ATTITUDES AND TREATMENT REGIMENS IN SUICIDE PREVENTION: THE ROLE OF RELIGIOUS LEADERS IN THE GA EAST MUNICIPAL DISTRICT

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JULY 2015
DECLARATION

This is to certify that this thesis is the result of research undertaken by Buernorkie Manyeyo Puplampu under supervision towards the award of Master of Philosophy in Social Psychology Degree in the University of Ghana.

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ABSTRACT

Reducing the loss of life due to suicide has become a critical international mental health goal. Several researches in the field of suicide prevention have focused on the role of medical facilities, schools and other local or state organizations and the role of religious leaders as gatekeepers has been overlooked. Using a qualitative approach, the study explored the attitudes of Christian, Islamic and Traditional religious leaders within the Ga East Municipal District of Ghana towards suicide, examined their treatment regimens and also assessed how they perceive their role in suicide prevention. Thematic analysis of transcribed data revealed that participants perceived suicide as abhorrent because life is sacrosanct and must be preserved. The motivations for attempting or committing suicide were also perceived by participants to be caused by both psychological and diabolical factors. Furthermore, participants detached their attitudes towards the suicidal person (someone who needs care) from suicide as an act (an act contradictory to their faith) and showed them care. The assessment of treatment regimens when they interact with suicidal persons showed that they create healing communities and also counsel and refer them for clinical and professional care. Besides the use of spiritual healing such as prayer and deliverance, participants also encourage social support and induce hope into suicidal persons to allay their fears through the use of religious or doctrinal teachings. Additional findings showed that the Ghanaian cultural setting abhors or perceives suicide as unacceptable hence the treatment regimens identified were more intervention based (i.e. employed only after suicidal persons have been identified) than prevention focused. Based on these findings, recommendations are made for possible improvement.
DEDICATION

To my late younger Sister Buernorkuor Siadeyo Puplampu. Kuor, you will forever remain in my heart.
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Foremost, my immense gratitude and appreciation goes to the God of my life, for being my Help in ages past, my Hope for the years to come, my Shelter from the stormy blast and my Eternal hope.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Study

Suicidal behavior has been the focus of a growing body of research internationally, cross-nationally as well as comparatively (Adinkrah, 2011). Durkheim (1896) identifies suicide as any death that is the immediate or eventual result of a negative (e.g. refusing to eat) or positive (e.g. shooting oneself) act accomplished by the victim himself or herself. Similarly, Silverman (2006) also assumes that ‘suicide is, by definition, not a disease, but a death that is caused by a self-inflicted intentional action or behavior’ (p.522). The phenomenon has become a continuous public health challenge around the world and, in countries where information on suicide is available, it is among the ten leading causes of death for all ages, while in some countries it is among the top three causes of death for people aged 15 to 34 years for both males and females (World Health Organization (WHO), 2011).

The World Health Organization estimates that about one million people kill themselves every year (WHO, 2011). Specifically, the global rates of suicide are estimated at 14 suicides per 100,000 inhabitants, including 18 suicides per 100,000 for males and 11 suicides per 100,000 for females (Bertolote & Fleischmann, 2009). The highest suicide rates for males and females are found predominantly in Eastern Europe, in countries such as Lithuania and Belarus (Bertolote & Fleischmann, 2009).

The lack of systematic data collection and good quality research due to sociopolitical and cultural reasons makes the statistics on suicide in Africa unreliable (Meel, 2006; Schlebusch, Burrows & Vawda, 2009). Reports however, indicate that suicide seems higher in the Eastern
and Southern parts of Africa compared to countries in the West and North of the continent (Kinyanda, Hjelmeland, Musisi, Kigosi, & Walugembe, 2005).

Similar to what is found in the Western world, suicide is more common among males than females with a varying ratio between 1.75 in Egypt to 9.00 in the Seychelles (Schlebusch, 2005). Particularly, South Africa has been described as one of the suicide capitals of the world where it is estimated that 10,000 people engage in suicide yearly, and one person takes his or her life every hour. This represents 10% of all non-natural deaths present in South Africa (Meel, 2006; South Africa National Injury Mortality Surveillance System, 2004) and Schlebusch (2005), suggests psychopathology, substance abuse, family dynamics and HIV AIDS as some of the factors responsible for these high suicide statistics. In India also, where the completion rates of suicide attempts may be higher than other Asian countries, Pillai, Andrews, and Patel (2009) report that violence and psychological distress are independently associated with suicidal behavior.

Domino (2005) suggests that attitudes toward suicide are quite complex and intertwined with the values and religious perspectives of a person. Religion therefore seems to be a major dimension of attitudes towards suicide as suggested by Domino, Niles and Raj (1993) because during suicidal crises, the religious beliefs and values held by an individual can act as a buffer against stress and provide an element of comfort to such distressed persons. It is therefore predictable that the religious beliefs and values held by an individual for whom these are important will affect how and who help is sought from (Bhugra, 2010).

Specifically, Early (1992) mentioned the responsibility of the church in the African American community and said ‘If the church is to provide social integration and moral values that will
pervade the African American community, then its role must go beyond the religiously active’ (p. 26). In this regard, outreach programs spearheaded by religious institutions might benefit non-religious survivors and hence, lead to social change. To capitalize on the role of religious leaders in suicide prevention therefore, it is necessary to develop an understanding of religious differences within and among religious communities.

1.2 Attitude towards suicide

Attitudes toward suicide have varied broadly throughout history. Tang and Yang (2003) describe suicide attitudes as a consistent and persistent tendency towards suicidal behavior that individuals hold. Presently, in Ghana, suicidal behavior is proscribed socio-culturally (e.g. Hjelmeland et al., 2008) fuelling negative attitudes toward the act, perpetuating secrecy and non-reporting. Hence, there are currently no reliable statistics to estimate the prevalence of suicide in the country (Adinkrah, 2010). Besides this socio-cultural position against the act, it is also prohibited legally. Explicitly, the 1960 Criminal Code, (Act 29) Section 57 (2) states categorically that ‘whoever attempts to commit suicide shall be guilty of a misdemeanor’ which could attract a jail term of about three years. Thus, the legal instrument criminalizing the act, coupled with the widespread sociocultural prohibition against suicide discourages accurate reporting of data and thus underestimates the size of the problem.

Also, based on Rosenberg and Hovland’s (1960) three-component model of attitude (attitude as a predisposition to some class of stimuli with cognitive, affective and behavioral responses), Wang et al. (2008) conceptualize suicide as approach-avoidance behavior and relentless positive or negative emotions towards suicidal behavior and people who commit suicide. McCormick (1964), for instance, reported that people in ancient Egypt considered suicide a humane way of
escaping from an intolerable condition. Japanese Kamikaze pilots for example, also considered it
honorable to perform suicidal missions by crashing their airplanes into an enemy target and for
centuries in Japan, indigenes respected shamed individuals who make amends for desertion of
their duties or failure by dying through the hara-kiri (ritual suicide with a dagger). Historically,
Indian women were expected to perform the ‘suttee’. Thus, they burned themselves to death on a
funeral pyre after their husband died.

In several other societies, suicide has been made illegal. For example, Plato, the ancient Greek
Philosopher vehemently disapproved of suicide (Carrick, 2001). Generally, ancient Roman
Governments countered suicide because the nation tends to lose assets such as slaves and
soldiers. Moreover, Judaism clearly prohibited suicide except when one faced capture by an
enemy, as in the mass suicides of Masada (Witztum & Stein, 2012; Zerubavel, 1994).

For instance, Christianity has generally condemned suicide as a failure to uphold the sacredness
of human life and Witztum and Stein (2012) also report that Saint Augustine, in the 4th Century
AD decreed suicide as a sin. Similarly, the Roman Catholic Church by the middle Ages forbade
the burial of suicide victims on consecrated ground. Furthermore, unless the suicide resulted due
to illness or madness, English Law, considered suicide to be a crime punishable by the forfeiture
of property and goods to the government. These criminal views of suicide immigrated to colonial
America where it was adopted by individual states.
1.3 Problem Statement

Suicide is a major public health problem as recognized by the World Health Organization. Completed and attempted suicides result in serious and enormous medical, economic and social costs. The phenomenon is also very disturbing to the quality of life of survivors and their families and friends.

Assimeng (1999) has described Ghana’s religious sphere as a zoo, implying that several religious sects coexist. Therefore, the religious attitudes towards suicidal behavior and the meaning uncovered cannot be generalized as representing the entire view of all the religious groups in Ghana. For instance, Osafo, Knizek, Akotia, and Hjelmeland (2013c) in a study on attitudes towards suicidal behavior found that participants’ religious orientation and commitment to observing fundamental religious beliefs affect their interpretation of suicidal behavior as unacceptable. Their religious practices and beliefs provided alternative avenues for dealing with such crises. Religion is therefore seen as life preserving and counteracting the decision for self-destructive behaviors such as suicide. Religion was a source of coping and thus could be protective of suicidal behaviors. It also provided the motivation for the participants’ willingness to provide help to suicidal persons. Religion in this cultural context thus influences attitudes towards suicide and becomes an important variable to be considered when planning future research and intervention programs on suicide in Ghana. The authors recommended that ‘future studies could therefore consider the opinions of people of other religious affiliations and their unique conceptualizations of suicide in order to further our understanding of the relationship between religious factors and attitudes towards suicidal behavior in Ghana’.
Correspondingly, the researcher after perusing the literature on suicide discovered that common
to all the three main religions in Ghana (Christianity, Islam and African Traditional Religion) is
the certainty in the judgment of the soul by God in the afterlife (e.g. Mbiti, 2006). Hence suicide
is perceived as a religious contravention connected with the eternal damnation of the soul of the
person who has killed him or herself as a consequence in the afterlife. This present study
therefore aims to explore the critical issues of the attitudes of religious leaders of these three
main religions in Ghana toward suicide, their treatment regimens and their role in suicide
prevention. Many people agree that suicide prevention is an emergent concern, yet they fail to
notice the role of religious leaders in the suicide prevention process (Hirono, 2010). Particularly,
several researches in the field of suicide prevention have focused on the role of medical facilities,
schools and other local or state organizations (e.g. Brunero, Smith, Bates & Fairbrother, 2008;
Carmona-Navarro & Pichardo-Martinez, 2012; Neville & Roan, 2008; Norheim, Grimholt &

The role of religious leaders in the literature has however had little attention; yet the researcher
presumes that religious leaders can stop people from committing suicide through counseling and
preaching. Several people who commit or attempt suicide are religious and in several instances,
are suicide survivors, that is, they have family members, relatives or friends who have committed
suicide (Sakinofsky, 2007). During funerals or memorial services, these survivors may have had
the chance to speak with their religious leaders about the meaning and morality of suicide.

If religious leaders speak negatively about suicide, then suicide survivors (persons who have lost
relatives, friends or family members by suicide) might become vulnerable to suicide. On the
other hand, if religious leaders express empathy and understanding towards the survivors, the
pain of losing their loved one will lessen. For example, many suicide survivors struggling with
the moral principles of suicide might be concerned whether suicide is a sin (e.g. if they are Christians). This therefore makes the role of religious leaders in suicide prevention very key (Hirono, 2010; Osafo et al., 2013c). Concisely, the key role of religious leaders in suicide prevention may be in the counseling and prevention of ‘inter-generational suicide’, which includes a sequence of suicides within the same family, among relatives and friends. Additionally, there might be differences between the views and treatment regimens of Christian, Islamic and Traditional leaders in suicide prevention.

Generally, suicidal behavior is condemned by major religions such as Christianity, Islam, Hinduism and Judaism (Gearing & Lizardi, 2009; Sisask et al., 2010); however, compared to Christianity and African Traditional Religion, there is an Islamic view that actions committed in the course of jihad resulting in one’s own death are not considered suicide, even if by the nature of the act, death is assured (e.g. suicide bombing). Instead, such acts are considered a form of martyrdom. Divergently, there is Quranic evidence stating that those involved in the killing of the innocent are transgressors and wrongdoers. Nonetheless, some argue that Islam does permit the use of suicide against oppressors and the unjust if one feels there is no other option available and life otherwise would end in death (Muslim Public Affairs Council, 2015).

Moreover, previous studies on attitudes towards suicide in Ghana have concentrated mainly on students, are largely quantitative, and have not examined and compared more specifically, the attitudes and treatment regimens of religious leaders in the three main religions within the country and how they perceive the crucial role they play in the suicide prevention process. How these religious leaders respond at points of contact with suicidal persons or attempters and survivors will influence how they respond to the support offered.
It is against this background and observation that this exploratory research is being embarked on to examine the attitudes and treatment regimens of Christian, Islamic and Traditional leaders and how they perceive the role they play in the prevention of suicide in Ghana.

1.4 Aim

The general aim of this study is to explore the attitudes of Christian, Islamic and Traditional religious leaders in the Ga East Municipal District towards suicide, examine their treatment regimens and how they perceive their role in suicide prevention in Ghana and its implication for the development of a suicide prevention strategy in Ghana.

1.5 Specific Objectives of the study

- To explore the attitudes of religious leaders towards suicide and suicidal persons.
- To explore the treatment regimens employed by religious leaders in suicide prevention.
- To compare the attitudes of Christian, Islamic and Traditional leaders towards supplicants who attempt suicide.

1.6 Significance of the Study

- Demonstrate the need to understand the role of religious leaders in suicide prevention.
- Contribute to knowledge on the relationship between religion, attitudes and suicide.
- The findings of this current study will contribute to the suicidology literature in general and research on Africa's suicidal behavior in particular.
1.7 Research Questions

- How do religious leaders in Ghana perceive suicide?
- What are the treatment regimens of these leaders?
- Are there any differences in the treatment regimens offered by Christian, Islamic and Traditional religious leaders?
- How do religious leaders perceive their role of suicide prevention in Ghana?
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter consists of the theoretical framework and review of relevant literature. Two theories significant to this study have been considered. The review of related studies aims to critically review previous research on suicide and their important contributions to the literature. In the light of the research objectives, the areas to be explored in the review of relevant literature include- attitudes of religious leaders towards suicide and suicidal persons, treatment regimens employed by religious leaders in suicide prevention and a comparison of the attitudes of Christian, Islamic and Traditional leaders towards supplicants who attempt suicide.

2.2 Theoretical Framework

A number of theoretical perspectives have been offered to explain suicidal behavior. For the purposes of this present research, two key theoretical frameworks are used to explain attitudes towards suicide and to a larger extent, suicidal behavior and ideation. These are Vygotsky’s (1978) sociocultural theory and Role Theory (Biddle, 1986; Katz & Kahn, 1978).

