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From condemnation to understanding: Views on suicidal behavior in Ghana in transition

Joseph Osafo, Charity S. Akotia, Heidi Hjelmeland, and Birthe L. Knizek

Department of Psychology, University of Ghana, Accra, Ghana; Department of Mental Health, Norwegian University of Science and Technology, Trondheim, Norway

ABSTRACT
The cultural context in which suicide occurs has been emphasized as critical in understanding the act and informing prevention. Yet the penchant of psychiatrizing suicidality in mainstream suicidology relegates cultural issues to the background. Through the lenses of critical cultural suicidology, the authors have re-emphasized the importance of culture by reviewing the two major meanings of suicide as observed in our 8-year study in Ghana: moral transgression and life crisis. They have also showed the usefulness of the life crisis perspective of suicidality in reducing stigma and sustaining advocacy in decriminalizing attempted suicide in the country.

An established fact in suicidology is that the act is a multidimensional malaise (Shneidman, 1985). This fact has given rise to various disciplines and theoretical postulations on suicidal behavior. However, an important current position in the field that appears to piece all differing views together is culture and context (Hjelmeland, 2013). Arguably, the most authoritative statement that drew culture into suicidology (and highlighted the psychological in suicidality) was made by Boldt (1988) when he asserted that, “no one who commits suicide does so without reference to the prevailing normative standards and attitudes of the cultural community” (p. 106). Context and suicide are therefore intertwined and the former becomes a critical element in understanding suicidal behavior in various settings. Consequently, in recent times, other suicidologists have reiterated Boldt’s assertion by emphasizing the need to understand the suicidal behavior in its cultural context rather than the prevailing “medical/biological” view. One of such emphasis on culture in suicidality has been argued by Hjelmeland (2013):

Thus the sociocultural context, and hence a cultural perspective, is crucial in suicide research and prevention. Suicide should never be reduced to a simplistic biological condition that can be treated with medicine for, by doing that we would go back to a very mechanistic view of human beings. (pp. 4–5)

The terms culture or sociocultural context are nebulous and difficult to define, as there is very little agreement on what culture is. In this article and our ongoing studies of suicidal behaviors in Ghana, we are largely guided by the definition of culture from Markus and Hamedani (2007): “the implicit and explicit patterns of meanings, practices and artifacts distributed throughout the contexts in which people participate and on how people are engaged, invoked, incorporated, contested or changed by agents to complete themselves and guide their behavior” (p. 12).

Such a view acknowledges culture as both occurring outside the person (Strodtbeck, 1964), as well as within the person (Triandis, 2007) and between persons (Markus & Hamedani, 2007). It provides a view of a dynamic relationship between the person and his or her environment in which the individual is not just a passive recipient of cultural influences but also an active meaning-making agent who interacts meaningfully with the environment.

In their bold attempt to examine the cultural elements in suicidality, the edited volume by Colucci and Lester (2012) presented gender and age differences in suicidality, religious beliefs about suicide, ethnic differences about suicide, circumstances surrounding the suicidal act/methods, and meanings of suicide as cultural and contextually relevant indices in understanding suicidality. One of such elements: the meaning of suicide has been of interest to scholars and they have attempted to unpack it in an attempt to further understand the dynamic relationship between culture...
and suicidality. In fact, Boldt (1988) found the meaning of suicide more important in exploring culture in suicides than definitions, although the role of definitions in the pursuit of understanding the meanings of suicide within a culture cannot be discounted (Lester, 2012).

The meaning of a phenomenon (event act, object, word, etc.) to an individual or a group of people is predicated on what they are experiencing at the moment, and the schemas they bring to the moment based on previous experience (Strauss & Quinn, 1997). An illustration at this point will be helpful. Supposing someone’s suicidal act led or leads to others avoiding further social interaction with his or her family, people are likely to view the act as socially injurious, that is, an act that inflicts collateral damage on the family (Osafo, Hjelmeland, Akotia, & Knizek, 2011c). In this case, the interpretive grid for what the act of suicide represents is influenced by the processing of cognitive-emotional responses interacting with extrapersonal experiences of the moment or the past.

