

Community leaders' attitudes towards and perceptions of suicide and suicide prevention in Ghana

Joseph Osafo and Charity S. Akotia

University of Ghana

Emmanuel Nii-Boye Quarshie

University of Leeds

Johnny Andoh-Arthur

Norwegian University of Science and Technology

Kofi E. Boakye

Anglia Ruskin University

Abstract

Community leaders can play an important role in suicide prevention because they are potential gatekeepers in resource-poor settings. To investigate their attitudes towards suicide and the role they play when people are in suicidal crisis, 10 community leaders were interviewed in a rural community in Ghana. Thematic Analysis of the interviews showed that leaders held two conflicting views about suicide: health crisis and moral taboo. They also viewed the reasons for suicide as psychosocial strains more than psychiatric factors. Though they viewed suicide as a moral taboo, they maintained a more neutral position in their gatekeeping role: providing support for persons in suicidal crisis more often than exerting a condemnatory attitude. Implications for gatekeeper training are discussed.

Keywords

attitudes toward suicide, community leaders, gatekeepers, Ghana, suicide prevention

Corresponding author:

Joseph Osafo, Department of Psychology/Centre for Suicide and Violence Research (CSV), University of Ghana.

Email: josaforo@hotmail.co.uk

Introduction

In much of the psychiatric literature, suicide continues to be addressed largely as an individual issue rather than a community or public health concern (Knox, Conwell, & Caine, 2004; Mohatt et al., 2013). Consequently, prevention strategies may focus on interventions to improve recognition and referral of individuals at risk to clinicians (Wexler & Gone, 2012), rather than addressing the community or social contexts. Several studies have therefore called for a community-wide prevention approach to suicide. Such calls point to the need to minimize the social stigma associated with suicidal behaviours and the social implications of such acts for families and communities surviving the loss of a member who died by suicide (Mohatt et al., 2013; Osafo, Akotia, Andoh-Arthur, & Quarshie, 2015; Sudak, Maxim, & Carpenter, 2008). Further, many researchers in the area of prevention science on suicide have underscored the need to understand public and popular perceptions, attitudes, and reactions towards suicide before developing and evaluating any effective community-wide preventive intervention (e.g., Fountoulakis & Rihmer, 2011; MacDonald, 2004). Understanding such attitudes has been found to be useful in identifying obstacles and facilitating factors prior to interventions (Barnett, Quackenbush, & Pierce, 1997).

In resource-poor countries, where the limited mental health workforce and related challenges widen the treatment gap for persons who may need professional attention, such calls for a community-wide prevention approach are especially relevant. Mental health is still a neglected area in healthcare in Ghana. In the country's 2009 budget, only 1% was allocated to mental health (Dixon, 2012) and the sector continues to be stigmatized (Barke, Nyarko, & Klecha, 2011). Ghana has only three public mental hospitals, all located in the southern part of the country (Fournier, 2011; Roberts, Morgan, & Asare, 2014). There is a huge shortfall in mental health professionals in the country (Ofori-Atta, Read, & Lund, 2010; Read & Doku, 2012), and in the absence of such trained health professionals, traditional healers provide many forms of treatment for supplicants (Appiah-Poku, Laugharne, Mensah, Osei, & Burns, 2004; Osafo, Agyapong, & Asamoah, 2015). Further, families and community support continue to be major sources of care for people with mental illness in Ghana (Quinn, 2007). Discussions of deinstitutionalizing mental healthcare in Ghana are underway, and this may have implications for home-based care delivered within community levels in the country (Mental Health Act 846, 2012).

In line with the agenda of deinstitutionalizing mental healthcare in Ghana are the key messages in the World Health Organization (WHO, 2014) report, concerning the role of the community in suicide prevention through social support for vulnerable persons, fighting stigma, and providing follow-up care. Gatekeeper programs have been identified by the WHO report as a selective prevention strategy that is low cost and can be deliverable at the community level. "Gatekeeper" refers to persons who come into frequent contact with members of the community on a regular basis, and who are in a position to identify whether someone is in suicidal crisis and to provide some help (WHO, 2012, 2014).

The limited professional resources pose major challenges to scaling-up mental health services in low- and middle-income countries (Saraceno et al., 2007; Saxena, Thornicroft, Knapp, & Whiteford, 2007). One way to address this challenge is to deliver mental health services in primary settings through community-wide programs and task-shifting. With brief training and appropriate supervision, non-specialist health professionals and lay workers may provide mental healthcare for individuals in crisis (Kakuma et al., 2011). Two Health Acts in Ghana, Mental Health Act 846 and Health Professionals Act 857 (Part 5 of which establishes a Council for psychological services), are consistent with this approach to improving mental health services. These Acts make clear provisions for collaboration with non-professionals or para-professionals to improve mental health services in the country.

