it postulates that persons with such histories of ACEs with their associated attachment needs are more likely to have predispositions towards dismissiveness, emotional avoidance, co-regulation difficulties, anxiety and high sensitivity to criticism among others and these characteristics stifle constructive communication and interpersonal relationships. Hence, the revelation of communication challenges as the fundamental marital challenge among participants with exposure to ACEs.

In summary, the fundamental marker of decline in marital satisfaction among married persons with histories of ACEs was communication challenges characterised by defensiveness and stonewalling. It is likely this might be due to the constant emotion-based interactions that transpire in marriage. The continuous interaction between spouses may be triggering for partners with histories of unresolved ACEs, particularly married persons who may be totally oblivious of how ACEs influence their interactions. Dugal et al. (2020) confirmed this finding in their study which realised an association between cumulative childhood trauma or ACEs and psychological intimate partner violence among couples. They found that ACEs were associated with increased levels of negative urgency which also results in a higher tendency for demand-withdrawal and or demand-demand communication pattern and perpetration of psychological intimate partner violence. Gottman (1999) marital satisfaction theory posits optimum marital satisfaction among married persons who engage in more positive communication than negative. They further indicated that stifled communication led to decline in marital satisfaction. Hence, for married persons who have suffered ACEs which predisposed them to insecure attachment styles and further led to maladaptive emotional regulation and bonding, communication challenges may be the obvious indicator and facilitator of decline in marital satisfaction. This may explain the reason for decline in marital satisfaction characterised by communication challenges owing to ACEs. Unfortunately, it was also found that, almost all the participants were oblivious of how much their childhood adversities had impacted them until they got married.

Secondly, the findings showed that SLEs also impacted marital satisfaction significantly. With respect to SLEs and marital satisfaction, it was found that a decrease in SLEs by one event predicted an increase in marital satisfaction by about 15% among married persons. Hence, for married persons with fewer experiences of SLEs, there was a greater possibility of better marital satisfaction.

The qualitative finding further unveiled the impact of SLEs on marital satisfaction. All but one participant indicated that their marriage was blissful until they encountered certain significant life stressors. According to these participants, these stressors swept the joy of their respective marriages away. Going by the results of the study, it appears that, indeed, the number of SLEs experienced by participants contributed to decline in marital satisfaction. For instance, some participants reported a noticeable decline in their marital satisfaction with the birth of every child because of the additional stress of childcare that accompanied each birth. Dong, Dong, Chen and Yang (2022) confirmed this by indicating that, in recent years parenting stress is considered one of the significant predictors of decline in marital satisfaction.

Hence it goes without saying that, for every increase in SLE there indeed is a corresponding decline in marital satisfaction. Thankfully, the quantitative findings revealed the possible extent of decline to be about 15%. These findings perhaps explain the reason for the significant decline in marital satisfaction over a longer period of marriage once SLEs are not intentionally mitigated.

Another unique contribution of the qualitative study was its findings regarding how SLEs possibly impacted marital satisfaction. The findings

showed that, the nature of the SLE; whether an acute, episodic acute or chronic SLE, could significantly determine the extent of impact it made on marital satisfaction. The findings revealed that, participants who experienced episodic acute SLE such as third party influence which connoted marital infidelity caused a steep decline in marital satisfaction even though it was one SLE just as much as child care demands over a period of time did. Therefore, the number of SLEs experienced as well as the type of SLE appeared to impact marital satisfaction significantly.

The findings further showed that, apart from the number and type of SLE experienced, participants' perception about the SLE's impact on them and their marriage seem to form the bedrock on which marital satisfaction was founded. Participants who perceived SLEs as potential or actual threats to their personal safety and or their marital satisfaction appeared to suffer significant marital distress compared to those who did not. On one hand, once a married person's perception of personal safety was threatened by their partner's behaviour, they appeared to act in ways that were targeted at preserving their sense of safety when the behaviour seems to be detrimental to their marital satisfaction regardless of the nature of the SLE. For instance, participants who depended on their spouses for financial assistance reported feeling threatened by their financial dependence them due to the dominance the exerted over them as a result of their financial strength.

Similarly, participants who reported child care as a significant SLE were also not as bothered by their child care responsibilities as they were about how much it was beginning to affect their physical health. Their distress was aggravated by their spouse' disregard about their struggles and call for

help. On the other hand, marital satisfaction declined on account of the stress of a perceived threat to both personal and marital satisfaction. This is evinced in the narratives of participants who reported persistent third-party influences. It appears these SLEs posed significant threat to both the personal and marital security of these participants.

Furthermore, the nature of interaction between SLEs and marital satisfaction revealed that, how a spouse responded to their partner's perceived threat, whether personal, marital or both appeared to be the most significant determinant of the direction of the marital satisfaction. Hence, once a spouse responded positively to their spouses' complaint about the threatening nature of a SLE, there was a higher possibility of the marital satisfaction taking an upward spiral. However, if the spouse responded negatively, marital satisfaction took a nose dive. This finding is confirmed by Li and Wickrama (2014) whose study on the association between SLEs and marital satisfaction with a focus on how three marital management skills found that, the marital management skills employed by spouses resulted in an increase in marital satisfaction. It revealed that, husbands' tolerance and empathy skills were associated with an increase in the wife's marital satisfaction and interacted significantly with the relationship between the wife's stress and her marital satisfaction. Some of the findings sufficiently demonstrated this confirmation.

The findings revealed that, in cases where spouses responded positively to the SLEs of their partners with encouraging and empathetic responses, it appeared that any possible perception of threat to their person and place in their marriages were kept at bay, reducing the likely negative marital impact of a threat perception on the marital satisfaction. On the contrary, in

cases where spouse's desires and requests were not well received and responded to, it usually resulted in a significant decline in their satisfaction in the marriage. The transactional stress theory explains that, in order for people to deal with the emotional distress associated with SLEs, they employ appraisal styles which help them make meaning of the situation in order to reduce its impact on them. However, in the event that the SLE is perceived as a threat, it usually results in anxiety, anger, sadness and other forms of physical and emotional distresses which negatively impact the victim (Dillard, 2019). This aptly explains the reason for most participants' distressing emotional response to their spouses and the SLEs, which eventually affects their marital satisfaction negatively. The marital satisfaction theory (Gottman, 1999) further throws more light on this trajectory as it expounds that, spouses' inability to control their emotional responses characterised by palpitations, cold sweats, trembling and agitation suggestive of emotional distress such as anger, frustration and anxiety is the reason for deficient responses to SLEs and spousal demands which culminate in marital problems.

Finally, the qualitative findings unveiled the role of ACEs and SLEs interaction in impacting marital satisfaction as it found that, the participants with histories of ACEs appeared to be severely thrown by SLEs compared to those without histories of ACEs. Incidentally, even though all participants reported experiencing varied SLEs and significant decline in marital satisfaction on the inception of the SLE, participants who had no histories of ACEs reported no decline in marital satisfaction. These findings were confirmed by Roberts et al. (2011) who examined SLEs, ACEs, and risk of perpetration of intimate partner violence. Their findings indicated that there

was a greater risk of intimate partner violence perpetration among individuals who were exposed to SLEs and ACEs. Also, participants with high levels of ACEs were more likely to perpetrate intimate partner violence in the event that they experience SLEs. This suggests that the way individuals react to childhood stress has a considerable effect on their mental health and behaviour in adulthood, regardless of whether those effects are expressed internally or externally. Also, Umberson et al. (2005) study also predicted that, positive marital satisfaction was not impaired by the experiences of either high ACEs or low ACEs once experiences of SLEs were significantly contained. However, they found that, marital satisfaction declined when SLEs increased among persons with histories of high ACEs and increased among the same persons when SLEs decreased. The transactional stress theory (Lazarus, 2012) sufficiently explained this eye-opening finding as due to the prolonged stress of ACEs and the detrimental impact of SLEs putting a strain on the emotional, cognitive and social resources of married persons. This strain could compromise the emotion regulatory capacities, appraisal and social competences required for meaningful marital relationships.

In summary, these findings go to emphasise that, it is not the number of SLE only, that affect the direction of the marital satisfaction, instead the type of SLE, perception of threat the SLE poses to a married person's personal safety or the safety of their marital satisfaction, their spouses' response to their threat perception as well as their histories of unresolved ACEs that determine a person's level of marital satisfaction. These may explain the differences in levels of marital satisfaction in spite of the similarity of SLEs experienced by married persons.

Influence of Adverse Childhood Experiences, Stressful Life Events and Marital Satisfaction on Health-Related Quality of Life.

The third hypothesis and fifth research question sought to unravel the influence of ACEs, SLEs and marital satisfaction on HRQoL among married persons in the Ga Central Municipality of the Greater Accra Region. The findings of the study revealed that ACEs have a significant negative influence on the HRQoL of married persons. Furthermore, the findings showed that SLEs also significantly influenced participants' HRQoL negatively. Contrarily, marital satisfaction was found to positively influence HRQoL of married persons. These findings imply that the HRQoL of married persons could be predicted by their experiences of childhood adversity, life stressors and sense of satisfaction with their marriage. The findings further revealed that, there is corresponding increase in HRQoL for every unit of increase in marital satisfaction among married persons. By implication, married persons who report satisfaction with their marriages are extremely likely to report optimum quality of life with respect to their health.

