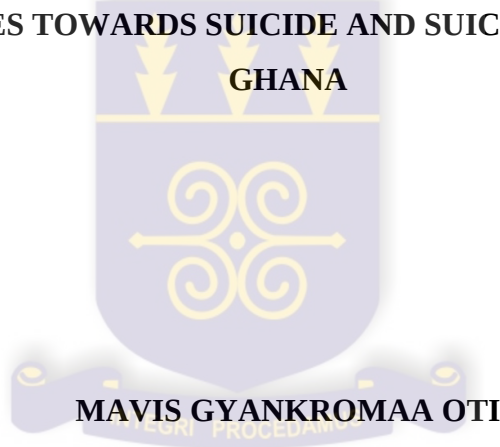


**UNIVERSITY OF GHANA, LEGON
DEPARTMENT OF PSYCHOLOGY**

**EXPLORING THE ATTITUDES OF PSYCHIATRIC AND COMMUNITY
HEALTH NURSES TOWARDS SUICIDE AND SUICIDE PREVENTION IN**

GHANA



MAVIS GYANKROMAA OTI

10363027

**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF
MPHIL SOCIAL PSYCHOLOGY DEGREE.**

JUNE, 2014

Declaration

I hereby declare that this research is conducted by me under the supervision of Prof. Charity S. Akotia and Dr. Joseph Osafo. This work has never been submitted to any other institution by anyone for any award. All references cited in this work have been duly acknowledged and I take full responsibility of any shortcomings associated with this work.

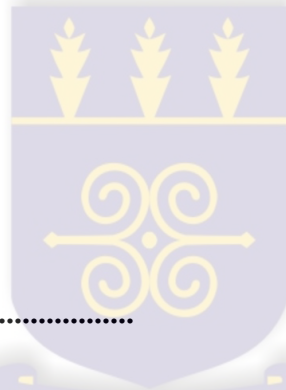
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Mavis Gyankromaa Oti

Date

(Student)



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Prof. Charity S. Akotia

Date

(Principal Supervisor)

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Dr. Joseph Osafo

Date

(Co-Supervisor)

Dedication

I dedicate this work whole heartedly to my Grandfather Rev. Dr. Stephen Gyermeh.

Sincerely, I would not have been this far if not for your unflinching support for me.



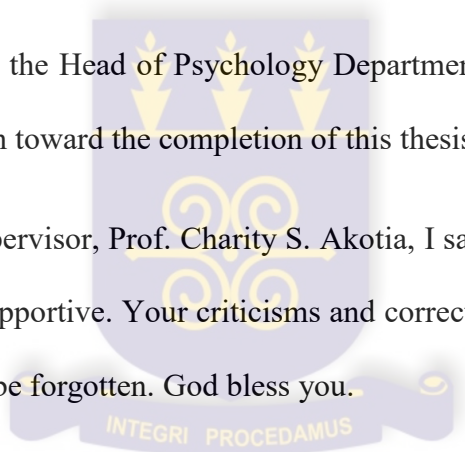
Acknowledgement

The God I serve has always been good to me. In the heated times of my academic work, He had always paved the way for me. I am very grateful for the protection, provision and guidance from the Lord Almighty. Ebenezer, thus far the Lord has brought me.

The people to acknowledge in this work cannot be exhausted. However, I will make the effort to touch on some of them. My mother and siblings are highly acknowledged for their support and patience to see me through another stage in academia. I owe them all I have, especially my mum, for they always maintained their assistance and encouragement for me.

I am very grateful to the Head of Psychology Department, Prof. C.C. Mate-Kole for his immense contribution toward the completion of this thesis.

To my Principal Supervisor, Prof. Charity S. Akotia, I say thanks to you. You have been very inspiring and supportive. Your criticisms and corrections and time spent supervising this work will never be forgotten. God bless you..



I must say a very big thank you to my second supervisor, Dr. Joseph Osafo. Even amidst your very busy schedules, you have always responded to my mails and did the necessary readings and corrections till the completion of this thesis. Thank you Doc.

I cannot forget Mr. Gladstone Fakor Agbakpe and the staff of the Department of Psychology, Methodist University College Ghana for their assistance and corrections. To Mr. Kingsley Kwabena Ansong and Felix Oppong, I say a very big thank you for your assistance. God bless you.

I also extend my acknowledgement to all my course mates and friends for their encouragement throughout the course. God bless you all, folks!

Abstract

This study investigated the attitude of psychiatric and community health nurses towards suicidal persons and suicide prevention in Ghana. The present study sampled 36 participants (18 psychiatric nurses and 18 community health nurses) from the Greater Accra Region of Ghana. A comparative study, using a qualitative approach, was employed to explore attitudes of psychiatric and community health nurses towards suicide and suicide prevention in Ghana. Thematic analysis of the data obtained from the informants' responses yielded three major themes: **conceptualizing suicide, behavioural and emotional response to suicidal persons, and suicide prevention strategies.** Subthemes were identified under each major thematic area to capture the relevant voices reflecting the attitudes of the informants toward suicide and suicidal persons. Informants suggested an evidence-based ecological system approach to the prevention of the phenomenon of suicide in Ghana. Based on the results provided by the current study, it could be concluded that both Psychiatric and Community Health Nurses held negative attitudes towards suicide as an act, whereas they expressed contradictory attitudes towards suicidal persons and had a positive attitude towards suicide Prevention. It is implicating from the finding of this study that suicide strike people across Ghana that is capable of resulting in severe psychological and social distresses; hence stakeholders must be proactive in suicide prevention.

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CHAPTER ONE

INTRODUCTION

1.0 Background

Suicidal behaviour is a continuous challenge all over the world and according to the World Health Organization (WHO, 2011) about one million people kill themselves every year worldwide. Many countries have now implemented suicide preventive efforts (DeLeo & Evans, 2004). However in Africa little has been done in this regard. Suicide remains a serious health care problem and a sentinel phenomenon.

O'Carroll (1996) regarded suicide as 'a death by self-inflicted means where there is evidence that the intent was to cause death'. According to American Psychiatric Association (2003), suicide is defined as a self death with evidence (either explicit or implicit) that the person intent to die; that has a life-threatening consequence, and the result of action can be entirely predictable.

Nurses are pivotal in evaluating risk and preventing suicide. These healthcare professionals are identified as frontline officers in the management of triage, further assessment, intermitted monitoring and rehabilitation activities. The Munich Declaration (WHO, 2000) stated that specialist nurses are the most appropriate and cost effective professionals to tackle the daily consequences of mental health problems which affect millions of people globally. In several countries community-based care psychiatric nurses play a key role in the early recognition of alarming symptoms and the long term monitoring after suicide attempts. An outreaching assertive approach of qualified psychiatric nurses is especially needed (Mulder, 2005, van de Sande, 2007). In outreach services, community health nurses are the most obvious frontline officers at all levels of prevention. In a study on the role of mental health nurses in this challenging field McAdam (2005) reveals that a balance in consistent risk assessment verses engagement and clinical knowledge and skills is absolutely essential.

Adequate and specialized trained nurses are able to provide continuity of care by combining health promotion, psychosocial and pharmacological interventions in the management of suicidal persons. In addition to that they can offer consultation to other professionals who are often confronted with self-harming or suicidal behaviour.

1.2 Attitude towards suicide

Attitudes toward suicide have varied widely throughout history. Tang (2003) defines suicide attitudes as a persistent and consistent tendency towards suicidal behaviour which individuals hold. In Ghana, suicidal behaviour is considered criminal and carries legal as well as social sanctions. According to the Ghana Criminal Code (1960, Act 29), nonfatal suicidal behaviour is a crime. Section 57 of the code stipulates that “whoever attempts to commit suicide shall be guilty of a misdemeanour.” Consequently, persons who engage in nonfatal suicidal behaviour in Ghana are subject to criminal apprehension and prosecution, and on conviction, receive criminal penalties. In addition to the strong legal stance against suicidal behaviour, a strong social stigma has surrounded suicidal behaviour in Ghana. Furthermore, Wang (2008), based on Hovland and Rosenberg's three-component model of attitude (attitude as a predisposition to some class of stimuli with cognitive, affective and behavioural responses), conceptualizes suicide attitudes as persistent positive or negative emotion and approach-avoidance behaviour towards suicidal behaviour and people who commit suicide.

In ancient Egypt for instance, people considered suicide as a humane way to escape intolerable condition (McCormick, 1964).

Research has shown that suicide is perceived negatively in African countries (Eshun, 2003; Hjelmeland, Akotia, Owens, Knizek, Nordvik, & Schroeder, 2008; Lester & Akande, 1994; Peltzer, Cherian, & Cherian, 1998). Negative attitudes are those attitudes which reinforce the patient's feelings of worthlessness and hopelessness such as judgment and rejection; whilst positive attitudes

refer to those attitudes which are protective, making the patient feeling loved and cared for (Aish et al., 2002).

Clinicians' attitudes contextually can influence proper management and follow-up of patients who are at risk of repeated self harm. Given the frequent and interventional opportunities of health care professionals' contacts, poor understanding of suicide from the medical viewpoint is of concern. Moreover, judgmental attitudes seem to be common, however better informed, more understanding on the part of health professionals could contribute greatly to prevention.

Attitudes toward suicide in a given setting cannot be overlooked in taking preventive actions. As pointed out by Osafo, Hjelmeland, Akotia, and Knizek, (2011b), in the African context, health care professionals are key opinion leaders and have the power to influence attitudes held by the society. Again, health professionals also are the first to meet suicidal persons when they seek help at a health facility, hence their attitude towards these patients is important. For instance, Bagley and Ramsey (1989) have pointed out that attitudes toward suicide may influence health care workers' willingness to intervene in suicidal crises or to treat those who deliberately have harmed themselves. It has repeatedly been shown that suicide is viewed negatively in African countries (Eshun, 2003; Hjelmeland et al., 2008; Lester & Akande, 1994; Osafo et al., 2011a, 2011b; Peltzer, Cherian, & Cherian, 1998).

Etzersdorfer, Vijayakumar, Schöny, Grausgruber, and Sonneck (1998) investigated medical undergraduates' attitudes towards suicide in both Austria and India. Two noteworthy conclusions were however drawn: First, medical undergraduates held serious and negative attitudes toward suicide in India, and the pattern came close to a 'medical' or 'disease model' (mental illness, impulsiveness and emotional aspects), while their Austrian counterparts held positive attitudes toward suicide, and the pattern reflected 'theoretical' and 'rational model' (cognitive factors);

second, medical undergraduates in both countries had different attitudes towards suicidal behaviour on ‘themselves’ and ‘others’ that they viewed attitudes towards suicide more tolerant for others and even their close relatives and friends, and regarded suicidal behaviour rational rather than impulse, whereas they viewed suicide as an intolerant behaviour for themselves, and they only accept to engage in self-destructive behaviours in non-rational condition.

Many people feel uneasy talking about suicide, in part because of a social taboo on talking or learning about suicide and the criminalization of the act in Ghana. One popular myth is that suicide should not be mentioned around people because it would plant the idea in their minds. However, mental health professionals agree that people who have suicidal wishes can benefit by talking about their feelings. Attitudes toward suicide have varied widely throughout history. In ancient Egypt people considered suicide a humane way to escape intolerable conditions (McCormick, 1964). For centuries in Japan, people respected instances of hara-kiri (ritual suicide with a dagger) as a way for a shamed individual to make amends for failure or desertion of duty. During World War II Japanese Kamikaze pilots considered it an honour to perform suicidal missions by crashing their airplanes into an enemy target. In India women were once expected to burn themselves on a funeral pyre after their husband died, a custom known as suttee.

In many other societies, however, suicide has been strongly condemned or made illegal. The Greek philosopher Plato strongly disapproved of suicide (Carrick, 2001). In general, ancient Roman governments opposed suicide when the state stood to lose assets, such as soldiers and slaves. Suicide was clearly prohibited by Judaism unless one faced capture by an enemy, as in the mass suicides at Masada (Zerubaul, 1994; Witztum & Stein, 2012).

Christianity has generally condemned suicide as a failure to uphold the sanctity of human life. In the 4th century AD, Saint Augustine decreed suicide a sin (Witztum & Stein, 2012). By the middle Ages, the Roman Catholic Church forbade the burial of suicide victims in consecrated ground. English law considered suicide to be a crime punishable by the forfeiture of goods and property to the government unless the suicide was the result of madness or illness. This criminal view of suicide immigrated to colonial America and was adopted by individual states.

People are changing their attitudes towards suicide in time. Until now, suicide as a controversial topic is still disputed in the field of ethic, law, medicine, and value. Zao (2007) classified five common attitudes towards suicide. The first view regards suicide as an immoral behaviour that coward people abandon their social responsibility and leave greater pain to others. It will bring a negative impact on family members, adolescent and the whole society, which should be subject to moral condemnation. The second view considers suicide as a crime. Before the French Revolution, suicidal behaviour was punished by law in accordance with relevant provisions in some European countries. Fortunately, the discipline of suicide decreased in modern legal systems. Also, suicide was sentenced as a sin, which is cursed and conspued in Moslem and Christian cultures. The third view believes that suicide is a performance of mental disease. Most people think that people who commit suicide have mental illnesses, although some studies had indicated that suicide was clinical manifestations of depression and other mental illnesses as well as a certain proportion of suicidal persons suffer from mental illnesses, but the actual situation is also evidence that a considerable number of suicidal persons are in their right minds. The fourth view shows that suicidal persons have freedom. People who hold this view believe that the value and significance of life consists of a person's freedom of choice, and individuals have the right to take their own lives. There is no sense if life cannot play social functions, so it is not worth to deliberately maintain. The last view is that suicide is an honourable and meaningful behaviour. For instance, people who sacrificed for their

country are regarded as heroes of their nation in Chinese culture, and suicide is considered as a responsible behaviour to offer an apology for a failure in Japanese culture (Zao, 2007).

1.3 Scope of mental health in Ghana

The treatment of the mentally ill from ancient times to the present reflects prevailing perceptions of mental illness.

Mental health is a very misunderstood concept especially in the developing world. To many, an African, mental health connotes insanity and related illnesses. However, the mental well being of a person is an integral component of the holistic well being of the person. Therefore, developing countries ought to pay more attention to this area of health since it invariably translates into the development of a country. Indeed the international community continues to recognize the importance of mental health as a component of general health and continues to attempt to take steps to safeguard the rights of persons with mental disorders.

Ghana has not been left out in the global recognition of the need to cater for mental health in its national agenda. This is typified by the fact that there has been a mental health law in the country since 1972 – the Mental Health Decree, 1972 (NRCD 30). Even more recently, Ghana successfully passed a Mental Health Bill in March 2012. The Act will not only safeguard the rights of persons suffering from mental disorders but ultimately strengthen mental health care delivery.

Mental health services in Ghana are available at most levels of care. However, more care is provided through specialized psychiatric hospitals (close to the capital and servicing only small proportion of the population), with relatively less government provision and funding for general hospital and primary health care based services. The few community based services being provided are private.

Great efforts are being made to change the model of service provision to one which emphasizes care in the community. This could ensure effective mental health care delivery which can partly facilitate the country's quest to develop a national policy on suicide prevention.

1.4 Suicidal Behaviour in Ghana

Suicide is a complex and multidimensional phenomenon stemming from the interaction of several factors.