Systematic exploration of community leaders' attitudes and psychological resources is needed to guide the development of culturally sensitive suicide prevention programs at community levels in Ghana. Public perceptions, opinions, and attitudes affect community-wide interventions, social policy, and the enactment of relevant laws (Barnett et al., 1997; Tipple & Speak, 2009). Several studies on attitudes towards suicide and suicide prevention in Ghana have been conducted with various groups and professionals including lay persons, psychology students, psychologists, nurses, police, and suicide attempters themselves (Hjelmeland et al., 2008; Knizek, Akotia, & Hjelmeland, 2010–2011; Osafo, Hjelmeland, Akotia, & Knizek, 2011a, 2011b; Osafo, Knizek, Akotia, & Hjelmeland, 2012). Most such studies have aimed to understand attitudes towards suicide and suicide prevention in the country in general and have not examined community leaders' attitudes, although in Africa, such leaders (e.g., chiefs, lineage heads, and religious leaders) occupy key positions of power and influence—both sacred and secular (Abotchie, 1997). Community leaders may function as gatekeepers for people experiencing mental health crisis in their communities as well as being defenders of moral norms and legal codes against suicidal acts. Suicide continues to be condemned socially and religiously, and attempters are socially taunted and legally criminalized in Ghana (Adinkrah, 2013; Knizek et al., 2010–2011; Osafo, Akotia, et al., 2015; Osafo et al., 2011a,b).

There is evidence from elsewhere showing that community leaders (including school staff, teachers, and religious leaders) can be engaged in suicide prevention (Capp, Deane, & Lambert, 2001; Kalafat, 2003; King & Smith, 2000; Molock, Matlin, Barksdale, Puri, & Lyles, 2008; Pompili, Innamorati, Girardi, Tatarelli, & Lester, 2011). For instance, working in Aboriginal communities in Australia, Capp et al. (2001) developed, implemented, and evaluated a community gatekeeper training project (involving elders groups, teachers and educational assistants, women's support groups, the police, youth groups, etc.). The program aimed to increase the potential of the participating community leaders to identify and help people at risk of suicide and to facilitate their access to support services. Analysis of the gatekeeper training workshops showed an increase in participants' knowledge about suicide, increased confidence in the identification of suicidal individuals, and

high levels of intentions to provide support. The authors concluded that community leaders (and community members) could be successfully trained in the identification of persons at risk of suicide in the community.

In Africa, a lineage head (often the most senior surviving male of a lineage group) is considered the best person to manage the welfare of the lineage. He ensures social control in the lineage and performs political, religious, and administrative functions. The lineage head is thus unanimously acknowledged by members of the lineage as a repository of wisdom who presides over the traditional moral code which prescribes the ideal norms of behaviour to guide the lineage members (Abotchie, 1997; Assimeng, 2007, 2010; Gyekye, 2003; Nukunya, 2004). His role may make him condemn suicidal persons, either because he defends the moral norm or because of his religious inclination but he may also provide some succour for a family member in crisis (Anarfi, 1995; Quinn, 2007).

The chief, by virtue of his direct link with the founder of the community or state, is the natural custodian of the customs and traditions of the people, hence the fulcrum around which all public activities of the people revolve. The chief's responsibility is to maintain a link between his people and the ancestors, to maintain law and order within his community. He is an embodiment of the moral and ritual purity of the people (Abotchie, 1997; Nukunya, 2004). The chief's position as either the original founder of the community or the direct successor of the original founder confers on him the status of a "father" responsible for the overall welfare of his community. His stool (or throne), therefore, is sacred and believed to be a repository of the "soul" of the community (Abotchie, 1997; Gyekye, 2003; Nukunya, 2004). His role and how it may play out with contact with persons experiencing suicidal crisis may not be different from the family or lineage head as indicated earlier.

Religious leaders are heads of faith-based organizations in the community and are noted for their frontline role in mental healthcare services (Assimeng, 2010; Leavey, 2008; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). A pastor may often be the first (and sometimes the only person) that individuals call on during a mental health crisis (Leavey, Loewenthal, & King, 2007; Appiah-Poku, J., Laugharne, R., Mensah, E., Osei, Y., & Burns, T., 2004; Taylor et al., 2000). There is evidence from the US and Japan showing that both Christian clergy from the US (27%) and Buddhist clergy from Japan (11%) have helped someone in suicidal crisis (Hirono, 2013). Further, 42% and 11%, respectively, have taken some training in suicide prevention (Hirono, 2013). In Ghana, there is burgeoning evidence of this frontline role of the clergy providing social support, and some form of health education (Ae-Ngibise et al., 2010; Appiah-Poku et al., 2004; Asamoah, Osafo, & Agyapong, 2014; Laugharne & Burns, 1999.; Osafo, Agyapong, et al., 2015). Exploring the attitudes and perceptions of faith-based leaders towards suicide and the role they can play in suicide prevention may provide insights into understanding a gatekeeper approach to suicide prevention. This can be potentially useful for developing models of evidence-based community-wide suicide prevention programs in Ghana.

The purpose of this study, therefore, is to explore the attitudes of key community leaders towards suicide in Ghana to inform the development of gatekeeper training programs for community-wide suicide prevention.