In respect of the influence that ACEs have on HRQoL of married persons, the findings of the study implied that, there is an increase in HRQoL for every decrease in experiences of ACEs among married persons. In essence, the chance that a married person with an extra experience of ACE will experience an increase in HRQoL compared to him or her not, is about .462. This suggests that for married persons, the more histories of ACEs they may have, the more health protective factors they need to embrace in order to enhance their HRQoL. This finding was strongly corroborated by the qualitative study, where HRQoL was significantly low for participants who

had experienced multiple ACEs, compared to those who had fewer or no history of ACEs. For instance, participants who had histories of about five ACEs reported experiencing recurrent depressive episodes, severe low self-worth, suicidal ideation and hospitalisation unlike their counterparts who encountered no ACEs.

van Duin et al. (2019) confirmed this finding by alluding to the fact that, adults who suffered severe depression reported significant emotional abuse during childhood compared to those who suffered less severe depression. They further stated that those who reported prolonged moderate depressive feelings had histories of emotional, sexual and physical abuse. In agreement also was Bellis et al. (2013) who confirmed the fact that cumulative ACEs were significantly associated with adverse behavioural, social and health outcomes with those who had experienced 4 ACEs having odds of about 4 for smoking, 4 for binge drinking, 9 for incarceration and 3 for morbid obesity compared to those with no ACE history. Also, persons with 4 ACEs had greater risk of a significant decline in mental wellbeing, life satisfaction and increased likelihood of violence, inpatient hospital care and chronic illnesses. ACEs were found to influence poor life course, health and social outcomes. Furthermore, Kalmakis et al. (2015) accentuated these findings by indicating that ACEs were associated with both physical and psychological conditions such as heart conditions, chronic lung conditions, headaches, autoimmune conditions, sleep difficulties clinical depression, post-traumatic stress disorder and substance use disorder as well as early death. According to the biopsychosocial theory, such health challenges are plausible as a result of the neurophysiological impact that ACEs have on the biological makeup of its

victims. The theory further explains that the higher a person's exposure to childhood adversities, the greater their vulnerability to a malfunctioning biological state. Unfortunately, these ACEs also impact victims' psychological state as the attachment theory explains and eventually impairs their social interactions. Consequently, the social dysfunctioning could pose as a significant stressor to the victims, as they appraise most social interactions as threatening to their well-being. Hence, the resulting physical and mental health challenges experienced by persons exposed to ACEs.

The qualitative findings further revealed that the form of ACEs married persons had been exposed to also predicted the nature of health challenges they experienced. Participants who had vicariously experienced physical abuse as they witnessed domestic violence meted against their mothers appeared to suffer severe anger and aggression challenges possibly targeted at self-preservation. For instance, participants who witnessed domestic violence appeared to have avowed to themselves never to condone demands they considered unreasonable, whether in the form of house chores and spouses' demands. Such demands were found to result in feelings of rage, shrouded in a sense of perceived threat against their personal safety as a result of the possible vicarious trauma of physical abuse meted against one of their parents.

On the other hand, those who had been exposed to multiple direct abuses appeared to suffer severe emotion dysregulation conditions such as depression, anxiety, rage and low self- esteem. Unfortunately, in such cases, participants alluded to repressing majority of the associated emotions of their ACEs, but persistently had flashbacks, rage, poor sleep, low self-worth and

panic symptoms suggestive of PTSD. While those who experienced emotional neglect and abuse appeared to show significant assertiveness difficulties as well as repressed emotions associated with self-doubt, rejection and need for affirmation. National Scientific Council on the Developing Child (2012) confirmed this finding by indicating that adults with histories of emotional neglect appeared to experience low self-esteem, diminished self-confidence and poor assertiveness.

It will therefore be right to conclude that ACEs indeed negatively impact HRQoL of married persons quite significantly even though all participants were oblivious of the mental health toll it placed on them. It appeared ACEs first impacted the mental health of participants before their physical health probably accounting for the reason its influence never seemed obvious. According to Bowlby's attachment theory, adults with insecure attachment styles are prone to anxiety-response characteristics as well as emotion-repression tendencies in the face of SLEs. These response styles and tendencies were postulated to result in some mental health challenges and poor help seeking behaviour (Smith, 2016). The theory adequately highlights the possible reason for the decline in HRQoL among participants with possibilities of suffering insecure attachment styles due to their experiences ACEs, particularly emotion neglect.

These findings highlight the need for married persons with histories of ACEs to seek mental health care just as they do for physical health. Again, the findings aptly unveil society including parents', spouses', victims and perpetrators of ACEs tendency to overlook, trivialize and sometimes criticize behaviours such as anger, anxiety, crying spells and depression among others

without recognizing them as mental health challenges which require clinical attention.

Finally, it seemed apparent that, HRQoL declined significantly in both mental and physical health domains whenever victims of ACEs suffered SLEs. In essence, it appeared that ACEs usually lead to a degeneration of HRQoL when triggered by SLEs. Similarly, regarding the influence that SLEs have on HRQoL of married persons, the quantitative findings of the study indicated that, there was a significant increase in HRQoL for every decrease in experiences of SLEs among married persons. In essence, the chance that a married person who faces an additional SLE will experience a decline in HRQoL compared to him or her not, is about .962. This suggests that married persons who experience more SLEs need to employ more health protective habits in order to enhance their HRQoL.

The qualitative findings expatiated the quantitative as it revealed that participants reported more physical and mental health challenges as their SLEs compounded overtime. Participants who reported multiple SLEs in close succession recounted significant decline in HRQoL evinced as bodily pains, cardiovascular problems, insomnia among others which affected their activities of daily living such as work compared to those who reported fewer SLEs. These findings are in consonance with Dorji et al., (2017) whose study indicated that participants who had experienced between eight to fourteen SLEs were about two times likely to have poorer health related quality of life compared to those who had experienced about 1 to 5 SLEs. Certain health conditions such as back pain, memory decline, depression, movement difficulties, sleeplessness and lung condition were significantly influenced by

the higher SLEs numbering between eight and fourteen. For instance, participants who experienced two separate but closely successive third party influences suggestive of marital infidelity experienced more health distress characterised by depression and sudden collapse. Whereas participants who experienced fewer SLEs such as miscarriage reported no other health challenges apart from low mood.

This suggests that even for married persons who have no history of ACEs but had been exposed to vicarious SLEs, they were still impacted by them, specifically in the area of their mental health. In essence, both ACEs and SLEs independently impact HRQoL leading to diverse mental and physical health conditions. Cleland et al. (2016) study further confirmed these findings as it revealed that, experiencing five stressful life events had a statistically significant negative impact on mental health. It was also revealed that as stressful life events accumulate, health outcomes deteriorate especially when people experience three or four stressful life events over a period of three years.

In spite of the number of SLEs impacting HRQoL, the qualitative finding further revealed that all participants experienced one SLE or another and also reported mental or physical health difficulties or both leading to a decline in HRQoL. However, it appeared that the nature of the SLE influenced the nature of health challenges experienced. Participants whose SLEs levied their cognitive and emotional domains appeared to suffer more mental health difficulties than physical health problems. For instance, for participants who reported third party influence, spousal threatened job loss and financial challenges reported mood disturbances, sleep problems, memory and attention

deficits. However, participants who reported childcare demands which levied their physical energy reported experiencing severe muscle tension and body pains. The transactional stress theory can better explain this outcome as it alludes that, SLEs which have overwhelming effect as those experienced by participants are often perceived as unbearable and are usually borne with less adaptive coping strategies. This results in a significant reduction in HRQoL characterised by the symptoms and conditions revealed in this study.

The qualitative finding further threw more light on the nature of interaction between ACEs and SLEs which results in a decline or increase in HRQoL. It seem quite obvious that for persons with histories of ACEs, a later experience of SLEs severely toppled their HRQoL over. For instance, participants barely reported decline in HRQoL whether in the form of mental health or physical health difficulties in spite of their histories of ACEs until they were exposed a significant SLE. Going by these findings, it could be summarized that, even though ACEs and SLEs independently impact HRQoL, whether mental or physical or both, it appears married persons without a history of ACEs experience better HRQoL in the face of SLEs compared to those with histories of ACEs. Hence, SLEs seem to be significant moderators between ACEs and HRQoL.

These outcomes are better explained by the biopsychosocial theory which postulates that health is not only determined by a person's biological factors but also by psychological and social factors. The theory further emphasises that a person's social constitution in the form of their marital situation, jobs and environment among others, could influence their psychological and biological states (Bolton & Gillet, 2019). The

biopsychosocial theory gives insight into the reason for participants' decline in HRQoL in the domains of their physical and mental health as it reveals that, the SLEs encountered by participants have the potential of affecting the biological and psychological make-up, leading to health challenges in both domains. The vulnerability-stress model (van Heeringen, 2012) expounded the biopsychosocial interaction as it advances the idea that, for people to suffer health challenges, there has to be a predisposition to the said condition, be it a genetic, biological or psychological vulnerability such as ACEs and this predispositional vulnerability require an SLE or more for married persons to experience a psychological or physical health problem. This interaction explains the reason for the onset of significant decline in HRQoL among participants who had experienced both ACEs and SLEs compared to those who had experienced only SLEs without ACEs.

These findings imply that when married persons anticipate any SLEs such as changing jobs, expecting a new child or any other such SLEs as well as sudden SLEs such as loss of a close relative, they can aptly safeguard their HRQoL when they thoroughly discuss how the SLE could possibly impact them. A careful assessment of the impending stressor with detailed interventions to facilitate a smooth management of the SLE could serve as a protective factor against HRQoL and decline in marital satisfaction. Also, in the event of unanticipated SLEs, married persons may prevent any form of decline in HRQoL by creating and ensuring significant buffers that would enhance their health through periodic health checks and healthy habit. Hence, for persons who suffer sudden loss of a close relative or property, these interventions may significantly enhance their HRQoL. Given that a history of

multiple ACEs coupled with cumulative SLEs were found to be significant precursors to lower HRQoL, an awareness of how a person's ACEs predisposes them to a significant decline in their HRQoL in the face of SLEs seem to be extremely crucial in preventing certain health challenges as revealed by Umberson et al. (2005). Unfortunately, all participants were not aware of the extent to which their childhood adversities had influenced their mental health. However, their narratives were highly suggestive of various mental health issues.