Suicidologists have often referred to a cultural meaning of suicide as an important synonym to the cultural in suicide. According to Strauss and Quinn (1997), “a cultural meaning is the typical (frequently recurring and widely shared aspects of the) interpretation of some type of object or event evoked in people as a result of their similar life experiences … To call it a cultural meaning is to imply that a different interpretation would be evoked in people with different characteristic life experiences …” (p. 6). Lester (2012) accordingly attempted to differentiate between the meaning of suicide (as it pertains to the motives for individual suicide) and the cultural meaning of suicide (as it pertains to the shared meanings of what the act represents by a cultural community). Lester argues that the meaning of suicide is often an individual motive undergirding the act, whilst a cultural meaning of suicide focuses on the reactions of others (persons living in a similar cultural setting) to the suicide. In present suicidology research, an approach to understand the cultural meaning of suicide has been labelled as “lay theories” of suicide (Lester, 2012) and these meanings of suicide from a group of people living in a cultural community might vary along subcultural groups (such as gender, ethnicity, class, etc.) and time. Thus, the meaning of suicide is dynamic rather than static (Boldt, 1988; Lester, 2012).

**Cultural context and suicidality in Ghana**

According to the Ghana Statistical Service (2010), there are three main religious traditions in the country: Christianity (71.2%), Islam (17.6%), traditionalists (5.2%), and nonaffiliated (5.3%). Ghana is constitutionally a secular state. However, religious beliefs (especially Pentecostal views) are deeply fused into people’s worldview and the public space (Meyer, 2006).

Ghana’s mental health landscape is saddled with challenges, including underfunding, understaffing, and stigma (Barke, Nyarko, & Klecha, 2011; Jack, Canavan, Ofori-Atta, Taylor, & Bradley, 2013). About 21% of adult Ghanaians surveyed (n = 5,391) are reported to have moderate or severe psychological distress accounting for a 7% loss of GDP (Canavan et al., 2013). There are no reliable national records on suicide in the country. Only crude inferences can be drawn from some studies about the trends of suicidality among the population. A recent analysis of suicidality among over 2,000 secondary school students reported 18.2% for suicide ideation, 22.5% for suicide plan, and 22.2% for suicide attempts (Oppong Asante, Kugbey, Osafo, Quashie, & Owusu Sarfo, 2017). Further, crude statistics from the homicide unit of the Ghana police indicated that from 2006 to 2011 there were 308 suicides across the country and 66 attempters. An autopsy study of 44,000 deaths at the Korle Bu Teaching Hospital Mortuary in the capital city of Accra reported 148 (0.34%) suicide cases due to hanging within 11 years (2003–2013). These suicides were predominantly males (130 or 87.8%) with a few (18 or 12.2%) being females (Der, Dakwah, Derkyi-Kwarteng, & Badu, 2016). These numbers may represent the tip of the iceberg because there is no available nationally coordinated mechanism to capture suicide data (Adinkrah, 2012). It is an undeniable fact, however, that suicidal behaviors are becoming a public health problem (Osafo, Akotia, Andoh-Arthur, & Quashie, 2015; Quashie, Osafo, Akotia, & Peprah, 2015).

Attempted suicide is criminalized in the country. This code is a colonial heritage based on British Common Law, which has long been repealed in the United Kingdom but is still active in our context (Adinkrah, 2016; Kahn & Lester, 2013). This code has been compounded and energized by the strong sociocultural proscriptions against suicide by most ethnic groups (Adinkrah, 2012). Suicide attempters, therefore, continue to be incarcerated and in some instances molested in their communities (Hjelmeland, Osafo, Akotia, & Knizek, 2014; Osafo, Akotia, Boakye, & Dickson, 2015).