However, incidence of suicide is often under-reported due to a number of reasons: In some instances, and for different reasons, (for example religious and/or social reasons) suicide as the cause of death might be hidden and in some areas it is completely unreported. In many countries around the world, particularly those that are less developed, basic data on the prevalence and risk factors for suicide and its immediate precursors—suicidal ideation, plans and attempts are unavailable (Adinkrah 2010).

Presently, there are no reliable statistics to estimate the prevalence of suicide in Ghana. Therefore, real figures may be higher than reported. Nevertheless, from reported cases, certain trends are apparent in some studies conducted.

For instance Adinkrah (2010) indicated that the official police report of suicide cases for the entire country showed that between 2006 to 2008, 287 persons engaged in suicidal behaviour with 243 completing the act. More males ($n=232$, 95.5%) completed the act than females ($n=11$, 4.5%).

Additionally, the 2010 Ghana's Population and Housing Census report by the Ghana Statistical Service (GSS, 2013) provided statistics on death by suicide, violence, accident, and homicide. The report shows 18,938 deaths were recorded and categorized under deaths by accident, violence, homicide, or suicide within a year preceding the census. Thus, the report lumps together, rather than isolates the statistics in respect of deaths by accident, violence, homicide, and suicide. However, an

anecdotal and journalistic report shows that about 1556 people (approximately five people daily) commit suicide annually in Ghana (Citifmonline, 2012).

Hjelmeland and colleagues (2008) in a study that compared the attitudes towards suicide among psychology students from Ghana with their Ugandan and Norwegian counterparts reported that more than 40% of the students knew someone both in and outside the family who had engaged in suicide. Suicidal behaviour is prohibited legally in Ghana. The 1960 Criminal Code states categorically that a person who attempts suicide shall be guilty of a misdemeanor which could attract a jail term of about 3 years. Besides the criminal position against suicide, socio-culturally, the act is strongly proscribed (Adinkrah, 2010; Hjelmeland et al. 2008, Knizek, Akotia & Hjelmeland, 2011). The legal instrument criminalizing the act, integrated with the inescapable sociocultural proscription against suicide could avert accurate reporting of data and thus underestimate the size of the problem.

Ghana, being a principally Christian country (71.2% adhere to the Christian faith-2010 Population Census), proscribe suicide (Johnstone, 2001). In addition, suicide is not tolerated in most cultural groups in the country. According to a study done by Kuada and Chachah (1999), suicide is a vilification to the dead person and his or her clan. The corpse is not given a befitting burial and rites are performed to remove "whatever curse had forced the person to commit suicide". Dali (2007, cited in Adinkrah, 2011) has found out that among some groups in Northern Ghana, when suicide occurs inside a house or an apartment, the corpse must be removed through a window or a special created perforation in the wall. This is because conveying the body through the doorway permanently defiles the doorway for the living.

In this way, the Ghanaian culture attempts to deter people from taking their own lives.

In a study by Quarshie, Osafo, Akotia and Peprah (2015), It was found that risk factors of suicide among adolescents in Ghana include the following, poor academic performance, socioeconomic

factors such as parental poverty, child marriage, unwanted pregnancy, psychological distress and conflictual relationships such as maltreatment, scolding and corporal punishment. The study also reported that hanging was the dominant method used and the behaviour usually occurs within or near the adolescent's home environment.

A study by Adinkrah (2010) revealed that more males than females attempted and successfully committed suicide. The rate in males was 20 times higher than in females. The gender distribution for attempted suicide in Ghana is different from those of industrialized countries where the rates are higher in females. This difference may be attributed to the extent to which Ghanaian women are religious and willing to seek help and speak about their problems which is a strong protective factor against suicide. The study also revealed that suicidal behaviour was also seen to be more recurrent in the age group 20-29 years and 30-39 years and were mostly from a low socioeconomic background. The commonest method used was hanging followed by shooting with firearms and ingestion of insecticides and acid. The study further revealed that in cases of unsuccessful suicide attempts, the most common method was cutting with a sharp object followed by poisonous ingestion.

Several studies conducted so far have shown that there has been a more negative attitude toward suicide and suicide ideation or thoughts about dying among Africans (Ghanaians) than their Western (Europeans and North Americans) counterparts. For instance, Hjelmeland et al. (2008) reported that Ghanaians saw suicide more as a taboo compared to Ugandans and Norwegians which emphasizes the need for culture-sensitive research and prevention. This also supports the study by Eshun (2003) which revealed that Ghanaians reported more negative attitudes about suicide than their American counterparts.

In traditional Ghanaian culture, if someone had committed suicide, the community's ancestors would not accept his spirit to the "land of the dead" (Schott, 1987). It is believed that the ancestors would

propel his spirit back to Earth, and he would potter around as a ghost, threatening his surviving relatives. In ancient times, those who committed suicide would receive the same burial treatment as thieves, adulterers, and witches. According to Justice Ocran of the Ghanaian Supreme Court (2006), in ancient times, suicide was considered to be a serious offense with far reaching repercussions such as decapitation and confiscation of all personal private property. Thus, the stigma of committing suicide is enormously entrenched in traditional Ghanaian culture. Rattray (1969) has noted that, in the past, the Ashanti ethnic group saw suicide as seeking to elude punishment for crimes or sins that they had committed, and so they tried the corpses and administered punishments such as decapitation.

In Ghana, suicide researches have focused mainly on epidemiological studies, attitudinal studies, adolescent suicide as well as studies documenting attempters' experiences of suicide.

Increase information about the extent of suicidal behaviour, both fatal (completed suicide) and non-fatal (attempted suicide), identifying risk factors, high risk groups and attitudes towards suicidal behaviour over time will help in the country's quest for a suicide prevention plan.

Ghana cannot afford to lose precious lives through suicide hence; something must be done without delay.

1.5 Problem Statement

Suicidal behaviour is becoming a growing public health problem in Ghana. Although there are no reliable official statistics on the act, a study among psychology students in the country showed that almost half (47%) of the students knew someone who had attempted suicide and one in five knew someone who had killed themselves (Hjelmeland et al., 2008). A recent review of police data in the country within the period 2006–2008 has also given some indications that 287 persons engaged in suicidal behaviour, with 84.7% fatal and 15.3% non-fatal. Young and poor men are at risk for suicidal behaviour and the major motive for the men was to avoid public shame and dishonour (Adinkrah, 2010, Adinkrah, 2011). These estimations are unreliable and may only be a tip of the iceberg. This can be attributed to the fear of social stigma which restrains families and other people from reporting a suicidal person to the police as well as giving a true verdict of the cause of death. Suicide is legally criminalized in Ghana, and the negative attitudes toward the act are underpinned by strong religious and societal values (Adinkrah, 2010; Knizek, Akotia & Hjelmeland, 2010; Osafo, Knizek, Akotia & Hjelmeland, 2002). Under reportage of incidents are frequently due to cultural sensitive matters or lack of communication between health and social services. Suicide is therefore, a major public health problem as recognized by the World Health Organization. Attempted and completed suicides result in enormous social, economic, and medical costs. Suicide is very disruptive to the quality of life of survivors and their families and friends. Nurses at all levels in a wide range of healthcare domains can contribute to the process of multi-disciplinary practice, development of early recognition, early intervention and the monitoring of high risk patients in a continuous care pathway (Backe, 1996). We must be aware that the published suicide and self-harming rates might only represent a tip of the iceberg. Despite these alarming figures there is the need to realize that we are not powerless in this social tragedy. Many opportunities are available to tackle self-destructive escalations. Health professionals have a major role to play in addressing the problem of suicide. Public health programs and policies can play a part before, during, and after

completed or attempted suicides. Clinician's attitudes can however, influence proper management and follow-up of patients who are at risk of repeated self-harm. Individuals who survive an act of attempted suicide are at a higher risk of reattempting using a highly lethal method. Clinical decision making is thus influenced by a complex interaction between the patient and clinicians, socio-cultural and contextual factors as well as religious beliefs. The management of a patient attempting suicide should be based on theoretical knowledge and empirical data but unfortunately, research shows that "unrelated" factors can also affect the clinician's judgment. Some of these are a patient's attractiveness, socio-economic status and the clinician's own values. These factors can interfere in the proper management and follow-up of patients who are at risk of repeated self-harms and the attitudes of clinicians often can interfere with prevention strategies. Health professionals come into frequent contact with individuals who are at high risk of self-harm and therefore, play pivotal role in the prevention of suicide. A study on attitudes of psychiatric and community health nurses towards patients who attempt suicide will however, help in identifying any negative attitudes and this can subsequently help plan training and education which can help in suicide prevention.

For instance, in Ghana, it has been reported that the way health workers relate with tuberculosis patients such as shouting at them and standing at a distance when talking to them contributes to the stigmatization of such patients (Dodor, 2008; Dodor et al., 2009). Like elsewhere in the world, nurses are the first point of contact when a suicide attempter seeks attention at a health facility (McCann, Clark, McConnachie, Harvey 2007).

Thus the psychiatric nurse where available is likely to encounter a considerable number of suicide attempters and their role become indispensable in the initial management. Psychiatric nurses provide comprehensive, patient-centred mental health, psychiatric care and outcome evaluation in a variety of settings across the entire continuum of care.

Psychiatric nursing involves the delivery of comprehensive primary mental health care in a variety of setting which involves the continuous and comprehensive services necessary for the promotion of optimal health; the prevention of mental illness; health maintenance and management of psychiatric disorders (Haber & Billings, 1995). Psychiatric nursing is necessarily holistic and considers the needs and strengths of the individual, family, group and community.

Community health nurses particularly have a long and close contact with the community and are well accepted by the community within which they work. They provide the vital link between the community and the health care system. In Ghana, where mental health services are not well developed, they are often the primary source of health care. Their knowledge of the community enables them to gather support from family, friends and organizations which make them entry point to health services for those in distress. It can however be said that they are available, accessible, knowledgeable, and committed to providing care.

The attitudes of health care professionals can be detrimental to suicide prevention (Lang et al., 1989) and as long as these two groups are key handlers of suicidal patients, it becomes essential to examine their attitudes toward suicide and suicide prevention in Ghana.

Improved attitudes will foster increased knowledge of assessment and treatment of suicidal patients in the healthcare centres. Globally, the urgent need to coordinate and intensify actions aimed at preventing suicide has been pointed out by the World Health Organization (WHO, 2004). One of the recommended ways of preventing suicide has been increasing awareness among health care professionals of their own attitudes and taboos toward suicide and its prevention (WHO, 2007). Attitudes studies on suicidal behaviour in Ghana have begun burgeoning but the studies have not exhaustively explored health workers attitude towards suicide prevention. Additionally, it will be noted that psychiatric nurses and community health nurses belong to different health categories by

way of their job description. It is therefore important to have a comparative analysis of how each of the group view suicide and reacts toward suicidal persons.

It is against this background and observation that this research is being embarked on to explore the attitudes of Psychiatric and Community Health Nurses towards suicide and Suicide Prevention in Ghana.

1.6 Aims and objectives

The general objective of the study was to understand the attitudes of psychiatric and community health nurses toward suicidal persons, the cultural and professional factors that might influence their attitudes and its implication for the development of a suicide prevention plan in Ghana.

1.7 Specific objectives of the study are;

- To explore the cultural factors that influences the attitudes of psychiatric and community health nurses towards suicidal persons.
- To explore factors that influence suicide prevention in Ghana.
- To compare the attitudes of psychiatric nurses and community health nurses towards patients who attempt suicide.

1.8 Purpose of the Study

The study aimed at examining the attitudes of psychiatric and community health nurses toward suicide and suicide prevention and examine the implications for suicide prevention in Ghana.

1.9 Significance of the Study

The findings have implications for the organization of clinical services and the training of health professionals.

Recommendations are made to support complementary improvements in quality and effectiveness of care for people at risk from the Ghanaian perspective.

1.9.1 Research Questions

- What are the principal attitudes of these nurses towards suicide?
- What are the principal attitudes of these nurses towards suicidal persons?
- What are the principal attitudes of these nurses towards suicide prevention?
- Are there cultural factors or professional issues which influences their principal attitudes towards both suicidal persons and suicide prevention

CHAPTER TWO

LITERATURE REVIEW

2.0 Theoretical Framework

Two main theoretical models are used in the study to explain attitudes toward suicide, and to a general extent suicidal ideation and behaviour. These models are the sociocultural theory by Vygotsky and the sociological theory by Durkheim.

2.1 Sociocultural Theory

Sociocultural theory is a theory that looks at the important contributions that society makes in individual development. This theory stresses the interaction between developing people and the culture in which they live. In a nutshell, it states that our individual behaviours and thoughts are products of our culture and interaction with society. Sociocultural theory appreciates the roles of social interaction, negotiation and collaboration in the learning and development process. Therefore, the discourse, norms and practices of communities must be taken into account as a function of attitude formation.

One of the most fundamental concepts of sociocultural theory, according to Lantolf (2000), is the claim that the human mind is mediated. It was reported by Lantolf that Vygotsky argued that just as humans do not act directly on the physical world but, instead, rely on tools, which allow us to change the world, and with it, the circumstances under which we live in the world, we also use symbolic tools, or signs, to mediate and regulate our relationships with others and with ourselves and thus change the nature of these relationships. Whether physical, symbolic or signs, tools according to Vygotsky are the artefacts created by humans under specific cultural (culture specific) and historical

conditions and are made available to succeeding generations, which then can also modify these artifacts before passing them on to future generations.

These symbolic tools include numbers and arithmetic systems, music, art, and language. Hence, as with physical tools, humans use symbolic artifacts to establish an indirect, or mediated, relationship between ourselves and the world. That is, they are used as aids in solving problems that cannot be solved in the same way in their absence. In turn, they also exert an influence on the individuals who use them in that they give rise to previously unknown activities and previously unknown ways of conceptualizing phenomena in the world. Therefore, they are subject to modification as they are passed from one generation to the next, and each generation reworks them in order to meet the needs and aspirations of its individuals and communities (Lantolf, 2000; Turuk, 2008). Vygotsky further advocated that the task of a psychologist is to understand how human social and mental activity is organized through culturally constructed artifacts.

In addition, the sociocultural environment as Vygotsky (1978 cited Lantolf 2000) posited, presents the child with a variety of tasks and demands, and therefore engages the child in his or her world through the use of the tools. Vygotsky claims that in the early stages, the child is completely dependent on other people, specifically the parents, who initiate the child's actions through instructions as to what to do, how to do it, as well as what not to do. The parents who serve as representatives of the culture and conduct, through which culture is passed unto the child, realize these instructions mainly through language. Hence, children start to 'assimilate and accommodate' societal customs, laws and values in their early stages of development. That is, the knowledge about cultural and social heritages, as stated by Vygotsky (1978 cited Wertsch 1985), are acquired by the child through contacts and interactions with people as the first step (interpsychological plane), then later assimilates and internalises this knowledge adding his or her personal value to it

(intrapsychological plane). This transition from social to personal property according to Vygotsky is not a mere copy, but a transformation of what had been learnt through interaction, into personal values.