In respect of the influence that marital satisfaction has on HRQoL of married persons, the findings of the study indicated that, there is an equal increase in HRQoL for every increase in marital satisfaction among married persons. In essence, married persons who reported higher marital satisfaction were likely to report better HRQoL to the same degree. This suggests that for married persons, marital satisfaction could be considered a significant health protective factor against decline in both mental and physical health domains of HRQoL.

This finding was strongly corroborated by the qualitative study. The findings revealed that indeed, HRQoL was significantly higher for participants who reported higher marital satisfaction in spite of the SLEs they were enduring compared to those who reported lower marital satisfaction. For instance, participants who reported optimum HRQoL even in the face of distressing SLEs including unexplainable medical conditions and life situations also reported better marital satisfaction. These participants' marital satisfaction was characterised by consistent positive communication patterns and engagement in many activities of common interest with their spouses

which appeared to help them deepen their marital bond. Going by these findings, it could be concluded that marital satisfaction is a strong indicator of optimum HRQoL and buffer against decline in HRQoL. These findings were confirmed by a similar study reported by (Gottman & Silver, 2015) which indicated that, decline in marital satisfaction could increase susceptibility to decline in HRQoL by about 35 percent and reduce life expectancy by an average of four to eight years. On the contrary, optimum marital satisfaction was found to contribute to longer life expectancy and higher HRQoL. Furthermore, in expounding on the likely reason for these outcomes, Gallo, Troxel, Matthews and Kuller (2003) reported that higher marital satisfaction enhance medication adherence, reduced health risk behaviours, better psychological and physiological activities resulting in optimum HRQoL. These findings aptly explain the reason for the changes in HRQoL in the same direction that marital satisfaction goes.

The biopsychosocial theory highlights the reason for these findings as it explained that married persons who have strong social support in the form of supportive and understanding spouses, friends or family as evinced in the findings are more likely to have positive thoughts and habits which eventually result in better physical health states. In the same vein, for married persons with difficult marital situations, the biopsychosocial theory propounds a definite decline in physical and mental health given how decline in marital satisfaction as a social phenomenon could cause faulty appraisal and thought patterns which also disturbs emotions and consequently result in health threatening physiological activities and behaviour. Evidently, studies found a drop in the blood pressure of married persons in satisfying marriages who

spent time with each other, while married persons in distressing marriages experienced an increase in blood pressure while physical proximity or contact were maintained (Levine & Heller, 2010). Hence, the need for marriage to be seen, not just as a social construct which lies only with the married persons but also as a health predicting construct which requires societal, governmental, educational and health care attention targeted at enhancing marital satisfaction.

In conclusion, married persons HRQoL seem pivoted on their experiences of childhood adversities. However, it takes an SLE which is perceived as an unsurmountable threat to set it on a declining course. Moreover, SLEs on their own can instigate a decline in HRQoL even though their sole impact on married persons may be lesser compared to SLEs that are coupled with ACEs. Thankfully, high marital satisfaction served as a protective and enhancing factor for HRQoL.

Chapter Summary

The quantitative study's findings demonstrated a significant prevalence of ACEs and SLEs among married individuals. The findings also showed that there was a significant negative relationship between ACEs and marital satisfaction as well as SLEs and marital satisfaction. Again, the findings of the study indicated that ACEs and SLEs negatively impacted marital satisfaction significantly. These were affirmed by the findings of the qualitative study. Also, ACEs and SLEs were found to significantly predict HRQoL negatively. However, marital satisfaction positively predicted HRQoL significantly. The qualitative findings aptly corroborated these findings.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Overview of the Research

This chapter mixed findings from both data sets (quantitative and qualitative) which constitutes the entire research. It presents an overview of the research and a summary of the key findings. Following the summary is a triangulated discussion of the findings that unearths how intensely correlated and predictive, the variables of ACEs, SLEs, marital satisfaction and HRQoL are, as revealed by this research. The discussion situated the research findings within the context of the theoretical review, adopted philosophical stance, as well as the reviewed related literature. The implications of the study's findings to future research, clinical practice, stakeholders and healthcare policies are equally further discussed in this chapter.

Summary

The pragmatist philosophy which supports the use of both quantitative and qualitative enquiries, integrated immensely with the adopted theoretical framework to firmly underpin the study. The goal of the study was to investigate the relationship among ACEs, SLEs, marital satisfaction and HRQoL and to also identify the commonest ACEs and SLEs that affected many married persons and how they predicted their marital satisfaction and HRQoL. A concurrent triangulated mixed-methods design was employed to achieve this goal. The quantitative research phase on the other hand comprised a cross-sectional survey of 400 married persons who lived in the Ga Central Municipality of the Greater Accra Region. A set of standardised questionnaires were used to assess the common ACEs and SLEs as well as

determine the relationship and predictability among ACEs, SLEs, marital satisfaction and HRQoL of the research participants. The study essentially addressed five research questions, with three of them being answered by the quantitative study and the remaining two by the qualitative research phase. Also, four hypotheses were tested. The research questions and hypothesis were as follows:

1. What are the common Adverse Childhood Experiences (ACEs) encountered by married persons in the Ga Central Municipality of the Greater Accra Region?
2. What are the common Stressful Life Events (SLEs) experienced by married persons in the Ga Central Municipality of the Greater Accra Region?
3. What is the prevalent rate of the cumulative number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region?
4. What influence do ACEs and SLEs have on marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region?
5. What influence do ACEs, SLEs and marital satisfaction have on Health-Related Quality of Life of married persons in the Ga Central Municipality of the Greater Accra Region?
6. There will be a relationship among adverse childhood experiences, stressful life events and marital satisfaction among married persons in the Ga Central Municipality of the Greater Accra Region.

7. There will be a significant difference in marital satisfaction with respect to the cumulative number of adverse childhood experiences encountered by married persons in the Ga Central Municipality of the Greater Accra Region.
8. Adverse childhood experiences, stressful life events, marital satisfaction will predict health-related quality of life of married persons in the Ga Central Municipality of the Greater Accra Region.
9. Adverse childhood experiences and stressful life events will predict marital satisfaction of married persons in the Ga Central Municipality of the Greater Accra Region.

Demographic characteristics, as well as research questions one and two, were analysed using frequencies and percentages. The Pearson's product-moment correlation coefficient was employed to examine hypothesis one, which aimed to determine the relationship between ACEs, SLEs, and marital satisfaction. Hypothesis two, investigating the variation in marital satisfaction based on the cumulative number of ACEs experienced by married individuals, was analysed using the One-Way Analysis of Variance (ANOVA) statistical tool. Multiple logistic regression was used to test hypothesis three which predicted HRQoL on the basis of ACEs, SLEs and marital satisfaction. Multiple regression analysis was used to determine the impact that ACEs and SLEs had on marital satisfaction of married persons.

The qualitative study was a phenomenological exploration of the ACEs, SLEs, marriage and health experiences among five of the 400 survey participants using a semi-structured interview guide. Research questions four and five which sought to determine the influence that ACEs, SLEs have on

marital satisfaction as well as the influence that ACEs, SLEs, marital satisfaction have on HRQoL were answered using interpretative phenomenological analysis.

Summary of Qualitative and Quantitative Key Findings

The Adverse Childhood Experiences of all the participants were measured across six constructs; physical abuse, verbal and emotional abuse, sexual abuse, emotion and physical neglect and household dysfunction. The main findings are as follows:

1. That ACEs are fundamentally common among majority of research participants, though a minority of them never encountered any such experiences in their life time. While many experienced duplicates and quadruples of ACEs, verbal abuse, emotional neglect and household dysfunction, characterised by parents' divorce or separation seemed to be the commonest experiences among the lot. The most common forms of ACEs experienced were verbal abuse, emotional neglect and household dysfunction characterised by parents' divorce or separation and the least common were domestic violence and physical neglect. The study findings confirmed a significant prevalence of childhood psychological trauma and converged with empirical data which indicated that when a person experiences at a least one ACE, it is significant enough to influence their health (Centres for Disease Control and Prevention, 2019).
2. It was also found that among the six constructs of ACEs, emotional neglect characterised by participants' inability to express their emotions and desires to a parent or guardian, negatively affected

participants' social interaction competence quite significantly. The qualitative findings revealed that this often resulted in maladaptive styles of communication such as defensiveness and stonewalling which Dugal et al. (2020) indicated as destructive to marital satisfaction.

3. As many as half of the participants had experienced significant SLEs which predisposed them to a decline in HRQoL and marital satisfaction. Common among the SLEs experienced by participants were financial challenges, sleep problems and eating habits. The qualitative findings also revealed that caring for children among other equally demanding roles, financial demands, spousal infidelity and spousal negative response to their requests were the most prevalent SLEs.
4. The study revealed that participants' marital satisfaction was significantly influenced by their ACEs and SLEs. The outcomes indicated that marital satisfaction was lower for participants who had experienced multiple ACEs and SLEs. Hence, marital satisfaction negatively correlated with ACEs and SLEs. Coincidentally, the qualitative findings indicated that, participants reported blissful marital experiences from the onset on their marriages but their satisfaction took a nose dive when they began experiencing various significant life stressors. This is consistent with the findings of Li and Wickrama (2014). Also, for participants who had experienced a number of ACEs, they recounted that having to deal with these life stressors was sometimes overwhelming compared to those who had not experienced

any ACEs just as Hammett, Karney and Bradbury (2020) also found in their study.