Method

Ghana is a multi-ethnic, multilingual, and a religiously diverse country. Of the total population of 24.6 million, 71% is Christian, 18% is Muslim, five percent adheres to African Traditional Religious beliefs, and six percent identifies as belonging to other religious groups or without any religious beliefs (Ghana Statistical Service (GSS), 2013). Officially, there are eight ethnic groups (which also represent the official local languages written and spoken) across the country: Akan; Ga-Dangme; Ewe; Guan; Gurma; Mole-Dagbon; Grusi; and Mande (GSS, 2013). However, Akan, Mole-Dagbon, Ga-Dangme, and Ewe constitute 85% of the national population (GSS, 2013). English is the lingua franca in Ghana.

A rural community in La-Nkwantanang Madina Municipal Assembly (LANMMA) district in the Greater Accra region was the site for the study. Generally, the Greater Accra region is cosmopolitan, as persons from various ethnic groups across the country (and foreign nationals) can be found within the towns and suburbs of the region. However, the indigenous (and predominant) people of the community are Ga-Dangme (GSS, 2014). This community is home for about 1,062 people: 533 males and 529 females (GSS, 2014). Settlements within the study community are homogeneous in terms of socio-cultural orientation, beliefs, and practices. Families are patriarchal and organized largely around the extended family system. There is a specialized psychiatric hospital in the municipality—this hospital has been organizing and providing mental health sensitization and education for the community members for four decades (LANMMA, 2013). Anecdotal reports in recent times indicate that suicide occurs in the community and yet the municipality has no official annual statistics on this (as an independent cause of death) and suicidal behaviour (LANMMA, 2013; Osafo, 2011).

The present study used qualitative methods to explore community leaders' perceptions and reactions to suicide and suicidal persons. In recent years, researchers on suicide have endorsed the use of qualitative approaches in suicide research as they yield an in-depth understanding of the phenomenon from the perspective of participants (Hjelmeland & Knizek, 2010; Kelly, 2013; Lester, 2010; Niner et al., 2009). Additionally, a qualitative approach was considered appropriate for this study because the issue of community leaders' perceptions and reactions to suicide and suicidal persons is a relatively new area of investigation in Ghana (Kvale & Brinkmann, 2009; Toomela, 2007a,b).

With a commitment to cultural competence undergirded by an ethical and moral imperative towards respecting the values and norms of the researched (Flaskerud, 2007), the researchers made the first contact with the traditional leader of the community and outlined the purpose of the study to him. After he had been informed about the purpose of the study, he also consented to be interviewed.

The main inclusion criteria were that participants were community leaders who had stayed in the community for more than 15 years and wielded influence in community decision-making processes. Based on this set of inclusion criteria, the chief led the researchers to people who were suitable for the study. The researchers, in turn, validated the position of the named persons in the community from randomly selected members of the community. Thus, a combination of convenient and purposive techniques were deployed in selecting 10 community leaders for the study: four females (three community women's leaders, and a church women's leader) and six males (the community chief, two family heads, a community kingmaker, a pastor, and a teacher).

Interviews were conducted face-to-face at respondents' convenience with the aid of a semi-structured interview guide developed by the researchers. Major items in the interview guide included: *What is your personal view about suicide? What are the reasons for suicide in this community? How are cases of suicide handled in your community? How are the families of suicidal persons treated by the community? What resources are there in this community to support suicidal persons and their families?* The informants were aged between 33 and 76 years. On average, each interview lasted for 45 minutes. Interviews were audio-recorded and transcribed. The interviews were conducted by the third (E.N.B.Q) and fourth (J.A.A.) authors in English and Ga-Dangme (the native language of the community of interest, GSS, 2014). The third author is a native speaker of Ga-Dangme and both interviewers have high spoken and written proficiency in English. Both interviewers are trained psychologists (with specialization in community psychology) who have several years' of experience in community and mental health promotion and research in Ghana and as such are competent in conducting (mental health) research interviews.

Thematic analysis (Braun & Clarke, 2006; Clarke & Braun, 2013) was used to analyse the transcribed interviews. Each of the authors independently read and re-read all the transcripts while listening to the recorded interviews to correct any omissions and misprints in the transcripts and noted initial thoughts and ideas. Having agreed on a set of initial codes related to the data relevant to the research questions, additional themes were sought in the interviews. The relevant codes generated and those that were similar were collapsed into themes to help explain larger sections of the data (Braun & Clarke, 2006). Further, we analysed the connections between the themes, and those which were too diverse and did not have adequate data support were eliminated. This was to ensure that the working themes adequately represented the evidence contained in the data. Analysis proceeded by discussing the identified themes at length during research team meetings in order to maintain the integrity of the responses. Finally, compelling quotes were selected from the transcripts to represent the working themes that addressed the research questions (Braun & Clarke, 2006; Clarke & Braun, 2013).

The study received ethical approval from the Ethics Committee for Humanities (ECH) of the University of Ghana. Participants' consent was sought, and their names as well as the name of the community were withheld to provide anonymity.

Only the gender, age range, and roles of the participants were reported. All participants who were approached gave consent for the study.

Findings

The analyses identified three main themes: 1) *Suicide as health crisis versus moral taboo*; 2) *Motivations: Psychosocial strains as motivation for suicide*; and 3) the *Gatekeeping positioning of community leaders*.