This therefore indicates that as a child grows up in a society which sees suicide as a taboo, despicable, unspeakable and unacceptable act, then this child will internalise this custom and that will be part of him or her until it is modified. That is, a child who is in a society that holds negative attitudes toward suicide will grow to hold the same attitude and further transfer it to his or her offsprings. On the other hand a child will also learn from a society that has liberal or positive attitudes toward suicide thereby also transferring it to his or her children. Therefore, the sociocultural theorists, pioneered by Vygotsky believed that society is responsible in inculcating societal values, norms and customs into a child right from birth with the parents serving as the primary representatives of their culture.

2.2 Durkheim's Theory

From the sociological perspective, suicidal behaviour cannot be viewed outside of societal or environmental context. Hence, Stillion and McDowell (1996) posited that different cultures experience different psychological and suicidal problems at different times. Durkheim (1897-1951) therefore proposed that suicide occurs as a result of the kind of 'fit' that an individual experiences in his or her society. He therefore postulated four different types of suicide. He labelled the first type as egoistic suicide.

This occurs when an individual suffers from excess individualism and becomes secluded from social life as a result of the relaxation of the bond attaching man to life since that attaching him to society is itself loosed (Taylor, 1982). Durkheim further pointed out that supportive system like religion

(especially belonging to a Catholic religion) and marriage, as evidence, buffers suicidal behaviour in the society. That is, he believed that in a society that is simple and efficient, the individual is protected and shielded by family, religious and other group systems. Thus the degree of integration between an individual and the society is an essential protective factor against self-destruction (Spencer, 1997; Stillion & McDowell, 1996). Durkheim therefore believed that there is an inverse relationship between the incidence of egoistic suicide and family density.

The second type of suicide discussed was labelled altruistic suicide. Altruistic suicide occurs when there is an over-integration of the individual into society. That is, a person kills himself or herself in an attempt to conform to societal rules or imperatives (Stillion & McDowell, 1996). Nolen-Hoeksem (2007) has posited that these individuals believe that taking their own lives will profit the society hence does so. For instance it was reported by Stillion and McDowell (1996) that altruistic suicide includes the actions of Japanese Kamikaze pilots during World War II who offered to fly planes on one way missions to destroy U.S. ships thereby killing themselves in that action. This usually results from the love for their country or members of the family or clan.

The third type of suicide was named anomic suicide. This results from a person's activity which lacks regulation. In other words, this suicide type is found both in times of economic depression or greater prosperity whereby suicide rates increase in both situations. That is, regardless of what goes on in the larger society, the suicidal individual feels cut off from it. There is a great deal of freedom felt and expressed by the individual (Stillion & McDowell, 1996). The drug related suicides of the late 1960's might be good examples of anomic suicides as young people during those times were not at ease with societies standards. Hence, most of them experimented wildly and fatally with toxic substances.

The last type discussed was called fatalistic suicide. This type was viewed as opposite to the anomic type of suicide. This type of suicide results from overregulation and oppressive discipline by a society, directed at a particular segment of that society (Stillion & McDowell, 1996). For instance, extremely harsh, brutal, and punitive conditions among prisoners or slaves in concentration camps and detention facilities are good examples of this type of suicide.

The sociological perspective calls for a broader view to suicide. That is, it challenges people to view conditions in their cultures at any point in history as factors that can influence suicide. According to Durkheim, egoistic and altruistic suicides are affected by the level of integration in the family and the society at large. Hence, the relationship between family and societal members of the respondents in this study could have an effect, either serving as a buffer against suicide or aiding suicide. It is widely recognized that social relationships and affiliations have powerful effects on physical and mental health. The sociological theory challenges us to understand how the patterning of the most psychological, intimate, and on the surface, individual acts rest not on psychological foundations but upon the patterning of social facts. The theory explains how social factors can be used in explaining the changing patterns of aggregate tendency toward suicide. The theory posits that social factors exist at the level of society as a whole arising from social relationships and association. They exist as a result of social interactions and historical developments over long periods of time. As individuals who are born and raised in a society, social facts are learned and generally accepted.

2.3 Review of Related Studies

This section reviewed several studies conducted on attitude towards suicide and suicidal persons for the past three decades. Specifically, these studies were reviewed in sections based on the aims of this current study which were the cultural factors that influences their attitudes towards suicidal persons, factors that influence suicide prevention, and attitudes of psychiatric nurses and community health nurses towards patients who attempt suicide.

2.4 Cultural factors that influences attitudes towards suicide

Culture provides a set of rules and standards that are shared by members of a society which shape and determine the range of appropriate behaviour. Culture therefore influences the behaviour of nationalities, ethnic groups and subgroups within a nation (Lester, 2008). Therefore, different continents and countries to be specific, present different ways of living. Hence, different countries might possibly present different cultural interpretation of suicidal behaviour or attitudes toward suicide. Some laid down cultural institutions as either law or by convention is hostile towards suicidal victims and living family members which reflect in their attitudes toward suicide.

A study by Eshun (2003) which investigated the role of gender, family cohesion, religiosity, and negative suicide attitudes as potential determinants of cultural differences in suicide ideation among 375 college students from Ghana and the United States revealed that family cohesion and negative attitudes were the significant predictors for both cultural groups and gender for only Ghanaians. Ghanaian college students were found to have more negative attitudes toward suicide than did American college students. This could be as a result of the general prohibition of suicide by law, some cultural practices and the religious proscriptions against the act.

A study also by Kim, Lee, Lee, Yu, and Hong's (2009) in Korea evaluated community mental health professionals and hospital workers attitude and awareness towards suicide. Therefore they examined

264 community mental health professionals and 228 hospital workers from July 2007 to September 2007 using the Suicidal Opinion Questionnaires. The results revealed significant differences in the attitude towards suicide according to religion, age, educational background, the marriage status, the economic position, and different professional licenses. That is, hospital workers judged 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. The lower educational group also thought that suicide was attributable to mental illness. The awareness for suicide was significantly higher in the group with a postgraduate education, unmarried people, mental health professionals and the persons who had concern and experience with suicide. The factors that had an influence on the awareness of suicide were the items of mental illness, religion, risk and motivational factors.

Lester (2008) also discussed that gender as viewed by culture can have influence on suicide. For instance, he mentioned that in the United States and in European nations, nonfatal suicidal behaviour appears to be more common among women than in men. Therefore, suicidal behaviour is viewed as a 'feminine' behaviour by the general public whilst the Nahane (or Kaska), a Native Canadian tribe located in British Columbia and the Yukon, provide a good example of males committing more nonfatal (especially in view of other) suicide than women. He further stated in his paper that cultures differ in ways of condemning suicidal behaviour. It is less acceptable among African-Americans, whilst it is a culturally recognised way of imposing social-sanctions among females in Papua-New Guinea.

Evans and Farberow (2003) have also given detail account of some ancient cultural factors that precipitated suicidal behaviour. They reported that among the ancient Indians, widows used to commit suicide on her husband's funeral pyre as sanctioned and institutionalised by culture's

doctrines. Hinduism called Sutte. A Japanese may also commit suicide to avoid disgrace or and to prove their sincerity. This indicates that attitudes toward suicide are imbibed in a specific cultural setting.

Mbiti (2006) pointed out that Africans are notoriously religious and that religion permeates into all their aspects of life so fully that it is not always easy or possible to isolate it. This is definitely not far from the truth as a study by Knizek, Akotia and Hjelmeland (2010) which investigated attitudes toward suicide and suicide prevention among psychology students in Ghana by means of a qualitative analysis of open-ended questions about causes of suicide and how suicide best can be prevented revealed that there was a huge impact of religion on the attitudes toward suicide as well as some lack of distinction between their religious and professional roles and responsibilities. That is, Ghanaian students trained to be professional psychologists were mostly found “caught up” in religious remedy. This religious position has also been supported by a study conducted by Osafo, Knizek, Akotia, and Hjelmeland (2013). Their results revealed that Ghanaian lay persons are committed to the core and normative religious beliefs and practices of preserving life. Hence, suicidal behaviour was unacceptable. However, religion facilitated their willingness to help people during suicidal crisis.

Another study by Segal, Mincic, Coolidge, and O’Riley (2004) in Colorado, USA examined the attitudes of 96 younger and 79 older adult toward suicide and suicidal risk found out that older adults had significantly more acceptable attitudes toward suicide than younger adults which was more strongly related to a lack of religious conviction.

Collectivism and Individualism, to a greater extent have been tagged in cultural factors influencing attitudes toward suicide. Goldston, Molock, Whitbeck, Murakami, Zayas, and Hall (2008) have

discussed collectivism as a central value of many cultures, although there may be within-group differences in the degree to which groups evidence a collectivist versus an individualistic orientation. Collectivism or interdependence among peoples may serve as support or provide a sense of belonging for at-risk individuals that may mitigate risk for suicidal behaviors. Studies that have also compared individuals from collectivistic and individualistic cultures have, most of the time, found negative attitudes toward suicide in favour of the collectivistic culture. For instance, a study by Peltzer, Cherian and Cherian (2000) which used three cultural groups (142 blacks, 112 whites, and 112 Asians) in South Africa found out that suicidal ideation and plans to commit suicide are highest among Asians and whites as compared to black students. Etzersdorfer, Vijayakumar, Schöny, Grausgruber and Sonneck (1998) also conducted a study on attitudes toward suicide among respondents in India (collectivistic culture) and Austria (individualistic culture) and revealed that respondents in collectivistic culture have more negative attitudes toward suicide than those in an individualistic culture.

2.5 Factors that influence suicide prevention

The attitudes of 229 professionals working in mental health care outpatient clinics in Child and Adolescent Psychiatry (CAP) (for children and adolescents aged 0–18 years) and District Psychiatric Centres (DPC) (for adults aged 18–67 years) were examined (Norheim, Grimholt, & Ekeberg, 2013). The results indicated that all professionals had positive attitudes and endorsed the view that suicide was preventable. Professionals who had received supervision or were specialists had attitudes that were more positive. However, professionals in Child and Adolescent Psychiatry were less satisfied with available treatment. Psychiatric disorders were considered the most common cause of suicidal behaviour, and psychotherapy the most appropriate form of treatment.

Another study by Carmona-Navarro and Pichardo-Martínez (2012) in the Netherlands assessed the attitudes and the influence of emotional intelligence among mental health and emergency nurses through responding to a questionnaire. The results of the data analysis showed a general adverse attitude towards suicidal behaviour. Furthermore, moral dimension of suicide made the difference between mental health and emergency professionals. It was also revealed that possessing a higher degree of mental health training and a high level of emotional intelligence is associated with a more positive attitude towards patients with suicidal behaviour.

Likewise, 45 nurses were conveniently sampled in another study which aimed at investigating nurses' attitudes toward suicide and to gain a better understanding of factors influencing the identification and management of suicide risk and ultimately improve patient safety. Results after data analysis indicated that nurses' age and educational level significantly correlated with positive attitudes toward suicide and that religion was also a significant predictor of positive attitudes toward suicide (Neville & Roan, 2013).

Brunero, Smith, Bates, and Fairbrother (2008) conducted a study which assessed a group of non-mental health professionals' attitude towards suicide prevention initiatives as the attitudes that clinicians hold towards suicide prevention initiatives may influence their suicide risk assessment and management skills. Health professionals that had attended suicide prevention education showed significantly more positive attitudes towards suicide prevention initiatives. Hence, there is also the need for educating non-mental health professionals in suicide risk awareness and management.

Osafo, Knizek, Akotia, and Hjelmeland (2012) interviewed a total of 17 informants (9 clinical psychologists and 8 emergency ward nurses) in an urban centre in their study to understand the attitudes of health professionals toward suicidal behaviour and its prevention in Ghana. The results

after the Interpretative Phenomenological Analysis (IPA) revealed that the attitudes of these health workers toward suicide and suicide prevention seemed to be transiting between morality and mental health. That is, the psychologists generally viewed suicide as a mental health issue, emphasizing a caring and empathic view of suicidal persons and approaching suicide prevention from a health-service point of view. Furthermore, it was reported that practical approaches toward suicide prevention should be based on mental health education and improvements in primary health care. On the other hand the nurses rather held a moralistic attitude toward suicide. They saw suicide as a crime and viewed suicidal persons as blameworthy and therefore approached suicide prevention from a proscriptive perspective. Informal approaches such as talking to people, strengthening the legal code against suicide and threatening suicidal persons with the religious consequences of the act were also indicated as practical approaches to suicide prevention. Educational level, clinical experience with suicidal persons, and religious values, were also discussed as influencing the differences in attitudes toward suicide and suicide prevention between psychologists and nurses.

A study by Goldston, Molock, Whitbeck, Murakami, Zayas, and Hall (2008) have also discussed that collectivist orientation may also increase acculturative stress as well as the awareness of racial oppression and discrimination which usually affects larger communities. Hence, collectivist orientation may serve as a risk factor rather than a protective factor for suicidal behaviours. For instance, degree of cohesion, attitudes toward substance abuse and antisocial behaviour as well as attitudes toward death have also been seen as factors influencing suicide prevention. Psychologists therefore, need to be aware of the degree to which the process of acculturation as well as history of racism and or societal pressures has served to erode a sense of community and interdependence among some people. Eshun (2003) has found family cohesion and negative attitudes toward suicide, and gender as the determinants of suicidal ideation among Ghanaian whilst family cohesion and negative attitudes toward suicide were the determinants of suicidal ideation among US students.

2.6 Attitudes of Psychiatric and Community Health Nurses toward Suicide

A study by Anderson (1997) compared the attitudes of community mental health nurses and registered nurses working in an accident and emergency department towards suicidal behaviour. Hence, a sample of 80 nurses were used to respond to statements from Domino's 'Suicide Opinion Questionnaire' (SOQ) and new statements based on a comprehensive survey of research in this area. Results of their analyses revealed that both groups of nurses held generally positive attitudes towards suicidal behaviour. Furthermore, there was no significant statistical difference between the nurses in any of the four attitudinal categories. Attitudes were significantly different in accordance with nurses' length of experience and age within both groups.

A quantitative study by Sun, Long, and Boore (2007) investigated a sample of 155 casualty nurses' attitudes towards patients who have attempted suicide as well as to identify factors that contributes to their attitudes towards attempted suicide in Taiwan. The result from the data analyses revealed that casualty nurses hold positive attitudes toward patients who have attempted suicide. Furthermore, it was found that the higher the level of nursing education, the more positive the nurses' attitudes towards patients who had attempted suicide. In addition, casualty nurses who did not have a religion held more positive attitudes towards suicidal behaviour than those who followed a religion. The analysis also revealed that casualty nurses who had suicide care experience with 1-10 patients had more positive attitudes towards suicidal patients than nurses who had nursed above 10 patients who had attempted suicide.

Similarly, a study conducted by McCann, Clark, McConnachie, and Harvey (2006) in Australia aimed at assessing if accident and emergency nurses have positive or negative attitudes towards patients with deliberate self-harm, and to find out if nurses' age, length of experience, or in-service education influence their attitudes towards these patients. In view of this, 43 registered nurses were

selected to respond to an adapted version of the Suicide Opinion Questionnaire which assessed attitudes towards patients with deliberate self-harm. Data analyses revealed that most nurses have had no educational preparation to care for patients with self-harm. Moreover, over 20% claimed that their department either had no practice guidelines for deliberate self-harm or they did not know of their existence, even though the one-third who knew about them had not read them. It was also revealed that older and more experienced nurses had more supportive attitudes than younger and less experienced nurses as well as nurses who had attended in-service education on deliberate self-harm having more positive attitudes than non-attendees.