5. ACEs, SLEs and marital satisfaction were found to significantly influence participants HRQoL. However, ACEs and SLEs related negatively with HRQoL while marital satisfaction related positively. In essence, the findings suggest that participants who had been exposed to multiple ACEs experienced a decline in HRQoL as their SLEs increased as Dorji and Dunne (2017) found in their studies. On the contrary, participants experienced an increase in HRQoL as their marital satisfaction also increased. Gharibi, Sanagouymoharer and Yaghoubinia (2015) study affirmed this finding. Furthermore, the qualitative findings revealed that participants experienced a decline in their mental and physical health when they began experiencing SLEs. Mental health decline was characterised by intense sadness, anxiety and anger while a decline in physical health was characterised by insomnia, pain and frequent hospitalisation among others. Those who had experienced ACEs also reported more significant decline in HRQoL such as recurrent feelings of suicidality when SLEs increased. On the contrary, participants who reported increase in marital satisfaction over the period had seemingly no complaints or challenges with their HRQoL. Rather, they reported experiencing a surge in their HRQoL.
6. It is quite apparent that, ACEs and SLEs will significantly predict marital satisfaction. Findings of the study alluded to this by indicating that participants' marital satisfaction was predicted by their history of

ACEs and experience of SLEs. It was discovered that the extent of a person's marital satisfaction could be estimated based on the number of ACEs they had experienced as well as SLEs suffered. In essence, based on the findings of this study, it is possible to predict the extent to which a married person may experience a decline in their marital satisfaction in the event that they had experienced SLEs or had suffered ACEs. In the same vein, the possibility of predicting a married person's HRQoL based on the level of marital satisfaction is plausible.

7. Findings from the qualitative study further revealed that, how a participants' spouse responded to their desires, needs or suggestions about an SLE seem to have determined to a significant extent, the coping strategy they employed in dealing with the SLE. Also, participants who reported having a more robust social support system appeared to have better handled the SLEs they were experiencing. Consequently, marital satisfaction and HRQoL were found to be better among participants who had stronger social support systems and employed problem-focused coping strategies.

Conclusions

The study found that the more ACEs such as physical abuse, verbal and sexual abuse or emotional neglect married persons had experienced, the greater the decline in their marital satisfaction over the period of their marriage. Similarly, the more SLEs married persons had experienced, the greater the decline in their marital satisfaction. SLEs comprised traumatic stress experiences such as loss of a loved one, loss of a job and major change in finances. For some, a decline in marital satisfaction implied increase in

quarrels, avoidance or withdrawal from a partner and defensiveness in communication among others as was discovered in the qualitative study.

Furthermore, it was found that the more ACEs and SLEs married persons had experienced, the greater the decline in their HRQoL. A decline in HRQoL meant experiencing physical pain, sleep difficulties, feelings of depression and anxiety which disrupt a person's daily functioning among others.

Quite revealing is the fact that HRQoL improved with every increase in marital satisfaction. For instance, participants who reported higher marital satisfaction characterised by emotional support, shared thoughts and joint efforts as well as pursuing common interests among others, often experienced better HRQoL in spite of their SLEs.

Participants who recounted experiences of spouses who did not respond favourably to their unique SLEs appeared to experience more significant declines in their marital satisfaction.

Contributions of the Study

In the area of knowledge, a major contribution of this study relates to the finding that ACEs have a detrimental influence on marital satisfaction in Ghana. The adopted mixed-methods approach demonstrated that married persons who had experienced ACEs were more susceptible to severe emotional distress in the face of marital differences and disagreements. This susceptibility appeared to make them prone to negative emotional response patterns such as anger, sadness, avoidance and withdrawal which seemed to have more detrimental ramifications on marital satisfaction. Hence, the influence of ACEs on marital satisfaction could be telling just as much as it

could on their HRQoL; both mental and or physical health. Married persons' awareness of the possible influence and extent of ACEs on their marital satisfaction and HRQoL could help them manage their marital challenges much better. This appears to be a novel addition to the myriad of literature that elucidate the probable causes of decline in marital satisfaction and HRQoL.

Also, SLEs were found to be the onset of decline in marital satisfaction. As the quantitative findings revealed that their influence and impact on marital satisfaction was dire, the qualitative findings echoed how this sometimes played out. It appeared that most married persons were enjoying blissful marriages during the earlier periods of their marriages until they experienced one SLE or another. Hence, an awareness of the influence and extent of influence of SLEs on marital satisfaction could help married persons recognise the need to focus on identifying and managing their SLEs instead of attacking their spouses. It appears this finding may also be significantly enlightening to married persons and counsellors given its novelty.

Similarly, health care practitioners may be awed to find that marital satisfaction is a significant contributor to better HRQoL going by the findings of this study. This outcome demonstrated the need for health care practitioners to include ACEs, SLEs and marital satisfaction in their list of enquiry they delve into when attending to clients who are married persons. This new approach, though unconventional, could enhance the quality of care than has ever been achieved.

Finally, this study makes up for the gap in the literature with novel knowledge about some of the most crucial causes of decline in marital satisfaction and HRQoL in Ghana. It also reveals that marital satisfaction is

not merely a social phenomenon but by extension a significant health phenomenon.

Practical implications of the Study

This study has significant implications for policy in four key areas: counselling, health and clinical practice, education, religious and humanitarian programmes. The researcher opines that government's focus on the above-mentioned key points, for appropriate policy development will go a long way to protect and strengthen the nation's entire human resource, for better and longer life. For instance, the Welsh Government's policy on ACEs which recognises childhood adversity as a barrier to a better start in life targets supporting families to reduce ACEs. It also focuses on mitigating its impact through public awareness creation and uses social intervention programmes to build resilience among the general populace particularly those prone and exposed to ACEs. These policies, among others, have been reported to reflect fundamentally favourable behavioural and educational outcomes on the Welsh people (Review of adverse childhood policy report, 2021).

Implications for Clinical and Counselling Practice

1. Based on the high prevalence of ACEs and SLEs coupled with their impact on marriage and health as found in this study, it is imperative that practitioners in the counselling profession screen their clients for ACEs and SLEs. This will help practitioners enlighten their clients on the influence of these experiences on their marriages, interpersonal relationships and their HRQoL. Also, counsellors and clinical psychologists who may be interested, could be trained in the area of

trauma-focused counselling in order to provide quality counselling services to clients who may have been traumatised by their ACEs and or SLEs. Marriage and family counsellors with the requisite training, can better inform and guide families on the influence their ACEs and or SLEs may be having on the family system, marital relationship and perhaps their HRQoL.

Furthermore, the findings imply that the clergy recognise the importance of ACEs and SLE screening just as would-be couples are expected and, in some cases, required to undergo medical screening before premarital counselling. It appears this type of screening will give the counsellor relevant information to aid their premarital and post-marital as well as family counselling.

2. The study unveiled the significant impact of ACEs, SLEs and marital satisfaction on HRQoL. This suggests that medical practitioners who attend to clients must attempt to explore their clients' history of childhood adversity, sources of stress and marital satisfaction in the case of those who may be married. It appears medical practitioners' recognition of the role of these phenomena in the illness presentation of their clients could help them take a holistic view at their client's condition and refer them to the appropriate experts; counselling psychologists, clinical psychologists, clinical social workers or even psychiatrists where need be. Also, health care practitioners could inculcate stress management and psychological well-being training into their staff training and public health interventions in order to equip

society with relevant skills to help in their management of their stressors.

Implications for key stakeholders

1. Implications of the research for parents, guardians and community leaders such as members of the clergy, chiefs and political leaders particularly regarding ACEs are immense. Given that these ACEs happen during childhood, it only stands to reason that, to avert its ramifications on society, parents and community leaders endeavour to put in measures to ensure that their children are not exposed to any of these ACEs. It is imperative that while they ensure this, they do not perpetuate such acts against their children recognising how detrimental it could be to their mental and physical health, interpersonal relationships as well as marital life.
2. Also, the tendency to trivialise and sometimes dismiss the complaints of victims of ACEs must be avoided particularly by parents, guardians and community leaders whose involvement in such issues could significantly change the course of events for the better. The findings of this study clearly elucidate the impact of ACEs on all persons regardless of creed or status. Hence, parental and community awareness and intervention are much likely to significantly reduce the incidence of ACEs and ensure victims receive the needed attention to avert future ramifications.
3. Findings of this study suggest that ACEs appear to disrupt adaptive social interaction, HRQoL and adaptation to stress. Hence, agencies and organisations whose vision and mission it is to help children and

married persons and encourage achievement of optimum health can arm themselves with the findings of this study in their awareness and intervention programmes. Also, these institutions can support in trauma-focused research by providing funding and collaborative opportunities for further research.

Suggestions for Further Research

The study prompted these suggestions for further research:

1. A number of the study hypotheses were investigated using regression analysis. It is suggested that future research consider a mediation approach to determine how ACEs and SLEs will mediate marital satisfaction and HRQoL. This suggestion stems from the qualitative findings which appears to give the impression that the influence of ACEs and SLEs on marital satisfaction results in a disruption of HRQoL.
2. It is also suggested that an action-partner model is employed in future study in order to gain perspective on couple's responses and narratives about the influence of their ACEs and SLEs on their marital satisfaction and HRQoL. This will give insight into how each partner's social demography, ACEs and SLEs may be contributing to their own as well as their partner's sense of satisfaction in their marriage as well as their HRQoL.
3. Future studies should consider the moderating effect of social support and coping skills on the relationship among ACEs, SLEs, and marital satisfaction.

4. It will be revealing to conduct a comparative study in some selected parts of Ghana to ascertain the nature of the phenomenon across Ghana.
5. Finally, it is suggested that a longitudinal study with a mixed method approach is conducted to ascertain the long term impact of ACEs and SLEs on marital satisfaction and HRQoL on the children of participants and if possible the children's own marriages and health.