Suicide as health crisis versus moral taboo

This theme examines the opinions and perceptions of the community leaders regarding the meaning of suicide. The meaning of suicide here refers to how the act is conceptualized with reference to the cultural values of a given community (Boldt, 1988). Thus, the theme explores the meaning of suicide from both the individual community leaders' perspectives and within the broader contexts of their community experience. Findings showed that community leaders' perception of suicide was identified to be multidimensional. They perceived suicide from two main perspectives: a *mental health dimension* and a *moral dimension*.

Some of the participants indicated that suicide reflects a mental health crisis. They reasoned that individuals with psychological problems such as anxiety or continuous worry may engage in suicidal behaviour. This is expressed in the quote as follows:

You see, a person commits suicide because a particular thing may be worrying him for which he has no cure or perhaps he has done something which will sooner or later come to the public and cause him shame or embarrassment and the fear of such embarrassment may lead him or her to engage in suicidal behaviour. (Female, religious leader)

Suicide is conceptualized, from the above quote, as a mental health crisis arising from two sources. One is the depletion of personal capacity or resources to deal with life's crises. Such a conception is consistent with three of Shneidman's (1985) commonalities in suicide: cessation of consciousness as the common goal, hopelessness-helplessness as the common emotion, and intolerable psychological pain as the common stimulus. The second stems from distress following shame, for which reason suicide is preferred. Such a view is also akin to Shneidman's common action in suicide-egression or escape. The person, as the participant explains, wants to escape from an unbearable moral experience such as shame, a common phenomenon in Ghana. In most communities in Ghana, shaming is a frequent punitive measure adopted to curb deviance and ensure social order (Abotchie, 1997; Nukunya, 2004). It appears sometimes that individual offenders have distortions in their thinking (Berk, 2005) by perceiving that an act they have committed in private would come to public knowledge, thereby incurring public shame. Therefore,

this religious leader reveals that individuals resort to suicide as a means of escaping an imagined or real public shame. Essentially, the first and second conceptions as indicated, are not mutually exclusive. The fundamental thread that connects them both may be psychological pain or distress, which might be anxiety. Perhaps the suicidal behaviour becomes a tool for dealing with such anxiety. Generally, the explication of suicide as health crisis as gleaned from this informant is akin to Shneidman's (1985) perspective of suicide as essentially psychological pain (*Psychache*).

Other informants however, took a moral standpoint that suicide, whether attempted or completed, is "tabooed" by the community, as expressed below:

When you commit or attempt suicide, one, you stain yourself and your personal image as reflecting God; again, you disgrace your family because it is an act that is abhorred by the community; and three, you stain the whole community. (Male, teacher)

There are two moral discourses sustaining the tabooing of suicide from the above narrative. The first is the religious discourse. It is argued that the act of suicide runs counter to the belief of bearing God's image. An attempt to destroy such image by suicide is considered an affront to God. An informant puts it succinctly: "*suicide is not accepted by God*" (Woman, community women's leader). Being a predominantly Christian community, suicide may thus be viewed as an infraction of religious standards of the community.

The second discourse views suicide as a violation of the norms of interdependence as experienced in a family setting. This view establishes the social consequences of the act of suicide on the individual, family, and finally the entire community. This view is akin to what Osafo and colleagues (2011b) call "social injury." The weight and abhorrence of the act appears to be justified by the extent to which an individual's act can affect the larger community. Consistent with this thinking, one of the participants indicated the potential reprisal from the community towards suicidal behaviour: "*suicidal behaviour engenders anger on the part of community members. The rest of the community becomes unhappy with him and his family*" (Chief of the town). A third moral discourse tabooing suicide in this community is the view that suicide constitutes a legal breach. Informants viewed this within the broader legal code that condemns attempted suicide in contemporary Ghana: "*as per the laws of Ghana, when someone engages in suicide in this community the case is reported first to the police because attempted suicide is a crime*" (Male, family head). This participant concurs with the position of the law criminalizing attempted suicide. This is reflected in the early engagement of law enforcement agents—the police—in the event of suicide, and one does not see where the health worker comes into the equation.

Motivations: Psychosocial strains as motivation for suicide

This theme relates to the perceptions of the reasons for suicidality as observed by the leaders in the community. Although this theme may not directly relate to the purpose of this study, it provides insights into people's reactions to suicidal

persons. For instance, an understanding that suicide can occur from feeling lonely may elicit more support from others than when they perceive it as stemming from moral weakness such as marital infidelity. There is evidence from Uganda showing that health workers were empathic of suicidal persons when the reason for the suicidal act was mental illness but expressed negative attitudes when the reason was a so-called “moral weakness” (Knizek, Kinyanda, Akotia, & Hjelmeland, 2012). Attitudes are complex (Domino, 2005) and therefore in exploring them it is important to look beyond the obvious to uncover hidden views.

Generally, psychosocial factors were implicated as reasons for suicide in this community. The informants, however, did not engage in any moralizing discourse to consider which reason for suicide was more understandable or condemnable. The reasons were thus devoid of any moral underpinnings. On the whole, the reasons identified as motivations for suicide were economic hardships, marital problems, and neglect.