Anderson, Standen, Nazir, and Noon (2000) conducted an exploratory study in the UK. The study intended to identify the attitudes toward suicidal behaviour in young people, amongst nurses, and doctors working in in-patient medical and mental health care settings. The Suicide Opinion Questionnaire (SOQ) as well as qualitative interviews was administered to 59 samples. The findings from the SOQ revealed that there were no overall significant differences in the relevant groups of nurses and doctors, with the exception of gender and the clinical scale relating to a 'Cry for Help'. The focused interviews generated five categories relating to suicidal behaviour and young people. Nurses and doctors working in these areas possess a range of influential perceptions of suicidal behaviour and need to be considered in the contexts of care and treatment of young people.

Another study by Anderson, Standen, and Noon, (2003) explored nurses and doctors perceptions of young people who engage in suicidal behaviour. The data used for the study forms part of a larger project conducted using both quantitative and qualitative methods, and a contemporary grounded theory approach for analysis. The findings after analysis revealed two main categories and associated subcategories being experiences of frustration in practice (subcategories: non-therapeutic situations, insubstantiality of interventions, and value of life) and strategies for relating to young people (sub-

categories: specialist skills in care and reflections on own experience). These categories therefore highlighted the barriers involved in the relationship nurses and doctors have with young people who engage in suicidal behaviour.

Similarly, a study by Anderson and Standen (2007) investigated the attitudes toward suicide in nurses and doctors who work with children and young people who self-harm. The effect of basic demographic factors on attitudes towards suicide in the staff group was also explored. One hundred and seventy-nine nurses and doctors working in three clinical areas being accident and emergency, paediatric medicine, and adolescent inpatient mental health services responded to the Suicide Opinion Questionnaire. Results after data analyses revealed that nurses and doctors indicated agreement on the Mental Illness, Cry for Help, Right to Die, Impulsivity, Normality and Aggression scales, and less agreement on the Religion and Moral Evil scale. The analyses further revealed that there were no significant differences in the clinical scales in relation to gender, age, clinical speciality and length of experience in current post except for Mental Illness in relation to professional group.

McCann, Clark, McConnachie, and Harvey (2007) also conducted an exploratory study to investigate emergency department nurses' attitudes toward patients who engaged in deliberate self-harm. Therefore, 43 emergency department nurses from a large Australian hospital were selected using a non-probability sampling technique to respond to a modified version of the Suicide Opinion Questionnaire. Results after the data analyses indicated that most nurses had not received any educational preparation to care for patients with self-harm with over 20% claiming that the department either had no practice guidelines for deliberate self-harm or they did not know of their existence. However, one-third of the nurses who knew of these practice guidelines had not read them. In general, it was found out that nurses had sympathetic attitudes towards patients who self-

harm, including both professional and lay conceptualizations of deliberate self-harm. Hence, they did not discriminate against this group of patients in their triage and care decisions.

Another study by McCarthy, and Gijbels (2010) which also examined 68 emergency department nurses' attitudes towards individuals presenting with deliberate self-harm (which included the relationship between attitudes and factors such as age, academic achievements, length of experience, and self-harm education) revealed that the nurses held positive attitudes toward individuals presenting with deliberate self-harm. Furthermore, no correlation was found between total scores and gender, experience, or a history of self-harm education. However, older nurses and hospital trained nurses had less positive attitudes as compared to their other counterparts. Age and length of clinical experience produced a trend in which attitudes increased, reached a peak and then declined.

McAllister, Creedy, Moyle, and Farrugia (2002) also examined 1008 emergency department nurses on attitudes toward clients who present with self-injury. This same study was aimed at developing and testing a scale on nurses' attitudes towards self-injury. Hence, a new scale (Attitudes Toward Deliberate Self-Harm Questionnaire, ADSHQ) was developed through drawing items from a thoroughly reviewed literature and focus group discussions and pilot tested on 20 nurses. Results of the data analyses revealed four factors that reflected nurses' attitudes toward these clients being nurses' perceived confidence in their assessment and referral skills, ability to deal effectively with clients, empathic approach, and ability to cope effectively with legal and hospital regulations that guide practice. In addition, the nurses have negative attitude towards clients who self-harm. Correlations were also found between years of experience and total score on the ADSHQ, and years of experience and an empathic approach towards clients who deliberately self-harm.

A questionnaire that assessed attitudes toward suicide prevention was constructed and used to investigate four groups of health professionals (general practitioners, accident and emergency nurses, psychiatrists in training, and community psychiatric nurses) who were in contact with suicidal patients. The analysis showed that attitudes toward suicide prevention were significantly different between the professional groups with more positive attitudes associated with mental health professionals, working in the community, and previous training in suicide risk assessment (Herron, Ticehurst, Appleby, Perry, & Cordingley, 2001)

Two hundred and thirty two professionals (38 psychiatrists, 50 general practitioners, 34 psychiatric nurses, 60 doctors and nurses working in accident and emergency services, and 50 medical students) were recruited in a study which aimed at comparing competence in assessing and managing suicidal patients (Palmieri et al., 2008). Hence these professionals responded to a Suicide Intervention Response Inventory (SIRI-2) and a questionnaire on perceptions of risk and protective factors in suicidal patients. The results indicated that exposure to suicidal patients was found to be widespread in all groups, but specific training in suicide assessment and intervention was conspicuously rare. Furthermore, psychiatrists outscored all the other groups and psychiatric nurses scored significantly higher than general practitioners in identifying appropriate responses to suicidal patients.

Another study which examined 980 health and community professionals' suicide intervention skills revealed that there are clearly different suicide intervention skills among professional groups and these were strongly related to experience, especially suicide-specific experience. Moreover, some community professionals scored below acceptable levels on their ability to respond appropriately to suicidal persons they encounter, and tend to overestimate their skills level (Scheerder, Reynders, Andriessen, & Van Audenhove, 2010).

A study by Botega et al. (2005) in Brazil measured attitudes of nursing personnel towards suicide and attitude differences among these professionals. Three hundred and seventeen nursing professionals were used and the result revealed that the belief that a person does not have the right to commit suicide was stronger among older professionals, those who had never taken care of suicidal patients, those who had a family history of suicide, as well as those who were Protestants and used to attend church services more frequently. In general, greater professional capacity was reported by nursing assistants and those who had already taken care of suicidal patients.

In a study conducted by Samuelsson, Asberg, and Gustavsson (1997) in Sweden which aimed at examining attitudes toward suicidal patients and to establishing a baseline of attitudinal measures against which the effects of a subsequent educational programme can be assessed among 197 psychiatric nursing personnel, it was found that women tended to be more sympathetic than men as well as older personnel being more favourably disposed than the younger nurses. Differences between personnel working in different settings were also found, which might be due to the differences in the frequency of contact with suicide-prone patients. That is, more frequent exposure was associated with more positive attitudes.

Another study by Samuelsson, Sunbring, Winell, and Asberg (1997) which investigated the attitudes towards attempted suicide patients among registered nurses involved in the somatic care of such patients revealed that nurses working within the psychiatric services were more understanding and more willing to nurse suicide attempt patients than nurses in somatic disciplines. It was also found that older nurses were more favourably disposed than their younger counterparts, and the more frequent contact with suicide-prone patients, the more the nurses' positive attitudes. Furthermore, it was discussed that nurses' 'negative attitudes' may to some extent be a result of lack of knowledge

and uncertainty rather than a hostile attitude as most nurses requested for further training in suicidology.

Therefore the attitudes of psychiatric nursing personnel towards patients who had attempted suicide were examined before and after a training program in psychiatric suicide prevention was examined (Samuelsson & Asberg, 2002). The attitudinal changes were measured by a newly constructed scale, the understanding of suicide attempt patients scale (USP-scale), and responses to three brief clinical vignettes. The results revealed that the general understanding and willingness to nurse, as measured by the USP-scale, increased significantly. Moreover, the suicide risk of patients described in the clinical vignettes was estimated more accurately after the program. This, therefore, suggested that it may be possible to enhance attitudes to attempted suicide patients among psychiatric nursing personnel (Samuelsson & Asberg, 2002).

A study compared the attitudes of 115 emergency room staff towards patients who have attempted suicide between two general hospitals, one with psychiatric consultation available and the other without. Results revealed clear differences in staff attitudes between the hospitals. For instance, females, older age, and working in Hospital without routine psychiatric consultation were associated with more positive attitudes towards attempted suicide patients. However, only working in a Hospital with routine psychiatric consultation was associated with more negative attitudes (Suominen, Suokas, & Lönnqvist, 2007).

Suokas, Suominen, and Lönnqvist (2008) conducted a study in Finland which examined the association between staff members' psychological distress and the attitudes towards suicide attempters as well as comparing the attitudes towards suicide attempters among emergency personnel between a general and a psychiatric hospital. Hence, 151 staff in the emergency rooms of

a general hospital and a psychiatric hospital was used. The result revealed a general tendency among emergency room staff to view attempted suicide patients in a positive and sympathetic manner. However, nurses working in the general hospital expressed more negative attitudes than those in the psychiatric hospital. There was also no association between staff members' psychological distress and negative attitudes towards suicide attempters.

Another study compared the attitudes of emergency room staff in a general hospital toward patients who had attempted suicide before and after establishment of a psychiatric consultation service. It was believed that the attitudes of nurses who have had the opportunity to consult a psychiatrist were less negative than those who have not. Hence, 100 respondents were used to ascertain this belief. The results showed that general understanding and willingness to nurse patients who attempted suicide did not increase. This then suggested that providing a psychiatric consultation service did not significantly affect attitudes among general hospital emergency room staff toward attempted suicide patients (Suokas, Suominen, & Lönnqvist, 2009).

Srivastava and Tiwari (2011) also conducted a study in India which sought to compare the attitudes of mental health and non-mental health workers towards patients who attempt suicide. A group of 30 non mental health clinicians working in an emergency department and a comparison group of 30 mental health professionals who were conveniently sampled responded to a self administered questionnaire that had 34 items with yes/no responses. The results revealed that mental health professionals had significantly higher positive attitude towards dealing with the patients who have attempted suicide, compared to non mental health professionals.

Meta analysis of studies over a 20-year period by McCormack, Clifford, and Conroy (2012) assessed the attitudes of UK doctors concerning active, voluntary euthanasia (AVE) and physician-assisted

suicide (PAS). Therefore, literature search of English articles between January 1990 and April 2010 from three electronic databases, four pertinent journals, reference lists of included studies were used for this study. Excluded criteria included studies that did not present independent data (e.g. commentaries) or if they related to doctors outside the UK, patients younger than 18 years old, terminal sedation, withdrawing or withholding treatment, or double-effect. Quantitative and qualitative data were extracted. Hence, following study selection and data extraction, 15 studies were included. It was therefore revealed that UK doctors oppose the introduction of both voluntary euthanasia and physician-assisted suicide in the majority of studies. The degree of religiosity appeared as a statistically significant factor in influencing doctors' attitudes.

A study compared the attitudes and practices concerning the end-of-life decisions between physicians in the United States and in the Netherlands using a total of 152 physicians from Oregon and 67 from the Netherlands. It was revealed that American physicians found euthanasia less often acceptable than the Dutch, but there was similarity in attitudes concerning increasing morphine and physician-assisted suicide. American physicians found increasing morphine and physician-assisted suicide more often acceptable in cases where patients were concerned about becoming a burden to their family. There was a discrepancy between the attitudes and practices of Dutch physicians concerning physician-assisted suicide. The proportions of physicians having practiced euthanasia, physician-assisted suicide, or ending of life without an explicit request from the patient differ more between the countries than do their attitudes, with American physicians having been involved in these practices less often than the Dutch (Willems, Daniels, van der Wal, van der Maas, & Emanuel, 2000).

Another study has examined 321 psychiatrists' attitudes toward assisted suicide, the factors influencing these attitudes, and how they might both respond to and follow up a request by a primary care physician to evaluate a terminally ill patient desiring assisted suicide using anonymous

questionnaire. The results revealed that two-thirds endorsed the view that a physician should be permitted, under some circumstances, to write a prescription for a medication whose sole purpose would be to allow a patient to end his or her life. However, one-third endorsed the view that this practice should never be permitted. Over half also favoured Oregon's assisted suicide initiative becoming law. Psychiatrists' position on legalization of assisted suicide influenced the likelihood that they would agree to evaluate patients requesting assisted suicide and how they would follow up an evaluation of a competent patient desiring assisted suicide. Only 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide. It can therefore be concluded that the belief about the ethical permissibility of assisted suicide is divided among psychiatrists as well as their moral beliefs potentially influencing how they might evaluate a patient requesting assisted suicide should this practice be legalized (Ganzini, Fenn, Lee, Heintz, & Bloom, 1996).

Another study has also reviewed nine empirical studies from Japan, the Netherlands, the United Kingdom and the U. S. which examine attitudes of psychiatrists toward physician-assisted suicide. The results revealed that psychiatrists showed a greater agreement with the attitudes as compared to the other physicians. Hence, a psychiatric examination in order to evaluate competence even in patients with severe somatic illness was advocated by the majority of psychiatrists (Vollmann, & Herrmann, 2002).

The attitudes of Japan and US psychiatrists were compared in order to investigate their ideas on whether patients in general medical hospitals who have a desire to die should be allowed to do so or be assisted in this regard, and whether they require psychiatric evaluation and intervention, and the cultural influences on these attitudes (Berger, Fukunishi, O'Dowd, Hosaka, Kuboki, & Ishikawa, 1997). That is, seventy-two American and 62 Japanese psychiatrists' attitudes towards the reasonability of suicide, physician-assisted suicide, and removal of life supports under various

medical and psychosocial situations were compared using the Suicidal Attitudes Inventory. The results revealed that both American and Japanese psychiatrists agreed that there may be times when suicidal ideation or completed suicide in med-surg patients could be reasonable. Significantly more Japanese psychiatrists responded with some agreement to the reasonability of suicide when one is unable to fulfil social role expectations, and had more concern about causing suicidal ideation by informing terminal patients of their diagnosis.

Attitudes toward suicide patients among 323 Japanese nurses together with their perceived need for training in relation to understanding the nature of suicidal behaviour and preventive strategies was studied by Kishi, Kurosawa, Morimura, Hatta, and Thurber (2011). The results revealed that nurses who worked in the psychiatric unit or had the experience in psychiatric nursing had more favourable attitudes toward suicidal patients and viewed themselves as having more relevant skill training in dealing with suicidal patients than those who did not. The nurses therefore thought that patients who attempted suicide were not treated well. Furthermore, nurses who worked at emergency care/intensive care unit were less likely to understand suicidal patients, and were less inclined to be sympathetic and to verbally interact with suicidal patients concerning their problems. The nurses who have confidence in the psychiatric care of suicidal patients, confidence in their own skills, and have a need for more training had the more positive attitudes.