The Sociocultural Theory

This theory focuses on the significant contributions which society makes to individual development. It emphasizes the interaction between developing societies and the culture in which they live. Summarily, sociocultural theory postulates that our individual behaviors and thoughts are products of our culture and the interaction we have with society at large. Sociocultural theory realizes the role co-operation, negotiation and social interaction play in the
course of learning and development. Inherently, the norms, practices and discourse of a particular society must be taken into cognizance as a function of attitude formation.

According to Lantolf (2000), one of the most basic concepts of sociocultural theory is the assertion that the human mind is mediated. Lantolf reports that just as humans do not straightforwardly act on the physical world but instead, rely on tools which allow them to change the world, and with it the circumstances under which they live in the world, they also use symbolic tools and signs to regulate and mediate their relationships and interactions with their fellow humans and thus change the nature of these interactions. According to Vygotsky, whether these artifacts created by humans are physical, tools, symbols or signs, they are made under cultural specific and historical conditions and are made available to successive generations, which they can then further modify before passing onto the next generation.

These conditions therefore point out that as a child grows up in a society where suicide is perceived as a taboo, an abominable, unacceptable and despicable act, this child will then internalize this custom and that will become a part of him or her until it is modified. Specifically, a child who grows up within a society that holds negative attitudes toward suicide will grow to hold the same attitude and further transfer it to his or her children. Contrarily, a child who grows up in a society that holds positive or liberal attitudes towards suicide will also learn this and pass it on to his or her off-springs. In sum, the sociocultural theory pioneered by Vygotsky (1978) suggests that society is responsible for inculcating societal values, customs and norms into a child right from birth with the parents of the child serving as the primary representatives of their culture.
Relating Vygotsky’s sociocultural theory to the Ghanaian setting, Osafo, Hjelmeland, Akotia, and Knizek (2011a) for example, report that there is a widespread stigma against suicide and suicidal persons. Furthermore, Osafo et al. (2011b, 2013c) report that people refuse to name a child after an attempter or individual who has died through suicide. In addition to these, the attempter is also criminally prosecuted (Adinkrah, 2010; Hjelmeland, Osafo, Akotia, & Knizek, 2013). These harmful reactions may expose the suicidal attempter to further traumatic experiences, which could aggravate their perturbation and gradual lethality. In such a cultural setting that has harsh reactions and social attitudes towards suicide and suicidal persons, these reactions might further agitate or perturb the suicidal individual.

A major aftermath of a suicide attempt that makes the experience more distressing than reparative for victims is the negative reactions from significant people in the society (Pompili, Girardi, Ruberto, Kotzalidis, & Tarelli, 2005). Attention has also been drawn to the cost effectiveness of harnessing important local resources in this regard since the country presently has a huge shortfall in mental health professionals (Fournier, 2011; Prince et al. 2007; Read, Adiibokah, & Nyame, 2009; Saraceno et al., 2007). Hence the best situation would be the provision of support services following a suicide attempt from important people in the society such as religious leaders. Additionally, religious groups have been found to be one of the means of bridging this gap (Ae-Ngibise et al. 2010; WHO, 2002) and evidence continues to reveal that religious groups in Ghana are engaged in some form of mental healthcare delivery and a large number of Ghanaians access such services (Ae-Ngibise et al., 2010; Read et al., 2009).
It is therefore especially important to examine how religious leaders perceive suicide in such a proscriptive moral and cultural context which stigmatizes suicide to ascertain how they perceive their role of suicide prevention in Ghana and what treatment regimens they employ in helping to modify the behavior of suicide attempters.

**Role Theory: Religious Leaders as Suicide Gatekeepers**

Role theory posits that most of everyday activity tends to be an acting out of socially defined categories (e.g. father, teacher, priest, manager). Therefore specific social roles are accompanied by sets of rights, duties, expectations, norms and behaviors that a person has to fulfill and face. This model is based on the observation that people behave in predictable ways, that is, an individual’s behavior is context-specific and based on social position and other factors.

The focus of this study is therefore on religious leaders’ role in suicide prevention. In this current study, the researcher conceptualized religious leaders as ‘suicide gatekeepers’, a terminology which was first used in the ‘Reading Eagle’ (a newspaper in Reading, Bergs County, PA) on the 30th of June in 1968. Regarding the role of religious leaders in the prevention of suicide, their unique role is that of counselor as part of their profession- specifically pastoral or religious counseling. Particularly, suicide prevention is an extension of pastoral counseling. Turner (1996) puts forward the argument that although pastoral counseling may be a regular job for religious leaders, some of them might be confronted with situations of ‘role ambiguity’ and ‘role confusion’ in the discharge of their duties specifically because their professional roles are restricted to religious activities. In other words, non-religious counseling might be beyond the obligations of religious leaders. Therefore, the perception of religious leaders as to whether counseling is part of their obligations might be largely dependent on the individual religious leader’s decision or their philosophy. If suicidal and depressed believers ask a religious leader
for pastoral or religious counseling, religious leaders have a responsibility to refer them to other mental health professionals. Nonetheless, religious leaders are in a position to advocate for a suicide prevention strategy through their advocacy efforts when they deal directly with the suicidal person or their community. Consequently, religious leaders have the potential to be advocates of policy change.

Role theory is also explained in public and social contexts. More specifically, individuals have public and social roles in addition to family roles such as mother, daughter, son or father. Public and social roles are imperative because the roles are not delineated by individual aspiration, but by public consensus and social norms. In the pastoral or religious counseling scenario, the religious leader ought to provide religious or pastoral counseling based on normative reasons. Hence, if religious leaders think that suicide prevention is part of the obligations of their role, they might then include suicide prevention as a part of their religious or pastoral counseling. Contrarily, if religious leaders do not see suicide prevention as part of their role responsibilities, then that individual religious leader might not incorporate suicide prevention as part of their religious or pastoral counseling. This scenario might create a role conflict, which might occur when there is a fissure in the expectations of role obligations between religious leaders and supplicants.

Consequently, Durkheim advocates that only comparative analysis affords the elucidation of suicide scientifically. Hence, he puts forward that, ‘a scientific investigation can be achieved only if it deals with comparable facts’ (Durkheim, 1897, p.41). This study therefore seeks to explore the role of religious leaders in suicide prevention by comparing Christian, Islamic and Traditional religious leaders’ perceptions of their role obligations and the treatment regimens they employ toward suicide prevention in the Ga East Municipal District of Ghana.
2.3 Review of Related Studies

This section below reviews studies conducted on attitudes toward suicide and suicidal persons for the past three decades.

**Cultural factors that influence attitudes toward suicide**

Lester (2008) asserts that culture provides a set of standards and rules that are shared by members of a society that shape and determine the range of appropriate behavior. Hence, culture impacts the behavior of nationalities, ethnic groups and subgroups within a nation. Consequently, different continents and nationalities present different ways of living. For this reason, different societies or countries are likely to present differing cultural explanations of behavior or attitudes toward suicide. Some laid down cultural traditions either by convention or law may be antagonistic towards suicidal individuals and surviving family members which reflect in their attitudes towards suicide.

In the attempt to address the impact of culture on suicidal behavior and to understand the variations in the meaning of suicide across cultures, Colucci (2008) for example, examined the social representations, values, beliefs, attitudes and meanings that 700 young Italian, Indian, and Australian University students aged between 18-24 years express in relation to suicide. Analysis of structured and open-ended questionnaire items and focus group verbatim transcripts revealed differences and similarities across cultures in meanings and social representations of suicide. First, there were differences on prevalence: more than half of the total sample reported suicide ideation but this was higher among Italian and Australian students, compared to Indians. In contrast, the latter reported more suicide attempts, followed by Australians, then Italians. Secondly, there were statistically significant differences on almost all suicide attempt reasons.
between cultures. For instance, Indians agreed more that some youth attempt suicide to force others to do what they want. Compared with the other two samples, Italian students disagreed more that youth who attempt suicide are mentally ill. Thirdly Indians, followed by Australians had more negative attitudes towards youth suicide compared to Italians.

But there were also differences, in that, Indian participants more frequently mentioned God as a deterrent against suicide compared to participants in Italy and Australia. Italians rarely expressed negative judgments towards suicide (e.g. suicide is selfish) to justify the choice not to commit suicide whereas this was quite frequent in Indians, followed by Australians. Additionally, Australians more often expressed that they would get some help and support compared with the other groups. In relation to help-seeking, overall, the majority of students reported that, if they are thinking about killing themselves, they would talk to no one or friends, followed by someone in the family.

In another cross-cultural study, Hjelemeland et al. (2010) also compared the level of suicide intent among 460 male and 752 female parasuicide patients from various European regions. Although some statistical significant differences in level of suicide intent between the regions in level of suicide between the regions and genders were found, the effect sizes of these relationships were so small that the differences have neither practical nor theoretical significance. As far as level of suicide intent is concerned however, the WHO/EURO Multicentre study has succeeded in recruiting a relatively homogeneous group of self-harming patients across borders of region, culture and country.

Furthermore, Mugisha, Hjelmeland, Kinyanda, and Knizek (2011) in a qualitative study, used both focus group discussions and key-informant interviews to examine the attitudes and cultural
responses to suicide among the Baganda in Uganda. Findings from interviews revealed that suicide is perceived as dangerous to the whole family and the entire community. Specifically, communities and family members adopt various ritual practices to distance themselves both socially and symbolically from the suicide. These rituals are characterized by broad themes: the regulation of affect and the attempt to secure future generations.

Additionally, Hjelmeland et al. (2008) studied the self-reported suicidal behavior and attitudes toward suicide in psychology students by comparing Ghana, Uganda and Norway. Minute differences only were found in own suicidal behavior. Nonetheless, knowledge of suicidal behavior in the surroundings was more common in Uganda, than in Norway and Ghana. Even though differences were found between the three countries in attitudes toward suicide, which stress the need for culture-sensitive research and prevention, many of the differences were marginal. The most profound difference discovered was that the Norwegian students were more reluctant to take a stand on these questions asked compared to their African counterparts.

Osafo, Hjelmeland, Akotia, and Knizek (2011b) in a qualitative study, also sought to understand how laypersons from rural and urban settings in Ghana conceived the impact of suicide on others and how that influences their attitudes towards suicide. Interpretative phenomenological analysis of data revealed that the perceived breach of interrelatedness between people due to suicidal behavior influenced respondents’ view of suicide. They viewed suicide as representing a social injury. Such perception of suicide influenced the negative attitudes the respondents expressed towards the act. The authors assert that these negative attitudes are cast in consequential terms. Hence, suicide is an immoral act because it socially affects others negatively.
Correspondingly, Eshun (2003) also examined the role of family cohesion, religiosity, gender and negative suicide attitudes as potential determinants of cultural differences in suicide ideation among 375 students from the United States and Ghana. Findings revealed significant cultural differences for suicide ideation, family closeness, religiosity, and negative suicide attitudes. Also, negative attitudes and family cohesion were the significant predictors for both cultural groups while gender was a significant determinant for suicide ideation among Ghanaians, but not Americans. Religiosity was a significant determinant for either group.

In another study, Osafo, Knizek, Akotia and Hjelmeland (2013c) examined the influence of religious factors on the attitudes towards suicidal behavior in Ghana. They discovered that largely, respondents were religiously committed individuals who greatly endorsed religious practices and beliefs as coping and survival norms. Inherently, the participants viewed suicide as the consequence of failure to make use of these coping and survival norms during crisis. Based on such a religious perception and conformity to such core religious beliefs, the participants perceived suicide as unacceptable. Thus as a religious country by behavior, and as people become more committed to such core religious beliefs and values, they condemn suicide. Notwithstanding, religion provides them with the motivation to help individuals experiencing suicidal crisis.

Lester (2008) also mentions that gender, as influenced by culture, can impact on suicide. Specifically, within European nations and the United States of America, non-fatal suicidal behavior appears to be less common among men than in women. Hence, suicidal behavior is perceived as a ‘feminine’ behavior by the general public (Linehan, 1973) and by suicidologists as well. Nevertheless, other cultures provide examples where non-fatal suicidal behavior, often carried out in front of others, is more common in men rather than women. The Yukon and the
Kaska (or Nahane), a Native Canadian tribe located in British Columbia provides a good example of this.

Additionally, Segal, Mincic, Coolidge, and O’Riley (2004) compared the attitudes of older and younger adults towards suicide and suicidal risk. They found that older adults had significantly more acceptable attitudes toward suicide than younger adults, which was largely related to a lack of religious conviction.

Evans and Farberow (2003) have also given a comprehensive account of some prehistoric cultural factors that precipitated suicidal behavior. They reported that Japanese may commit suicide to prove their sincerity or avoid disgrace. Also, widows among prehistoric Indians, used to commit suicide on their husband’s funeral pyre as institutionalized and sanctioned by their culture’s doctrine in Hinduism called Suttee. These indicate that attitudes toward suicide are imbibed in specific cultural doctrines.

Largely, collectivism and individualism have also been tagged as cultural factors that influence attitudes toward suicide. For example, Goldston et al. (2008) have discussed collectivism as a central value of many cultures, although there may be within-group differences in the degree to which groups indicate a collectivist versus an individualistic orientation. Interdependence or collectivism among people may provide a sense of belonging for individuals at risk for attempting suicide and this may mitigate risk for suicidal behaviors. Some studies have compared these cultural factors and have mostly found more negative attitudes toward suicide in collectivistic than individualistic cultures. For example, Etzersdorfer, Vijayakumar, Schony, Grausbruger, and Sonneck (1998) found in a study on attitudes toward suicide among respondents in Austria (Individualistic culture) and India (collectivistic culture) that respondents
in the collectivistic culture had more negative attitudes toward suicide than their counterparts in the individualistic culture. Correspondingly, Peltzer, Cherian, and Cherian (2000) compared Blacks, Whites and Asians in South Africa and discovered that plans to commit suicide and suicidal ideation are highest among Asians and Whites as compared to blacks.

In another study, Carmona-Navarro and Pichardo-Martinez (2012) evaluated the attitudes and impact of emotional intelligence among mental and emergency health nurses via a questionnaire. Generally, data analysis showed an adverse attitude towards suicidal behavior. Moreover, the findings on the moral dimension of the questionnaire differentiated between mental health and emergency professionals. Additionally, possessing a high level of emotional intelligence and a higher degree of mental health training is connected with a more positive attitude towards patients with suicidal behavior.