In 2008, our African Norwegian Research Group on Mental Health launched a larger study into the meanings of suicide. Attitude studies were identified as one important approach toward studying the cultural meanings of suicide within African contexts. Attitudes serve certain functions. Two of such functions, as indicated by Oskamp and Schultz (2005), are attitudes aid people to understand their world and attitudes reflect the
values of people. In our studies, we interviewed various groups of people. Interviews began from 2008 and included psychology students, health professionals (emergency ward nurses and psychologists), law enforcers (police), and lay persons (nonhealth professionals including artisans in cities and villages). Our studies were seminal and inspired later studies that focused on suicide attempters and their families, religious leaders, community health nurses, physicians, lawyers, and judges.

Findings from the 8-year study on the cultural meaning/s of suicide showed a lay theory about what suicide is and how it is evaluated (Akotia, Hjelmeland, Knizek, Kinyanda, & Osafo, in press; Asare-Doku, 2015; Osafo, 2016; Osafo, Akotia, Quarshie, Andoh-Arthur, & Boakye, in press). Akotia et al. (in press) address views about what makes people suicidal. The authors refer to this as the crisis perspective and emphasize suicide as a reaction following: (a) psychosocial strains (e.g., unemployment, social taunting, academic stress, hopelessness, fear of shame, interpersonal tensions, neglect, faith crisis, and other general existential struggles) that may lead to despair; and (b) mental illness (e.g., depression). Sociological studies have also implicated psychosocial strains such as perceived infidelity, poverty, shame, the death of a child, and threat of divorce in suicidality in the country (Adinkrah, 2011a, 2011b, 2012, 2014). In this article, we shall refer to these psychosocial strains as the “life crisis perspective” of suicidality. In terms of how suicide is evaluated, this represents a moral perspective on the act (Osafo, 2012; Osafo et al., in press). The evaluations are based on the social consequences of the act and highlights the unacceptability of suicide on grounds, such as (a) suicide is injurious to the family, (b) suicide is religious transgression, and (c) suicide is a criminal act (Osafo, 2016; Osafo, Hjelmeland, Akotia, & Knizek, 2011a; Osafo, Knizek, Akotia, & Hjelmeland, 2011b; Osafo et al., 2011c; Osafo, Knizek, Akotia, & Hjelmeland, 2012).

The relationship between these perspectives (i.e., life crisis and moral view) is complementary in nature. The crisis perspective addresses how lay people perceive the etiological dimensions of suicidality and the moral perspective examines the reactions of people toward the act. These reactions are laden with moral themes. As an illustration, when suicidal behavior occurs people may be asking why the person did that and there may be various lay theories put forward to explain the act. These lay theories may give rise to reactions of abhorrence and condemnation (Osafo, 2012). In this regard, the moral and etiological perspectives provide opportunities to reflect on the meanings of suicide from the cultural contexts of Ghana.

In current studies among the police, judges, lawyers, and physicians, such as Osafo, Boakye, and Akotia’s (2016) Suicide Risks and the Law in Ghana, preliminary findings are showing that participants draw on these perspectives (crisis and moral) when expressing their views on suicide, the suicidal person, and related issues. The purpose of this article is to examine these perspectives, highlighting them as cultural dynamics in suicidality, and to address the practical relevance of viewing suicidality as a life crisis, with implications for stigma reduction and advocacy programs in the country.

**The suicidal person and the discourses on suicidality**

Generally, the arguments about the morality of suicide have issued from two opposing angles. The first angle celebrates suicide as a heroic and rationally acceptable act for a free moral agent who viewed death as a choice as much as living (Young, 2002). The second dimension of the morality of suicide runs counter to the first. Here, suicide is unacceptable and viewed as an affront to the supreme ethic of self-love and neighbor love. The second dimension of the morality of suicide is what we have observed in our studies: Suicide is perceived as an act that cannot be acceptable to society, religious groups, or the law (Osafo, 2016).