2.7 Rationale

Clinician's attitudes can influence proper management and follow-up of patients who are at risk of repeated self harm. Clinical decision making is thus influenced by a complex interplay of patient–clinician relationship, socio-cultural and contextual factors as well as religious beliefs. The management of a patient attempting suicide should be based on theoretical knowledge and empirical data but unfortunately research shows that “unrelated” factors can also affect the clinician's judgment. Some of these are a patient's attractiveness, socio-economic status and the clinician's own values. These factors can interfere in the proper management and follow-up of patients who are at risk of repeated self harm and the attitudes of clinicians often can interfere with prevention strategies.

Health professionals come into frequent contact with individuals who are at high risk of self harm and therefore play pivotal role in the prevention of suicide. A study on attitudes of psychiatric and community health nurses towards patients who attempt suicide will however help in identifying any negative attitudes and this can subsequently help plan training and education which can help in suicide prevention.

For instance in Ghana, it has been reported that the way health workers' relate with tuberculosis patients such as shouting at them and standing at a distance when talking to them contributes to the stigmatization of such patients (Dodor, 2008; Dodor et al., 2009).

Like elsewhere in the world, nurses are the first point of contact when a suicide attempter seeks attention at a health facility (McCann et al., 2007).

Thus the psychiatric nurse where available is likely to encounter a considerable number of suicide attempters and their role becomes indispensable in the initial management of suicidal cases.

Psychiatric mental health nurses provide comprehensive, patient-centred mental health and psychiatric care and outcome evaluation in a variety of settings across the entire continuum of care.

Psychiatric mental health nursing involves the delivery of comprehensive primary mental health care in a variety of setting which involves the continuous and comprehensive services necessary for the promotion of optimal health (Haber & Billings, 1995). Psychiatric mental health nursing is necessarily holistic and considers the needs and strengths of the individual, family, group and community.

Community health nurses particularly have a long and close contact with the community and are well accepted by the community. They provide the vital link between the community and the health care system. In Ghana where mental health services are not well developed, they are often the primary source of health care. Their knowledge of the community enables them to gather support from family, friends and organizations which make them entry point to health services for those in distress. It can however be said that they are available, accessible, knowledgeable, and committed to providing care.

The attitudes of health care professionals can be detrimental to suicide prevention (Lang et al., 1989) and as long as these two groups are active key handlers of suicidal patients, it becomes essential to examine their attitudes toward suicide and suicide prevention in Ghana.

Improved attitudes will foster increased knowledge of assessment and treatment of suicidal patients in the healthcare centres. Globally, the urgent need to coordinate and intensify actions aimed at preventing suicide has been pointed out by the World Health Organization (WHO, 2004). One of the recommended ways of preventing suicide has been increasing awareness among health care professionals of their own attitudes and taboos toward suicide and its prevention (WHO, 2007). Studies examining this issue seem less adequate in number in Ghana. Additionally, it will be noted

that psychiatric nurses and community health nurses belong to different health categories by way of their job description. It is therefore important to have a comparative analysis of how each views suicide and reacts toward suicidal persons.

The studies that have examined attitudes toward suicide in Ghana have been predominantly quantitative (e.g., Eshun, 2003; Hjelmeland et al., 2008a, b). However, we need to understand the perceptual experience and meaning(s) behind the statistical explanations offered for the kind of attitudes people express toward suicide. For instance, what meaning does the act of “suicide” constitute for a person who is reported to have a negative attitude toward it? An answer to such a question requires a method which is meaning-driven, such as a qualitative method (Silverman, 2006). Moreover, the need to consider the local cultural context as a step toward understanding suicide has been emphasized by various authors (Boldt, 1988; Colucci, 2006, 2009; Hjelmeland, 2010). Again studies on attitudes toward suicide and suicide prevention seem less focused on nurses with the exception of a study conducted by Osafo et al (2013) and even with this study the nurses were few and worked in clinical settings.

However there is the need to consider a community based research by focusing on nurses who usually works at the community level and may encounter suicidal cases in the community. This present study sought to achieve this by using psychiatric and community health nurses.

Most especially up until now there has not been any study in the suicidological literature in Ghana that examines exhaustively health workers attitudes toward suicide prevention. The present study sought to exhaustively document suicide prevention strategies that could inform a national suicide prevention plan.

“In the context of Africa, health care professionals are key opinion leaders in their communities and in most social settings are in a power category whose attitudes can affect the views held by society” (Awusabo-Asare & Marfo, 1997; Dodor et al., 2009).

It is against this background and observation that this research is being embarked on to explore the attitudes of psychiatric and community health nurses towards suicide and suicide prevention in Ghana.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter outlines the methodological approaches adopted in this study. It presents the population and setting for the study, the sample and techniques used in the selection of samples and the design of the study.

3.1 Population

The populations chosen for the study were psychiatric nurses and community health nurses at the Accra psychiatric hospital, Kaneshie Polyclinic and Korle-bu Teaching Hospital in the Greater Accra Region of the Republic of Ghana. The choice of the population was informed by the nature of the topic which aims to explore Health professionals' role in addressing the problem of suicide.

3.2 Participants/ sampling technique

Informants for this study were 36 adults made up of 18 psychiatric and 18 community health nurses. Five of the informants were males while 31 were females. Thirty were married and the rest were single. Informants were predominantly Christians, with two traditionalists and six Moslems. Informants' age range from 20 to 55 years whereas their tenure in the health profession also ranged between 3 months to 25 years. Majority of the informants (20) were Akans, and the rest were Ewes (8), Ga-Adangbe (6) and northern Ghana ethnic groups (2). (Refer to Table 1.1)

Table 1.1

Participant Demographics (N=36)

Variable	Frequency (n)	Percentage (%)
Age:		
20 – 30	16	44.4
31 – 40	13	36.1
41 – 50	5	13.8
51 – 60	2	5.5
Gender:		
Female	31	86.1
Male	5	13.9
Marital Status:		
Single	6	16.7
Married	30	83.3
Nurse Category:		
Psychiatric Nurse	18	50
Community Health Nurse	18	50
Religion:		
Muslim	6	16.7
African Traditional Religion	2	5.5
Christian	28	77.8
Ethnicity:		
Akans	20	55.5
Ewes	8	22.2
Ga-Adangbe	6	16.7
Dagomba	2	5.6

Purposive, convenient and snowballing sampling techniques were used in selecting informants. The sampling was informed by the conviction that the rigour of sample selection involves explicit and thoughtful picking of cases that are in line with the purpose of the study (Patton, 1999) and also based on the availability and willingness of informants to participate in the study. In view of this, psychiatric nurses who were available and consented to participate were interviewed. Again, to allow the study to take its natural course, there were no strict criteria for inclusion. However, some informants might have richer knowledge and could provide more insight into the issue of interest than others (Marshall, 1996), hence guided by this understanding, some informants recommended other useful persons for the study, whose consent was sought after and interviewed.

3.3 Criteria for inclusion

The participants for the study qualified for selection based on the following conditions;

Participants must be either a psychiatric nurse or a community health nurse. Additionally participants must be at least eighteen (18) years of age.

3.4 Research Design

A comparative study, using a qualitative approach, was employed to explore attitudes of psychiatric and community health nurses toward suicide and suicide prevention in Ghana. Suicide is a complex issue (Silverman, 2007), and to understand the meaning people make out of this phenomenon in a cultural context requires a qualitative method as espoused by (Boldt, 1988; Colucci, 2006, 2009; Hjelmeland, 2010).

Qualitative research design involves the study of respondents in their natural environment whereby the researcher is advantaged to conduct systematic enquiry into meanings, attempting to interpret and make sense of phenomena and the meanings that people attribute to them (Shank, 2002). Qualitative research is useful for studying a phenomenon in depth, describing complex phenomena.

It however provides understanding and description of people's personal experiences of phenomenon and can therefore yield rich and detailed information on a phenomenon as they are situated and embedded in local contexts. Qualitative research is highly sensitive to changes that occur during the conduct of a study which expands its knowledge base. In view of this, conducting a study into suicide and the attitudes held about the phenomenon contextually requires a qualitative approach which is open to emergent concepts and ideas and may produce detailed description and classification, identify patterns of association and explanations which may represent the social world of participants.

3.5 Measuring Instrument

A semi-structured interview guide for health professionals by (Osafo et.al 2008) was used to examine the informants' experience and attitudes toward suicide and suicide prevention. The researchers' interest was to analyse in detail how participants perceive and make sense of the concept "suicide" and suicide prevention. Therefore, there was a need for a flexible data collection instrument which allows for deep exploration into the social and personal worlds of the participant. This form of interviewing allows the researcher and participant to engage in a dialogue whereby initial questions can be modified in the light of the participants' responses and the investigator is able to probe interesting and important areas which arise. Some of the items on the guide included: What is your own principal attitude toward suicide? Do you think suicide can be prevented? How do you feel about suicidal persons, and how do you react when you discover that your patient/client is suicidal? Do you think suicide should be prevented? What can you do as a health professional to help prevent suicide? Do you think you have the know-how in assisting suicidal persons? What kind of treatment do you think is the most appropriate for suicidal persons?

3.6 Procedure

Ethical clearance was obtained from the Institutional Review Board at Noguchi Memorial Institute for Medical Research, university of Ghana, Legon. Consent forms were designed and presented to every individual who agreed to participate in the study. Introductory letters signed by the Head of Psychology Department of the University of Ghana revealing the researchers identity , the purpose and how significant the study will be to the health sector were given to the hospitals involved. The researcher herself conducted the interview using the interview guide prepared. Interviews were conducted from April 2013 to July 2013 using an interview guide. Appointment was booked with respondents who consented to participate after permission was granted. The interviews were conducted in the offices, common rooms of the informants and on few occasions in their homes. Validity of interpretation is a key issue in qualitative studies (Whitehorse et al., 2001). Therefore to ensure validity, the researcher summarized and checked during the interview process whether views of informants have been correctly recorded (Kardoff, 2004). With permission from the informants, the interviews were audio-recorded and later transcribed verbatim.

3.7 Analysis of data

The interviews were audio-recorded, transcribed verbatim and analysed by the researcher using thematic analysis. The transcribed data was read over and over again which helped to identify words, ideas, concepts and themes that appeared frequently. Themes, concepts and words that frequently appeared in the interviews were compared and cross-checked with other interviews and found to be consistent and saturated by the end of the thirty-sixth participant.

Thematic analysis involves searching through data to identify any recurrent patterns. Thematic analysis attempts to represent a view of reality via systematically working through text to identify topics that are progressively integrated. It involved the preparation of data to be analyzed by

transcribing the interview into text and reading the text to note items of interest in order to acquire a sense of the various topics embedded in the data. Again the text was read thoroughly by way of examining text closely, line by line to facilitate a micro analysis of the data.

Following from the close examination of the text, items of interest were sorted out into proto-themes, where themes begin to emerge by organizing items relating to similar topics into categories as well as examining the proto-themes and attempt was made to define the proto-themes. The text was re-examined carefully for relevant incidents of data for each proto-theme by taking each theme separately and re-examining the original data for information relating to that theme. The final form of each theme was reconstructed and the meanings of the themes were closely looked at using all the materials relating to each theme.

The name, definition and supporting data was re-examined for the final construction of each theme, using all the material relating to it. Finally each theme was reported with its description in addition to illustrating it with a few quotations from the original text to help communicate its meaning to readers.

Qualitative study is highly interpretative (Whittemore, Chase & Mandle, 2001) and therefore structured measures to minimize errors that might compromise the trustworthiness of the explanations are vital. The quality and rigour of interpretations in this study went through a thorough discussion by the supervisors. Themes gleamed were thoroughly scrutinized, and the quotes that could typically represent them were cross validated by the supervisors.

3.8 Ethical considerations

Ethical clearance was obtained from the Institutional Review Board at Noguchi Memorial Institute for Medical Research, university of Ghana, Legon. Approval was sought from the departmental heads in the three hospitals from which respondents were chosen. The nurses were informed about the nature of the study through their in-charge following from the issuance of introductory letter from the Department of Psychology, University of Ghana. Nurses who consented to participate were given informed consent forms to formalize their participation in the study. Again they were informed that participation was entirely voluntary and that they could opt-out at any time during the sessions. They were also assured of confidentiality by way of withholding their names in relation to the highly sensitive nature of suicide. Arrangements were made for informants who may need attention from a qualified counsellor or clinical psychologist following the interview.

CHAPTER 4

RESULTS

4.0 Introduction

This chapter presents the results of the thematic analysis of the data obtained from the field. Basically, the chapter covers the themes that were gleaned from the responses of the informants. The themes were organized into meaningful patterns using the sub-themes derived from them. The key findings of the analysis of the transcribed interviews were organized around three major thematic areas: conceptualizing suicide, behavioural and emotional response to suicidal persons, and suicide prevention strategies. Sub-themes were identified under each major thematic area to capture the relevant voices reflecting the attitudes of the informants toward suicide and suicidal persons.

4.1. Conceptualizing Suicide

In an attempt to find out nurses' attitude toward suicide and suicidal persons, it is imperative to uncover nurses' understanding and their general conception of the phenomenon of suicide. Thus, the theme, Conceptualizing Suicide, relates to how nurses (who participated in this study) perceive suicide and suicidal persons. It covers the various worldviews of the informants on the basis of which they establish meaning regarding the phenomenon of suicide in Ghana. Analysis of the informants' responses to questions regarding their perception of suicide revealed that suicide is conceived as a *social taboo*, a *religious infraction*, and as a *mental health issue*. These views were identified and categorized as three distinct sub-themes capturing the nurses' conception of suicide and suicidal persons in Ghana.

4.1.1. *Suicide as a Social Taboo*

Informants in this study perceive suicide from the perspective of a generally held traditional conception in Ghana that the phenomenon of suicide is socially wrong and as such a taboo – a phenomenon forbidden by society. Taboos can be entrenched in a society to the extent that people in the society are not even allowed to publicly discuss the acts or behaviours (e.g., suicide, incest, murder etc.)

An informant puts it succinctly as follows, *“Don’t go there. You don’t have to be seen openly discuss it (suicide). It is a taboo. When your relative dies through suicide, you don’t report the true cause of the death but rather give another cause, else you (the family) will not get a befitting funeral”* (CHN¹ Woman, 35 years). It can be inferred from the foregoing opinion that, it amounts to a taboo to mention or even discuss suicide publicly because society prohibits such engagements. Like all other taboos, suicide is defied. The punishment seems automatic as the culprit (in the case of suicide, the bereaved family) becomes expectant of it. Thus, when a member commits suicide, the rest of the family immediately seeks to provide a more socially ‘acceptable’ aetiological explanation to the rest of the society in order to avert any punishment. (Kauda & Chachah 1999). The most pronounced punishment appears to be stigmatization of the suicidal person’s family and other surviving social relations. For example, an informant observes, *“in my local community, your family will be greatly stigmatized, because of that they (your family) will not even disclose how you died, so that you can get a befitting burial”* (PN². Woman, 42 years). The implication is that although suicide occurs, it is not considered an acceptable cause of death. It can be observed that informants in this study appear to draw on the generally held views of their local communities (that suicide is a taboo) to construct their conception of suicide as a social taboo defined by the whole community as unacceptable.

¹ CHN is used to mean Community Health Nurse

² PN is used to mean Psychiatric Nurse

Comparing the nurses' conception of suicide, It is deductive of the preceding quotes from the two groups of health professionals being studied in this research that there is no major difference in the conceptualization of suicide as a social taboo. The groups consider suicide as an inappropriate cause of death which is denounced by all standards socially and culturally. The excerpts clearly reveals that suicide is highly stigmatized and as a result characterized by families unwillingness to disclose the cause of death should a relative die by committing suicide.