Using the Suicide Opinion Questionnaire, Kim, Lee, Lee, Yu, and Hong (2009) also evaluated the awareness and attitude toward suicide in 264 community mental health professionals and 228 hospital workers in Korea from July to September 2007. Findings revealed significant differences in attitudes in terms of religion, age, marital status, educational background, the economic position, and different professional licenses. Specifically, the hospital workers were of the view that suicide was due to mental illness, and suicide was high for the people in a special environment and who lacked motivation, which caused them to fall in a dangerous situation. Additionally, respondents with lower educational levels attributed suicide to mental illness. The awareness for suicide was also significantly higher in the group with postgraduate education, unmarried people, mental health professionals and the individuals who had concern and experience with suicide. Items such as mental illness, religion, risk and motivation were the factors that had an influence on the awareness of suicide.
Likewise, Anderson and Standen (2007) investigated the attitudes of one hundred and seventy-nine nurses and doctors who work with children and young people who self-harm. Using the Suicide Opinion Questionnaire (SOQ), they explored the effect of basic demographic factors on attitudes towards suicide in the staff group. They found no significant differences between staff working in the accident and emergency area, pediatric medicine or adolescent inpatient mental health services in relation to gender, age, clinical specialty and length of experience in current post. Both doctors and nurses indicated agreement on the Mental Illness, Cry for Help, Right to Die, Impulsivity, Normality and Aggression Scales. They however had less agreement on the religion and moral evil scale. Only the scores for mental illness were statistically different in relation to professional group. There were no other significant differences on the other clinical scales in relation to age, length of experience in current post, gender and clinical specialty. It is argued that complex attitudes need to be considered in the training for healthcare professionals and in the development of current suicide prevention policy.

Correspondingly, Lee, Tsang, Li, Phillips, and Kleinman (2007) conducted a study which evaluated the attitudes toward suicide, suicidal inclination under 12 hypothetical scenarios and prior suicidal experience using a convenience sample of 1,226 people who completed the self-report Chinese Attitude toward Suicide Questionnaire (CASQ-HK). Respondents revealed, in keeping with Chinese tradition, both tolerant and condemning attitudes, which varied with their socio-demographic characteristics. Largely, they were not strongly persuaded to consider the presence of complex situations. Female gender, the presence of suicidal ideation and older age were associated with more contemplation of suicide.
Factors that influence suicide prevention

Some factors have generally been identified to impact both the content and intervention of programs aimed at helping people in a suicidal crisis or those who deliberately self-harm. For instance, Adinkrah (2010) investigated the current patterns and meanings of male suicidal behavior in Ghana by examining official police data spanning 2006-2008 and found that reported cases of fatal and non-fatal suicidal behavior tremendously involved males. Additionally, the investigation discovered that majority of males who engaged in suicidal acts did so to deal with dishonor of variable sources and feelings of shame. The author stresses the need to change the rigid dichotomization connected with male-female gender roles and socialization that accentuate masculinity ideals in Ghana and the need for increased research and the support for counseling for males facing emotional stress. Similarly, Sefa-Dedeh and Canetto (1992) report that among other things, suicidal behavior among women in Ghana comprised insubordination to the domineering expectations in the family and society. Akotia, Knizek, Kinyanda, and Hjelmeland (2013) also indicate that religion played a double-edged role in suicidality: on one hand suicide attempters found religion helpful during life crisis, but on the other hand, their religious belief augmented self-condemnation and feelings of guilt.

The attitudes that clinicians hold towards suicide and suicide prevention initiatives may also impact their management skills and suicide risk assessment. Brunero, Smith, Bates and Fairbrother (2008) conducted a study that assessed the attitudes of a group of non-mental health professionals toward suicide prevention initiatives. They discovered that health professionals who had suicide prevention education demonstrated considerably more affirmative attitudes toward suicide prevention initiatives. This therefore demonstrates the need to educate non-mental health professionals in suicide risk management and awareness.
Barriers to accessing health care are other factors that influence suicide prevention. Specifically, Cho et al. (2013) suggest that suicide risk increases significantly with comorbidity; so effective and timely access to health care is essential to reducing the risk of suicide. However, health systems in many countries are not only complex but limited in resources as well; navigating these systems is a huge challenge for persons with low health literacy and low mental health literacy in particular (WHO, 2013). Additionally, the stigma related with seeking help for mental health disorders and suicide attempts further aggravates the difficulty, leading to inappropriate access to care and to higher suicide risk.

Furthermore, the World Health Organization (2014) asserts that the stigma against seeking help for suicidal behaviors, problems of substance abuse or mental health, or other emotional stressors continues to exist in many societies and can be a substantial barrier to individuals receiving the aid that they need. Moreover, stigma can discourage the families and friends of vulnerable people from providing them with the support they might need or even from acknowledging their situation. Stigma therefore plays a major role in the resistance to change and implementation of suicide prevention responses (Matsubayash, Sawada, & Ueda, 2014; Reynders, Kerkhof, Molenberghs, & Audenhove, 2014). For example, a multicomponent mental health awareness program for young people was developed and tested in the Saving and Empowering Young Lives in Europe (SEYLE) project. SEYLE is a preventive program which was tested in 11 European countries and which seeks to promote mental health among school-based adolescents in European schools (Carli et al., 2013). Every country performed a randomized controlled trial consisting of three active interventions and one minimal intervention that served as a control. The active interventions comprised professional screening for at-risk adolescents, gatekeeper training and a mental health awareness program (Wasserman et al., 2012). Compared to those in
the minimal intervention, adolescents who took part in the mental health awareness program had significantly lower rates of both severe suicidal ideation or plans and suicide attempts at 12-month follow-up. Wasserman et al. (2014) recommends that for optimal implementation of awareness programs, it is necessary to consider the help and support of local schools, teacher, politicians and other stakeholders.

The lack of adequate mental health training is another factor that influences suicide prevention initiatives. For instance, Osafo, Knizek, Akotia, and Hjelmeland (2012) analyzed the interviews of 9 clinical psychologists and 8 emergency ward nurses to examine their attitudes toward suicidal behavior and its prevention in Ghana. They discovered that the attitudes of these health workers seemed to be transiting between morality and mental health. Specifically, the psychologists generally viewed suicide as a mental health issue, stressing an empathic and caring view of suicidal individuals and approaching suicide prevention from a health-service viewpoint. In contrast, the nurses to a certain extent held a moralistic attitude toward suicide. They viewed suicide as a crime and saw suicidal persons as blameworthy and hence approached suicide prevention from a proscriptive standpoint. The authors argued that clinical experience with suicidal persons, religious values and educational level were the factors influencing the differences in attitudes toward suicide and suicide prevention between nurses and psychologists. The authors therefore recommended that pragmatic suicide prevention efforts should be based on mental health education and improvements in primary health care. Informal approaches such as strengthening the legal code against suicide, threatening suicidal persons with the religious consequences of the act and talking to people were also recommended by the authors as realistic approaches to suicide prevention.
Furthermore, Norheim, Grimholt, and Ekeberg (2013) examined the attitudes of 229 professionals working in mental healthcare outpatient clinics in Child Adolescent Psychiatry (CAP) and District Psychiatric Centers (DPC). Findings revealed that all respondents had positive attitudes and endorsed that suicide was preventable. However, professionals who were specialists or who had received supervision were more positive. CAP professionals were less pleased with available treatment. Psychotherapy was considered the most suitable form of treatment whereas psychiatric disorders were considered the most common cause of suicidal behavior.

Goldston et al. (2008) have also discussed that collectivist orientation may also augment acculturative stress and discrimination as well as the awareness of racial oppression, which usually affects bigger communities. Therefore, rather than serving as a protective factor, collectivist orientation may serve as a risk factor for suicidal behaviors. For example, attitudes toward substance abuse, antisocial behavior and degree of cohesion as well as attitudes toward death have also been discovered as factors influencing suicide prevention (WHO, 2014). Psychologists therefore, need to be conscious of the degree to which the history of racism and or societal pressures as well as the process of acculturation has eroded a sense of community and interdependence amongst some people.

Notably, the WHO (2014) points out that there are multiple causes and pathways for suicide. Interventions that contain more than one prevention strategy might therefore be principally useful for preventing suicide. Particularly, research suggests that multicomponent program strategies are associated with successful treatment regimen aimed at reducing suicide rates. For example, the United States Air Force program consisting of 11 community and health-care components with accountability and protocols was shown to be very effective in preventing
suicides in the Air Force (Knox et al., 2010). Similarly, another multicomponent program targeting depressive disorders in Nuremberg, Germany, significantly reduced suicide and attempted suicide rates (Hegerl, Rummel-Kluge, Varnik, Arensman, & Koburger, 2013). Specifically, the program consisted of four different interventions: a public relations campaign targeting the general public; training of community facilitators such as journalists, teachers and police; training of general practitioners; and supporting patients and their families. This multifaceted intervention has now been applied by the European Alliance against Depression, which comprises partners from 17 countries (Hegerl & Network EAAD, 2009). Multicomponent interventions for high-risk individuals also appear to be effective. For instance, a study by While et al. (2012) investigated the effect of nine components of health-service reform on suicide outcomes in the UK. The study revealed that health trusts that implemented more service reforms showed larger reductions in suicide. Specifically, a 24-hour crisis response, dual diagnosis policies, and a multidisciplinary review after a suicide death were the three programs associated with suicide reduction. These studies collectively demonstrate that there may be additive and synergistic effects of integrating multiple interventions.

The role of religion and religious leaders in suicide prevention

Africans have been noted as disreputably religious. Specifically, Mbiti (2006) asserts that religion pervades all their aspects of life so fully that it is not always possible or easy to segregate or detach it. Osafo, Knizek, Akotia, and Hjelmeland (2011b) have confirmed this assertion. They discovered that Ghanaian laypersons are dedicated to the normative and core religious values, belief and practices of preserving life. Consequently, suicidal behavior was unacceptable. Nonetheless, religion aided their willingness to help people during suicidal crisis. Moreover, Knizek, Akotia, and Hjelmeland (2010) examined the attitudes of Ghanaian
Psychology students towards suicide using a qualitative analysis of open-ended questions to investigate what they perceived to be the causes of suicide and how suicide could best be prevented. The study revealed that there was a huge impact of religion on the attitudes toward suicide as well as some difficulty in distinguishing between their religious and professional roles and responsibilities.

Likewise, Akotia, Knizek, Kinyanda, and Hjelmeland (2013) in a qualitative study investigated the role of religion in the experiences of persons who attempted suicide in Ghana. They interviewed 12 men and 18 women on admission at various hospitals and clinics in Accra. Findings showed that religion provided an extensive context within which informants’ experiences could be understood. All interviewees acknowledged God as the owner of life and death. A few informants reacted to the suicidal act in opposition to their religious system and expressed anger and disappointment in God while the majority reacted in a way that resonates with the system and sought for forgiveness from God.

Neville and Roan (2013) in another study, conveniently sampled 45 nurses in a different study, which was aimed at examining their attitudes toward suicide and to achieve a better understanding of factors impacting the identification and management of suicide risk and ultimately improve patient safety. Findings after analysis of data showed that nurses’ educational level and age considerably correlated with affirmative attitudes toward suicide and that religion was also a significant predictor of positive attitudes toward suicide.

Gielen, van den Branden, and Broeckaert (2009) also used PubMed to search and review articles published before August 2008 with the aim of evaluating the impact of religion and worldview on the attitudes of nurses toward euthanasia and physician assisted suicide. Majority of the
studies that were identified demonstrated a clear relationship between religion or worldview and nurses’ attitudes toward euthanasia or physician assisted suicide. Furthermore, ideological affiliation or religion, observance of religious practices, religious doctrines, and personal importance attributed to religion or worldview influenced disparities in attitudes. Nonetheless, a logical relative interpretation of the results of the identified studies was difficult. The authors therefore concluded that no study had so far explored the relationship between worldview or religion and nurses’ attitudes toward physician-assisted suicide or euthanasia and that more research is required.

Hirono (2013) in a survey also examined American Christian and Japanese Buddhist clergy’s perception of their role in the prevention of suicide. Analysis of responses using both quantitative and qualitative methods revealed that many Japanese Buddhist clergy think that the issue of how one dies is not the most important issue. Many American Christian clergy considered suicide to be a sin, but that ‘God’s love is available for people who committed suicide’.

Correspondingly, Agilkaya (n.d.) interviewed and compared the religious dispositions among Turkish-Muslims who attempted to commit suicide. Interviews were analyzed under headings like religious beliefs and behaviors, God images and relations and the meaning of life. Content analysis of interviews showed that with the exception of one atheist, the rest of the sample had religious beliefs. Additional analysis showed that differentiation had to be made concerning religious beliefs, since the sample demonstrated that 29% had individual religiosity while the remaining 67% had formal religiosity.
To comprehend the experiences of suicidal persons in Ghana, Osafo, Akotia, Andoh-Arthur, and Quarshie (2015) interviewed 10 persons after they had attempted suicide. Thematic analysis of data revealed that motivation for suicidal behavior included partner’s infidelity, social taunting and hopelessness. Suicidal persons reported stigma expressed through social ostracism and physical molestation that left them traumatized. They however coped through religious faith, social support from relations and use of avoidance.

In a different study, Yapici (cited in Agilkaya, n.d) in his comprehensive study on Mental Health and Religion discovered that hopelessness, depression, self-esteem and suicide risks which are predictors for suicidal behavior differ among Turkish students regarding their level of experiencing Gods existence in their inner world. Consequently, students who develop an inner relation with God, take refuge with and rely on God and remember God regularly are in better mental health. Students who pray for the help and support of God, that means who turn to God in the awareness of their weakness, helplessness and desperation, cope much better with daily stress, depression, hopelessness and thereby suicide risks.

Remarkably, apart from this particular research by Osafo, Agyapong, and Asamoah (2015) which aimed at carefully outlining and bringing to the fore the role of religious groups in mental health, the review of literature did not reveal much on the attitudes of religious leaders towards suicide and the specific treatment regimens they employ in preventing suicide. Specifically, the study by Osafo et al. (2015) explored the nature of treatment regimen for mentally ill persons by interviewing 12 clergy from a particular Christian strand called the neo-prophetic Christian ministries or churches. Analysis of data using interpretative phenomenological analysis (IPA) showed that these clergy perceived mental illness as a spiritual rather than a biomedical problem. Also, the treatments they prescribed for mental illness advance toward two key approaches
namely the hope induction approach and the prophetic deliverance approach. Assessment of cure for illness also involved self-care and community participation, perceived complete exorcism and observation of restored orientation.

