



Inter-Sectoral Management of Suicidal Persons in Ghana: Tensions and Prospects

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Abstract

Inter-sectoral collaboration health care model is essential for effective suicide prevention and treatment. This brief report presents three cases to illustrate two important facts in suicidology and related observed dynamics working as suicide researchers in Ghana. The first fact is that suicidal work is a multidisciplinary approach. The second: there may be contextual factors which may make a multidisciplinary approach in working with a suicidal person difficult in Ghana. The first two cases involved the work of a Clinical Psychologist/Suicidologist (First author), while the third involved the work of a Community Psychologist/Suicidologist (Second Author). Thematic analysis of experiences showed the trajectories of tensions and prospects involved when working as a team in providing help for persons in suicidal crisis in Ghana. Based on the findings, we make recommendations for scaling up mental health education and suicide training for allied professionals towards enriching and expanding inter-sectoral collaboration in preventing and treating suicidality.

Keywords Suicide · Prevention · Collaboration · Ghana

Introduction

In various spheres of health management, multiple professional involvement in prevention has been a commonplace. For instance, there is evidence of multidisciplinary approach in managing stroke (Tyson et al. 2014), and in managing pain (Murphy and Anderson 1984; Pape and Rafiullah 2005). The field of suicidology is multidisciplinary as it draws on the intellectual and clinical traditions of various disciplines such as psychology, sociology, epidemiology, medicine, theology, public health and others (Silverman 2006). Perhaps the best slogan that captures the multidisciplinary nature of the science of suicidology is the slogan “suicide prevention is everybody’s business”. The multidisciplinary approach to suicide prevention, however, does come with challenges. De Leo (2002) has observed that at the macro level of multidisciplinary cooperation, it is difficult to achieve a balanced composition between biologically and psychologically

oriented investigators in any collaboration effort. At the micro level of multidisciplinary cooperation, there may be other challenges that bedevil the relationship. Views and reactions towards suicides within a particular context can also inhibit or foster collaboration.

In Ghana, there are three levels at which negative attitudes towards suicide are expressed: at the family/community level, the religious level and the legal level (see Osafo 2016 for an extensive discussion of these). The Ghanaian eminent scholar Kwame Gyekye (1995) has succinctly represented the social/community view in his assertion thus:

“Suicide is ... a great extraordinary moral evil; it is viewed by the community with particular abhorrence and revulsion because its commission is believed not only to bring shame to the whole community, but also, in the minds of many ordinary people, to invite the wrath of the supernatural powers”(P. 133p.?)

This view as indicated by Gyekye has been confirmed in a study as a social injury (Osafo et al. 2011), which thus attract mainly harsh retributive and reparative societal reactions (Andoh-Arthur et al. 2019). The second is the *monotheistic religions view*. This view represents two foreign religions: Judeo Christian view and the Islamic view. A Gallup pool in 2012 indicated that 96% of the Ghanaian population profess

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some faith, which makes the country the most religious society in the world. Studies show that in Ghana people are committed to core and normative religious beliefs and practices they perceived as life preserving, and thus suicidal behaviour becomes unacceptable (Osafo et al. 2011). The third is the *legal view*. The 1960 Criminal Code Act 29, Section 57, states: “Whoever attempts to commit suicide shall be guilty of a misdemeanour.” Reports show that criminal prosecutions of suicidal persons have taken place in Ghana with some monetary fines and incarcerations (Adinkrah 2013). Since 2011, we have seen several persons in suicidal crisis. We have worked together with nurses, medical doctors and pastors, parents, the police etc, in providing treatment and support for suicidal patients. This paper seeks to examine the trajectories of tensions and prospects of collaborating with three of such groups- physicians, the clergy and the police in the Ghanaian context.

Methods

The method is qualitative, using case study approach. Case study aims to understand the internal dynamics of specific cases or situations. In this report, the cases under study are not individuals, or organizations but rather situations, incidents or experiences (Willig 2013), and these experiences are the unique nature of working with medical doctors, religious clerics and police personnel to provide help for some persons in suicidal crisis. The import thus is not to seek for any representativeness but rather an in-depth and intensive analysis of the experiences. The specific case study design is instrumental case study in the sense that the authors were interested in specific cases such as suicide attempters and how they are managed by a group of helpers.