4.1.2. *Suicide as a Religious Infraction*

Some informants in the present study adopted a religious stance on conceptualizing suicide. In this regard, suicide was conceptualized as a religious infraction (Mbiti 2006) associated with eternal damnation of the soul of the suicidal person as a consequence in the afterlife. Common to all three dominant religious systems (Christianity, Muslim, and African Traditional Religion) in Ghana is the belief in the judgment of the soul by God in the afterlife. Consequently, every soul, depending on the outcome, the judgement would either be damned or rewarded eternally. Some informants stated as follows:

“My religion is totally against it. You try and you face the wrath of God. I know per my religion that if you take your life you will go to hell” (PN. Woman, 30 years).

“It is a big sin, if you take your life. You are going to hell, no matter what... God has the final say, so why commit suicide and rot in hell?” (PN. Woman, 25 years).

“My Bible teaches me that it is a sin to take one's own life” (CHN. Woman, 25 years). Within the lens of religion, suicide is viewed as sinful and as such unacceptable behaviour punishable by God. Like the taboo perspective, the punishment for suicide viewed in religious terms is automatic and known to the culprit. However, unlike the taboo perspective (where a suicidal person together with his or her family is punished by the rest of the society), in religious terms it is held that the suicidal person receives the punishment alone from God. Thus, whether suicide is attempted or completed,

the suicidal person is liable to punishment by God. This implies that, in terms of religious beliefs, irrespective of the motivation, cause or precursor behind the suicidal behaviour, the suicidal person is not justified and the suicidal act is unacceptable. This remains consistent with the findings of Zao (2007) who classified five common attitudes towards suicide. The first view regards suicide as an immoral behaviour that coward people abandon their social responsibility and leave greater pain to others. It will bring a negative impact on family members, adolescent and the whole society, which should be subject to moral condemnation.

Comparatively, there seems to be no major variation in the nurses' conceptualization of suicide as a religious infraction. Informants from each group stated as follows:

"My religion is totally against it. If you commit suicide and die you will be punished by God. I know per my religion that if you take your life you will go to hell straight away no matter how good you have lived your life. Taking your life is sinful" (PN. Woman, 32 years)

"It is a big sin, if you take your life. You are going to hell, no matter what... God has the final say, so why commit suicide and rot in hell?" (CHN. Woman, 28 years).

"My Bible teaches me that it is a sin to take one's own life" (CHN. Woman, 25 years).

It is deducible from the aforementioned quotes from the two groups of nurses being studied in this research that they hold a similar conception of suicide as a moral infraction. The groups consider suicide as an unacceptable cause of death by religious standards and a punishable offense. This implies that, in terms of religious beliefs, irrespective of the motivation, cause or precursor behind the suicidal behaviour, the suicidal person is not justified and the suicidal act is unacceptable.

4.1.3. *Suicide as a Mental Health Issue*

Virtually, all the informants interviewed in this study referred to their respective previous encounters – in the line of duty – with a patient who had attempted suicide. An informant observes that, *“I see it (suicide) to be an irrational act not typical of human beings and must not be entertained at all”* (PN. Woman, 27years). This opinion is suggestive of the view that suicide is an abnormal human behaviour perhaps because it is harmful to the well-being, not only of the suicidal person, but the rest of the social relations around him or her. The act is perceived as *irrational*, perhaps largely because the choice to commit suicide is not based on sound reasoning and judgement, but on distorted emotions. To buttress this observation, another informant reports that, *“some of our (suicide) patients are very aggressive and sometimes may want to hurt you in one way or the other. That is why sometimes people complain that we (nurses) are not caring but that is not the case: we (nurses) must also be protective”* (CHN. Woman, 24). That is to say that suicidal persons exhibit ‘unwarranted’ aggressive behaviours which can (or have the potential to) harm the self or others, even in clinical settings where they are given professional help, is an indication that suicide can be categorized as a mental health issue (Kim, Lee, Lee, Yu, and Hong’s 2009). Thus, informants from the two groups of health professionals interviewed in the study perceive suicide as a mental health issue which is projected in the quotes from each group. Conceptualizing suicide as a mental health issue is attributed to the view that suicidal persons have distorted thoughts and feelings, and engage in actions that are harmful to themselves or to others.

4.2. Behavioural and Emotional Response to Suicidal Persons

This theme focuses on informants' reactions and emotional responses toward suicidal persons and the families of suicidal persons. The sub-themes which emerged in this regard are *empathetic responses*, *ambivalent responses* and, *alienation and avoidance reactions*. They are discussed as follows.

4.2.1. Empathetic Responses

A significant number of the informants (n=18) expressed empathetic and sympathetic emotions towards suicidal persons. An informant (PN. Woman, 27 years old) empathized as follows,

I am prepared to listen to them and pay attention to them and give them the best of my ability in terms of caring for people in such situations. It could be me, probably, in his or her shoes. So, why will I not help: love your neighbour as thyself, the Bible says?

Another informant opined that;

We have to show them love by way of giving them a listening ear because some of them only need someone to be there and listen to them. We, nurses, have to 'pamper' them so they can share their feelings with us. I give them all the needed attention, warmth and care. I try to maintain professional standard. It motivates me to establish friendly relationship with them so they can open up for treatment (PN. Man, 28 years old).

In the former opinion, the expression of empathetic emotions toward suicidal persons appears to be hinged on the belief that everyone is vulnerable or at risk of attempting or committing suicide. That means irrespective of one's socio-economic status or background, one is prone to becoming suicidal at any point in time. Therefore, the need for significant others to help suicidal persons through the expression of empathetic emotions. Again, the expression of empathy towards suicidal persons is informed by the religious belief in communal living: *love your neighbour as thyself*. This religious

belief appears to encourage significant others to 'isolate' the suicidal person from the suicidal act and show love and care to the suicidal person. Thus, although in religious terms the act of suicide is unacceptable, the suicidal person should not be denied the required attention in terms of care to recover by significant others. It can be deduced from the latter opinion that nurses have to show empathy towards suicidal persons by virtue of their profession as nurses. In this regard, nurses have to establish rapport with their patients (suicidal persons) in order to win their confidence thereby encouraging them (suicidal persons) to tell their stories. Thus, nurses' expression of empathy and sympathy toward suicidal persons is informed by three divergent perspectives: the belief in suicidal vulnerability, the religious belief in communal living, and the motivation to maintain professional ethics of care. The adoption of any or all three perspectives of expressing empathy could translate into positive emotional responses (e.g., love, care, warmth and friendliness) and helping behaviour toward suicidal persons as the participants were expressing.

Comparatively, there seems to be variations in the motivation for empathetic and sympathetic emotions expressed by informants in the two groups studied. Psychiatric nurses seem to be motivated by their professional ethics of care whereas community health nurses appears to be motivated by the belief in suicidal vulnerability and the religious belief in communal living.

The former observation could be attributed to the professional training in promoting mental health whereas the latter could be attributed to the somewhat informal relationship that exist between the community health nurses and members of the community as their job description may require. It is however worth mentioning that these motivations underlying the expression of empathy and sympathy could translate into positive emotional responses (e.g., love, care, warmth and friendliness) and helping behaviour toward suicidal persons as the informants were expressing. Therefore, it can be concluded there were no major differences in the expression of empathetic and sympathetic emotions towards suicidal persons as expressed by the informants.

4.2.2. Ambivalent Responses

An observation markedly evident in the responses of some of the informants to questions regarding nurses' behavioural reactions toward suicidal persons is ambivalence. These informants reported that simultaneously they exhibit a sense of security and insecurity in their behavioural reactions toward suicidal persons, especially in the context of delivering health care service on cases involving persons who had attempted suicide. For instance, an informant describes her reactions as follows: *"I try to render a helping hand. But I do that cautiously because they (suicidal persons) can be threatening to my life. I try to calm them down so they can open up for discussions"* (CHN. Woman, 22 years old). Similarly, another nurse stated that, *"if someone had attempted suicide and was not successful there is the possibility that they can hurt me, so sometimes I am very observant when I am treating them."* (PN. Woman, 21 years old). None of the informants who participated in this study reported of any previous violent attack or any direct threat by a suicidal person. However, some informants appear to associate suicidal persons with life-threatening violent behaviour. Hence, some informants showed a mixed perception of suicidal persons as potentially dangerous but at the same time vulnerable people who need help. Therefore, in providing nursing services to suicidal persons, some nurses exhibit both anxiety (fear of threat from the patient) and helping behaviour (professional care for the patient). This equivocal behavioural response on the part of nurses toward suicidal persons stems from the nurses' mere estimation of a probable life-threatening behaviour by the suicidal person which appears to be emphasized by both the community health nurses and the psychiatric nurses as evident in the preceding quotes.

4.2.3. Alienation and Avoidant Reactions

In the various opinions of the informants and in response to the interview questions regarding attitudes toward suicidal persons, it was evidenced that the informants resorted to reporting their attitudes (as nurses, i.e., empathetic responses and ambivalence responses, discussed above) and the attitudes of mainstream society toward suicidal persons. This sub-theme, *alienation and avoidant reactions*, thus, represents the dominant attitude of society toward suicidal persons, as reported by the nurses who participated in this study. For example, an informant stated that, “*if you attempt suicide and it becomes public knowledge, the gossip and rumour that will go round about you, even in the church, will be enough to make you depressed*” (PN. Woman, 25 years old). According to another informant, in the society, “*we don’t want to hear about suicide and many people do not want to associate themselves with people they know or have even heard have attempted suicide before*” (CHN.Woman, 26 years old). It appears suicidal persons are alienated and avoided by the larger society, perhaps because of the popular belief that suicide is a taboo and as such punishable. The punishment can take several forms (e.g. stigmatization, rejection, excommunication, banishment, imprisonment etc.) and is meted out to the suicidal person (and sometimes his or her family members or other social relations). Therefore, significant others in the society may want to avoid being punished together with the suicidal person by alienating them or avoiding their company altogether.

4.3. Suicide Prevention Strategies

This major theme relates to the informants' perceptions as to the preventability of the phenomenon of suicide and their suggestions as to plausible preventive strategies which can be adopted by stakeholders. Informants' responses regarding the preventability of suicide showed that suicide should be prevented not only because the country has what it takes to do so, but because suicide involves the loss of human life – which is irreplaceable. Some informants observed as follows: *“It is human life we are talking about here. Suicide can be prevented and must be: it is not a matter of choice. Death is irretrievable”* (PN, Woman, 24, years).precious

“Yes, suicide can be prevented. We, as a country, are in the position to do so. We have what it takes to do that. We’ve got to do something before it gets out of hand. We have the men – I mean we have personnel like the nurses, psychiatrists and Psychologists. The money is also there” (PN. Man, 28 years).

Another informant added that, *“in fact we have to invest resources into preventing it; it is not a matter of choice because we are losing precious lives; even professors and learned people are committing suicide”* (CHN. Woman, 25 years).

Informants' position on the prevention of suicide in Ghana appears to be one of a necessity than a choice as both groups posits and is evidenced in the quotes above. This position is anchored in the informants' awareness that, as a country, Ghana has the required professional mental health personnel base: psychiatrists and psychologists. Additionally, suicide leads to an untimely loss of (irreplaceable) human life, which often ‘open up’ the surviving families and communities to ‘social injury’ in the form of stigma and psychological trauma and pain (Osafo 2012).

With regard to the preventive strategies, the analysis of informants' responses resulted in a radial chart (see figure 1) covering all the responses made.

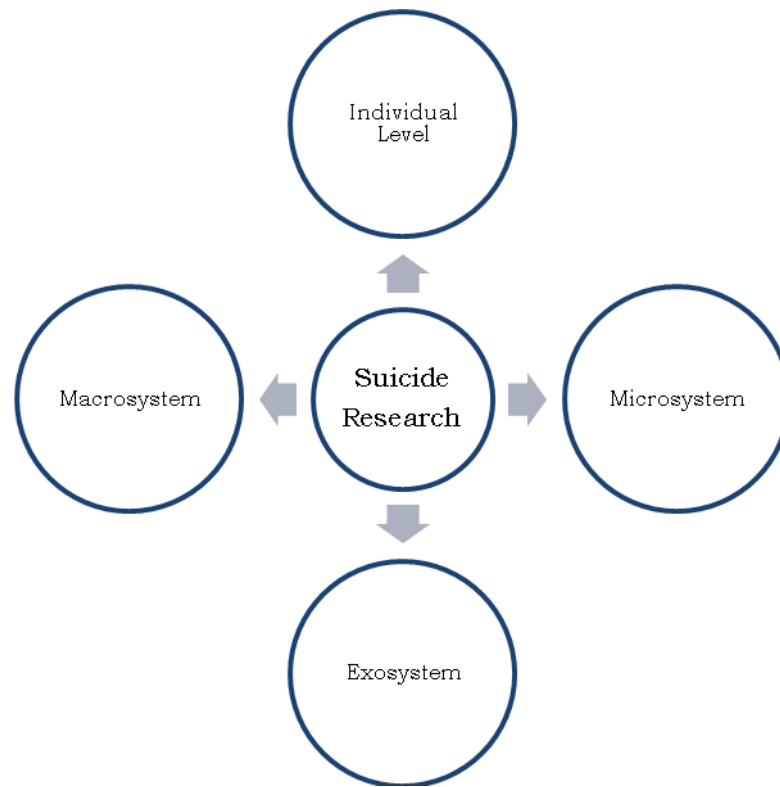


Figure 1: Diverging radial chart covering informants' responses as to evidence-based suicide preventive strategies

Informants from their narratives seem to suggest an ecological system approach to the prevention of the phenomenon of suicide in Ghana. In this ecological system approach, every level of the society is included in the prevention process – the individual, the microsystem, exosystem and the macrosystem. To prevent suicide, *“each and every one of us has a role to play. That is, the media, families, the government and individuals”* (CHN. Woman, 27 years). *“Each and every one of us must play a role; the Government, media, individuals and all of us”* (PN. Woman, 26 years). Thus, the diverse resources and contributions of individuals, groups and institutions at the various levels of society should be harnessed to facilitate the prevention process.

However, central to the various levels of the ecological system (as shown in figure 1) is suicide research. The ecological system (composed of the individual, the microsystem, exosystem and the macrosystem) is hinged upon suicide research outcomes. Thus, informants suggested that suicide research forms the bedrock of the success of the ecological system suicide prevention strategy.

4.3.1. *Suicide Research*

According to the informants, the first step toward preventing suicide in Ghana is conducting research on the phenomenon. In the opinion of an informant:

“Suicide is preventable, but it begins with doing researches such as this to help identify the areas within which it can be tackled from. Then we take it from there. So I think more researches should be done to make informed decisions about the concept”
(PN. Man, 28 years).