All the respondents indicated that a major reason for suicidal behaviour was economic hardship, as expressed in the following quotes:

Financial problems and unemployment underlie why people commit suicide or attempt suicide in this community. Many people don't have work to do and so find out that there is no sense in continuing to live without what may make such living meaningful and worthwhile. (Female, community women's leader)

There are many who harbour suicidal thoughts because of poverty and financial difficulties. They do not have anything to live on and may therefore reason it is better they die. (Chief of the town)

From these quotes a sense of purposeful living appears to be related to employment. Perhaps it is so because when one is employed it reduces existential indifference. Some studies have confirmed that unemployed persons experience crises in meaning (Schnell, 2010). A crisis of meaning is “a judgment on one's life as empty, pointless and lacking of meaning” (Schnell, 2010, p. 354). In some recent studies in Ghana, financial hardships have been implicated in suicidal crises (Akotia, Knizek, Hjelmeland, Kinyanda, & Osafo, 2018; Andoh-Arthur, Knizek, Osafo, & Hjelmeland, 2018). This is consistent with the views of the community leaders on the importance of economic circumstances as suicidogenic factors.

The second reason for suicidal behaviour in this community was marital difficulties. One leader explained this as follows:

Sometimes infidelity in relationships and marriages can lead to suicide. When a man finds out that the wife is flirting with another man, they can be jealous and kill themselves because they might think they have lost their dignity as a man. (Female, community women's leader)

Noteworthy in the quote is the ideology that masculinity is intact when a man is in control of his wife. In Ghana, a man who is divorced is seen to have lost patriarchal

control over his wife. In such instances the men may stalk their wives and even kill them and kill themselves (Adinkrah, 2008, 2012). The latter is consistent with the views of the leaders in this community.

Third, community leaders reported that people become suicidal because they feel both physical and emotional detachment from significant others and from the community at large. This was particularly observed among adolescents. One of the leaders indicated that

Some people feel they are not needed again in the family and community in which they live. You see people are busy trying to make ends meet and so may find only few times to interact with their children. Our children do experience this kind of neglect and may do something stupid. (Male, teacher)

In this quote, neglect is viewed as both an adult and a child problem. This respondent seems to establish a relationship between the modern “busy lifestyle” which drives the pressure for survival, leading to decreases in times for interaction between relations and creating a sense of alienation. Alienation is a common experience in most cosmopolitan centres (Putnam, 2001). As people move from their rural enclaves to cosmopolitan centres within the context of Ghana, there is likely a diminution of their traditional obligations. By implication, their hitherto strong traditional social ties and support systems founded on familial face-to-face daily interactions may get ruptured (Andoh-Arthur, 2011). The setting for the present study is a rural setting that is relatively closer to a fast-growing suburb of the capital city, Accra. Opportunities for selling wares at urban markets and engaging in menial jobs to make ends meet are available. As a consequence, daily life for most people may be characterized by commuting between the city and the community in pursuit of diverse agenda. In a situation such as this, a typical sense of community in the rural area might be blurred given the constant interaction and exposure to the urban culture. Social interactions in the rural area might consequently be minimal, leading to a feeling of alienation by others, as expressed. Also the cacophony of cosmopolitanism symbolized by competition for survival rather than cooperation for survival may eventually lead to the creation of daily busy life routines as expressed in the quotes. Ultimately, this might affect quality care and interactions with the children, with implications for mental health outcomes.

Gatekeeping positioning of community leaders

This theme covers how community leaders respond to the aftermath of suicide. Their posture appears to diverge from the inhumane reactions towards suicide (as observed in other studies) to the provision of specific intervention and preventive strategies to help suicidal persons manage their crisis. Analysis of their reactions was generally positive and focused on three main areas: 1) Crisis intervention and provision of supportive systems, 2) Adoption of preventive measures, and 3) Education and sensitization.

In the aftermath of a suicide or attempted suicide, community leaders provide suicidal persons and their families with some supportive services aimed at helping them to cope with the distress following the act. Community leaders render these services through some form of lay counselling, as one informant pointed out: *The chief makes the community talk to you so that all the time people are available to interact with you, talking about life issues and how to cope with difficulties in life* (Male, community elder). This sharply diverges from the reported reactions of condemnation and stigmatization often expressed towards people in suicidal crisis in some communities in Ghana. In the current study, the reaction is non-threatening and rather supportive. In a recent report in another community, suicidal persons reported inhumane treatment meted out against them, eventually leading to death by suicide (Osafo, Akotia, et al., 2015). Other informants corroborated such supportive systems for persons following suicidal crisis:

The elders will sit with the remaining family and talk to them about what has happened. The young men and women, old men and women in the family are counselled and encouraged. The purpose is to prevent other living members from committing the act. (Woman, religious leader)

The above supportive system could be best described as reparative, in the sense that the leaders recognize that the behaviour of the suicidal person might leave other family members traumatized. Further, this trauma might provide a powerful impetus for other persons in the family to engage in copycat suicide. The leaders recognize that an empathic understanding and approach to the issue might better alleviate the pains and decrease preventable suicide than would the expression of negative attitudes towards the victim and family. In some reports, even the family of the suicidal person is stigmatized, and this might be the motivation underlying the lack of support and failure from the family to report completed suicide at the hospital (Adinkrah, 2013; Osafo et al., 2011b).

Other informants thus provided directed actions with regard to what should be done for the victims of attempted suicide and what can be done for them:

We should bring the victim close to us to find out why he took the decision to kill himself. If we find the cause, we can find solution for him. For us in this community, we are there for each other . . . (Male, teacher)

Another indicated that practical religious action should be taken in providing support for such suicidal persons, including rituals such as prayer and fasting: *“We have to pray enough: fast and pray about the situation. You have to be with the person and frequently visit him, pray and talk with him”* (Woman, religious leader). The approach is spiritual support mixed with some types of social support.

The informants also indicated the need to adopt preventive measures in the aftermath of suicide. These measures refer to certain arrangements that are put in place to generally make certain that suicides do not occur. These measures are

rooted in the urgency with which community leaders respond to people's personal crises. For example, one of the leaders pointed out that "*when we hear someone is going through crisis such as threatening suicide, we advise them to see us, the elders or even the chief, and not to go ahead and take their lives*" (Woman, community women's leader). Implied in this statement is the idea of urgent response from the community leaders. In a typical Ghanaian community such suicidal threat might immediately call for a sanction, or perhaps become trivialized and ignored (Osafo et al., 2011a). However, the leaders in this community appear to have taken a more preventative approach. One informant corroborates this:

... I don't take it lightly when any matter is brought to me including suicidal cases, no matter how trivial the case may be or whether those involved are indigenes or foreigners... I do everything necessary to resolve them. (Chief of the town)

The import of this statement is the caution exercised not to trivialize the reasons for the person's crisis. Perhaps these leaders' attitudes towards suicide and suicidal persons are crystallized in the warmth and supportive posture of the chief in the way he relates with the members of the community. A community leader captures this as:

The chief ... personally helps the people in the community. He helps in times of crises to resolve any problems which may lead to suicide. (Man, community elder)

The effectiveness or efficiency of such an approach is possibly attested to in the reverence that is attached to whatever the chief says to the community members:

We listen to our chief a lot. We respect him so whatever he says, we abide by it. (Woman, community women's leader)

By implication, perhaps, in the process of attempting to alleviate a crisis, the chief's counsel may elicit complete adherence from the community members. This might mean that a potential helper might suppress an inner revulsion towards a suicidal person when asked by the chief to help someone in such crisis. Such reports of warm-hearted supportive responses from the leaders of this community do run contrary to reported attitudes of trivialization and condemnation from psychology students, as well as lay persons, towards suicide and suicidal persons in Ghana (Osafo et al., 2011a; Osafo, Knizek, Akotia, & Hjelmeland, 2013).

Education was another form of reaction towards suicide in this community. This community proposed education as a means of addressing suicide. Such education was explained as the dissemination of information to the community members on how to cope with life's crises:

The chief assembles the people and educates them on how to deal with challenges that might make life stressful and difficult for people and how best they can cope. (Woman, community women's leader)

The church setting was also used to provide members with health education, as reported by another informant: “*Religious leaders factor the issue of suicide into their preaching plans*” (Man, teacher). Here, preaching is viewed as an outlet to provide health information and ultimately educate the congregation on important health matters. Evidence from Tanzania shows that religious leaders are a major source of health information (Mboera et al., 2007). In earlier studies on suicide and suicide prevention, religious leaders were called upon to participate in reducing stigma towards suicide (Akotia, Knizek, Kinyanda, & Hjelmeland, 2013; Osafo et al., 2011c). Religion is a major cultural entity in Africa, and the role of religious leaders in public health programming is phenomenal. In Africa, church services provide an environment which facilitates social interactions and the learning and sharing of new ideas (Agadjanian, 2001). For example, there are reports that religion has provided the impetus for all forms of health education on various conditions such as cholera, tuberculosis, HIV, depression, and chronic diseases (see de-Graft Aikins, Boynton, & Atanga, 2010; Gyimah, Takyi, & Addai, 2006; Takyi, 2003; Van der Werf, Dade, & Van der Mark, 1990).

Discussion

The purpose of this study was to examine the attitudes and perceptions of key community leaders towards suicide and suicide prevention in Ghana. The study has reported that although suicide was predominantly considered a moral taboo, the view that suicide represents a health crisis was also present. This is consistent with a report of the views of mental health professionals towards suicide in Uganda where a moral perspective towards suicide coexisted with a healthcare view (Knizek et al., 2013). To the best of our knowledge, this is the first study reporting on community leaders’ attitudes towards suicide in which alternative viewpoints about the meaning of suicidal behaviour as mental health crisis appear to co-exist with the moral taboo perspective. An earlier study that examined the views of laypersons in rural and urban Ghana found that both held a predominant moral view of suicide that almost excludes any alternative view of what the act represents (Osafo et al., 2011a, 2011b). This moral view condemned the suicidal person as someone whose act breaks communal morality and injures the family. The moral taboo view in this study is consistent with such a view. However, these community leaders also held a mental health crisis view. The reasons for this multidimensional view could vary. One is that the study site appears to have engaged with health workers for more than four decades on public health education programming using a community-based health promotion approach. These programs include family planning, which aims, among other things, to explore the factors contributing to effective participation in health programs in the rural community (Neumann, Prince, Gilbert, & Lourie, 1972), and training of traditional birth attendants (Ampofo, Nicholas, Amonoo-Acquah, Ofosu-Amaah, & Neumann, 1977). These programs might be viewed as health promotional in nature with either an intended or unintended aim of changing the attitudes of people towards health. It is possible that these long and consistent health

programs in this community have improved health literacy and eventually had a positive impact on attitudes towards persons experiencing mental health crises.