The moral condemnation of suicide, as we observed, is widespread among both rural and urban people and appears to represent a cultural meaning of the act (Osafo, 2012). It was also predominant among nonmental health workers such as religious leaders (Puplampu, 2015), although some health workers held both perspectives (Osafo et al., 2012). There were dire consequences for the suicidal person when people moralized the act of suicide. The suicidal person (whether attempter or dead) was viewed as antisocial, a sinner, and a criminal (Osafo, 2016).

The suicide attempter experiences such moral condemnations to a heightened degree with evidence of criminalization (Adinkrah, 2013, 2016) and social molestation in their communities (Osafo et al., 2015). The morality of suicide, as we observed in our studies, is rooted within sociality and intentionality; in the sense that it is determined by the social consequences of the act, by someone who is considered careless about how the act affects others (Hjelmeland et al., 2008; Osafo, 2016). Stigma is thus shared and such suicide stigma appears institutionalized at the family/community, religious, and legal levels (Osafo, 2016).

Another moral dimension of suicidality that appears to cast a slur on the act is the intentionality involved in the act. Intentions in suicidality are regarded as a central
tenet in the definitional features of the act (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006). Basically, it means the person who dies is adjudged to have taken his life, without anybody’s involvement (Klinefelter, 1984). In our 8 years of suicide research, we have observed that the moral discourse of suicide views the person as sane and capable. The notion of a person’s mental health seems conceptualized unidimensionally: Either you are sane or insane. This view does not allow for potential changed states of affect or cognitions following life’s distress. This resonates with the polarized evaluation of a person’s character as good or bad within the African ethical framework (Gyekye, 2013). In fact, the equating of the suicidal person to a murderer (Osafo et al., in press; Osafo et al., 2011c) seems to arise from such understanding that the act is intentional and goal-directed. The intention to self-destruct is viewed to be loaded with the same emotively charged properties for the destruction of others. Such a view appears to undergird the penalization and incarceration of the act. During fieldwork, most of our informants were heard condemning the suicidal act because the person was careless about the social consequences of the act (Osafo et al., 2011c; Osafo et al., 2015). The philosophical or theological views on suicide in communal settings such as Ghana are thus set along consequential terms (Gyekye, 1995), which then establishes suicidality as proscriptive moral behavior.

The crisis perspective (as indicated earlier) views suicide as a response to distress following psychosocial strains and mental illness. The latter view is widespread among health professionals including psychologists, nurses, and physicians (Osafo et al., 2015, April). Traces of psychiatrizing or medicalizing suicide appear to be consistently pushed forward by officialdom. On March 10, 2014, the chief psychiatrist in Ghana (who is also the head of the Mental Health Authority) is reported to have said most suicides are attributable to depression (as diagnosed by relevant health professionals at various health units) and cited studies to back his claim (Ghanaweb, 2014). For purposes of deeper analysis, we reproduce sections of the report below:

Depression is the commonest cause of suicide, “Scientific evidence shows that for every ten (10) people who attempt suicide or commit suicide, nine of them have mental health problem or ten (10) had depression … Suicide, I want to emphasize is a symptom of an outcome of mental illness for most cases.” (General News of Wednesday, 27 August 2014)

On 2016 World Suicide Prevention Day in Ghana, when the chief psychiatrist was speaking about decriminalizing suicide he was quoted to have said that “mental illness accounted for 95 per cent of all suicide cases in the country” (Ghanaweb, 2016), a statistic that appears unsupported by initial findings from the project, Suicide, Risks and the Law in Ghana (Osafo, Boakye, & Akotia, 2016). In this project, which seeks to identify various risks for suicidality, initial analyses show that psychosocial strains (life crises) such as poverty, family conflict, poor supervision, lack of parental warmth, parental abuse, educational stressors, and hopelessness are significant factors in suicidality more than psychiatric conditions such as diagnosed depression. Thus the medical/pathological view of suicidality is not strongly supported by our continuous research on suicidality in the country as claimed by officialdom.