2.4 Rationale

As efforts accumulate towards the vital need to improve mental healthcare services in low and middle-income nations, attention has been drawn to the cost effectiveness of harnessing vital local resources in this regard (Prince et al. 2007). Ae-Ngibise et al. (2010) and WHO (2014) have discovered religious groups as one of the means of bridging this gap. Furthermore, there is increasing evidence that religious groups in Ghana are engaged in some form of mental healthcare delivery (e.g. Ae-Ngibise et al., 2010; Laugharne & Burns, 1999; Read, Adiibokah & Nyame, 2009).

Accordingly, the Ghana Ministry of Health (2005) also indicates that there are about 45,000 traditional healers registered in Ghana, with many churches providing a syncretic spiritual healing to about 70-80% of persons using them as forefront service workers. Furthermore, Roberts, Asare, Mogan, Adjase, and Osei (2013) in a recent report on Ghana’s mental health system also indicate that a huge proportion of traditional practitioners and faith healers offer treatments such as medications, refer mental illness cases to psychiatric services for attention and also use mechanical shackles to restrain about 41-57% of patients.

This present study therefore explores the critical issues of the attitudes of religious leaders toward suicide, their treatment regimens and their role in suicide prevention in Ghana. Many people agree that suicide prevention is an emergent issue, yet they overlook the role of religious leaders in the suicide prevention process (Hirono, 2010). Additionally, several researchers in the
field of suicide prevention have focused on the role of medical facilities, schools and other local or state organizations. The role of religious leaders in the literature has however had little attention yet the researcher believes religious can stop people from committing suicide through doctrinal teachings, counseling and preaching. Several suicide attempters are religious people who ascribe to one religion or the other. Still, others are suicide survivors, that is, they have family members, relatives or friends who have committed suicide. During funerals or memorial services, these survivors may have had the chance to speak with their religious leaders about the meaning and morality of suicide.

If religious leaders speak negatively about suicide, then suicide survivors might become vulnerable to suicide. On the other hand, if empathy and understanding is expressed towards the survivors, the pain of losing their loved one will alleviate. For example, many suicide survivors struggling with the moral principles of suicide might be concerned whether suicide is a sin (e.g. if they are Christians). This therefore makes the role of religious leaders in suicide prevention very key (Hirono, 2013). Concisely, the key role of religious leaders in suicide prevention may be in the counseling and prevention of ‘inter-generational suicide’, which includes a sequence of suicides in the same family, among relatives and friends (Hirono, 2010). Additionally, there might be differences between the views and treatment regimens of Christian, Islamic and traditional leaders in suicide prevention.

Furthermore, the 1960 Criminal Code of Ghana criminalizes suicide (Adinkrah, 2010), and there are no official public figures on suicide in the country. Additionally, Osafo et al. (2011a), in a study among psychology students in Ghana also found that almost half (47%) of the students knew someone who had attempted suicide. Similarly, Hjelmeland et al. (2008) discovered that although there are no reliable official statistics on the act, one in five knew someone who had
killed him or herself. Based on these findings, the researchers specified that suicidal behavior could be an extensive public health crisis in Ghana.

Additionally, previous studies on attitudes towards suicide in Ghana have concentrated mainly on students, are largely quantitative, and have not examined more specifically, the attitudes, role and treatment regimens of religious leaders in the suicide prevention process. How these religious leaders respond at points of contact will influence how suicidal persons as well as survivors respond to the support offered.

It is against this background and observation that this exploratory research is being embarked on to examine the attitudes and treatment regimens of Christian, Islamic and Traditional leaders and their role in the prevention of suicide in Ghana.
CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter outlines the methodological approaches adopted in this study. It also presents the population and setting for the study and the techniques used for the design of the study and data gathering. The populations chosen for the study were Christian, Islamic and Traditional leaders in the Ga East Municipal District located in the Greater Accra Region of the Republic of Ghana. The choice of the population was informed by the nature of the research topic, which aims to explore Religious Leaders’ role in addressing the problem of suicide.

3.2 GHANA: THE RESEARCH SETTING

Ghana is a culturally heterogeneous (Adinkrah, 2011) and sovereign state situated just north of the Equator on the West Coast of Africa and shares borders with the Ivory Coast to the West, Togo to the East, Burkina Faso to the North, and the Atlantic Ocean to the south. It is a developing country occupied by diverse groups of approximately twenty-three million people distinguished mainly by language.

The Akan-speaking ethnic groups (e.g., Ashante, Fante, Kwahu, etc) are numerically dominant, collectively constituting 49.1% of the entire Ghanaian population. The Mole-Dagbani, Ewe and Ga-Dangme are some of the other ethnic groups and constitute 16.5%, 12.7% and 8% respectively.

Religious heterogeneity in Ghana is reflected in the various institutionalized and traditional religious faiths with which Ghanaians identify. According to the 2000 census, 68.8% of the
population indicated an affiliation with one of several Christian denominational churches, followed by Islamic adherents (15.9%) and subscribers of traditional faiths such as ancestor veneration (8.5%). Another 6.1% of Ghanaians reported no affiliation with any religion (Care International, 2009; Ghana Statistical Service, 2002).

3.3 Population

Christian, Islamic and Traditional Religious Leaders within the Ga East Municipal District of the Greater Accra Region served as the population for the study out of which 14 males and 14 females between the ages of 20 to 60 years took part in the study. The Ga East Municipal District was chosen because of the inability of nationwide study due to time and financial constraints. Also, it is a heterogeneous setting made up of urban and rural dwellers. Branches of all the three major religious denominations in Ghana are found within the District. Participants are easily accessible and this therefore provided a clearer picture on the attitudes and treatment regimens utilized by these religious leaders in suicide prevention.

Participants/sampling technique

Informants for this study were 28 adults made up of 16 Christian (Ordained Reverend Ministers / Pastors), 8 Muslim (Imams) and 4 Traditional (Chief/ Elder/Priest) religious leaders. The major factors guiding the choice of this sample size was the concept of f saturation. Qualitative studies are cautious of saturation where the data being collected or cases being examined may not throw any further light on the issue under investigation hence the researcher stops conducting further interviews (Mason, 2010). Other factors included the heterogeneity of the population under study, the selection criteria, the multiple samples within one study as well as the budget and resources available to the researcher (Ritchie, Lewis and Elam, 2003). Fourteen of the informants
were females while fourteen were males. Two participants were unmarried and the rest were married. The ages of the informants ranged between 20 to 60 years whereas their tenure in their roles as religious leaders was ten years and more. Majority of the informants (12) were Ga-Dangme’s, 3 were Ewe’s, 11 were Akan and the remaining 2 were from the Northern Ghana ethnic groups. (Refer to Table 3.1).

**Table 3.1**

**Demographic Characteristics of Participants**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>1</td>
<td>3.6</td>
</tr>
<tr>
<td>31-40</td>
<td>5</td>
<td>17.8</td>
</tr>
<tr>
<td>41-50</td>
<td>11</td>
<td>39.3</td>
</tr>
<tr>
<td>51-60</td>
<td>11</td>
<td>39.3</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>50.0</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>50.0</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Married</td>
<td>26</td>
<td>90.90</td>
</tr>
<tr>
<td><strong>Religious Leader Category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>16</td>
<td>59.09</td>
</tr>
<tr>
<td>Muslim</td>
<td>8</td>
<td>31.82</td>
</tr>
<tr>
<td>Traditional Religion</td>
<td>4</td>
<td>9.09</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ga-Dangme</td>
<td>12</td>
<td>42.9</td>
</tr>
<tr>
<td>Ewe</td>
<td>3</td>
<td>10.7</td>
</tr>
<tr>
<td>Akan</td>
<td>11</td>
<td>39.3</td>
</tr>
<tr>
<td>Dagomba</td>
<td>2</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Purposive and snowballing sampling techniques were used in the selection of informants. These techniques were chosen because of the conviction that the rigidity of sample selection involves thoughtful and precise picking of cases, which are in line with the purpose of the research (Patton, 1999) and additionally based on the willingness and availability of informants to
participate in the research. Furthermore, some informants, due to their longer tenures as religious leaders might have richer knowledge hence, they could provide more insight into the issue of interest than others (Marshall, 1996). Led by this understanding, some informants recommended other helpful persons for the study, whose consents were sought and interviewed.

3.4 Criteria for selection

The participants for the research were eligible for selection based on the following conditions:

- Participants must either be Christian (Ordained Reverend Ministers / Pastors), Muslim (Imams) or Traditional (Chief/ Elder/Priest) religious leaders.
- Participants should have been in leadership positions for ten years and more.

3.5 Research Design

A comparative design, using a qualitative approach was employed by the researcher to explore the attitudes of religious leaders and the treatment regimens they use in suicide prevention. According to Silverman (2006), suicide is a complex issue and Hjelmeland (2010) and Colucci (2006, 2008) assert that in a cultural environment, a qualitative approach is required in order to understand the meaning people make out of the phenomenon.

Qualitative research design is based on the stance that people understand and relate to things cognitively- from within the mind. This design seeks to provide contexts, like one-on-one interviewing, that allow a participant to express their beliefs, assumptions, desires and understandings (Willig, 2001). Qualitative research is valuable for the in-depth study of complex phenomena (Hjelmeland & Knizek, 2010). Additionally, it provides understanding and description of people’s personal experiences of phenomena and can therefore generate detailed
and rich information on a phenomenon as they are embedded and situated in local contexts. The qualitative researcher is highly sensitive to modifications that occur during the conduct of the research, which broadens its knowledge base. Hence, the qualitative approach would be used to explore the phenomenon under study, which is ‘suicide’.

### 3.6 Measuring Instrument

A semi-structured interview guide was used to assess the informants’ attitudes towards suicide and suicide prevention. The investigator’s focus was to examine in detail how informants perceive and make sense of the phenomenon ‘suicide’ and the treatment regimens they use in suicide prevention. This therefore necessitated the use of a flexible data collection tool to serve as a guide and which would also allowed an in-depth examination of the personal and social worlds of the informants (Smith & Osborne, 2003). This form of interviewing allows the researcher and participant to engage in a dialogue and the interviewer is freer to probe interesting areas that arise. Additionally, the interview can follow the respondent’s interests or concerns (Smith & Osborne, 2003). Some of the items on the guide are:

- Please explain how religious leaders treat persons with suicidal crisis (explore all the treatment regimens that informant provide or list- e.g., prayers, fasting, counseling, deliverance etc.)
- How do you use counseling (and other treatment regimens listed above) to help someone in suicidal crisis?
- Have you counseled with any individual/s who reported thinking about committing suicide in this your profession?

(Refer to Appendix C for the Interview Guide)
3.7 Procedure

Ethical clearance was attained from the Ethics Committee for the Humanities at the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana, Legon. Consent forms were designed and presented to every informant who agreed to participate in the research. Introductory letters signed by the Head of the Department of Psychology, University of Ghana revealing the researcher’s identity, the rationale and the significance of the study in the prevention of suicide were given to the religious denominations involved. Interviews were conducted predominantly in English between January 2015 and February 2015 by the researcher using the interview guide prepared. However, where participants felt more comfortable using any local dialect, they were granted the opportunity to do so especially in Dangme, Ga and Twi since the researcher is familiar and fluent in such local dialects. Appointments were booked with informants who consented to participate after permission was granted. Interviews were conducted mainly in their offices and in their homes on a few occasions. Whittemore, Chase, and Mandle, (2001) argues that the validity of interpretation is a key issue in qualitative studies. Therefore to ensure validity, the investigator checked and summarized during the interview process whether the views of informants have been rightly recorded (Whittemore et al., 2001). With permission from the participants, the interviews were audio-recorded and later transcribed accurately.

3.8 Analysis of data

Thematic analysis was used to analyze the audio-recorded and accurately transcribed data. The transcribed data was read over and over again which assisted in the easy identification of words, concepts, ideas and themes that appeared recurrently. Themes, words, ideas and concepts that
appeared repeatedly in the interviews were compared and cross-checked with other interviews and found to be consistent and saturated by the end of the twenty-eighth interview.

Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data (Braun & Clark, 2006). This method minimally organizes and describes data set in (rich) detail. It however goes further than this to interpret various aspects of the research topic (Boyatzis, 1998). Thematic analysis differs from other analytic methods that seek to describe patterns across qualitative data and does not require the detailed theoretical and technological knowledge of approaches such as ‘thematic DA, grounded theory, interpretive phenomenological analysis and thematic decomposition analysis. Thematic analysis is flexible. Through its theoretical freedom, it can provide a rich and detailed yet complex account of data (Braun & Clarke, 2006).

The analysis involved the preparation of data to be examined by transcribing the interview into text and reading the text to note items of interest in order to gain a sense of the various issues entrenched in the data. Further microanalysis of the data was done by thoroughly reading and examining the text closely, line by line.

After close examination of the text, items of interest were grouped into proto-themes, where themes begin to emerge by organizing comparable items into categories as well as investigating the proto-themes and efforts were made to define these proto-themes. The text was re-examined cautiously for significant incidents of data for each proto-theme by taking each theme individually and re-examining the original data for information relating to that theme. Additionally, the final form of each theme was restructured and the meanings of the themes were examined closely using all the materials connecting to each theme.
The name, definition and supporting information were re-assessed for the final conclusion of each theme, using all the data relating to it. Finally, each theme was reported with its description in addition to exemplifying it with some quotations from the original text to help convey its meaning to readers.

3.9 Ethical considerations

Ethical clearance was attained from the Ethics Committee for the Humanities at the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana, Legon. Approval was sought from the head pastors, imams and chiefs of the various religions from which participants were chosen. The religious leaders were informed about the nature of the study through their Heads following from the issuance of an introductory letter from the Department of Psychology, University of Ghana. Religious leaders who consented to participate in the study were given forms to formalize their participation. Moreover, participants were notified that participation was completely voluntary and that they could opt out at any time during the interview sessions. Furthermore, they were also guaranteed of confidentiality by way of withholding their names due to the highly sensitive nature of suicide. Arrangements were made for participants who may need attention from a clinical psychologist or competent counselor following the interview session.
CHAPTER 4

4.0 FINDINGS

4.1 Introduction

This chapter presents the findings based on the data obtained from the field. Essentially, the chapter covers the themes that originated from the responses of participants. These themes were then structured into meaningful units using the sub-themes derived from them. After analysis of the transcribed data, findings were organized around six major thematic areas: The Context: Cultural Abhorrence, Diverge to Converge: Life Preservation, Motivations: Psychological and Diabolism, Care or condemnation? Sub-themes were recognized under each key thematic area to capture the pertinent voices reflecting the treatment regimens and the attitudes of the respondents toward suicide and suicidal persons.