Recommendations for Practice and Policy

The following recommendations were made on the basis of the findings of the study in furtherance of practice and policy:

1. It is recommended that community-based interventions targeted at raising awareness about the impact of ACEs and SLEs on marital relationships and overall well-being be established.
2. It is also recommended that early interventions and support systems be instituted within educational institutions, healthcare settings and community centres to identify individuals at risk of ACEs and SLEs.
3. Robust support systems that offer timely counselling, therapeutic interventions, and educational resources to mitigate the long-term impacts on marital satisfaction and health outcomes should be established.
4. Advocacy activities targeted at policy reformation and initiatives that prioritise family support and marital health within the municipalities of Ghana is strongly recommended.
5. Policymakers will be encouraged to allocate resources for research, prevention programmes and supportive interventions that promote

healthy marital relationships and mitigate the impact of adverse childhood experiences and stressful life events.

REFERENCES

Andrade, C. (2021). The inconvenient truth about convenience and purposive samples. *Indian Journal of Psychological Medicine, 43*(1), 86-88.

American Association for Marriage and Family Therapy (2016). *Marital distress.* Retrieved (March 3rd, 2022) from https:// aamft.org/ consumer_updates/marital _distress.

Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2013). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health, 36*(1), 81–91.

Bellis, M. A., Ashtoni, K., Hughesii, K., Fordii, K., Bishopi, J., & Paranjothyi, S. (2015). *Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population.* Cardiff: Centre for Public Health.

Bodenmann, G. (2005). Dyadic coping and its significant for marital functioning. In T.Revenson, K. Kayser, & G. Bodenmann (Eds.), *Couples coping with stress: Emerging perspectives on dyadic coping* (pp. 33−50). Washington, D.C.: American Psychological Association.

Bolton, D., & Gillet, G. (2019). *The biopsychosocial model of health and disease new philosophical and scientific developments.* Springer.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London, UK: Routledge.

Campbell, J. A., Walker, R. J., & Egede, L. E. (2016). Associations between adverse childhood experiences, high-risk behaviours, and morbidity in adulthood. *American Journal of Preventive Medicine, 50*(3), 344 - 352.

Carlson, D. (2014) Stressful life events. In: Michalos A. C. (eds) *Encyclopedia of Quality of Life and Well-Being Research*. Springer, Dordrecht. https://doi.org/10.1007/978-94-007-0753-5_2880

Carver, C. S. (2001). Depression, hopelessness, optimism and health. In N. J. Smelser & P. B.Baltes (Eds.), *The international encyclopedia of the social and behavioural sciences*. Oxford, England: Elsevier.

Centres for Disease Control and Prevention (2021). *Adverse childhood experiences prevention strategy.* Atlanta, GA: National Centre for Injury Prevention and Control.

Centres for Disease Control and Prevention (2019). *Preventing adverse childhood experiences: leveraging the best available evidence.* Atlanta, GA: National Centre for Injury Prevention and Control

Centres for Disease Control and Prevention. (2000). *Measuring healthy days*. Atlanta, Georgia: CDC.

Chanlongbutra, A., Singh, G. K., & Mueller, C. D. (2018). Adverse childhood experiences, health-related quality of life, and chronic disease risks in rural areas of the United States. *Journal of Environmental and Public Health, 15.* doi:/10.1155/2018/7151297.

Cheong, E.V., Sinnott, C., Dahly, D., & Kearney, M.P. (2017). Adverse childhood experiences and later-life depression: perceived social support as a potential protective factor. *British Medical Journal*. *open, 7*(9), e013228. https://doi.org/10.1136/bmjopen-2016-013228doi:10.1136/.

Cleland, C., Kearns, A., Tannahill, C., & Ellaway, A. (2016). The impact of life events on adult physical and mental health and well-being: longitudinal analysis using the GoWell health and well-being survey. *BMC Res Notes, 9,* 470.

Cluver, L., Orkin, M., Boyes, M. E., & Sherr, L. (2015). Child and adolescent suicide attempts, suicidal hehaviour, and adverse childhood experiences in South Africa: A prospective study. *Journal of Adolescent Health 57,* 52-59.

Cohen, S. D. (2013). *Social support interventions will improve the quality of life of ESRD patients.* Seminars in dialysis: Wiley Online Library.

Coker, T. R., Elliott, M. N., Wallander, J. L., Cuccaro, P., Grunbaum, J. A., Corona, R., Saunders, A. E., & Schuster, M. A. (2011). Association of family stressful life-change events and health-related quality of life in fifth-grade children. *Arch Pediatric Adolescence Medicine, 165*(4), 354-359.

Covey, H. C., Menard, S., & Franzese, R. J. (2013). Effects of adolescent physical abuse, exposure to neighbourhood violence, and witnessing parental violence on adult socioeconomic status. *Child Maltreatment, 18(*2), 85–97.

Creswell, J. W., & Creswell, J. D. (2018). *Research Design*. Los Angeles: SAGE Publications Inc.

Creswell, J. W. (2013). *Qualitative inquiry & research design: choosing among five approaches*. Los Angeles: SAGE Publications Inc.

Creswell, J. W. (2003). *Research design: qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. W., & Zhang, W. (2009). The application of mixed methods designs to trauma research. *Journal of Traumatic Stress, 22*(6), 612 – 621.

Creswell, J. W., & Plano, C. V. L. (2018). *Designing and conducting mixed methods research.* Los Angeles: Sage.

Dane, F. C. (2011). *Evaluating research: methodology for people who need to read research.* Los Angeles, CA: Sage Publications.

Dawadi, S., Shrestha, S., & Giri, R. A. (2021). Mixed-methods research: a discussion on its types, challenges, and criticisms. *Journal of Practical Studies in Education, 2*(2), 25-36.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314 – 321.

DiLillo, D., Lewis, T., & Loreto-Colgan, A. D.(2007). Child maltreatment history and subsequent romantic relationships. *Journal of Aggression, Maltreatment & Trauma, 15*(1), 19-36.

Dillard, D. M. (2019). *The Transactional Theory of Stress and Coping: Predicting Posttraumatic Distress in Telecommunicators* (Doctoral Thesis). Retrieved from https://scholarworks.waldenu.edu/dissertations.

Dong, S., Dong, Q., Chen, H., & Yang, S. (2022). Mother's parenting stress and marital satisfaction during the parenting period: examining the role of depression, solitude, and time alone. *Frontiers of Psychology,* 13(8) http://doi: 10.3389/fpsyg.2022.847419.

Donnelly, R., Umberson, D., & Kroeger, R. A. (2018). Childhood adversity, daily stress, and marital strain in same- sex and different-sex marriages. *Journal of Family Issues, 39*(7), 2085–2106.

Dorji, N., & Dunne, M. (2017). Stressful life events: association with physical and mental health conditions among older adults in Bhutan. *MOJ Public Health, 6*(5), 413-419.

Dugal, C., Belanger, C., Brassad, A., & Godbout, N. (2020). A dyadic analysis of the associations between cumulative childhood trauma and psychological intimate partner violence: the mediating roles of negative urgency and communication patterns. *Journal of Marital and Family Therapy 46*(2), 337–351.

Evans, S. E., Steel, A. L., & DiLillo, D. (2013). Child maltreatment severity and adult trauma symptoms: does perceived social support play a buffering role? *Child Abuse Neglect, 37,* 934-943.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the causes of death in adults. The Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Fink, A. (2009). *How to conduct survey*. Thousand Oaks, CA: Sage.

Finlay, L. (2012). Unfolding the phenomenological research process: iterative stages of "seeing afresh". *Journal of Humanistic Psychology, 53*(2), 172 – 201.

Fowers, B. J., & Olson, D. H. (1993). ENRICH marital satisfaction scale: a brief research and clinical tool. *Journal of Family Psychology, 7*(2), 176-185.

Fowler, F. J. (2009). Methods of data collection. In F. J. Fowler *Methods of data collection* (pp. 68-85). Sage.

Gallo, L. C., Troxel, W. M., Matthews, K. A., & Kuller, L. H. (2003). Marital Status and Quality in Middle-Aged Women: Associations with Levels and Trajectories of Cardiovascular Risk Factors. *Health Psychology, 22*(5), 453 - 463

Gay, L. R., Mills, G. E., & Airasian, P. W. (2009). *Educational research: Competencies for analysis and applications.* Merrill/Pearson.

Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: beyond the debate. *Integrative Psychological and Behavioural Science, 42*, 226 – 290.

Ghana Statistical Service (2021). 2021 Population and housing census: District analytical report- Ga central. Accra, Ghana: Ghana Statistical Service.

Gharibi, M., Sanagouymoharer, G., & Yaghoubinia, F. (2015). The Relationship Between Quality of Life With Marital Satisfaction in Nurses in Social Security Hospital in Zahedan. *Global Journal of Health Science, 8*(2), 178–184. https://doi.org/10.5539/gjhs.v8n2p178

Gottman, J. S., & Gottman, J. M. (2014). *10 principles for doing effective couples' therapy*. New York: W. W Norton & Company.

Gottman, J. M., & Silver, N. (2015). *The seven principles for making marriage*

work: A practical guide from the country's foremost relationship expert. New York: Harmony publications.

Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy.* New York: W. W Norton & Company.

Gottman, J. M. (1999). *The seven principles for making marriage work.* New York: Random House.

Hammett, J. F., Karney, B. R., & Bradbury, T. N. (2020). Adverse childhood experiences, stress, and intimate partner violence among newlywed couples living with low incomes. *Journal of Family Psychology*, *34*(4), 436–447.

Harper, J. M., Schaalje, B. G., & Sandburg, J. G. (2000). Daily hassles, intimacy, and marital quality in later life marriages. *The American Journal of Family Therapy, 28*(1), 1–18.