The medical perspective in contemporary suicidology has been criticized by various researchers such as Marsh (2016). Marsh (2010, 2016) has indicated that such posturing of contemporary suicidology is plagued with some major problematic assumptions: (a) suicide is pathology, and (b) suicide is an individual problem. These assumptions resonate with the mental illness or psychiatric view of suicide from our contextual experience and present difficulties that deserve further discussion.

The dominance of the biomedical view in suicidology has produced and continues to reproduce suicide as a tragic act of mental illness (Marsh, 2016). This medicalization has often led to the generalized claim that some mental illness, usually depression, leads to suicidality (Hjelmeland, 2013). Such association established between depression and suicide has been interrogated and found unsubstantiated (Hjelmeland, 2013; Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012; Meng, 2002; Vijayakumar, John, Pirkis, & Whiteford, 2005). For instance, in Northern Uganda, suicidal behavior among men was reported to arise from the despair following “the many social changes that have evolved over time and affected their traditional roles and responsibilities” (Kizza, Knizek, Kinyanda, & Hjelmeland, 2012, p. 696).

The etiological mechanisms underlying the mental illness-suicide death is yet to be established in objective terms, just as in the case, for example, of heart attack and death. Still, the objectification of the medical dimension of suicide continues to be viewed as the instituted “truth” within professional communities (Hjelmeland, 2016). Generally, the medicalization of mental illness has been criticized by some critical psychiatrists (Mills, 2014). One of their views is that there is an agenda to psychiatrize the global south, a move that has failed in the global north.
a psychiatristized conception, every human distress is pathologized and alternative forms of healing or help are discredited (Mills, 2014; Watters, 2010). Such views resonate with traditional suicidology. In our own works in the Ghanaian context, the reasons for suicide as narrated by suicidal persons were unpsychiatric and thus not pathological. Rather, they are more psychosocial (i.e., financial problems, marital distress, social taunting, faith crisis, etc.) than typically psychiatric (Akotia, Knizek, Kinyanda, & Hjelmeland, 2014; Akotia et al., in press).

Another problem of medicalizing suicide is that it creates an exclusive expertise and methodology for suicide where those who manage suicide and study it (e.g., psychiatrists, psychologists, nurses, social workers) work in a controlled and medically delineated space (Marsh, 2010). It creates a sort of esoteric perspective that restricts knowledge to a small group. As suicide workers, we were awakened to the stark reality of suicidality as a public health and existential issue in the country. Consequently, the practical implication of building bridges and approaching suicide prevention as a collaborative enterprise with non-professional health workers dawns on us. Such reality resonates with current recommendations for low and middle-income countries (LMICs) to scale up mental health care services in resource-poor settings through task-shifting. Task-shifting is an emerging recommended global mental health strategy in resource-poor countries, in which responsibility for tasks is transferred from higher to lesser specialized providers (McInnis & Merajver, 2011; McPake & Mensah, 2008). Since 2008, our research group has been building bridges and seeking to collaborate with groups such as pastors, nurses, community leaders, medical health workers, and nongovernmental organizations. Taking a scientific path in studying suicide is not discounted, but the narrowly delineated approach to what is “scientific” in suicidology, a complex phenomenon, has been viewed as flawed (Marsh, 2016). Further, pathologizing suicide and keeping those with legitimate qualification to diagnose and treat it at arm’s length is also viewed by expert patients as grossly misunderstood. Rowe (2016), a suicide attempt survivor consequently argues that,

Suicidality is grossly misunderstood by the general public and poorly understood by many of the professionals who treat it. It has been tainted by the negativity of the medical and social stigma born out of a lack of understanding of the torment of the chronically suicidal. (p. 161)