Similarly, another informant emphasized thus; *“Yes. We can prevent suicide. We have experts who can conduct research into it and come out with recommendations which can help to formulate and implement informed policies for suicide prevention”* (CHN. Woman, 30 years). It can be inferred from the foregoing assertions that any intervention drive aimed at suicide prevention should be rooted in research; it should be evidence-based. That is, the informants suggest that knowledge of research evidence is the first step to understanding the suicide phenomenon from the perspectives of the contexts in which it occurs. Additionally, knowledge of research evidence is the first step to designing or planning any suicide prevention programme. Suicide research will, most certainly, provide evidence as to the location and prevalence of suicide in the country; the demographic information of suicidal persons, causes and precursors of suicide, and recommendations for prevention among other such vital information and evidence. This implies that for the various stakeholders within the various layers of the ecological system to play their respective roles effectively toward suicide prevention, these roles must be defined and couched within the lenses of suicide research evidence. Thus, suicide research will provide scientific evidence and information to the individual, the microsystem, mesosystem and the macrosystem as to their positions and roles (and how to play these roles effectively) to help prevent suicide in Ghana.

4.3.2. *Ecological System Preventive Approach*

As shown in figure 2, the ecological system preventive approach to suicide encompasses the various layers of the society and identifies the respective roles various stakeholders within the layers can play toward suicide prevention in Ghana. The main layers are the individual, the microsystem, mesosystem and the macrosystem.

4.3.2.1. Individual Level: Survivalism

The individual level of the ecological system approach to suicide prevention focuses on the individual person (whether suicidal or not) as a unit of prevention. According to the informants, individuals should learn to build resilience against stressors and to seek help when one is unable to cope with challenges or crisis in life. The following are some opinions of informants:

“Thinking of ending your life does not solve the problem. Yes, I know you may feel at a point that your problems are too much so taking your life is okay. But it is rather good to talk to someone. Face the reality.” (CHN. Woman, 24 years).

“There is a solution to every problem. Stay and find lasting solutions rather than ending your life. Be real and face reality. Seek help from professionals or talk to someone for help” (PN. Woman, 20 years).

“Problems will come but one must face life squarely. Life, they say, is war; so let’s face it as it is” (PN. Woman, 25 years).

It can be inferred from the foregoing views that, as a unit of suicide prevention, the individual can be an effective party to suicide prevention by building the resilience or defence mechanism against life stressors and challenges which are precursors of suicide. Again, the individual can seek help (probably from family members, friends or professionals) to manage life stressors that have the potential of leading one to the ideation, attempt or commitment of suicide.

It was also revealing from the narratives of informants that human life is priceless, irrespective of situational pressures; under no circumstance must one take his or her life.

4.3.2.2. *The Microsystem: The need for social connections*

In the ecological model, the microsystem encompasses such institution as the family (Bronfenbrenner, 1979). Thus, as a unit of suicide prevention, stakeholders within the microsystem (i.e., family members of the suicidal person) have a role to play. The following are some opinions of informants:

“...The family have to keep close eyes on them and engage them in dialogue as well as checking occasionally for objects present in their environment which can serve as a buffer for suicide”. (PN. Woman, 29years)

“Family members especially have to keep close eye on their relatives and draw the attention of significant other if their people start making utterance such as I wish I am dead. Life is not worth living” such statement should not be taken for granted”. (PN. Woman, 26 years).

“The very close relations, we should be each other’s keeper. Pay attention to what people say and the strange actions they sometimes put up. Some of these issues should not be taken for granted at all. (CHN.Woman, 32 years).

It can be deduced from the submissions of these informants that the role of the family and relations has become indispensable. It can be said that they are the primary source of preventing suicide. Therefore, they must ensure vigilant supportive family living system so they can detect the possibility of suicide occurrence. When the family remain vigilant they can recognize signals and intervene before a life is lost.

4.3.2.3. *The Exosystem*

The exosystem within the ecological model is a system in which the individual plays no role in the construction of experiences. Thus, as a unit of suicide prevention, stakeholders within the exosystem (i.e society leaders and mental health institutions) have a role to play. The following are some opinions of informants:

Improved Mental Health Services

“Psychological Counselling, they also need us the psychiatric nurses and most importantly community psychiatric nurses on home visitation and constant monitoring” (PN.Woman, 30 years).

“...Health workers can also spend some few minutes and educate people at the Outpatient Department.”(CHN.Woman, 36 years).

“They need good counselling: “not the way side” counselling they have been having with unqualified professionals. I mean the counselling should be rendered by skilful and qualified persons. Like the Counselling Psychologist and clinical Psychologist and the psychiatric nurses”. (PN. Male 30 years).

It is deductive from these voices that provision of quality mental health services is very important in suicide prevention. This is however implicating that mental health service institutions should be resourced to enhance their service delivery so they can be proactive.

The provision of Religious hope

The three major religions outrightly reject suicide. Religious leaders are highly respected in society and sometimes are taken to be Gods representative on earth therefore if they should lead the campaign against suicide prevention by using their prestigious platform, there could be a positive future so far as suicide prevention is concerned as expressed by some informants.;

“I think my religion is helping a lot not to consider suicide in any case and for my church you can approach the elders and men of God when you are faced with some challenges and I think that is also helping remove this act of suicide.” (CHN. Female 46)

“Religion continues to preach unconditional love. So, for me in this context I will help. I can use the teachings from the Bible”. (PN. Woman 36)

“To every beginning there is an end. No matter what the problem is it will end One day. Religious leaders must give hope to its followers” (CHN. Woman22)

It can be inferred from the narratives above that participant perceives that religious leaders must intensify teachings on the message of hope to prevent people from taking their life, implying that the potency of the supreme being should be constantly communicated so that people can grow and affirm their faith in the doings of the sacred being, so that even when solutions to problems tarry, they may still expect something positive for the future which will keep them going as they trust their sustainer of values to supply their needs.

4.3.2.4. *The Macrosystem*

The macrosystem describes the culture in which individuals live. Cultural contexts include developing and industrialized countries, policies, media socioeconomic status, poverty, and ethnicity. Within the macrosystem informants assert that there should be an *enforcement of the Mental Health Act, change of unhelpful Social norms, Public education* as well as *Open public discourse* where suicide can be subject to public discussions just as any social issue.

4.4 *Institutional Empowerment*

Enforcement of the Institutions directly responsible for suicide prevention was explicitly emphasized by informants. Informants had this to say.

“The government can also do so by empowering the institutions which directly deal with such persons. Improved Mental health care.” (PN. Female 26).

“Because most of the people, who attempt suicide I presume, are having some mental problems also they should implement the mental health act, especially making sure that; psychologists are available to help manage suicide as a phenomenon” an informant added.

Hence, it is evidenced that all stakeholders led by the government should work together to enforce the implementation of the Mental Health Act in the shortest possible time. When this is done the general perception that government and other stakeholders are not committed to the implementation of the Mental Health Act in Ghana would be neutralized and would help prevent and manage suicide effectively.

4.4.1 *Intensified Public Education*

The thought of education was very revealing and practicable in the quest to find lasting solutions to suicide. This implies that efforts must be geared towards sensitizing the Society on suicide, for instance, on the prevalence, possible signs and symptoms as well as where help can be sought when there is a crisis.

The importance of education was expressed in the words of the following informants.

“...Intensive education and campaign will help a lot. That will be a step in the right direction.

Nurses have a role to play, media can give it publicity, and Psychologist should organize seminars for stakeholders so they can have a different look at the issue especially for our traditional leaders and council as well as religious leaders”.(PN Woman 37)

“...For even the Bible says for lack of knowledge my people perish. Ignorance is a very big disease.

I am highly optimistic that it will be under control provided education on suicide is intensified”. (CHN Woman 30)

It is perceived by this participant that the general perception about suicide partly emanates from ignorance therefore the general public must be educated intensively on the phenomenon. Suicide, the prevalence, susceptibility, signs, possible causes, consequences and the way forward so people will become more enlightened and change their thoughts on the act and begin to have an objective appreciation of suicide.

4.4.1 *Change of Unhelpful Social Norms*

According to the informants suicide prevention will be effective if and only if the larger society takes a different view of suicide and review certain believes they hold about suicide. For instance tabooing the act was not appreciated by the informants because in their view it does not necessarily serve the purpose for which it was enacted and that is to say is not an effective deterrent tool. The following informants have these to say.

“Don’t go there; You don’t have to be seen openly discussing it. It is like a taboo. Even when your relative dies through suicide, they don’t report the cause of death because of the way society looks at it especially in the smaller communities. (CHN Woman 26)

“Committing suicide is like a forbidden fruit. It is something we don’t want to hear about in Ghana, the stigma alone the person will suffer if they are not successful and that of the family. Our attitude toward suicide is just not right” (CHN. Woman, 24 years)

“People normally think condemning suicide outrightly helps. We should rather take an objective view of it so we can be more informed and act accordingly Instead of a particular mind set about suicide”

The foregoing discussion clearly indicates that Stigmatization, discrimination and tabooing against suicide and their families is outrageous and must therefore be stopped to enable the society have a more informed and objective analysis of suicide.

4.4.3 *Open Public Discourse*

It was revealing in the submissions of informants that the time has come to openly discuss Suicide as a social phenomenon in order to find lasting solutions to this social canker. Breaking of silence is a social compulsion for self-disclosure during crisis; a communal deed professed as divergent to suppression. Unreservedly, such professed connectedness also engenders a view of a rich communal support network that persons experiencing crisis could turn to for help.

“If we continue to cover it by way of not talking about it and so on nothing positive will occur so far as suicide prevention is concerned.”(PN Woman 29).

“Let’s be willing to discuss it just like we do on other social issues so people will not feel bad to open up when they are flooded with such thoughts”.(CHN Woman 30)

“...Mmm if we keep quiet about it that is what will happen? Perpetuation of the act. It is something ooo, nobody wants to talk about it Suicide should be discussed like any other thing. Once we are discussing it then we are paving ways for provisions to be made towards it.”(PN Male 30)

In view of the aforementioned discussions it is deductive that informants are of the view that open discussion of suicide is definitely an inevitable necessity, especially as it can save someone’s life. It will offer a relief as it is no longer a burdening secret that makes the individual feel deviant and isolated.

Breaking the silence about suicide will rather help save lives. Making suicide a public discourse does not cause someone to become suicidal (Schwartz & Rogers, 2004). This is to say that ignoring the issue does not make it go away; neither does it make it diminish in intensity, therefore breaking the silence around suicide is also beneficial as it can increase public awareness and education, thus facilitate suicide prevention.

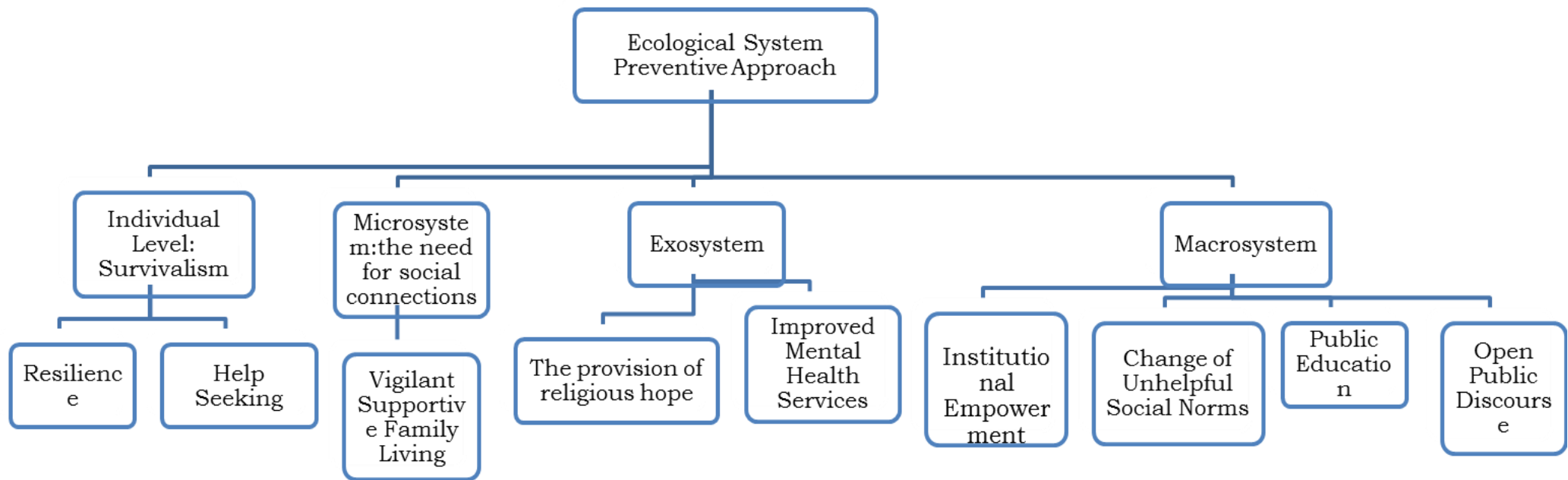


Figure 2: Branched chart showing the ecological system preventive approach to suicide in Ghana

4.4.4 Attitudes according to professional background and religious background

4.5 Professional Background

This is an analysis of differences and similarities in Psychiatric and community health nurses attitude towards suicidal persons and suicide prevention base on some demographic variables.

Overall, there seem not to be any major variation between psychiatric and community health nurses in preparedness in working towards suicide prevention. Both Professionals believed that suicide must be prevented at all cost and espoused their preparedness to contribute their quota in that regard. Even though, it was revealing in the submissions of community health nurses that their professional training background places limitations on the extent of help they could give, they agreed that it must be prevented and called for training in mental health so they could be resourceful and efficient in dealing with suicidal cases especially looking at the proactive nature of their job.

The following psychiatric nurses have this to say:

“It is human life we are talking about here. Suicide can be prevented and must be: it is not a matter of choice. Life is irreversible” (PN, Woman, 24, years).

“Yes, suicide can be prevented. We, as a country, are in the position to do so. We have what it takes to do that. We’ve got to do something before it gets out of hand.

Community health nurse opined

We have the men – I mean we have personnel like the nurses, psychiatrists and Psychologist and we the community health nurses who are mostly on outreach health service delivery can be trained so we can do more to help.”(CN.Woman, 28 years).

“in fact we have to invest resources into preventing it; because we are losing precious lives; even professors and learned people are committing suicide” (CN. Woman, 30 years).

Nurse’s attitude towards suicide and suicide prevention seem to be highly favourable, emanating from the assertion that death is irretrievable and therefore is an obligation to prevent suicide.

4.6 *Religiosity and attitudes*

Religious background tends to impact on attitudes towards suicide. Many religions portray suicide as sinful. Suicide has been forbidden in many countries. In this study, professionals were to consider the influence of their religious background on their views of suicide. The majority indicated it had on their conception of suicide, attitude towards the act and attitude towards suicidal persons. The study suggests that religious background continues to have some impact on attitudes. These were observed from informants’ submissions

“My religion is against taking one’s life, but what will I do? I have to help because his same religion teaches us to engage in helping behaviors coupled with professional responsibility I have to help”. (CHN Woman 38)

“My religion is really helping me not to consider suicide as a solution to anything. It also motivates me to help people in crisis”. (PN Woman 29)

“My religion promotes helping people in distress. So although I may not be happy it happened I will never hesitate to help” (Male PN 32)

It is deductive from the submissions above that religion has impact on the attitude of informants towards suicide and suicide prevention coupled with professional expectations.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

The study explored the attitude of psychiatric and community health nurses towards suicide and suicide prevention in Ghana. This chapter discusses the findings of the study and outlines some recommendations for future researches.