Harris, M. A., & Orth, U. (2019). The link between self-esteem and social relationships: a meta-analysis of longitudinal studies. *Journal of Personality and Social Psychology*. http://dx.doi.org/10.1037/pspp000

Healthy Days Guide (2019). *Measuring healthy days*. Retrieved from https://populationhealth.humana.com/

Institute of Development Studies. (2016). *Domestic violence in Ghana: incidence, attitudes, determinants and consequences.* Brighton: IDS

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: a research paradigm whose time has come. *Educational Researcher, 33*(7), 14 – 26.

Kalmakis, K. A., & Chandler, G. E. (2015). Health consequences of adverse childhood experiences: A systematic review. *Journal of the American Association of Nurse Practitioners 27*, 457–465.

Karney, B. R., Story, L. B., & Bradbury, T. N. (2005). Marriages in context: Interactions between chronic an acute stress among newlyweds. In T. A. Revenson, K. Kayser, & G. Bodenmann (Eds.), *Couples coping with stress: Emerging perspectives on dyadic coping* (pp. 13−32). Washington, D.C.: American Psychological Association.

King, M. E. (2019). *Marital satisfaction*. Wiley & Sons, Inc.

Laerd dissertation (2012). *Purposive sampling*. Retrieved from https:// dissertation. laerd.com/purposive- sampling.php.

Larsen, C. D., Sandberg, J. G., Harper, J. M., & Bean, R. (2011). The effect of childhood abuse in relationship quality: Gender differences and clinical implications. *Family Relations, 60,* 435 – 445.

Lazarus, R. S. (2012). Evolution of a model of stress, coping, and discrete emotions. In V. Hill- Rice (Ed.), *Handbook of stress, coping, and health* (2nd ed., pp. 199- 223). Thousand Oaks, CA: SAGE Publications.

Leavy, P. (2017). *Research design: Quantitative, qualitative, mixed methods, art-based and community-based participatory research approaches.* New York: The Guilford Press.

Ledermann, T., Bodenmann, G., Rudaz, M., & Bradbury, T.N. (2010). Stress, communication, and marital quality in couples. *Family Relations, 59*, 195 – 206.

Leech, N.L., & Donovan, C. (2023). *Mixed methods sampling and data collection*. International Encyclopedia of Education: Elsevier.

Levine, A., & Heller, R. (2010). *Attached: the new science of adult attachment and how it can help you find and keep love.* Penguin Books.

Li, P. F., & Wickrama, K. A. S. (2014). Stressful life events, marital satisfaction, and marital management skills of Taiwanese couples. *Family Relations, 63,*193–205.

Löblich, M. (2017). *Rigor in qualitative research*. Wiley Online Library.

Manyema, M., & Richter, L. M. (2018). Adverse childhood experiences: prevalence and associated factors among South African young adults. *Heliyon, 5*(12). https://doi.org/10.1016/j.heliyon.2019.e03003

McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: Central role of the brain. *Physiological Reviews, 87,* 873–904.

Miles, M. B., & Huberman, A, M. (1994*). Qualitative data analysis: An expande sourcebook* (2nd ed.). Newbury Park CA: Sage.

Monnat, S. M., & Chandler, R. F. (2015). Long-term physical health consequences of adverse childhood experiences. *The Sociological Quarterly*. doi: 10.1111/tsq.12107.

Moriarty, D. G., Zack, M. M., & Kobau, R. (2003). The Centres for Disease Control and Prevention's Healthy Days Measures – Population tracking of perceived physical and mental health over time. *Health and Quality of Life Outcomes, 1*(37), 1477 – 7525.

Mosley-Johnson, E., Garacci, E., Wagner, N., Mendez, C., William, S. J., & Egede, E. L. (2019). Assessing the relationship between adverse childhood experiences and life satisfaction, psychological well-being, and social well-being: United States Longitudinal Cohort 1995–2014. *Quality of Life Research, 28*(4), 907–914.

Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., Goldman, H., & Steele, H. (2014). Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships. *Child Abuse & Neglect, 38*(2), 224-233.

Muwanguzi, M., Kaggwa, M. M., Najjuka, S. M., Mamun, M. A., Arinaitwe, I., Kajjimu, J., Nduhuura, E., & Ashaba, S. (2023). Exploring adverse childhood experiences (ACEs) among Ugandan university students: its associations with academic performance, depression, and suicidal ideations. *BMC Psychology, 11*(11). https://doi.org/10.1186/s40359-023-01044-2

National Scientific Council on the Developing Child. (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain: working paper 12*. Retrieved from http:// www. developing child.harvard.edu

Nezu, A. M., Nezu, C. M., & Geller, P. A. (2003). *Handbook of psychology: Health psychology*. New Jersey: Wiley & Sons Inc.

Nguyen, T. P., Karney, B. R., & Bradbury, T. H. (2017). Childhood abuse and later marital outcomes: do partner characteristics moderate the association? *Journal of Family Psychology*, *31*(1), 82–92.

Noone, P. A. (2017). The Holmes-Rahe stress inventory. *Occupational Medicine, 67,* 581–582.

Nurhayati, S. R., Faturochman., & Helmi, A. F. (2019). Marital quality: A conceptual review. *Buletin Psikologi*, *27*(2), 109 – 124.

Ouyang, M., Gui, D., Cai, X., Yin, Y., Mao, X., Huang, S., Zeng, P., & Wang, P. (2021). Stressful Life Events and Subjective Well-Being in Vocational School Female Adolescents: The Mediating Role of Depression and the Moderating Role of Perceived Social Support. *Frontiers of Psychology, 11*:603511. doi: 10.3389/fpsyg.2020.603511

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K.(2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administrative Policy of Mental Health, 42*(5), 533–544.

Pallant, J. (2016) *SPSS survival guide: A step by step guide to data analysis using SPSS for windows*. Chicago, IL: Open University Press.

Parenting Fundamentals (2012). *ACE Awareness for prevention*. Retrieved from https://www.pacesconnection.com/

Park, C. L. (2010). Making sense of the meaning literature: an integrative review of meaning-making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*(2), 257-301.

Patel-Davis, D., & Rhodes, A. (2017). Stress *and health: learn the effects of stress and how to deal with it.* UME: Maryland.

Perry, M. A., DiLillo, D., & Peugh, J. (2007) Childhood psychological maltreatment and quality of marriage. *Journal of Emotional Abuse, 7*(2), 117-142.

Pervanidou, P., & Chrousos, G. P. (2007). Post-traumatic stress disorder in children and adolescents: from Sigmund Freud's "trauma," to psychopathology and the (dys)metabolic syndrome. *Hormone and Metabolic Research, 39*(6), 413–419.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne – Psychological Journal, 20*(1), 7-14.

Pole, K. (2007). Mixed method designs: a review of strategies for blending quantitative and qualitative methodologies. *Mid-Western Educational Researcher, 20*(4), 35 – 38.

Randall, A. K., & Bodenmann, G. (2009). The role of stress on close relationship and marital satisfaction. *Clinical psychology review, 29*(2), 105–115.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20 – 23.

Review of adverse childhood experiences (ACE) policy: report (2021). *How the ACE policy has performed and how it can be developed in the future*. Retrieved from https://gov.wales/review-adverse-childhood-experiences-ace-policy-report-

Roberts, A. L., Mclaughlin, K. A., Conron, K. J., & Koenen, K. C. (2011). Adulthood stressors, history of childhood adversity, and risk of perpetration of intimate partner violence. *American Journal of Preventive Medicine, 40*(2), 128–138.

Runswick-Cole, K. (2011). Interviewing. In P. Banister, G. Bunn, E. Burman, J. Daniels, P. Duckett, D. Goodley, R. Lawthom, I. Parker, K. Runswick-Cole, J. Sixsmith, S. Smailes, C. Tindall, & P. Whelan (Eds.) *Qualitative Methods in Psychology: A Research Guide* (2nd ed.) (pp.100 – 114). Maidenhead: Open University Press.

Samios, C., & Baran, S. (2018). Couple adjustment to a stressful life event: A dyadic investigation of the roles of positive re-framing and perceived benefits. *Anxiety, stress, & coping, 31*(2), 188–205.

Samios, C., & Khatri, V. (2019). When times get tough: Savouring and relationship satisfaction in couples coping with a stressful life event. *Anxiety, Stress, & Coping, 32*(2), 125-140.

Schilling, E. A., Aseltine, R. H., & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: a longitudinal survey. *BMC Public Health, 7*(30), 1471-2458.

Sekaran, U. (2003). *Research methods for business: A skill–building approach* (2nd ed.). New York, NY: John Wiley & Sons, Inc.

Seyle, H. (1936). A Syndrome produced by Diverse Nocuous Agents. *Nature, 138*, 32. https://doi.org/10.1038/138032a0

Sherien, S. M. M., & Kader, N. M. A. (2016). The relationship between stressful life events and quality of life of adolescent patients. *Egyptian Nursing Journal, 13*(3), 193–199.

Shrout, M. R. (2021). The health consequences of stress in couples: A review and new integrated dyadic biobehavioral stress model. *Brain, Behaviour, & Immunity - Health, 16,* 2666-3546. http://doi.org/10.1016/j.bbih.2021.100328.

Smith, M., Williamson, A. E., Walsh, D., & McCartney, G. (2016). Is there a link between childhood adversity, attachment style and Scotland's excess mortality? Evidence, challenges and potential research. *BMC Public Health, 16,* 655. doi 10.1186/s12889-016-3201-z.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9 – 27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory Method and Research.* London: Sage Publications Ltd.

Spencer-Hwang, R., Torres, X., Valladares, J., Pasco-Rubio, M., Dougherty, M., & Kim, W. (2018). Adverse Childhood Experiences among a Community of Resilient Centenarians and Seniors: Implications for a Chronic Disease Prevention Framework. *The Permanente Journal, 22*, 17-146. https://doi.org/10.7812/TPP/17-146

Solísa, C. B. (2014). Adverse childhood experiences and physiological wear-and-tear in midlife: Findings from the 1958 British birth cohort. Retrieved from http://www.pnas.org/cgi

Sperandei, S. (2013). Understanding logistic regression. *Biochemia Medica, 24*(1), 12-18.