For ease of reference and to see whether there are differences due to gender and religious affiliation, codes were used to identify respondents as such: CRL Man/Woman refers to a male or female Christian religious leader, IRL Man/ Woman refers to a male or female Islamic religious leader and TRL Man or Woman refers to a male or female Traditional religious leader.

4.2 The Context: Cultural Abhorrence

In the effort to discover the attitudes of religious persons toward suicide and suicidal persons, it is necessary to unearth religious leaders’ estimation of the cultural context within which suicidal behavior occurs and how it is viewed. Generally, the participants provided a cultural context that abhors suicidal behavior, with strong stigma practices towards the suicidal person.
A Moslem respondent clearly put it thus:

‘…it is not acceptable. To the Ghanaian, nobody should commit suicide.’ (IRL Man, 59 years).

The implication here from this Moslem respondent is that, although suicide occurs, it is not considered an acceptable cause of death because the Ghanaian society prohibits such actions.

A Christian respondent also goes further to indicate a similar view of suicide that is widespread in Ghana. Specifically, she said:

‘….they have a very hard attitude towards it. They feel it’s a disgrace to the family and people are very unsympathetic…Generally, people consider it a taboo….a shame… a disgrace’ (CRL Woman, 58 years).

This participant’s utterance indicates that within the Ghanaian culture, there is a perceived interrelatedness of people and the consciousness that suicidal behavior affects the family’s social image (Osafo et al., 2011a). Hence the act is considered as shameful and disgraceful. This view appears to facilitate the general attitude of abhorrence towards the phenomenon of suicide in Ghana (Osafo, Akotia, Andoh-Arthur, & Quarshie, 2015).

A Traditional leader also observes how people dissociate themselves from the corpse of a person who has died through suicide.

‘There’s an elderly soldier in this town. He died suddenly. It was said that he shot himself…The whole town saw it as an abominable act. He was not originally from
this town. He was taken to his own hometown and even there, they didn’t bury him in the public cemetery. They went to search for somewhere, dug a hole and brought a pastor from Accra to come and bury him because the town pastor said he wouldn’t bury him because he committed suicide (TRL, Woman, 60 years).

The sense that the dead soldiers’ act of shooting himself affects the town’s social image is demonstrated in how they relate to the corpse by sending it back to its hometown. In its hometown, the digging of a pit for burial rather than the public cemetery shows how the corpse of suicide deaths are treated and buried. Also, the refusal of the town pastor to bury the corpse resulting in a pastor being brought from Accra to carry out the burial are all measures which these two towns have employed to distance themselves from the corpse and to endorse their social disavowal of the act (Mugisha et al., 2011).

4.3 Diverge to Converge: Life Preservation

This theme examines the dynamic nature of the attitudes of these religious leaders toward suicide. It shows that the religious leaders did not appear to have a personal attitude towards suicide, but rather relied on either one or multiple views to adduce their perspective on suicide (religious, or traditional). However, the end result of this divergent perspective was to affirm that suicide was not acceptable and thus life-preservation should be the supreme action during distress. Illustrative of these are voices below:

‘In Islam, Allah did not say we should kill ourselves. If you intentionally kill yourself...on judgment day, Allah would punish you’ (IRL, Woman, 51 years).

This Islamic respondent’s standpoint is hinged on the single religious belief that suicide is forbidden in Islam as stated in stated in many verses of the Qur’an. For example ‘And spend in
the way of Allah and do not throw [yourselves] with your [own] hands into destruction. And do good; indeed, Allah loves the doers of good.’ (Al-Baqara 2: 195). Therefore this participant perceives that committing suicide is destructive and makes the dead person liable to punishment from Allah on the day of Judgment (e.g. Mbiti, 2006).

However, a Christian respondent draws from multiple (cultural and Christian) perspectives to expatiate her attitude towards suicide. She states:

‘Ehhhm not really, it is my Christian view that has affected my thinking. Ehhm, because I think if you commit your life to Christ, you would depend on Him and wouldn’t have to go this far. So the fact that our culture doesn’t accept it… Well, I know it isn’t a good thing to do, but it isn’t that which has affected my thinking. It is my Christian background that is affecting my thinking’ (CRL, Man, 43 years).

This participant accedes that generally the Ghanaian cultural context is abhorrent to suicide. Nonetheless, her attitude towards the act stems mainly from her Christian beliefs as stated in many verses in the Holy Bible. For example, ‘You Shall not Kill’ (Exodus 20:13). According to this participant, *if*-meaning on condition (Merriam-Webster dictionary, 2015) that the suicidal person commits his or her life to Christ, he or she would *depend* on Him as espoused in the Christian doctrine. ‘*Depend*’ means ‘to place reliance or trust someone *(Merriam-Webster dictionary, 2015). Thus this participant perceives that assuming that the committed Christian relies or trusts in God, apparently tells Him his problems and has faith that He is in control, this ongoing relationship will keep the person away from taking his or her life (e.g.Yapici, cited in Agilkaya, n.d).

Another respondent from the Traditional Religion strand also added:
'So generally, because of our understanding that no one owns life by him/herself, it becomes offensive if you take that which you do not own by yourself.' (TRL, Man, 60 years).

This respondent assents that because of our understanding (either this is his view or he has come to agree with this general view) that ‘someone or somebody’ has given all humans, including the person who attempts or commits suicide life. Hence, this person owns us. Thus, he perceives that committing suicide is an offense because the act equals taking that which is not yours.

These viewpoints diverge in terms of how participants process their views on suicide and demonstrate how suicide is perceived from these three religious strands and converge at the point: strong disavowal towards suicide with the endorsement of self-preservation rather than self-destruction. Thus the attitude of these religious leaders towards suicide is a mixture of both religious and societal beliefs.

Summarily, this study sought to comparatively explore the attitudes of Christian, Islamic and Traditional Religious leaders towards supplicants who attempt or complete suicide. The current study revealed that, irrespective of religious faith, age, gender and length of service as religious leader, respondents have similar attitudes towards suicide and supplicants who attempt or complete the act. Specifically, respondents perceived suicide as a cultural abhorrence and religious contravention connected with the eternal damnation of the soul of the person who has killed himself or herself as a consequence in the afterlife (Mbiti, 2006). Consequently, whether the suicidal act is attempted or completed, the suicidal person is liable to punishment by God. Thus, by religious implication, the suicidal person and the act itself are unacceptable and not justifiable irrespective of the antecedent or motivation behind the suicidal behavior. This finding
contradicts the findings by Hirono (2013), in which he discovered that many American Christian Clergy consider suicide to be a sin, but that ‘Gods love is available for people who committed suicide’ and that many Japanese Buddhist clergy think how one dies is not the important issue. However, it is consistent with that of Akotia, Knizek, Kinyanda, and Hjelmeland (2013) who discovered that generally, religion provided a broad context within which the suicidal experiences of interviewees in their qualitative study could be comprehended. Specifically, ‘the acknowledgement of God’s superiority’ and ‘ownership of life’ formed the extensive basis for comprehending how their informants interpreted their suicidal experiences using a religious lens.

4.4 Motivations: Psychological and Diabolism

Almost all interviewees referred to encounters in their line of duty with persons who had attempted or completed suicide. The participants assigned various reasons for suicidal behavior. These included psychological distress, and diabolical interference. They referred to cases of suicide attempters they have worked with to illustrate this:

On psychological distress, one informant said:

‘Well I am aware of the issue of sickness/un-wellness...not necessarily sickness, I will prefer to call it un-wellness. Someone is unwell. It could be whatever dimensions mental, social pressure, it could be any other thing. So un-wellness in general can bring people to question the value of life as they have and whether they have any other hope for the future (CRL Man, 47 years).’

Another respondent put it thus,
‘...devastated, overwhelmed by pressures and harassed (emotional harassment) leading to severe depression’ (TRL, Man, 60 years).

These views are indicative of the fact that suicide is viewed as a product of psychological distress and as a sign of un-wellness. These are unpleasant feelings or emotions that affect the level of functioning of suicidal individuals because they may be severely depressed people who feel there is no cause to live (e.g. Pillai et al., 2008). This psychological state of imbalance may cause them to resort to self-blame, self-pity or guilt due to their inability to handle or solve whatever problems they may be facing. Thus, they make the choice to end their life.

One informant also cited the loss of drive to continue living perhaps because of social pressures or the failure of their marriages, ambitions or even relationships as another source of frustration:

‘.When people are frustrated or have shattered dreams. The intense form of frustration ends in depression. Once somebody feels depressed, they feel there is no cause to live so I have to terminate my life... (IRL, Man, 55 years)’.

To probe further, respondents were asked why suicidal persons would get seriously frustrated and emotional and get to this point of ending it all. Some had this to say,

‘I would say the person is lonely, I would say the person is disturbed in the mind, what shall I also say, the person feels unwanted and the person feels he or she can’t make it...’

(IRL Woman, 40 years).

Another participant also described suicidal persons using these adjectives;

‘Lonely, lonesome, and sad with a sense of hopelessness’ (CRL Male, 43 years).
That fact that suicidal persons appear unwell and frustrated and question the value of this life to the extent that they decide to end it all by attempting or completing suicide is an indication that, suicide can be classified as a mental health issue (Kim, Lee, Lee, Yu, & Hong, 2009). Respondents therefore, perceive suicide as a mental health concern because of their perception that suicidal persons have distorted feelings and thoughts.

Therefore, due to the sense of loneliness, hopelessness and feelings of being unwanted, the need for significant others to help suicidal persons through the expression of sympathetic emotions as one respondent put it clearly;

‘Like I have said, I see them as people who are unwell, who need all …they need us to understand them, they need us to step into their world and speak their language. So they need all the love, the warmth, the affirmation and above all the steering away from that which will destroy them (TRL, Man, 50 years).

Another respondent also surmises;

‘I am not sure, but I could say they mimic an aspect of society that we may not be seeing. If you live in a home and one person in the home gets to the point of losing their sense of value of life, there could be something wrong in that home. That someone because of temperament or other combinations of factors is at the point where that person is absorbing that negative thing, so the person is an aspect of society that you may not be bringing into proper focus. So they are unwell, they need help. They mimic an aspect of society we are not focusing on’ (CRL, Man, 48 years).

It can be deduced from the above narratives that though the act of suicide is unacceptable, the suicidal individual should not be denied the needed attention in terms of care to recuperate by
significant others. Essentially, the former opinion suggests that majority of religious leaders show sympathy towards suicidal persons by virtue of their position as religious leaders and the latter opinion buttresses the fact that society needs to focus particularly on finding out what might be causing such individuals to become suicidal. In this regard, religious leaders have to establish a good relationship with suicidal persons to enable them confide in them to share their problems. Accordingly, religious leaders’ expression of sympathy and compassion toward suicidal individuals is informed by two distinctive perspectives: the belief in suicidal vulnerability, the belief in communal living and the motivation to show care as a result of their position. The implementation of any or all of these three viewpoints of showing sympathy, could translate into helping behavior towards suicidal individuals and affirmative emotional responses (e.g. love, warmth and affirmation) as the participants were expressing.

Another reason participants cited for suicidal behavior was diabolical interference, which involved demonic possessions and curses that run through families. One respondent indicated that:

‘……there could also be spiritual connotations to it as well. When spiritual beings take advantage of people. These people tend to hear voices. Some of these voices could be evil spirits or demons. These spirits or demons whisper to these people to go and do funny things. For example, take a knife, kill yourself or go to a high height, throw yourself down and end it all. So aside the physical, we also add the spiritual connotation to it... ’ (TRL, Man, 40 years).
Another respondent also stressed thus:

‘There are some people who can receive counseling from psychologists. They would be okay for a period of time. But if the thing is from a lineage where there has been suicidal tendencies, then of course that thing can resurface again...then you need to handle it spiritually’ (CRL, Man, 60 years)

From the foregoing views of participants, it can be gleaned that religious leaders perceive that suicide can result from spiritual factors because suicidal persons are sometimes tormented and buffeted by spiritual forces such as demons and spirits. These views were however expressed largely by male religious leaders than by females. The perception that suicide is caused by spiritual interference is an indication that suicide can be categorized as a spiritual issue. Hence, religious leaders can be of help in this regard.

4.5 Care or condemnation?

This theme focuses on the emotional and behavioral reactions of respondents toward suicidal persons as well as how they perceive the reactions of society towards suicidal persons. The reactions involved a mixture of sympathetic care and condemnation.

More females than male respondents conveyed sympathetic and compassionate sentiments towards suicidal persons. One respondent sympathized:

‘...I look at it sympathetically, and wonder what the person was thinking of before he or she decided to take his or her own life. What factors pushed that person over the wall’ (CRL Woman, 30 years).

Another respondent also opined:
‘I see them as normal human beings who have gone through a lot of emotional problems. But it is pitiful to see people with so much potential just end it because of their problems.’

(TRL Woman, 58 years).

In the former opinion, the participant expresses sympathetic emotions towards suicidal persons because he perceives that there are certain factors beyond the control of suicidal persons which pushed them to engage in the act while in the latter opinion, the expression of such emotions appears to be hinged on the notion that suicidal persons are healthy and normal persons who have serious emotional problems which they cannot handle and as a result, they engage in the act. Hence, they need some form of psychological and social support from significant others to help them handle such problems as the narrative below indicates:

‘Oh I really pity them. I feel sorry for them and I think these people need support from family members or people who are around them’. (IRL, Man, 47 years).

Some respondents also expressed that they had observed a mix of demeaning and compassionate reactions from their congregation and the general public regarding suicidal behavior as expressed in the voices below:

‘Oh normally, what I hear is that everybody says oooh! You can feel that they feel sorry for what happened. When such incidents occur, you can see this expression on the faces of the people who gather there. Everybody feels worried and concerned. You can see that they are worried about what they see. (IRL, Man, 48 years).

Another respondent stated emphatically in response;
‘Hmm, the reaction is why should somebody kill himself. That is the question everybody would ask. For instance I witnessed one, a relative’s spouse who killed himself and that morning when the police got to the house, the police man...he looked around, saw the mansion in which this man lived and he just expressed ‘this die be foolish die...even me I no go kill myself, you big man like this...so ibi foolish die’. Well, in summary, this is the way we view it’ (CRL, Man, 43 years).