5.1 Culture and attitude towards suicide and suicide Prevention

The importance and impact of culture on life can by no means be overemphasized. In this regards, the current study sought as part of its key aims to explore whether culture plays a role in attitude of health professionals towards suicide. As indicated by Lester (2008), culture could influence people across nationality and even profession/workplace. Among the health workers surveyed for the study, it was supposed that they will have a particular attitude towards suicide and the people who commit suicide. This idea is engineered by the view that their profession witnesses many suicide cases and the individual personnel will form particular attitudes towards suicide. This was highly coupled with the Ghanaian culture and legislation that forbids suicide. Thus, the knowledge and socialization of the culture of forbidden suicide, was to serve as a strong catalyst for many people including health professionals such as those in this study to frown on suicide.

The finding of this study revealed an affirmative result, showing that cultural dispositions among nurses influence their attitude towards suicide. The cultural dynamic in the Ghanaian setting has made many condemn the act. This was particularly found in the study by Osafo, Hjelmeland et al. (2011).

By the collective and more interdependent nature of the Ghanaian culture, this finding concurs with Peltzer, Cherian and Cherian (2000) where they found that people in collectivist culture have more negative attitudes toward suicide than those in an individualistic culture. This reflects the

connectedness, collectivism and interdependence of the Ghanaian society. It was seen as stigmatizing not only to the demised individual but to the family as well since they are inter-connected. Again, the finding of Osafo, Hjelmeland et al. (2011) is confirmed in this case. Their study had it that lay persons in Ghana view suicide as an immoral act because it socially affects others negatively as it breaches the interrelatedness between people causing a social injury and strongly condemned.

5.2 Factors that influence suicide Prevention

5.2.1 Comparative Analysis of psychiatric and community health nurses

The study sought to comparatively explore the attitudes of psychiatric and community health nurses attitude towards suicidal persons. The present study revealed that there is no major variation in attitude towards suicidal persons according to professional licence. The finding of the current study however did not support the findings by Samuelsson, Sunbring, Winell and Asberg (1997) which investigated the attitudes towards attempted suicide patients among registered nurses involved in the somatic care of such patients. Their study revealed that nurses working within the psychiatric services were more understanding and more willing to nurse suicide attempt patients than nurses in somatic disciplines which were not the case in the current study.

The current study did not record any noticeable difference in the suicide intervention skills by community health nurses and psychiatric nurses as espoused by Scheerder, Reynders Andriessen, and Van Audenhove (2010). Their study revealed that community health professionals' suicide intervention techniques differ significantly from professional groups.

The two groups of nurses interviewed in the current study indicated similar responses on their intervention strategies as far as suicide prevention is concerned. The trivial difference was that community health nurses handles suicidal cases with less expertise and administers the fact that the

Psychiatric nurses with their professional training background gives them an upper hand in dealing with suicidal cases.

Additionally, the belief that a person does not have the right to commit suicide was stronger among all the two groups of nurses irrespective of age, gender and professional experience. In general, greater professional capacity was reported by the two groups of health professionals. This finding however partly affirms the findings by (Botega et al, 2005)

The current findings from the study however indicate the united front by these health professionals to meaningfully contribute their quota to suicide prevention.

5.3 Conception of Suicide and Suicide Prevention

Respondents in their narrations seem to have a positive attitude towards people who attempts to take their life irrespective of the general negative perception towards the act itself. They are however of the view that there should be sympathy and empathy towards people in such crisis. It can however be said that for someone to attempt ending his life, then they may be some compelling issues surrounding the situation which makes a lot of people susceptible to having the thoughts of suicide. The implication is that the general public must begin to think positively and develop some emotional attachment which is likely to trigger favourable actions towards people in suicidal crisis so they could also feel a sense of belongingness which may help lessen the woes of people going through suicidal crisis.

Suicide prevention has been explicitly espoused in this study. Nurse's attitude towards suicide prevention seem to be highly favourable because most of the informants seem to appreciate the dice consequences such as stigma, emotional pain, that victims and relations suffer. This however implies that suicide have lasting harmful effects on individuals, families, communities and the nation at large.

The existence of humans is very important for the perpetuation of the human species. To commit suicide is irreversible which might have influenced this unanimous positive attitude towards suicide prevention. This unfavourable consequence however might have informed their cry for drastic measures to curb Suicide in Ghana.

It is implicating that suicide prevention is not a matter of choice but is an obligation to perpetuate the human species because lives lost as a result of suicide are irreversible. Additionally it is also evident in the current study that suicide prevention is the responsibility of all, as a sovereign nation we must work towards achieving a common goal, implying that we must all contribute our quota to ensuring the achievement of a broader goal which is suicide prevention.

Prevention however should occur at all levels of society; from the individual, family, friends as well as community levels to the broader social environment. Effective prevention strategies have become a necessity and a prudent obligation to promote sensitization, resilience and commitment to social change.

5.3.1 Positive attitude towards suicidal persons

The study revealed that nurses interviewed irrespective of their strong negative attitude towards suicide and out right condemnation of the act, reasoned that persons involved must be given the needed attention to facilitate inquiries into the push factors which triggered such intentions and actions so the problem can be addressed more effectively for the benefit of the victims and society at large.

A striking feature also evident in the submissions of informants is ambivalence. Inasmuch as nurses interviewed in the current study are willing to help people in suicidal crisis, there is this egoistic thought of endangering their lives which sometimes adversely affect effective helping relationship with suicidal persons. Their perception seems to be motivated by the thought of suicidal persons' possibility of displacing their suicidal tendencies unto them. Thus the thoughts of taking their lives could be extended to them as well which informed their perception of insecurity.

5.3.2 Negative attitude towards suicide

In spite of the positive concerns spelt out by informants, they seem to reason negatively towards suicide as an act. Respondents out rightly rejects the taking of one's life which to a larger extent is underpinned by religion, values, norms and believe system as found in a study conducted by Osafo, Knizek, Akotia, and Hjelmeland (2013). Their results revealed that Ghanaian lay persons are committed to the core and normative religious beliefs and practices of preserving life. Hence, suicidal behaviour is unanimously unacceptable. The act of killing is considered one of the most heinous acts in our society because taking a life is irreversible. To commit suicide is not only irreversible, but it is the greatest harm that one can inflict upon oneself. The stigma attached to committing suicide is highly intense to the extent that it is considered a criminal act and almost all the religions in Ghana consider prohibits. Human life is a sovereign gift from a Supreme Being therefore the decision to end it is the sole prerogative of the Supreme Being.

5.4 Implications of Findings for Clinical Practice

These findings have implications for changing nurses' attitudes towards patients with self-harm. It may be considered by enhancing educational exposure of nurses especially the community health nurses who seem to have limited experience in mental health care at the earliest opportunity through regular training programs/workshops, improving their awareness, knowledge, and communications and clinical

skills for managing suicidal patients with the help of easily understandable and implementable suicide risk assessment methods. Such formal training should be made available to all medical and clinical staff to make them resourceful so far as suicide prevention is concerned

It is quite clear that the mental health impact of suicide is not much appreciated yet in the country. Successive Governments have not called for any form of assessment nor treatment for suicidal victims. It therefore befalls the clinical practitioners to find a way of reaching to such people. They may conduct researches among these victims in order to reveal consistent findings of mental health issues that will substantiate their efforts to help the victims. This will also serve as recommendation notes to authorities or government on their findings and intentions.

Clinical experts could also make efforts to immune people against suicide by equipping people with adaptive coping skills, so they can develop resilience when the unexpected occurs. This effort will also provide information on suicide, their effects and possible prevention methods. Activities such as these will help direct the attention of government to be proactive.

These findings provide a lot of room for clinical concern since suicide is revealed as a mental health issue. As much as possible, Ghana must take the mental health impact of suicide that has become common into consideration. This alone will make the care provided for the victims of suicide and their family complete and leave the victims in their best state of health and mind.

5.4.1 Limitations of the Study

This study was not without limitations. As Etzersdorfer, et al. (1998) stated ‘research on attitudes involves several methodological difficulties possibly leading to biases, the willingness to answer freely may be particularly reduced in discussing an emotive topic such as suicide’. (p. 107). It is hard to avoid biases from researchers and respondents on such a sensitive topic.

Again, this study is limited in the way that it did not consider the many other categories of all health professionals in The Ghana Health Service. It would therefore be interesting to conduct a study that would be able to tap the attitudes of other health professionals toward suicidal persons and suicide prevention in Ghana. Another limitation of the study was that, informants were predominantly females which made it impossible to make gender comparison on attitudes toward suicidal persons and suicide prevention in Ghana.

However, it is important to have a gender balance sample which might throw light on a gendered analysis on the phenomenon suicide.

5.4.2 Recommendations for future Researches

Future studies in the same area, especially in Ghana, should consider a much detailed design, perhaps mixed method design, thus qualitative and quantitative approach that would provide the opportunity for a thorough analysis of attitude towards suicide which might also consider a relatively larger sample size. This would allow for a comparison of the attitudes of nurses toward suicide and suicide prevention from different health professional backgrounds. In addition, the relationship between socio-demographics and suicide attitudes were not adequately analyzed since this research was purely qualitative and warrants further exploration.

Suicide strike people across Ghana that is capable of resulting in severe psychological and social distresses, hence, researches could be conducted into the phenomenon of suicide. By so doing, enough data and information on the impact of suicide in the country would be much appreciated and treatment approaches instituted for them.

5.6 Conclusions

Suicidal behaviour is a growing public health problem in Ghana as projected by the statistics reviewed in the current study. Suicide often comes with a lot of negative effects. Unfortunately, the impact/effect seems not to be appreciated. This study explored the attitudes of Psychiatric and community health nurses towards suicidal persons and suicide prevention in Ghana.

In an attempt to find out nurses' attitude toward suicide and suicidal persons, it was revealed that suicide is conceived as a *social taboo*, a *religious infraction*, and as a *mental health issue*. These views were identified and categorized as three distinct sub-themes capturing the nurses' conception of suicide and suicidal persons in Ghana.

An appreciable number of the informants expressed empathetic and sympathetic emotions toward suicidal persons.

An observation markedly evident in the responses of some of the informants to questions regarding nurses' behavioural reactions toward suicidal persons was ambivalence.

This sub-theme, *alienation and avoidant reactions*, represented the dominant attitude of society toward suicidal persons.

Informants' responses regarding the preventability of suicide showed that suicide should be prevented not only because the country, has what it takes to do so, but because suicide involves the loss of human life which is irretrievable.

Based on the results provided by the current study, it could be concluded that both Psychiatric and Community Health Nurses had negative attitude towards suicide as an act, whereas they expressed contradictory attitudes toward suicidal persons. Additionally, it was evident from this study that informants have positive attitude towards suicide prevention and were not hesitant to recommend an all inclusive strategy for preventing suicide.

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INTERVIEW GUIDE FOR HEALTH PROFESSIONALS

BACKGROUND INFORMATION

GENDER

AGE

PROFESSION

PREVIOUS POSITIONS

NUMBER OF YEARS IN THIS/THOSE PROFESSIONS

ETHNIC GROUP

RELIGION

FAMILY SITUATION -LIVING ALONE

LIVING ALONE WITH CHILD OR (REN)

MARRIED/COHABITING WITHOUT CHILDREN

MARRIED/COHABITING WITH CHILDREN

LIVING WITH PARENTS

OTHER (PLEASE DESCRIBE.....)

Introduction of interviewer

Introduction of project; Interview study on attitudes towards suicide and suicide prevention in different groups of professional. You can withdraw from participating or refuse to answer some questions at anytime during the interview. Information from you will be used for only academic purposes and nothing else. Therefore personal details such as your name will not be needed in this interview. The information you give will be treated with absolute confidentiality.



Introduction of recorder

Informed consent is signed

Recorder is switched on

General opening questions

How prevalent do you think suicidal behaviour is in Ghana?

Do you think it will change in the future? If so, in what direction and why?

How is the topic suicide handled/viewed in Ghana?

In general (do people talk about it? How is the general opinion, etc)

In the media

In your local community (ethnic/tribe)

How do you feel about the way it is handled/viewed/discussed?

Do you think it should be considered a crime? (as it is at present according to Ghanaian law)?

What is your own principal attitude towards suicide? I mean how do you presently view suicide?

QUESTIONS RELATED TO PROFESSION

Do you meet suicidal persons in your job/position?

If yes: how often? How many?

How do you feel about suicidal persons?

How do you react when you find out that your patient is/ client is suicidal?

What kind of treatment do you think is the most appropriate for suicidal person?



Do you have any question to me?

How did you feel about being interviewed on this topic?

Is there anything you wish had been done differently?

I want to once again emphasize that this information will be treated with absolute confidentiality.



NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979 *A Constituent of the College of Health Sciences*
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.mimcom.org
Telex No: 2556 UGL GH



Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

8th May, 2013

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 099/12-13

IORG 0000908

On 8th May, 2013, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Exploring the attitudes of psychiatric and community health nurses towards suicide and suicide prevention in Ghana**

PRINCIPAL INVESTIGATOR : **Mavis Oti Gyankromaa, MPhil Candidate**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 7th May, 2014. You are to submit annual reports for continuing review.

Signature of Chairman:
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

CONSENT FORM

Title: Exploring the attitude of psychiatric and community health nurses towards suicide and suicide Prevention in Ghana.

Principal Investigator: Mavis Oti Gyankromaa

Address: Department of Psychology, University of Ghana, P. O. Box 89

Dear valued participant,

You are invited to participate in an academic research project on the topic 'Exploring the attitude of psychiatric and community health nurses towards suicide and suicide Prevention in Ghana'. This study is to examine the attitudes of psychiatric and community health nurses toward Suicide and suicide prevention and examine the implications for suicide prevention in Ghana. The findings will have implications for the organization of clinical services and the training of health professionals. Recommendations would be made to support complementary improvements in quality and effectiveness of care for people at risk from the Ghanaian perspective. If you decide to participate, you will be asked to participate in a short interview which seeks to explore attitudes towards suicide and Suicide Prevention as well as personal characteristics. This study will contribute towards the researcher's effort at meeting the requirements for the award of MPhil in Social Psychology. It should take us not more than 15-45 minutes to complete. Kindly respond to questions to the best of your ability.

Possible Risks and Discomforts

This interview may require you to give in depth information hence it may invoke suicidal thoughts. There is the possibility that this may create some discomfort to you. However the researcher will be available to help handle any discomfort that might arise. She will also not hesitate to refer you to a clinician if the need be.

Possible Benefits

This research will benefit you and the society at large by helping you know varied attitudes on suicide. The final project output in the form of a completed dissertation will be made available to University of Ghana, and copies could be accessed for references in future for research and/ or practical application.



Confidentiality

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. Results from this project will only be presented to the scientific community. In any publication, information will be provided in such a way that you cannot be identified.

Compensation

There will be no compensation for participants.

Voluntary Participation and Right to Leave the Research

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your future relations with the researcher or any official. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

Contacts for Additional Information

If you have any questions, please feel free to ask. If you have any additional questions later, Miss. Mavis Oti Gyankromaa (phone 0247868078) will be happy to answer them. Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org.



VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title *(Exploring the attitude of psychiatric and community health nurses towards suicide and suicide prevention in Ghana.)* has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent