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative* R*esearch Journal*, *11*(2), 63-75.

Tanko, Y., Kang, C. Y., & Islam, R. (2019). Data screening and preliminary analysis on the impact of rural infrastructure on rice productivity in Kano state, Nigeria. *Journal of Economic Info, 6*(2), 4-11.

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53-55. https://doi.org/10.5116/ijme.4dfb.8dfd

Teddlie, C., & Tashakkori, A. (2012). Common "core" characteristics of mixed methods research: a review of critical issues and call for greater convergence. *American Behavioural Scientist, 56*(6), 774 – 788.

Trickett, P. K. (2010). Attenuation of cortisol across development for victims of sexual abuse. *Development and Psychopathology, 22*(1), 165–175.

Ujhelyi Nagy, A., Kuritár Szabó, I., Hann, E., & Kósa, K. (2019). Measuring the Prevalence of Adverse Childhood Experiences by Survey Research Methods. *International Journal of Environmental Research and Public health, 16*(6). https://doi.org/10.3390/ijerph16061048

Umberson, D., Williams, K., Powers, D.A., Liu, H., & Needham, B. (2005). Stress in childhood and adulthood: effects on marital quality over time. *Journal of Marriage and Family, 67*(5), 1332–1347.

Uyanil, G. K., & Guler, N. (2013). A study on multiple linear regression analysis. *Procedia –Social and Behavioural Sciences, 106*, 234 – 240. https://doi.org/10.1016/j.sbspro.2013.12.027.

Vaez, E. & Juhari, R. (2017). Stress and marital satisfaction of married middle eastern students in Malaysia. *The Family Journal: Counselling and Therapy for Couples and Families, 25*(2), 146-155.

van Duin, L., Bevaart, F., Zijlmans, J., Luijks, M. A., Doreleijers, T. A. H., Wierdsma, A. I., Oldehinkel, A. J., Marhe, R., & Popma, A. (2019). The role of adverse childhood experiences and mental health care use in psychological dysfunction of male multi-problem young adults. *European Child & Adolescent Psychiatry, 28*(8), 1065–1078.

van Heeringen, K. (2012). Stress–Diathesis Model of Suicidal Behavior. In: Dwivedi, Y. *The neurobiological basis of suicide*. Boca Raton (FL): CRC Press.

Vatcheva, K. P., Lee, M., McCormick, J. B., & Rahbar, M. H. (2016). Multicollinearity in regression analyses conducted in epidemiologic studies. *Epidemiology, 6*(2), 1165-2161.

Verbrugge, L., & House, J. (1981). Job, marital satisfaction and the quality of life among adults. In J. M, Gottman., & N, Silver. (2015). *The seven principles for making marriage work: a practical guide from the country's foremost relationship expert.* New York: Harmony publications.

Villalonga-Olives, E., Rojas-Farreras, S., Vilagut, G., Palacio-Vieira, J. A., Valderas, J. M., Herdman, M., Ferrer, M., Rajmil, L., & Alonso, J. (2010). Impact of recent life events on the health-related quality of life of adolescents and youths: the role of gender and life events typologies in a follow-up study. *Health and Quality of Life Outcomes, 8*(1), 71. https://doi.org/10.1186/1477-7525-8-71

Whisman, M. A. (2006). Childhood trauma and marital outcomes in adulthood. *Journal of the international association for relationship research, 14*(4), 375-551.

Wingenfeld, K., Schäfer, I., Terfehr, K., Grabski, H., Driessen, M., Grabe, H., Lowe, B., & Spitzer, C. (2010). The reliable, valid and economic assessment of early traumatization: first psychometric characteristics of the German version of the adverse childhood experiences questionnaire

(ACE). *Psychotherapie, Psychosomatik, Medizinische Psychologie, 61*(1), 10-14.

Woszidlo, A., & Segrin, C. (2013). Direct and indirect effects of newlywed couples' neuroticism and stressful events on marital satisfaction through mutual problem solving. *Marriage & Family Review, 49*(6), 520-545.

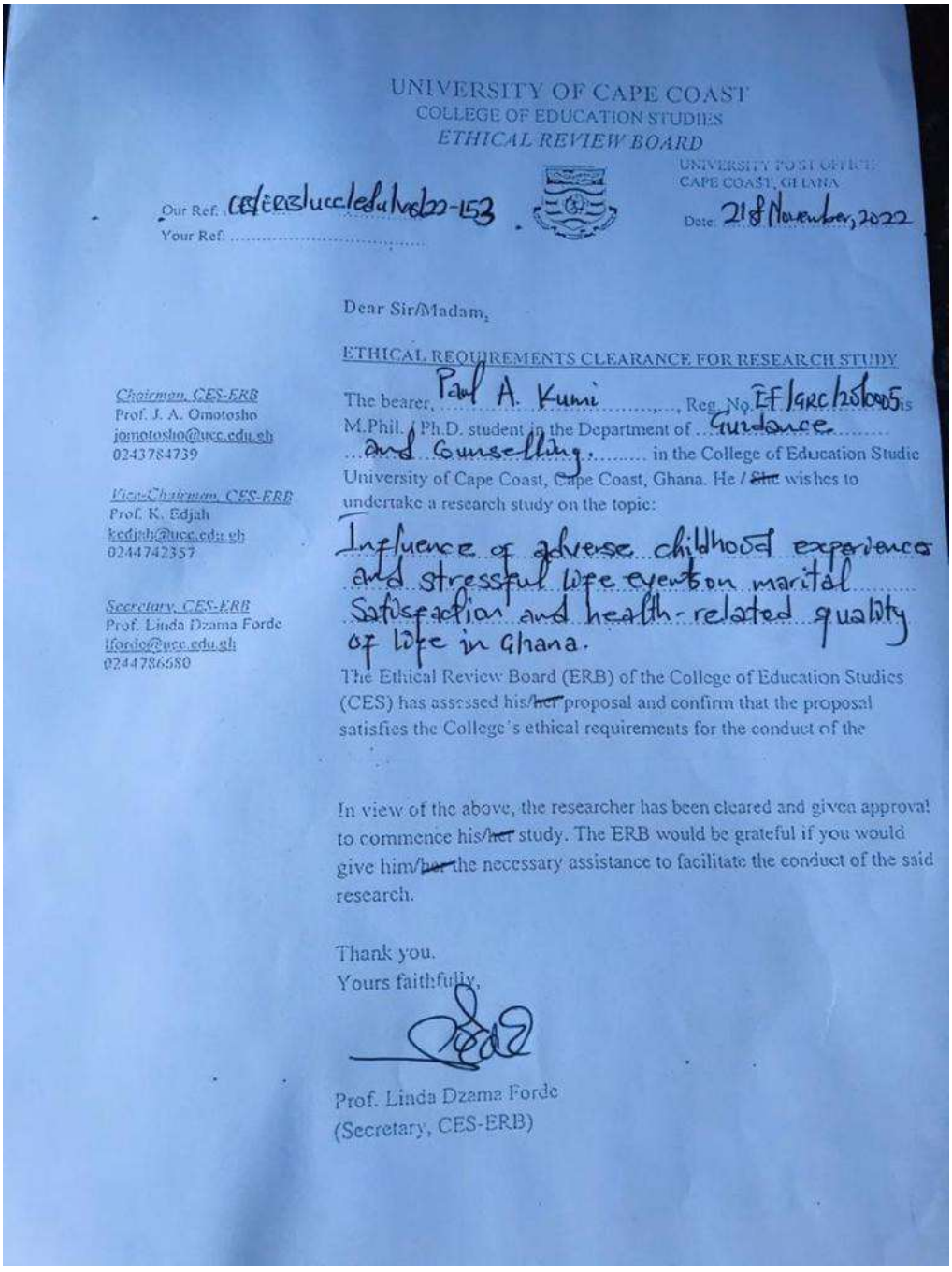
Yamane, T. (1967). *Statistics, an introductory analysis*. New York: Harper and Row.

Zangirolami-Raimundo, J., Echeimberg, J. I., & Leone, C. (2018). Research methodology topics: Cross-sectional studies. *Journal of Human Growth and Development, 28*(3), 356-360.

Zielinksi, D. S. (2009). Child maltreatment and adult socioeconomic well-being. *Child Abuse and Neglect, 33*(10), 666–678.

APPENDICES

APPENDIX A: 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.lv/22-153
Your Ref: .....
Date: 21st November, 2022

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

Chairman, CES-ERB
Prof. J. A. Omotosho
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Vice-Chairman, CES-ERB
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Secretary, CES-ERB
Prof. Linda Dzama Forde
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The bearer, Paul A. Kumi, Reg. No. EF/GRC/20/0005 is M.Phil. / Ph.D. student in the Department of Guidance and Counselling. in the College of Education Studie University of Cape Coast, Cape Coast, Ghana. He / ~~She~~ wishes to undertake a research study on the topic:

Influence of adverse childhood experience and stressful life event on marital satisfaction and health-related quality of life in Ghana.

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

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)

APPENDIX B: QUESTIONNAIRE

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF EDUCATIONAL FOUNDATIONS

DEPARTMENT OF GUIDANCE AND COUNSELLING

Participants' Questionnaire

The purpose of this questionnaire is to investigate the influence that adverse childhood experiences and stressful life events have on marital satisfaction and health-related quality of life among married persons in the Ga Central Municipality of the Greater Accra Region. I humbly request that you sincerely respond to the items on the questionnaire after you read them. You are assured of utmost confidentiality with respect to the information you provide. Thank you.

SECTION A

Personal Data of Participants

Please respond to the following items by ticking the appropriate box.

1. Gender: Male [ ] Female [ ]
2. Age:
    a. 18-23 [ ]
    b. 24-29 [ ]
    c. 30-35 [ ]
    d. 36-40 [ ]
    e. 41-45 [ ]
    f. 46-50 [ ]
    g. 50+ [ ]

3. Age Difference

    a. 1day- 2 years [ ]
    b. 3-5 years [ ]
    c. 6-8 years [ ]
    d. 9-10 years [ ]
    e. >10 years [ ]

4. Duration of Marriage

    a. 1day- 2years [ ]
    b. 3-5years [ ]
    c. 6-8years [ ]
    d. 9-10years [ ]
    e. 10years+ [ ]

SECTION B

Adverse Childhood Experiences

Please review the items and select the appropriate checkbox that corresponds to your situation. Employ the provided scales to express your degree of agreement with each item.; **Yes or No.**

S/N	ITEMS	Yes	No
1	Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you?		
2	Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?		
3	Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? Or Try to or actually have oral, anal, or vaginal sex with you?		
4	Did you often feel that ... No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?		
5	Did you often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect		

	you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6	Were your parents ever separated or divorced?		
7	Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
9	Was a household member depressed or mentally ill or did a household member attempt suicide?		
10	Did a household member go to prison?		

SECTION C

ENRICH Marital Satisfaction Scale Items

Please review the items and select the appropriate checkbox that corresponds to your situation. Employ the provided scales to express your degree of agreement with each item; **1= strongly agree. 2= Agree, 3= neither agree nor disagree, 4= Disagree and 5= Strongly Disagree**

s/n	Items	1	2	3	4	5
1.	My partner and I understand each Other perfectly.					
2.	I am not pleased with the personality characteristics and personal habits of my partner,					
3.	I am very happy with how we handle role responsibilities in our marriage.					
4.	My partner completely understands and sympathizes with my every mood.					
5.	I am not happy about our communication and feel my partner does not understand me					
6.	Our relationship is a perfect success.					
7.	1 am very happy about how we make decisions and resolve conflicts.					
8.	I am unhappy about our financial position and the way we make financial decisions.					
9.	I have some needs that are not being met by our relationship.					
10.	I am very happy with how we manage our					

	leisure activities and the time we spend together,					
11.	1 am very pleased about how we express affection and relate sexually					
12.	I am not satisfied with the way we each handle our responsibilities as parents.					
13.	I have never regretted my relationship with my partner, not even for a moment.					
14.	I am dissatisfied about our relationship with my parents, in-laws, and/or friends.					
15.	I feel very good about how we each practice our religious beliefs and values.					

SECTION D

Stressful Life Event

Please review the items and select the appropriate checkbox that corresponds to your situation. Employ the provided scales to express your degree of agreement with each item; **Yes or No.**

s/n	Items	Yes	No
1.	Death of spouse		
2.	Divorce		
3.	Marital Separation from spouse		
4.	Detention in prison or other institution		
5.	Death of a close family member		
6.	Major personal injury or illness		
7.	Marriage		
8.	Being fired at work		
9.	Marital reconciliation with spouse		
10.	Retirement from work		
11.	Major change in the health or behavior of a family member		
12.	Pregnancy		
13.	Sexual Difficulties		
14.	Gaining a new family member (i.e. birth, older adult moving in, etc.)		
15.	Major business adjustment		
16.	Major change in financial state (i.e. a lot worse or better than usual)		

17.	Death of a close friend		
18.	Changing to a different line of work		
19.	Major change in number of arguments with spouse (i.e. a lot more or less)		
20.	Taking on a loan (for home, business, etc.)		
21.	Ejection from a rented apartment		
22.	Major change in responsibilities at work (i.e. promotion, demotion, etc;)		
23.	Son or daughter leaving home (due to marriage, school, etc.)		
24.	In-law troubles		
25.	Outstanding personal achievement		
26.	Spouse beginning or ceasing work outside the home		
27.	Beginning or ceasing formal schooling		
28.	Major change in living condition (i.e. new home, re-modeling, deterioration, etc.)		
29.	Revision of personal habits (i.e. dress, associations, quit smoking or alcohol use, etc.)		
30.	Troubles with your boss or superior.		
31.	Major changes in working hours or conditions		
32.	Changes in residence		
33.	Changing to a new school		
34.	Major change in usual type and/or amount of recreation		
35.	Major change in church activity (i.e. a lot more or less)		
36.	Major change in social activities (i.e. clubs, movies, visiting, etc.)		
37.	Taking on a loan (i.e. car, rent, funeral etc.)		
38.	Major change in sleeping habits (i.e. a lot more or less)		
39.	Major change in number of family get-togethers (i.e. a lot more or less)		
40.	Major change in eating habits (i.e. a lot more or less, eating hours, surroundings, etc)		
41.	Vacation or travels		
42.	Major holidays or breaks		
43.	Minor violations of law (i.e; crossing red light etc.)		

SECTION E

Health-Related Quality Of Life-14 (HRQOL-14)

Please read the items and circle, fill or tick the space as it applies to you.

Healthy Days Core Module

1. Would you say that in general your health is,

   a. Excellent [ ]
   b. Very good [ ]
   c. Good [ ]
   d. Fair [ ]
   e. Poor [ ]

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

   a. 1-5 days [ ]
   b. 6-10 days [ ]
   c. 11-15 days [ ]
   d. 16-19 days [ ]
   e. 20 days + [ ]
   f. None [ ]

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

   a. 1-5 days [ ]
   b. 6-10 days [ ]
   c. 11-15 days [ ]
   d. 16-19 days [ ]
   e. 20 days + [ ]
   f. None [ ]

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

a. 1-5 days [ ]
b. 6-10 days [ ]
c. 11-15 days [ ]
d. 16-19 days [ ]
e. 20 days + [ ]
f. None [ ]

Activity Limitations Module

These next questions are about physical, mental, or emotional problems or limitations you may have in your daily life.

1. Are you LIMITED in any way in any activities because of any impairment or health problem?

a. Yes [ ]
b. No [ ]

Healthy Days Symptoms Module.

2. What is the MAJOR impairment or health problem that limits your activities? Please **tick** the space next to the health problem that applies to you

a.	Arthritis/rheumatism		h. Heart problem	
b.	Back or neck problem		i. Stroke problem	
c.	Fractures, bone / joint injury		j. Hypertension / high blood pressure	
d.	Walking problem		k. Diabetes	
e.	Lung/breathing problem		l. Cancer	
f.	Hearing problem		Depression /anxiety/emotional problem	
g.	Eye/vision problem		n. Other impairment/problem	

3. For HOW LONG have your activities been limited because of your major impairment or health problem?

a. Days [ ]
b. Weeks [ ]
c. Months [ ]
d. Years [ ]
e. None [ ]

4. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

a. Yes [ ]
b. No [ ]

5. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

a. Yes [ ]
b. No [ ]

Healthy Days Symptoms Module

1. During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?

a. 1-5 days [ ]
b. 6-10 days [ ]
c. 11-15 days [ ]
d. 16-19 days [ ]
e. 20 days + [ ]
f. None [ ]

2. During the past 30 days, for about how many days have you felt SAD, BLUE, or DEPRESSED?

a. 1-5 days [ ]
b. 6-10 days [ ]
c. 11-15 days [ ]
d. 16-19 days [ ]
e. 20 days + [ ]
f. None [ ]

3. During the past 30 days, for about how many days have you felt WORRIED, TENSE, or ANXIOUS?

a. 1-5 days [ ]
b. 6-10 days [ ]
c. 11-15 days [ ]
d. 16-19 days [ ]
e. 20 days + [ ]
f. None [ ]

4. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?

a. 1-5 days [ ]
b. 6-10 days [ ]
c. 11-15 days [ ]
d. 16-19 days [ ]
e. 20 days + [ ]
f. None [ ]

5. During the past 30 days, for about how many days have you felt very healthy and full of energy?

a. 1-5 days [ ]
b. 6-10 days [ ]
c. 11-15 days [ ]
d. 16-19 days [ ]
e. 20 days + [ ]
f. None [ ]

APPENDIX C: INTERVIEW GUIDE

Qualitative Interview Guide

Thank you for agreeing to participate in this study. We shall be discussing your adverse childhood experiences and how they impacted you along your life course especially in respect of your overall health, quality of life and marital satisfaction. I'd also like you to mention some of the stressful life experiences you have had to endure and help me appreciate how they affected your health, quality of life and marriage. Please feel at ease to share your emotions, and do not feel obliged to respond to any questions that make you uncomfortable. You have the freedom to conclude the interview at any point as well.

Background and relevant information

* What is your age, age difference between self and spouse, number of children, level of education?

* What are some of the adverse childhood experiences you've encountered?

* What are some of the stressful life events you have experienced?

* Can you describe how your marital journey has been?

* Tell me how your overall quality of life has been when you consider your health

Experiences of adverse childhood experiences and marriage

* How have these childhood adversities affected you?

* Share how you think ACEs has impacted your relationships?

* How has ACEs affected your marital relationship?

ACEs and HRQoL

* How has childhood adversities impacted your mental health?

* How has these adversities also influenced your physical health?

* Overall, how has ACEs affected the quality of your life especially health-wise?

Experiences of SLEs and marital satisfaction

* Describe how various stressful life experiences in your life have affected you?

* How has these experiences influenced your marital life?

SLEs and HRQoL

* How has SLEs impacted your mental health?

* How has these stressors also affected your physical health?

* Overall, how has SLEs affected the quality of your life especially health-wise?

Marriage and HRQoL

* Share with me, how your marriage has influenced the quality of your life particularly in respect of your health.

Coping Strategies

* How have you dealt with the ramifications of your childhood adversities?

* Share with me, how you have handled the stressful life events you have encountered?

* Tell me how you have coped with your marriage