An observation noticeably evident in these responses is that generally, people feel sorry and express concern and worry when a suicide incident occurs and this perhaps, could be attributable to the widespread notion that people who commit suicide have problems which they are unable to handle (Osafo et al., 2015). However, the policeman’s expression of ‘this die be foolish die’ in the latter response stems from the fact that from what he was gleaning at the suicide scene, the dead person was well to do because he lived in a mansion and should be able to handle whatever problems he had. Thus, he wondered why such a ‘bigman’ (referring to his wealth) should commit such an act. The use of the word ‘foolish’ to refer to the death through suicide has also been supported in earlier studies where suicidal persons were described with demeaning labels such as ‘murderer’, ‘fool’, ‘coward’ and ‘transgressor’ (Osafo, Knizek, Akotia, & Hjelmeland (2013d). What can further be viewed from the latter narrative is that the informant bundles himself up with the prevailing negative reaction toward suicidal persons as “Well, in summary, this is the way we view it”. Initially it appears he covers his personal reaction towards suicide by the prevailing condemnatory public reaction, but his personal view pops up through the narration at the tail end. May be a as a clergy, he might feel embarrassed to share a personal condemnatory view and so hides it under the public’s
Correspondingly, some respondents mentioned that they had never (expressly) mentioned the issue of suicide during worship. However those who did, depending on whether supplicants had experienced it before or otherwise and the stance from which they approached it, have had two types of responses. First, if it was mentioned from the standpoint of *condemning the act*, then people are ‘silent’ or they may ask why people would commit such an act. Second, if it was mentioned from the standpoint of *sympathizing* with suicidal persons, you see some relief on peoples’ faces. One respondent put it succinctly;

‘you see a certain amount of relief on people’s faces and the sigh, and people open up and they are ready to talk and more often after service, if you apply it from the sympathetic view, you will see that a few days that follow, you have a lot of people coming to share’ (CRL, Man, 55 years).

Another respondent put it this way;

‘For those who have not come to terms with the issue before…it is nothing to fear... to worry about. But for those who have come to terms with it, it is nothing pleasant....for those who know why the person committed the suicide and know the solution to it, they feel, why should he do it? What’s wrong with him?’ (IRL, Man 48 years).

Another respondent also surmises;

‘It depends on how you mention it, if someone mentions it in the context of people who jest with life, the general response might be different. He is reinforcing the already known stand. If he mentions it from the perspective of the pressures of life or pain that is driving people into that which is what I have experienced a lot of times, you see a big
sigh which gives an indication that you are touching on something that is bothering a lot of people but do not have a place of respite’ (IRL, Man, 58 years).

Therefore, in providing pastoral care to supplicants, religious leaders have witnessed both condemning and sympathetic attitudes whenever they mention the issue of suicide. This confirms Hirono’s (2010) assertion that if religious leaders speak negatively (condemn) about suicide, then suicide survivors might become vulnerable to suicide. On the other hand, if sympathy and understanding is expressed towards the survivors (by religious leaders), the pain of losing their loved one will alleviate and they may then open up and talk about it.

Categorically, participants in this study conveyed similar sympathetic responses towards suicidal persons and expressed their willingness to help them. This perhaps, may be attributed to the fact that religious traditions support prosocial behavior in theory and practice (Oman & Thoresen, 2005). Also, the perceived religious consciousness of participants and the understanding of their role in preventing suicide in relation to their negative attitudes toward the act might account for their willingness to give physical, emotional and psychological support to suicidal persons. Noteworthy however is the finding that more female respondents compared to males expressed such sympathetic sentiments. Conceivably, this may be due to the fact that generally, females are more emotionally expressive than males.

Moreover, depending on whether religious leaders sympathized with or condemned suicide, some participants have witnessed a mix of both demeaning and compassionate reactions from their supplicants. This finding indicates that religious leaders have a key role to play in suicide prevention and also designates the need for religious leaders to be equipped with requisite skills
in handling and giving care to suicide attempters and survivors as highlighted in earlier studies (Osafo et al., 2011b, 2012).

4.6 Caring to Treat

This major theme relates to the role religious leaders play when they interact with suicidal persons. Specifically, it deals with how they perceive this role and the treatment regimens they employ in helping suicidal persons.

All participants expressly stated that suicidal behavior can be modified and that they as religious leaders act as frontliners with a caring obligation to help such persons because it borders on taking life.

Analysis of expressions from majority of respondents suggested that they served as frontliners or persons who are in a leading position to help identify and help modify the behavior of persons presenting with suicidal tendencies. This finding is similar to a finding by the Ministry of Health (2005) that suggests that many churches serve as frontline service personnel, providing syncretic spiritual healing to about 70-80% of people in Ghana. This is demonstrated in the expressions below:

‘Ehrrm, I think we get close when we suspect there’s a problem somewhere. Not all religious leaders are able to see through and to know what to do’. (TRL, Man, 55 years).

‘I met a man who didn’t say he was going to commit suicide but from conversation, I noticed some marks on the body, the forehead...so I started asking questions and I realized from what he told me that he was a Presbyterian, he had gotten ill, gone to a mallam, had those scars and was given some instructions. Even before having sex with
the wife, he had to do some things and I asked, for how long...and he said oooh, he will always do it. I realized this was somebody in bondage. So we talked, we prayed...but I encouraged him to go to Grace Presbyterian Church at Akropong, Catechist Abboah-Offei’s place for continuous prayers because he stays on the ridge at Aburi which is close...erhhhm’. (CRL, Woman, 55 years).

Thus, it can be noted from the above expressions, that participants view themselves as responsible for recognizing suicidal persons within their congregations. For instance, when they notice certain suicidal tendencies, they first get closer to probe further through talking to the person or investigating by asking questions. The answers to these questions help them to determine the next most appropriate line of action. In the latter expression, the informant identifies this individual as someone in bondage and then takes a further step to provide direction by referring the supplicant to a senior minister for continuous prayers.

Moreover, participants felt it was their obligation, after they have identified supplicants presenting suicidal tendencies, to show empathy and compassion by giving them care. This is hinged on the notion that life is sanctimonious and suicide centers on taking life. For example;

‘My obligation as a minister is to everybody, suicide is one of the needs. There are other needs that are equally serious, yet suicide borders on taking life and so becomes an issue. So as a minister, I have an obligation towards the sanctity of life, to everybody, so whether you are going to get married or you are going to school or you are looking for a job or you want a house-help or you are becoming a potential suicide case, I have an obligation towards you’ (CRL, Man, 55 years).
‘Definitely. It is my responsibility to help anybody in my congregation with such a problem’. (IRL, Man, 48 years).

‘Yes. We as leaders in this community have a responsibility toward suicidal persons. When they share their problem with any of us, we can then direct them on what they can do to help them in solving the problem’ (TRL, Man, 48 years).

Researchers such as Ratnarajah and Schofield (2000) and Joiner (2007) posit that the role of religious leaders in modifying suicidal behavior is very important, especially in helping to prevent ‘inter-generational suicide’ among friends, relatives or even within the same family. Hence, the indication from the above viewpoints that suggests that religious leaders perceive that they are frontliners and that it is their responsibility to help modify the behavior of their congregants presenting suicidal tendencies via their demonstration of care towards them or their survivors is very encouraging.

Armed with this understanding that participants perceived that they had a caring obligation towards suicidal persons, the analysis examined further to ascertain from respondents the treatment regimens they employ in carrying out this obligation towards suicidal persons. These included: ‘healing communities, ‘counseling and referral’, ‘spiritual healing’, ‘social support’ and ‘hope induction’.

*Healing community:* According to participants, one of the key means by which they help modify the behavior of suicidal persons is creating a healing community around them. Specifically, they befriend them, and also ask other key persons like the friends and family of the individual to keep an eye on them and support them out of the situation, which is making them suicidal. These were some of their responses;
‘...you keep befriending them, you keep following up on them until you have come to the point of healing for them. Immediately, you also ask people to keep an eye on the person and form a healing community around the person.’ (CRL, Man, 52 years)

‘..religious leaders can advise the close people around them like friends and family to support them out of the situation’ (MRL, Man, 42 years).

‘..But above all, try to be very close to the person, if you try to be very close to the person, monitor the person’s movement, I think you would help the person.’ (TRL, Man, 42 years).

According to respondents, they create a healing community around suicidal persons by befriending, following up and advising people close to the suicidal individual to monitor them by keeping an eye on their movements since this can help them overcome the suicidal tendencies.

Counseling and Referral: Analysis of narratives from informants on treatment regimens suggested that more often, Christian religious leaders (compared to Islamic and Traditional religious leaders) mainly use counseling as a diagnostic and therapeutic tool to offer hope, support and encouragement to persons who have suicidal tendencies. As a diagnostic tool, an attempt is made through the use of counseling to explore the potential cause of the problem and as a therapeutic tool, counseling is used to give health or restore sanity to the suicidal individual. A respondent asserts;

‘Well, some ministers use counseling only as a diagnostic tool but I believe also that counseling is foremost a therapeutic tool, so through counseling, you can actually bring therapy- treatment and healing to people’ (CRL, Man, 55 years).
Other participants also indicated that they counsel suicidal persons by talking to them, sharing other people’s experiences with them to make them realize that the problems they are encountering is universal and that they are not the first to face such a problem (Yalom, 2005b). According to respondents this helps to steer suicidal congregants away from attempting or completing suicide. The practice of religious faith in Ghana is widespread. Here, the participant views suicidal behavior as a failure on the part of the suicidal individual to utilize their religious faith during crisis hence the emphasis to make the person put his or her trust in God because this might deter the person from future attempts. For instance a respondent states;

‘Ehmm by talking to the person, maybe sharing other peoples experiences to make the person feel that, he or she is not the first to go through such a thing. And also to make the person put either his or her trust in God’ (TRL Man, 50 years).

‘As a leader, I try to assuage the problems that can lead to suicide by talking to the person and trying to identify any suicidal tendencies and then try to help. Quite recently, a gentleman came here and said he was indebted to a company and they had instituted a court action against him and he had nowhere to turn to. We readily assisted him. If it’s a marital problem, there is a marriage committee and if our attention is drawn to it, we give them advice. In effect, we take a proactive stance. (CRL, Woman, 55 years).

Specifically, the latter narrative suggests that the loss of a job and financial as well as marital problems could cause individuals to get suicidal. This opinion is supported by Hjelmeland et al. (2008) who report that in Ghana, risk factors for suicide include the following family dynamics (e.g. lack of support, relationships); shame and embarrassment; lack of self-worth (feelings of inadequacy), loss of face and spiritual forces. Accordingly, the narratives indicate that adequate
counseling (both diagnostic and therapeutic) from the religious leaders through the dissection of the problem and seeking of requisite support made it solvable. Thus, counseling is restorative and helpful in modifying the behavior of suicidal individuals and hence preventing them from attempting or completing suicide (e.g. Sandage, 2009; Stake, 2005).

Although this finding might be based only on persons who had some training in suicide prevention and those who have engaged with the doctrines and practices of their respective faiths as it relates to suicide, some respondents reported that in extreme cases, they refer suicidal persons to professionals such as Psychiatrists or Psychologists for clinical care. Some participants had this to say:

‘.. now whenever I have opportunity and depending on the level I think they (suicidal persons) are, for instance if they are just at the beginning, affirmation and re-orientation will help them. If they are beyond that, then they need immediate attention and we refer or ask that they be immediately sent to see the psychologist. (CRL Man, 55 years).

‘..Yes, on a few occasions. I quite remember, we had a worker who was exhibiting some weird symptoms and at a point we had to rush him to go and see a specialist. (IRL Woman, 55 years).

Analysis of these expressions suggest that after the cause of the suicidal case has been determined at the counseling stage, respondents might then refer them to a clinician or psychologist for clinical care when they think that it is necessary. Interestingly, Christian and Islamic religious leaders with higher levels of training in suicide prevention than their relatively lowly educated counterparts largely emphasized ‘referral’ for clinical and professional care. On
the other hand, the rest of the religious leaders who had less training in suicide prevention emphasized the spiritual healing approach.

**Spiritual Healing:** In other instances, such as when certain families have a history of completed suicides, when suicidal tendencies in certain individuals keep recurring or there was a suspicion of diabolical interference, participants reported that they resort to spiritual healing such as prayer or deliverance in helping to treat suicidal persons as some participants stated below:

‘Pastors, Psychologists, psychiatrists but I feel majority of suicidal cases can be handled by religious folks, by pastors. Because you deal with the physical aspect through counseling and if there is any spiritual connotation to it, you pray and deal with it too. Because there are some people who can receive counseling from psychologists, they will be okay for a period of time. But if the thing is from a lineage where there has been suicidal tendencies, then of course that thing can resurface again...then you need to handle it spiritually’ (CRL, Woman, 40 years).

‘I teach the women, so some of them often bring problems concerning their marriages and children to me for counseling. I then bring together such people among them and pray for them’ (MRL, Woman, 55 years).

‘If the suicidal person opens up to share his or her problems with top leaders in the community, he or she can be helped with prayers but if he or she doesn’t, then it becomes their individual problem’. (TRL, Man, 60 years).

It appears from the above quotes that the spiritual healing regimen largely depends on the subjective spiritual potency of the religious leader. Specifically, there is a celebration of this regimen over the perceived limitation of the professional and clinical care from Clinicians or
Psychologists. Furthermore, using this regimen, religious leaders relied heavily on their *spiritual abilities* to either discern or diagnose the cause of the suicidal problem. According to Omenyo (2011), this is similar to *akwankyere* or *abisa* (Akan words used to refer to counseling and direction), where a diviner gives direction in life or instruction to avert a possible future mishap.

**Social Support:** According to respondents, the lack of social support from close friends and family seems to be the major factor that made certain individuals suicidal. Therefore in dealing with suicidal persons, they encourage that friends and family should support suicidal persons out of the situation that makes them suicidal. For example, an Islamic respondent draws on his religious belief to justify his argument for social support as he states below:

> ‘..in such cases, if there is enough support- let us say from their friends, so they can get back on their feet, this wouldn’t happen. But when they feel there is nobody to help them out of the situation, they resort to committing suicide. A respected person, who is humiliated, could do anything to himself. So prophet Mohammed admonished us to help them so that they would still feel big (MRL, Man 50 years).

According to respondents, family and social support from friends can protect suicidal persons from further suicide attempts. These sources of support are curative, highly beneficial and can mitigate the incidence of suicidal cases because, they fall within the inner social circles of the suicidal individual hence they can easily detect any suicidal tendencies (Quinn, 2007). For example some respondents put it this way:

> ‘Well, religious leaders can help suicidal persons through counseling and they can also advise the close people around them like family and friends to support them out of the situation’ (TRL, Woman, 60 years).
‘..Ehrmm, the first group I would mention would be parents, family members, because we spend so much time at home and we are ourselves when we are at home (CRL, Woman, 50 years).

Hope induction: A closer examination of the therapies revealed that in dealing with suicidal persons, respondents induce religious hope in suicidal persons who appeared hopeless. The following quotes are illustrations of the hope induction approach.

‘...religious leaders can encourage you, give you hope’ (MRL, Woman, 50 years).

‘..Yes, definitely. Our task is to give people hope and encouragement and to let them know that God has left them on this earth for a purpose’ (CRL, Man 56 years).

‘I also encourage the person to put his or her trust in God’. (TRL, Man, 48 years)

This hope induction segment appears to be grounded in the fact that the supplicant’s suicidal tendencies are by-products of faith-failure or immature faith and was common to all the three religious strands. Hence these religious leaders in utilizing this regimen invite the suicidal individual to partake in the healing process by giving them encouragement through religious teachings. This diverts their attention from whatever problems they may be facing and re-focuses their attention on God (Osafo et al., 2015).

These findings show that all the three groups of interviewees use some sort of treatment regimen when dealing with suicidal persons. However, majority of Christian religious leaders compared to their Islamic and Traditional religion counterparts, appeared largely to utilize counseling to determine the cause of suicidal behavior. More often, religious leaders induced hope in suicidal persons to encourage them to have a more positive outlook on life and also resorted to spiritual
healing to help suicidal persons with family histories of recurrent attempted or completed suicide. Moreover, only highly educated Christian and Islamic religious leaders rather than their relatively lowly educated counterparts specified that they might refer suicidal persons or supplicants to a clinician or psychologist for clinical care when they think that it is necessary.

The assessment of the attitudes of Christian, Islamic and Traditional Religious leaders towards suicidal persons and suicide prevention shows that largely, these three groups of religious leaders hold similar attitudes in their preparedness in working towards suicide prevention. They all held strong viewpoints that suicide should and must be prevented. This was indicated in the treatment regimens they employed when dealing with suicidal persons. Summarily they expressed their willingness to deliver to the best of their ability when administering care to such persons.

Accordingly, participants expressed that despite their willingness to help suicidal persons they faced certain challenges. These challenges prevented them from fully giving adequate help to suicidal persons. For example, only four interviewees out of the total of twenty-eight respondents acceded to the fact that they have had some form of suicide prevention training as part of specialist counseling courses they had taken in the course of their education. The remaining twenty-four had had no form of suicide prevention training whatsoever. Responses therefore revealed that lack of requisite training and resources were the major barriers.

Lack of requisite training: It was clear from the responses of these religious leaders that they lacked adequate professional training and skills. Nonetheless, they consented that suicide must be prevented and requested that they are given requisite suicide prevention training so that they can be capable and effective when dealing with cases of suicide particularly because of the key
role they play in suicide prevention. Largely, the need for requisite training was emphasized more by Christian religious leaders than their Islamic and Traditional counterparts.

These were the opinions of some Christian respondents:

‘Like I said, from the very point of training, it is all about preparing people to become academic theologians instead of becoming ministry practitioners...there isn’t any in-service training, specialized courses and seminars done for people or training for people to take care of such things’ (CRL, Man, 48 years).

‘I have the opportunity to speak to the moderator...but we do not have any resources as at yet’ (CRL, Woman, 58 years).

Lack of resources: Majority of religious leaders stressed that though they used religious teachings mainly to give hope, and comfort to suicidal persons, their respective denominations or communities however did not have any other physical resources for preventing suicide. Some of them opined:

‘I don’t think any such thing is in place. We don’t encounter such things. If we did then, we might have the resources’. (IRL, Man, 55 years).

‘I am not aware of any resources my church has for preventing suicide. (CLR, Woman, 40 years).

‘I am not sure...I don’t think it exists, even if it does, perhaps I don’t know about it’ (TRL, Man, 48 years).
They were however quick to state that this lack of resources could be attributed to the fact that they hardly encountered suicide cases and in instances where resources may have been available for suicide prevention, they may not have known about it.
CHAPTER 5

5.0 DISCUSSION

5.1 Introduction

The aim of this study was to explore the attitudes of religious leaders in the Ga East Municipal District towards suicide and the treatment regimens they utilize in prevention. This chapter therefore discusses the findings of the research and outlines some recommendations for future research.

5.2 Attitude towards suicide: Cultural Artifact

This study set out to examine how religious leaders in Ghana perceive suicide and the analysis has revealed that cultural factors influence their attitudes toward suicide. According to Marsella, Dubanoski, Hamada, and Morse (2000), ‘culture is the shared acquired patterns of behavior and meanings that are constructed and transmitted within social-life contexts for the purposes of promoting individual and group survival, adaptation and adjustment’ (p.50). These shared patterns are continuously subject to change and revision and they can become dysfunctional. Suicidal behavior is a crime in Ghana and persons who attempt suicide are subject to arrest and trial, and upon conviction, are liable to criminal penalties as stipulated in Act 29, Section 57, of the Criminal Code of Ghana (1960). Suicide is also tabooed culturally with severe consequences for the surviving family members; hence people who decide to end their lives often go to extensive lengths to conceal their behavior (Adinkrah, 2011). Additionally, Christianity, Islam and the traditional religion, which are the three main religious groupings within the country, also abhor suicide (e.g. Mbiti, 2006). Drawing all these together, it is possible to draw a conclusion that because the Ghanaian cultural setting abhors or perceives suicide as unacceptable (there is
no claim here that individual behavior is always coherent with socio-cultural dictates (see Boldt, 1998, p.96) the individual meanings and attitudes which participants in this study held towards suicide were largely influenced by the prevailing normative standards of the Ghanaian cultural setting. Specifically, they viewed the act as abhorrent and abominable. They also believed that committing suicide was a violation of religious beliefs and likewise conceived that suicide could be caused by diabolical interference.

This finding on suicide as a cultural artifact could be explained within the postulations of the sociocultural theory of Vygotsky (1978). This theory proposes that an individual who grows up in a society where suicide is perceived as an abomination is likely to internalize this custom until it is modified. Thus, growing up in a society that holds negative attitude towards suicide can lead to less acceptability of suicide (Osafo et al., 2013c, 2015). This is consistent with the understanding that societies make up concepts in their past and use them subsequently as norms and standards. This could be referred to as cultural artifact (see e.g. Marsella et al., 2000). In the present study, the participants’ commitment to internalized cultural norms and core religious beliefs such as sacredness of life, salvation and the after-life, communication and faith, dependence on God through prayer and hope was the basis of rejecting suicidal behavior. These cultural and religious components (artifacts) nurtured a negative attitude of suicidal behavior as contradictory to life preservation and therefore should not be accepted. Additionally, respondents in this study have clearly demonstrated that culture and religion are perceived as protective during times of crisis and particularly suicidal ones. The ascription of suicidal behavior to dearth of religious commitment could be an indirect allusion to the importance the participants place on religious coping and therefore, the dearth of coping on the part of those who are not religious. Anglin et al. (2005), Dervic et al. (2004) and Sisask et al. (2010) are some examples of studies
that have reported that moral condemnations of suicide, ratifying religious coping and perceiving oneself as religious could be protective of suicidal behavior. Hence, these should lead us to engage religious resources such as faith, hope, and dependency on God through prayer among other things in suicide prevention. Conceivably, this is the understanding of the participants of this study when they espoused that religion is pragmatic as a coping and survival norm.

Furthermore, Traditional and Christian leaders more than Islamic leaders perceived that though suicide could be caused by several psychological and biological factors, it was also necessary to take cognizance of the fact that suicide can be caused by diabolical agents. This perception that suicidal behavior can be caused by diabolical interference may explain the reason why these participants are very much involved in using spiritual healing regimen to aid suicidal persons. Specifically, Kyei, Dueck, Indart, and Nyarko (2014) observed rightly, ‘in Ghana’s highly superstitious culture, a problem conceptualized as supernatural in origin must ‘logically’ be solved supernaturally’ (p.2).

5.3 Suicide as Pathology

Although attitudes towards suicide were viewed as a cultural artifact, another major finding of this study was that participants viewed suicide as pathology or disease. Specifically, participants in this study viewed suicide as a sign of ‘sign of un-wellness’, ‘sign of frustration’, and ‘mental illness’. Thus, participants in this study perceived that suicidal persons are in poor mental health because of the heightened level of psychological distress due to their sense of loneliness, frustration caused by failure of marriages, ambitions or even relationships and feelings of being unwanted that they face and are unable to handle. This finding is consistent with the literature on psychological distress and suicidal behavior. For example, Lester (2013) puts forward that depression, especially hopelessness, and psychological disturbance such as emotional instability,
neuroticism or anxiety are some major factors associated with suicidal behavior. Pillai et al. (2008) also concluded after their cross-sectional study of 3662 youth (16-24 years) from urban and rural communities in Goa (India) that psychological distress was independently associated with suicidal behavior.

5.4 Suicide Intervention

This study sought to examine how participants perceive their role in suicide prevention as well as the treatment regimens they employ when they engage with suicidal persons. In line with these, participants in this study perceived that they have a key role to play in suicide prevention. This finding is congruent with the postulations of Role theory which suggests that most of everyday activity tends to be an acting out of socially defined categories such as father, teacher, priest, manager etc. and these specific social roles are accompanied by sets of rights, duties, expectations, norms and behaviors that a person has to fulfill and face. (Biddle, 1986; Katz & Kahn, 1978). Thus, participants perceived that as religious leaders, they are frontliners with a caring obligation or duty to help suicidal persons because it borders on taking life. Furthermore, the Ghanaian cultural setting abhors or perceives suicide as unacceptable as was discovered in this study. Hence the treatment regimens identified were more intervention based than prevention focused. Specifically, these regimens were employed as interventions only after a suicidal individual has been identified. Accordingly, the findings revealed five main treatment regimens which participants employed when interacting with or caring for suicidal persons. These included creating healing communities around suicidal persons, counseling and referral, spiritual healing, social support and hope induction.
Hope Induction and Counseling and Referral: Participants after identifying persons who are suicidal, first talk to the individual through the use of the counseling regimen to ascertain what may be the cause of the suicidal tendency. Specifically, when they noticed that a suicidal individual was exhibiting a sense of hopelessness, psychological distress or frustration etc., participants then induce religious hope into them to allay their fears through the use of religious or doctrinal teachings (see chapter 4 for detailed findings on hope induction).

These findings on how religious leaders in this study explicitly blend the hope induction regimen into the counseling session is indeed encouraging and shows that religious leaders have ways of engaging suicidal persons and determining a cure or healing for them. Specifically, Rasmussen and Wingate (2011) posit that hope induction lessens the probability for suicidal ideation and also accelerates clients’ recovery (e.g. Larsen, Edey, & Lemay, 2007) hence it is a critical component in mental or psychiatric nursing. Therefore, to widen the outlook of suicidal persons whose alternatives in handling crisis have been limited by feelings of hopelessness, participants in this study encourage, talk to and listen to suicidal persons. This finding is similar to that of Ae-Ngibise et al. (2010) who specified in a prior study that a key reason why people seek the services of traditional and faith healers in Ghana is due to the psychosocial support offered to patients through talking to them as psychologists do, to assuage their fears and infuse into them positive thoughts. However, this study also discovered that majority of respondents lacked any form of training in suicide prevention. Hence it was only persons with suicidal tendencies, which were more physical in nature, or easily identifiable that caught their attention and which they tried to attend to. The problem here then is that, the suicidal person with suicidal tendencies, which are more psychological, innate or unidentifiable, which may require some expertise or
training on the part of religious leaders to identify, may go unnoticed thereby inadvertently resulting in a completed suicide.

**Spiritual Healing:** Furthermore, after identifying a suicidal person, participants first try to analyze the patterns of suicidal tendencies to try to discover whether any patterns exist (e.g. history of completed or attempted suicide within the family, diabolical interference etc.). If in their estimation or understanding, these tendencies are more spiritual than physical for example, they then resort to spiritual healing such as prayers and deliverance (see chapter 4 for detailed findings on the spiritual healing regimen).

Concisely, the spiritual healing regimen assists participants to analyze and understand the causative agent of the suicidal case. It also helps participants to offer a solution to improve the suicidal persons crisis (Osafo et al., 2015). However, the spiritual insight for determining if a suicidal case is occurring due to diabolical interference depends widely on the subjective spiritual potency of the religious leader and is unquestionable hence, the suicidal person is more inactive and passive when this regimen is used (compared to the hope induction approach where the suicidal person participates and is more active in the healing process). Furthermore, participants in this study indicated their revel for this regimen due to the perception that conventional or orthodox care is limited. This requires more reflection because according to the WHO (2014), there are several causes and pathways for suicide. Some of these are psychopathology, substance abuse, family dynamics, HIV AIDS, violence, psychological distress etc. (Pillai et al., 2009; Schlebusch, 2005). Thus intervention programs that consist of more than one prevention strategy might be useful for preventing suicide than single strategies such as the single use of the spiritual healing regimen as espoused by participants in the study.
Healing Communities and Social Support: Respondents conceived that the lack of social support from close friends and family seems to be the major factor that made certain individuals suicidal. Therefore when they identify a suicidal person, they create healing communities around suicidal persons by encouraging close friends and family to monitor, keep an eye on and support suicidal persons out of the situation that makes them suicidal. (See chapter 4 for detailed findings on the Healing Communities and Social Support regimen).

In this present study, although the interviewees’ religious beliefs (e.g. belief that God is responsible for life and divine retribution for suicidal individuals) could promote stigmatization of suicidal behavior, I did not find that extended toward suicidal persons. They appeared to have disconnected their attitudes towards the suicidal person (somebody who needs care and support) from suicide as a phenomenon (an act divergent to their faith). The Suicide Prevention Resource Centre (2009) funded by the United States Department of Health and Human Science for example, discovered that faith communities and religious persons show compassion towards and support suicidal persons. This conceivably, may be what the respondents in this study demonstrate. Such support and care norms that are fostered by these religious leaders’ beliefs could lessen the potential impact of stigma on suicidal individuals. Moreover, this impact religion exerted on the respondents’ moral resolution to offer assistance during suicidal crisis could lend further support to the association between prosociality and religion in this specific cultural context. This is because such an act could be conceived as a manifestation of true religiosity.

However, after a completed or attempted suicidal act, close family and friends, the local community and both the attempter and suicide counselor are themselves at risk for committing suicide due to the deep and potential stigmatization, condemnation, loss of self-esteem, persistent
intrusive dreams and feelings of both anger and guilt in response to the death (WHO, 2006). Specifically, Rogers (2001) reports that client suicide is considered an ‘occupational hazard’ in the counseling profession and he estimated that about 25% of counselors who have had a suicide client commit suicide. Also, Qin, Agerbo, and Mortensen (2003) report that for close family relations for example, completed suicide is associated with 2.1 fold increase in risk for completion of suicide themselves (1.9 fold increase for males and 2.95 increase for females), in young survivors less than 21, paternal suicide is associated with a 2.3 fold increase, and maternal suicide is associated with 4.8 fold increase in risk for suicide completion. The loss of a child is also associated with increased risk in suicide survivors and loss to suicide increases risk even more. Hence there is the apparent need for a clear set of guidelines for counselors that are informative, practical, and accessible in dealing with suicide crises since majority of participants in this study lacked any training in suicide prevention. They may also therefore lack the required expertise in carefully choosing persons to provide the social support or consist of the healing community. Inadvertently, they may put themselves and these survivors at risk.

Participants also declared that the lack of physical resources and requisite training was a major setback in their provision of help to suicidal persons. Specifically, their denominations were not well resourced in helping prevent suicide. Also, in instances where such resources may be available, they did not know or were not aware of such arrangements. This implies that religious denominations and traditional communities need to be resourced to improve their service delivery so that they can be proactive in preventing suicide. Additionally, where these resources are already available, these should be communicated to religious leaders so that they can make use of such resources.
5.5 Trustworthiness of the Study

Ensuring the credibility of findings in qualitative research is an important issue. Consequently, guided by Guba’s recommendations of credibility, transferability, dependability and confirmability, the study discusses how validity issues were addressed. In addressing the issue of credibility, the researcher sought to demonstrate a true and clear picture of the phenomenon of suicide within the first and second chapters of the study. To allow transferability, the researcher went further to provide adequate detail of the context of the fieldwork within chapter three of the study. Furthermore, Shenton (2004) put forward that it is difficult to meet the dependability criterion in qualitative research. Nonetheless, the researcher in this study has sought to give a clear picture of the phenomenon of suicide, sufficient description of participants interviewed and the context to enable an investigator to repeat the study in the future. The researcher also demonstrated the confirmability criterion within chapter four of this study in two ways. First, the investigator spent a considerable amount in the field after each interview, to check and summarize during the interview process to confirm whether the views of respondents have been rightly recorded. Second, by transcribing interviews verbatim and citing extractions from interviews conducted in order to demonstrate that findings emerged from the data and not from the researcher’s own predispositions. Additionally, the researcher had several rigorous exchanges and inter-subjective discussions with her supervisors who ensured that the analysis and interpretations of data gathered from respondents were fair and objective. Overall, these elements give credence to the trustworthiness of the research.
5.6 Implications

The findings on the treatments regimens employed by the religious leaders in this study indicate how they are already providing some help to people who are at risk for suicide and can have implications for the prevention of suicide in Ghana. Specifically, the study discovered that the Ghanaian cultural setting abhors or perceives suicide as unacceptable thus the treatment regimens identified were more intervention based than prevention focused. These regimens were therefore employed as interventions only after a suicidal individual has been identified. Particularly, when participants noticed through counseling that a suicidal individual was exhibiting a sense of hopelessness, psychological distress or frustration etc., they then induce religious hope into them to allay their fears through the use of religious or doctrinal teachings. However, the lack of training in suicide prevention may make it difficult for religious leaders to identify suicidal individuals with more innate or not easily identifiable suicidal tendencies. Also, the creation of healing communities and social support regimen, though helpful puts the people involved, including both the religious leader and the attempter at potential suicidal risk due to the deep and further potential stigmatization, condemnation, loss of self-esteem, persistent intrusive dreams and feelings of both anger and guilt in response to attempted or completed suicide death. This calls for adequate training in the selection of persons who should consist of the healing community formed around the suicidal person to provide social support.

The celebration of spiritual healing (which is largely dependent on the spiritual potency of the religious leader) as a single treatment regimen over conventional or orthodox medicine due to its perceived limitations also calls for more reflection and research since the causes and pathways for suicide are multifactorial and multi-component intervention strategies aimed at prevention are more effective than single strategies.
Summarily, there is the need for a paradigm shift from a culture that abhors suicide to a nurturing culture that is more acceptable of suicide- that like any other type of death, suicide can and does happen. There is also the need for training and public education about the risk and protective factors in suicidal behavior as well as to how to help mitigate stigma towards suicidal persons.

5.7 Methodological Limitations

The study has provided a close investigation and delineation of the treatment regimens religious leaders of the main religious strands in Ghana employ in suicide prevention, which to the best of my knowledge, is the initial endeavor in the Ghana suicidology literature. However, this research was not without limitations. Qualitative research is an interpretative enterprise (Whittemore, Chase, & Mandle, 2001) and therefore, by taking a purely qualitative approach, findings might not be generalizable to other people or settings. Particularly, findings might be unique to the relatively few people interviewed for this research. According to Etzersdofer, Vijayakumar, Schöny, Grausgruber, and Sonneck (1998), research on attitudes includes many methodological difficulties possibly leading to biases hence, the willingness to answer freely, may be particularly reduced in discussing an emotive topic such as suicide. Thus, it is difficult to avoid biases from researchers and interviewees on such a sensitive topic.

Again, this study is limited in a way that participants were Christian, Islamic and Traditional religious leaders. It did not consider the many other religious denominations in Ghana since Assimeng (1999) describes Ghana’s religious sphere as a zoo, implying several other religious sects co-existing. Future research could therefore consider the opinions of religious leaders in other religious faiths and their distinctive conceptualization of suicide in order to broaden our
understanding of the connection between religion and attitudes toward suicidal behavior in Ghana.

5.8 Recommendations for Future Research

Future research particularly in the same area should consider a much more detailed design, perhaps a mixed-method design, specifically a quantitative and qualitative approach using a relatively larger sample size that would provide a detailed examination of the attitudes of religious leaders towards suicide. This would allow for the comparison of the attitudes of religious leaders towards suicide and suicide prevention from diverse religious faiths.

5.9 Conclusion

The general aim of this study was to explore the attitudes of Christian, Islamic and Traditional religious leaders in the Ga East Municipal East District towards suicide and examine their treatment regimens as well as their role in suicide prevention. Conclusively, empirical data revealed that participants’ cultural and religious orientation, commitment to observing fundamental religious beliefs affected their interpretation of suicidal behavior as a cultural abhorrence. The perception of their role as frontliners who need to help suicidal persons influenced their understanding that suicide must be prevented and this is indicated by the treatment regimens they employ when dealing with suicidal persons. Noteworthy however, is the fact that the Ghanaian cultural setting abhors or perceives suicide as unacceptable hence the regimens identified were more intervention based (i.e. employed only after suicidal persons have been identified) than prevention focused.

Foremost, though largely based on persons who had some training in suicide prevention and those who have engaged with the doctrines and practices of their respective faiths as it relates to
suicide, the counseling and referral regimen was used more by Christian religious leaders than their Islamic and Traditional counterparts as a diagnostic and therapeutic tool to offer hope, support and encouragement to suicidal persons. Additionally, Christian and Islamic religious leaders with higher levels of training in suicide prevention than their relatively less trained counterparts largely emphasized ‘referral’ for clinical and professional care when it became necessary. Furthermore, religious leaders who had less or no formal training in suicide prevention emphasized the spiritual healing regimen. Specifically, religious leaders utilized the spiritual healing regimen when they estimated that suicidal tendencies were more spiritual than physical. The celebration of this regimen (which is largely dependent on the spiritual potency of the religious leader) as a single treatment regimen over conventional or orthodox medicine due to its perceived limitations also calls for more reflection and research since the causes and pathways for suicide are multifactorial and multi-component intervention strategies aimed at prevention are more effective than single strategies. Additionally, when participants noticed through counseling that a suicidal individual was exhibiting a sense of hopelessness, psychological distress or frustration etc., the hope induction regimen was employed during counseling sessions to allay their fears. However, the lack of training in suicide prevention may make it difficult for religious leaders to identify suicidal individuals with more innate or not easily identifiable suicidal tendencies.

Also, participants conceived that the lack of social support from close friends and family seems to be the major factor that made certain individuals suicidal. Therefore when they identify a suicidal person, they create healing communities around them by encouraging close friends and family to monitor, keep an eye on and socially support suicidal persons out of the situation that makes them suicidal. This regimen, though helpful puts these people including the religious
leader and the attempter at potential suicidal risk due to the deep and further potential stigmatization, condemnation, loss of self-esteem, persistent intrusive dreams and feelings of both anger and guilt in response to attempted or completed suicide death. This calls for adequate training in the selection of persons who should consist of the healing community formed around the suicidal person to provide social support.

This study has therefore demonstrated that religious leaders are key people who can help suicidal persons through their interactions with them thereby counteracting their decision for self-destructive behaviors such as suicide. Additionally, the study has demonstrated that Christian, Islamic and Traditional religious leaders are engaged in mental health care and their treatment regimens have the potential to supplement conventional therapies if improved through professional education and training. Religious groups should therefore be strategically enrolled in the vibrant discourse of searching for effective ways of enhancing mental healthcare services in Ghana.
REFERENCES


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ATTITUDES AND TREATMENT REGIMENS IN SUICIDE PREVENTION: THE ROLE OF RELIGIOUS LEADERS IN THE GA EAST MUNICIPAL DISTRICT

and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.


APPENDICES

APPENDIX A: ETHICAL CLEARANCE

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No. ………………………………………………………………………………………………………………

Buernorkie M. Puplampu
Department of Psychology
University of Ghana
Legon

Dear Ms. Puplampu,

ECH 030/14-15: ATTITUDES AND TREATMENT REGIMENS IN SUICIDE PREVENTION: THE ROLE OF RELIGIOUS LEADERS IN GHANA.

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 17/07/15
On Agenda for: Initial Submission
Date of Submission:: 23/10/14
ECH Action: Approved
Reporting: Quarterly

Please accept my congratulations.

Yours Sincerely,

[Signature]

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Dr. Joseph Osafo, Department of Psychology, University of Ghana
    Prof. C Charles Mate-Kole, Department of Psychology, University of Ghana
    Director, ISSER

Tel: +233-244855638 Email: ech@isser.edu.gh

19th January 2015
APPENDIX B: INTERVIEW GUIDE

INTERVIEW GUIDE

ATTITUDES AND TREATMENT REGIMENS IN SUICIDE PREVENTION: THE ROLE OF RELIGIOUS LEADERS IN GHANA

DEMOGRAPHIC DATA

Gender:
Year of Birth:
Ethnicity:
Marital status:
Religion:
Years of formal education:
Job Title:
Years in position:
Approximate gross annual income:

Have you taken any ‘suicide prevention training’?
Please describe.

About how many people are in your congregation?

Who are you leaving with?

  o With wife and children
  o With husband and children
  o With wife alone
  o With children alone
  o With other family relatives
  o With friends
  o Alone

ATTITUDES

  • What in your view are the most important factors that contribute to suicide?
    • Could you explain how these factors make someone suicidal?
  • What is your view of suicidal behaviour?
  • How do you view Ghanaians attitude toward suicide?
Do you think their view of suicide influences the way you view the act? if NO why?

How do you see suicidal persons? (Explore/probe)
  o In three words describe a suicidal person

What reactions do people express toward suicidal persons in Ghana? How do you view these actions (probe)

When you mention suicide during service how do your supplicants respond?

TREATMENT REGIMENS

Do you think suicidal behaviour can be modified? Please explain your answer

Which category of persons in your view can modify the behavior of suicidal persons?
  o (if he doesn’t add himself/herself ask “are you one of those who can help modify the behavior of suicidal persons?)

Are religious leaders able to modify the behavior of suicidal persons?

Please explain how religious leaders help persons with suicidal crisis (explore all the treatment regimens that informant provide or list- e.g., prayers, fasting, counseling, deliverance etc)

How do you use counselling (and other treatment regimen listed above) to help someone in suicidal crisis?

Have you counseled with any individual/s who reported thinking about committing suicide this in your profession? If yes which year?
  o How did you go about it? How much time did you spend with each person?

Do you think that you have an obligation to help people who are thinking about suicide?
  o Explain your response

PREVENTION

Can suicide be prevented?

Should suicide be prevented?

Do you think religion can help the prevention of suicide? Explain your response

Are there aspects of religion that can also make people suicidal?

Do you refer cases to a specialist? Please which specialist and what kind of cases do you refer to such specialist?

In the past few years, are you aware of any attempted or completed suicides among your congregation or their relatives? If yes
  o What happened?
  o What was the reaction of the supplicants?
  o How did the church leadership respond to the incident?

1. What resources are available in your church for preventing suicide?
2. Are there any penalties for members who engage in suicidal behaviour? If yes what are some of these penalties? If no why aren’t there any of such punishment?
3. Would you be willing or not to counsel people who are not members of your congregation or religious affiliation?
4. What do you do for members who have lost a family member through suicide?
5. Are you aware of the penal code against suicidal behaviour in Ghana? (if informant says No explain the code and proceed to find …) What is your view about it?

DISCLOSURE

- How did you feel being interviewed
- Are there other questions you want to ask me?
- Are there aspects of these issues we discussed that you wanted asked or done in another way?
APPENDIX C: LETTER OF INTRODUCTION

UNIVERSITY OF GHANA
DEPARTMENT OF PSYCHOLOGY

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028 955 04 83

Our Ref. No. PSYC 2/33/01 December 3, 2014

The Administrator
Ethics Committee for Humanities
Institute of Statistical, Social and Economic Research (ISSER)
University of Ghana
Legon

Dear Sir/Madam,

LETTER OF INTRODUCTION

BUERNORKIE M. PUPLAMPU – ID NO. 10225576

The above-named is an M.Phil Social Psychology student in the Department of Psychology, University of Ghana, Legon.

As part of the requirement, Buernorkie M. Puplammu has to write and submit an original thesis. The title of her thesis is “Attitude And Treatment Regimens In Suicide Prevention; The Role of Religious Leaders In Ghana”. She is planning to conduct her study in Religious denominations within the Ga East Municipal Assembly of the Greater Accra Region.

She is applying to your Board for institutional approval/clearance to enable her carry on with her Research Work. She has received approval from our department. Your assistance in reviewing her proposal is much appreciated.

Yours sincerely,

Prof. C.C. Mate-Kole
(Head of Department)