Motivations for suicide vary and that is one major reason why suicide is viewed as a multidimensional malaise. In this study the motivations for suicide were essentially found to stem from psychosocial strains. In 2011, Ghana's economy reached approximately 15% growth with the injection of the revenue accruing from oil, but unemployment has continued to be a challenge particularly affecting youth and urban dwellers (Baah-Boateng, 2013). Based on the population and housing census, in 2010 the unemployment index in Ghana stood at 10.4%. Various studies have indicated the existence of a vicious cycle between poverty and mental illness in low- and middle-income countries (Lund et al., 2011; Patel & Kleinman, 2003). The indication that economic hardship is a reason for suicide in this study is consistent with other reports in both Ghana and South Africa. In Ghana, a recent study has reported a significant association between psychological distress and unemployment with greater likelihood for men than for women (Canavan et al., 2013). Another study in Durban that analysed sociodemographic characteristics and trends relating to suicides in South Africa showed that the majority of suicides occurred in single unemployed persons, men, and younger age groups (Naidoo & Schlebusch, 2014).

The finding that marital difficulties were motivations for suicide is also consistent in the literature in Ghana and other low- and middle-income countries, including Pakistan and China. In urban Pakistan, for example, marital stressors are noted as risk factors for suicidal behaviour among women (Khan, Mahmud, Karim, Zaman, & Prince, 2008). Evidence from China also indicates that marriage was not protective against suicide and that women who were involved in relationships were about three times more likely to die by suicide than were single women (Zhang et al., 2010). Psychosocial assessment is thus viewed as an important suicide patient-care strategy in eight low- and middle-income countries (Fleischmann et al., 2005). Further, some studies in Ghana have also indicated that infidelity in love and marital relationships can lead male partners who feel cheated or betrayed by their female partners to engage in suicidal behaviour (Adinkrah, 2012; Osafo, Akotia, et al., 2015).

Neglect is identified by the WHO (2014) report on suicide as one of the important associations with suicide risks factors in communities. Other studies have reported a relationship between adverse experiences during childhood such as neglect and suicidality (Brodsky & Stanley, 2008). Situational analysis of adolescent suicide shows a steady rise in Ghana, with risks factors including parental and adolescent conflictual relationships (Quarshie, Osafo, Akotia, & Peparah, 2015). The sense of neglect adults expressed in this study, however, may reflect social ostracism as one of the reasons for suicide in another community in Ghana (Osafo, Akotia, et al., 2015).

Generally, the motivations for suicide as identified in this study reflect the observed report that in low- and middle-income countries, motivations for suicide are often more psychosocial than psychiatric (WHO, 2015).

The positive reactions of the leaders in this community reflect a gatekeeping role and represent an important finding in this study. Gatekeeper training is one major

public health strategy in suicide prevention. Community leaders, teachers, and religious leaders (as reflected by the participants in the present study) are identified as key gatekeeper groups in suicide prevention by the World Health Organization (WHO, 2012, 2014). These leaders are potential gatekeepers who may require tailored training to improve what they are already doing in providing services to persons in suicidal crisis. There is evidence of improved attitudes towards attempted suicide patients and suicide prevention when a gatekeeper group (psychiatric care staff) received education in suicide prevention (Ramberg & Wasserman, 2004). As a best practice, gatekeeper training and its effectiveness in the reduction of the rates in suicidal behaviour in communities is inconclusive (Mann & Currier, 2011; WHO, 2014). However, in this study, though these leaders are not professional suicide workers, their ability to deploy community-wide supportive systems and create safety networks for persons in crisis is demonstrative of a cultural resource that should be used in suicide prevention programs in Ghana. Such a gatekeeping posture, as shown by these leaders, is an important index in determining who to engage in gatekeeper training programs.

Typically, reactions towards suicide in Ghana following the act have been negative, including insults, alienation, physical molestation, and other stigmatizing actions (Osafo, Akotia, et al., 2015). However, in this community, although participants viewed suicide as a moral taboo, they did not report any corresponding negative reactions which are often meted out to suicidal persons. Such a complete absence of negative attitudes towards suicide in this community could reflect the potential positive impact of community health educational programs on attitudes towards mental health issues in this populace. Attitudes are dynamic and people negotiate their attitudes over time (Petty & Brinol, 2010). The resource potential of this community in providing for the health needs of community members by the presence of a community health centre as well as the empathic posture of the chief is noteworthy. On the other hand, such positive responses could also reflect social desirability responses. Suicide is a sensitive issue in Ghana and the potential for shared stigma abounds (Osafo et al., 2011b). It is possible that community leaders were projecting the positive aspects of the supportive systems available to persons in crisis more than the harsh social reactions towards suicide.

A wider implication of this study for suicide prevention in Ghana in view of the workforce crisis bedevilling the mental health sector can be postulated. Community leaders in this study, and the psychological resources they outlined as tools in helping individuals experiencing mental health crisis, represent clearly that task-shifting, in health promotional programs in some communities Ghana, could be possible. These leaders represent laypersons who are not skilled and yet demonstrate the willingness to provide support services to suicidal persons. Reports indicate that such community-based personnel may become effective in detecting, diagnosing, treating, and monitoring persons with mental health difficulties after receiving training from professional mental health workers (Kakuma et al., 2011). Suicide prevention in Ghana might benefit from task-shifting, as this study is presently suggesting. In the face of low numbers of professional mental health workers in Ghana, community leaders'

roles should not be underrated in any suicide prevention attempts. In a concluding remark on the role of religious leaders in suicide prevention, Hirono (2013), for instance, argued that “The role of the clergy is the missing link in the prevention of suicide . . . Although collaboration between clergy and mental health professionals is essential for suicide prevention, many workers are overlooking the role of clergy in suicide prevention” (pp. 10–11). This is an important caveat in planning community-based suicide prevention programs in Ghana.

Another wider implication of the findings of this study for the discourse on deinstitutionalizing mental healthcare as enshrined in the recently passed Mental Health Act (2012) could be envisaged. The Act seeks to deinstitutionalize healthcare for mentally vulnerable groups by exploring close-to-client community-based approaches in providing care. To the best of our knowledge, no clear guidelines have been provided with respect to how mental healthcare will be integrated into the existing Community-based Health Planning and Services (CHPS) framework and also how community health volunteers could be used to deliver these services. This study has demonstrated that community leaders could serve as important gatekeepers in the implementation of this provision of the law if their potential is properly harnessed and guided by training and supervision.

Conclusion

This study has highlighted the importance of community leaders in Ghana as a potential resource for gatekeeping in suicide prevention. Community leaders are key gatekeepers in suicide prevention programs. The potential for a community-based suicide prevention approach in Ghana should be explored as an important strategy in promoting positive attitudes towards suicidal persons and other persons with mental health crises. To better inform this effort, future studies should use larger samples of community members and examine the views of Assemblymen/women, community police chiefs, and others who may be important gatekeepers.

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Joseph Osafo, MPhil, PhD, is an Associate Professor and Head of Department of Psychology, University of Ghana. He researches suicide/suicide prevention, religion and mental health, adolescent sexuality and other issues relating to marriage. He is currently a Co-chair of the Interest group on Culture and Suicidal Behaviour of the International Association for Suicide Prevention (IASP). His published works focus on suicide and its prevention, stigma, parental–adolescent sexual communication, intimate partner violence, religion and mental health, and collaboration between religious leaders and mental health professionals. He is also a Senior Researcher and Executive Director at the Centre for Suicide and Violence Research (CSVR) in Ghana.

Charity S. Akotia, MA, PhD, is an Associate Professor at the Department of Psychology and Dean of the School of Social Sciences, University of Ghana. She researches suicide and suicide prevention in cross-cultural settings, as well as gender role attitudes and work-related issues. She is currently National Representative of the International Association for Suicide Prevention (IASP). Her published works focus on suicide, suicide prevention, the law criminalizing suicide in Ghana, and gender role attitudes. She is a Senior Researcher at the Centre for Suicide and Violence Research (CSVR), Ghana.

Emmanuel Nii-Boye Quarshie, MPhil, BA (Hons), is a PhD Candidate in the School of Psychology, University of Leeds, UK. He was, until recently, an Assistant Lecturer in the Department of Psychology, University of Ghana, Legon. His research interests centre on (community) mental health – with focus on children

and youth – and implementation science. His current research explores self-harm and suicide in adolescents in Ghana using mixed methodologies. He is a Research Fellow at the Centre for Suicide and Violence Research (CSVR), Ghana.

Johnny Andoh-Arthur, is a PhD candidate at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway. He has an MPhil Degree in Human Development (with specialization in Community Psychology) from NTNU, Norway and a Bachelor of Arts degree (Psychology with Political Science) from the University of Ghana, Legon. He researches suicide, mental health and community health promotion. Currently he is researching suicide using the qualitative psychological autopsy method. He has published works in *Journal of Affective Disorders*, *International Journal of Psychology*, *Death Studies* and *International Journal for the Advancement of Counselling*. He is a Research Fellow at the Centre for Suicide and Violence Research (CSVR), Ghana.

Kofi E. Boakye, PhD, is a Senior Lecturer in Criminology at Anglia Ruskin University and a Postdoctoral Fellow at the Institute of Criminology, Cambridge University. Dr. Boakye researches suicide and violence prevention from a comparative perspective. His published works focus on youth crime, sexual violence, suicidal behaviour and violence prevention. He is a Senior Researcher at the Centre for Suicide and Violence Research (CSVR), Ghana.