As extensively discussed elsewhere suicidology leans toward a positivistic, reductionist, quantitative approach and sidelining interpretive and qualitative methodologies (Hjelmeland, 2016; Hjelmeland & Knizek, 2010; Marsh, 2016). Marsh (2016) opined that, “This positioning of suicidology as particular sort of (positivistic) scientific venture produces many effects, not the least of which concerns the sorts of research that are deemed legitimate, fundable and publishable” (p. 20). Hjelmeland (2010, 2016) has thus repeatedly called for an increased understanding of suicide through properly conducted qualitative research more than quantitative approaches. Qualitative methods are likely to provide researchers the possibility of examining complex relationships in suicide within context, thereby facilitating our understanding of the issue (Hjelmeland, 2010).

The mental illness view presents suicide as an individual internal crisis (either psychiatric or psychological); a narrow perspective that seeks to locate suicide within the minds of people, a view Marsh calls psychocentric, implying that suicide sits deep within the “interiorities” of individual person (Marsh, 2010, 2016). This privatization of suicide has been referred by Kral (1998) as “the great origin myth” in suicidology. From its definition (Jaworski, 2010a) to its treatment (Maris, 1997), suicide has been viewed as an individual problem. As Jaworski (2010b) put it, “The individual is assumed to be the origin of the intention to die, a reference point for the activities of a disembodied mind filled with agency” (p. 677). Such a reading of suicidality excludes issues of social justice, oppression politics, stigma, relations of power, and the like (Marsh, 2016). Human life cannot be private and suicidality never occurs without a context (Boldt, 1988; Hjelmeland, 2011). Sociological perspectives have held this view and, as Maris (1997) pointed out, “In much the same way that water is not the same as two parts hydrogen and one part oxygen, society or suicide is not reducible to the individuals that comprise it” (p. 42). Maris (1997) further argued that suicide is privatized because the act is defined by the individual’s mind and intentions, although suicide is also eminently public and social due to the social forces that act in concert with the unique characteristics of the individual. The implication of social forces in suicidality is consistent with contemporary observations of risks for the act in LMICs (World Health Organization, 2014). Nonpsychiatric and psychosocial reasons are emerging as major risks for suicide and make the privatization of suicide in such contexts problematic and acontextual. It minimizes and obscures the external realities surrounding individual suicides. For instance, in a recent systematic review that analyzed the association between suicide and poverty, positive associations were reported between poverty
unemployed (Canavan et al., 2013). This has been reported, in that psychological distress was strongly associated with increased odds of being unemployed (Canavan et al., 2013).

From a social justice perspective, for instance, Reynolds (2016) asserted that hate kills and as a result a social justice frame of suicide will always encourage a thorough examination of the social contexts of the suicidal act to understand events. In that regard, oppression, occupation, torture, discrimination, hate, and other social ills rob people of their lives and not the other way around. As clearly expatiated by Reynolds:

> Suicide is not something that happens to a person, and it is not something that one person does. Nobody simply kills themselves. Events occur in context, and because we live in a society that has not delivered on the promises of social justice, which we are well qualified and able to deliver, we have to structure into our analysis of a person’s death the context of social justice in which they live. (p. 170)

Basically, Reynolds challenged the dominant view of suicide as a consequence of mental illness and clearly contended that the social forces around people facilitate suicidality. Although not discounting the existence of mental illness in the scientific analysis of suicidality, she believed it is overstated and overrepresented in many instances. Suicide, she believed, is politically crafted with the power of language to denigrate the contexts of social injustice and highlight the mental states of the oppressed. Maris (1997) has thus advised that, “Suicide prevention requires social, economic, and cultural transformations at the primary prevention level, not just individual psychotherapy and dispensing of the latest antidepressants” (p. 22).

The aforementioned problems of the mental illness perspective reduces opportunities in thinking beyond the box and taking a holistic perspective of suicidality within context in order to plan relevant intervention schemes. We have, however, seen an opportunity within the life crisis perspective to educate the public on suicidality and to solicit the public’s and stakeholders’ understanding of persons in suicidal crisis and to provide them with help. Decriminalizing attempted suicide in such cultural contexts is an important public health policy to facilitate suicide prevention. It therefore requires holistic and evidence-based messages to sustain advocacy. On World Suicide Prevention Day in 2016, we continued to do this by organizing a one-day workshop with police officers on their role in suicide prevention. Feedback from the present workshop, together with previous ones, are very revealing as to the utility of presenting suicidality as a life crisis issue in the country. They present opportunities for strengthening the social architecture for reducing stigma and increasing advocacy toward decriminalizing suicide.

**The utility of viewing suicidality as life crisis**

In the Ghanaian cultural context, we have found two main practical utilities of viewing suicidality as life crisis and we discuss them below.

**The suicidal person is empathized with**

Conceptually, the ability to imagine oneself in another’s place and understand the other’s feelings is empathy (Iacoboni, 2007). This has to be differentiated from sympathy in which a person’s feeling may correspond to what another person feels. Empathy is a primary principle and necessary condition in helping people (Breggin, 1999). An empathic response from a helper starts from empathizing with oneself and with the other person to create an encouraging and safe place and environment in which the person in crisis explores the self and grows. An empathic response toward suicidality is an important attribute from those who work on suicide and is an aspect of the entire therapeutic relationship and alliance that is required to work with suicidal persons (Leenaars, 2004). In our studies and work on suicidal behavior, we have observed consistent connection between the conceptualization of suicide as a crisis (especially a life crisis) and positive attitudes (e.g., sympathy/empathy) toward the person in suicidal crisis. Professional health workers who have shown positive attitudes of care and nonjudgmental postures toward the suicidal person may be demonstrating empathy as professionals (as required by the ethics of their profession and effective therapeutic alliance). However, our lay respondents who showed such positive attitudes often measured the importance of such attitudes toward the suicidal person on grounds of sheer humanitarian sympathy. In a recent study, all 15 physicians interviewed viewed suicide as an existential crisis and were empathic toward the suicidal patient (Osafo, Akotia, Boakye, & Dickson, 2016). In that regard, they also viewed their role in suicide prevention as referral agents, lay counselors, and community educators. An important observation made in our studies was the impact of religious views on readiness to help the suicidal person. Although lay persons reported their disavowal attitudes toward suicide, they nonetheless reported their willingness to provide help for the suicidal person on account of their religious faith. Religion, although
implicated for processing stigma toward suicide (Jung & Olson, 2014), is also found to be a protective factor and strong predictor for prosocial tendencies (Fayard & Koenig, 2016).

In our training sessions with various groups of people—students, religious leaders, media personnel, police, health professionals, community leaders and the general public—when we presented suicide as a life crisis that may lead to despair, it elicited understanding and empathic responses from the audience. In one of the community outreach programs we organized in a location where there had been more than eight cases of suicide within one year, the evidence of moralizing suicide exuded from their reactions, which were not very responsive to our solicitation to show concern and care for persons in suicidal crisis. However, when we described how certain life circumstances led some people to feel hopeless and, as a result, engage in suicide, they were understanding, receptive, and began interacting with us for further clarification. Later, one of the attempt survivors went ahead and took his life when he was being socially taunted (Osafo et al., 2015).

We share the view of Shneidman (1985) that relating with the suicidal person is a special relationship with the goal of reducing perturbation in order to keep the person alive. With such a perspective, we educate the public to provide such initial help as referring a suicidal person to any nearby health post, counselor, psychologist, clergy, or police station for help. From our experience, the life crisis view elicits supportive responses from people toward suicidal persons. One reason, perhaps, is that when people have understood that individuals become suicidal following certain austere life circumstances which diminish their personal coping resources, such an explanation provides for them a means of humanizing and identifying with the experiences of the suicidal person. Suicide attempt survivors we spoke to in some communities shared dehumanizing experiences including molestation and isolation (Osafo et al., 2015). The life crisis view, however, provides some way of escape from such dehumanizing cultural perspectives and brings people closer to the existential struggles of other people.

**Facilitation of advocacy efforts toward decriminalization**

Ghana still exercises punitive measures against attempted suicide (Adinkrah, 2016; Mishara & Weisstub, 2015) as enshrined in Act 29, Section 57, Subsection II of the Criminal Code of Ghana (1960). Fundamentally, such a legal position views suicide as a transgression, which is in tandem with cultural views on suicide. Reviewing the legal position of any country in relation to suicide (specifically, decriminalizing attempted suicide) requires customized, contextually relevant, and culturally sensitive research evidence to convince law makers or the legislature of the country to repeal any such legal position (Adinkrah, 2016; Aggarwal, 2015; Kahn & Lester, 2013; Neелеman, 1996). The burgeoning research efforts aimed at building evidence to push for the decriminalization of attempted suicide have, thus far, focused on exploring the views and attitudes of various stakeholders (e.g., media, university students, nurses, psychologists, nongovernmental organizations, and researchers) toward suicide, suicide prevention, and the law criminalizing attempted suicide (see Adinkrah, 2012; Hjelmeland et al., 2014; Knizek, Akotia, & Hjelmeland, 2011; Osafo et al., 2012). In recent times, efforts have been extended to include the views of key stakeholders such as lawyers, judges, police, and medical health professionals. In a seminal project that aimed at exploring the risks for suicide and opinions of physicians, judges, lawyers and police toward the act, the life crisis view resonated predominantly in their discourses on decriminalizing suicide (Akotia, Osafo, & Boakye, 2016; Osafo, Akotia, & Boakye, 2016). In other words, they clearly supported advocacy efforts to repeal the penalty against attempted suicide from their understanding that the act results from crisis following psychosocial strains in life.

We observed this link between viewing suicides as life crisis and the support from professional health workers and the media for advocacy efforts since 2012. In 2012, a group of suicide researchers and workers (including Joseph Osafo and Charity S. Akotia) formed a coalition with some nongovernmental organizations, such as the Network for Anti-Suicide and Crisis International (NACI), to submit a petition to the Parliament of Ghana to consider decriminalizing attempted suicide (Kahn & Lester, 2013). When this was presented, empathic responses were elicited from the general public, evident from the many media invitations to discuss suicide and explain the life crisis perspective further. In one such program, a suicide attempter (as “expert patient”) was in the studios with the first author to share with the general public how he (the suicide attempt survivor) experienced despair following the loss of a huge sum of loaned money invested in poultry, and how he became hopeful through the help he received from the first author. Such a suicide-life crisis connection has promoted an interest in understanding suicide and we (the Ghanaian authors) have accordingly been invited by various groups including churches, medical doctors, and nurses for education on suicide.
Concluding thoughts

The medical view of suicidality is a dominant perspective in suicidology. However, this generalized perspective in the field has come under severe interrogation because of its reductionist and exclusionist proclivity. The rising reality of cultural factors and social forces such as oppression, injustice, poverty, and their dynamic relationship with suicidality in LMIC settings makes psychiatrizing suicidology untenable in similar settings such as Ghana. What has, rather, been useful is the presentation of suicidality as a life crisis condition, a perspective that is counter to the medical view. The life crisis view is different from the mainstream, as it focuses on the relationship between the individual and his or her context instead of viewing suicide as an individual’s illness or atrocity. It becomes a dynamic concept between the individual and his or her contextual circumstances. Holding such a view of suicidality has practical utility in enlisting public empathy and promoting advocacy activities toward decriminalizing attempted suicide in the country. Although the argument for the utility of the life crisis view of suicide may not radically change the generalized moral view of suicide in the country, the feasibility of expanding the frontiers of understanding cultural dynamics in suicidality, public education about suicide, and advocacy toward decriminalization of attempted suicide may be attainable goals.

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