Participants

Participants involved in these three case studies include the two authors (Suicidologists), two medical doctors, two clergy, two policemen, and three suicide attempt survivors, a total of 11. The medical doctors were specialists with one (male) who has over 30 years of medical experience and the other about 10 years (female) of expertise in internal medicine. The clergy included a male and a female with more than 10 years of pastoral care and pulpit ministry. The two policemen had an average of six years of experience in the service. The two Suicidologists have 19 and nine years of experience in researching suicide and treating and managing persons in suicidal crises respectively. The suicide attempt survivors were two females and one male in their mid-twenties. One is employed, another is an apprentice and the third is unemployed. One has attempted suicide four times, another twice and the

third person has had serious ideation leading to self-harm. Sources of data for this brief report included conversations with team members, the clinical reports on patients, and patient’s experiences with other team members during therapeutic encounters. The narratives provided are not verbatim transcripts but represent retrospective collections of conversations during discussions over case management. A summary of each individual case is provided below. The names used in this write up are pseudonyms to satisfy anonymity and confidentiality.

Case 1

This involved a young married woman (identified as TP) who had attempted suicide and was seen by the first author (FA). She desired to assert her independence from an abusive auntie with whom she had lived for more than 20 years. She married and yet continued to suffer harassment and abuses from her aunty including being falsely accused of infidelity, an accusation that was reported to the husband and eventually became the cause of divorce. She felt distressed and betrayed and attempted suicide. When FA started working with her, he saw she had other medical conditions which necessitated the engagement of a medic. She was quite religious, and so her pastor became aware of her suicidal attempt, and consistent with cultural competency practice, he was engaged to provide help for her.

Case 2

BJ (a pseudonym for a client) was seen by FA. She had suffered multiple sexual molestations for more than 15 years in the hands of friends, acquaintances and worst of all families. She was presenting with panic attacks with some depressive tendencies. She had also begun cutting herself with sharp objects including blades and knives. She had reported occasional series of fainting and thus needed to work with a neurosurgeon who was going to closely monitor the potential neurological basis of such condition. Further, clinical interviews revealed a serious spiritual crisis as she doubted all religious leaders (apparently some have sexually molested her and gone away with it). She also questioned the goodness of God and finally believed that she might have been made to sexually satisfy the insatiable cravings of some men. Notwithstanding this history with some pastors, she came into the therapy with FA, and had to maintain a close relationship with her pastor who worked closely with FA. Later she had to be referred to a medical doctor to work with when she began experiencing other medical conditions that needed urgent attention.

Case 3

This involved the second author (SA). He had been invited by a Clinical Psychologist friend of his to join the therapy for a client who lost some business deals, and eventually, his girlfriend of 6 years after he got addicted to a drug he was using to manage routine stresses from his business. He attempted suicide and was arrested by the police.¹ He was warned, made to sign a bond of good behaviour and released. Prior to the therapy, he had attempted suicide again, and was being sought for by the police for re-arrest. SA engaged the police to have a better perspective of the client's problem through sustained dialogue that was fused with education on suicide in general and circumstances of the client. SA created a supportive network around the client involving himself, the client's uncle, the policemen, two of the clients' close friends, and the clinician. The network offered support in terms of prayer, material assistance and informational support. The client responded positively.

Findings

We discuss our experiences of collaboratively managing suicidal cases under two main themes with sub-themes: *Tensions* (sub-themes: the medicalization of person with suicidal crisis, interprofessional territoriality, ethics- Sexualisation of care, and supernaturalization of suicide), and *Prospects* (sub-themes: provision for referrals, readiness for co-learning)

The Tensions

There are four sources of tensions that we have observed from the working relationship with physicians, pastors, and police on suicidal patients. These are *medicalization of the suicidal person*, *inter-professional territoriality*, *over-supernaturalization of suicide*, and *ethics-sexualisation of care*. Each of these are discussed below

The Medicalization of the Suicidal Person

In this first scenario, the first author (FA) co-managed a suicidal patient with a medical doctor. A very good working relationship was established between the physician and the patient as well as the therapist as she continued therapy with FA just as her routine medical check-ups. During one of such visits to the medical doctor, the hitherto cordial relationship was marred. This was the conversation the medical doctor (Physician GF) had with FA.

Physician GF: Your client is too careless and reckless! She is that stupid and difficult to work with. She doesn't listen so today I insulted her when she came here and I saw her health was bad again. You've got to seriously talk to her"

FA: Oh, sorry about that. Truly sorry about that but as I have always shared with you, this patient has other underlying psychological issues which I am managing and so you may have to be a bit more patient so she doesn't become averse to attending her routine medicals.

Later in the day, FA got a call from the patient who reported:

"Hello Sir, I have been insulted very much by Dr GF. She said I was stupid and I don't listen. Sir why should my doctor also make life so difficult for me? I am upset now and very bothered too. It is as if everyone is against me, and even my doctor too. Wondering when this will all end" (patient)

The medical doctor clearly views this person as a medical patient who should follow strict medical advice and regulations purported to bring a cure. Consequently, the medical advice is to achieve this purpose. A deviation from this was considered by him as a non-cooperative behaviour by a patient. Perhaps the insults were meant to call the patient attention to focusing on the cure and nothing else. However, the patient equally perceives the physician's posture threatening and stress-provoking. She concludes that the physician is adding unto her already many stressors she was dealing with.

Inter-Professional Territoriality

In this second scenario, a few weeks after a collaborative working alliance had been established between a physician and the patient, there was an observed jealousy on the part of the physician toward the very cordial relationship between the patient and FA. The physician on several occasions has called demanding an equal chemistry with the client. On one of such occasions, the physician called FA for a conversation that went like this:

Physician YZ: I just wanted to tell you that I also want to be a part of this girl's (referring to patient) life, but she sees no one or listens to no one like you. I want to be in her life just like you, but I am not getting that chance. It is always my psychologist, my psychologist. (Male Dr. YZ).

FA: ok please do not be bothered much about this. I shall call you later to discuss this ok?

¹ Attempted suicide is a crime in Ghana's penal code.

The voice above clearly illustrates anxieties over a loss of territorial space. Territoriality is the behaviour of certain professionals in marking out or defending their own territory against other members of the same profession. In Uganda, the Professional Council of Pharmacists opposed the introduction of training for pharmacy assistants (McPake and Mensha 2008). The Nurses and Midwives Council opposed the accelerated training of nurse assistants (McPake and Mensha 2008). The public health decision to train general medical doctors to take on the role of psychiatrists in small municipal districts in Brazil was met with great resistance in the medical establishment and consequently subjected to continuous negotiations (Saraceno et al. 2007). In Ghana the idea of exploiting the potential of task shifting and allowing faith-healers/religious leaders to be part of mental healthcare services raises tensions between formal mental health workers and this informal group (Osafu 2013; Asamoah et al. 2014; Arias et al. 2016). We know that in health care, the efficiency and quality of care may be dependent on the degree to which inter-professional relationships are collaborative (Zwarenstein and Bryant 2000). Psychologists and medical doctors are essentially *care professionals* who work on patients and any tension between both jeopardizes quality care.

The Over-Supernaturalization of Suicide

In case 2 for example, the patient's pastor has asked her to pray rather than see a mental health professional. One day FA decided to have a chat with the pastor and encouraged him to allow the patient continue to receive psychological services and that it was good to have a collaborative relationship in helping the patient. The conversation went like this:

FA: good afternoon pastor. How are you? I called concerning the lady who was suicidal and was referred to me which I am told you are aware of

Pastor: oh yes, yes FA. Thanks for your help. Yes I am praying with her. We have seen in prayer that it is spiritual and so advised her to be in prayer and fasting,
Psychologist: oh ok.. errm but how about we working together with you on that. Let us encourage her to pray but she can also benefit from my therapy sessions, please encourage her.

Pastor: well, I am not too sure about that. Well I will think about it but you see spiritual things are spiritual and can only be addressed from a spiritual point of view. Well, I shall think through this.

Psychologist: ok thanks.

However, later I had a call from the patient which went like this:

Good morning sir, my pastor says I should stop seeing you and rather concentrate on the prayers and fasting. He told me he has seen my problem is caused by someone who is opposed to seeing my progress and success in life. Please what do I do now? I want your view"

The heightened sense of "*inter-professional egoism*"- the belief that one's profession is superior to another in inter-professional care and practice is clearly illustrated in the pastor's view. The patient on the other hand appears ambivalent in the advice and wanted FA's opinion to which she was advised to combine her prayers with psychological services but later incurred the displeasure of the pastor. Most of the patients FA has seen with suicidal crisis also do have concomitant faith crisis or religious struggles (Koenig 2008). In one of our research papers, some attempted suicide patients have reacted in opposition to the prevailing religious system and expressed anger and disappointment in God during their suicidal crisis (Akotia et al. 2014). Such patients do not often benefit much from their religious leaders' support. This is due to the potential for judgment and condemnation within a theological space that could be meted against the patient's reconstructed religious faith thus: "backsliding from the faith, "falling from the faith", "blaspheming in the faith". In such instances two things are needed: the reorientation of the pastor to appreciate the mental health aspects of health and well-being and an assessment of the extent of such faith crisis in the patient and providing immediate psychological support (Koenig 2008)

Ethics: Sexualisation of Care

FA has also encountered one major ethical breach he refers to as the "sexualisation of care". This was observed in case 1 when a physician sexually abused the client. The physician claimed to be in love with the client and proposed to marry her. After the client threatened to inform the psychologist for advice on how to seek redress, FA received a short message service from the patient which the physician had sent to her. It read thus:

Honey, am truly sorry for doing this to you under this condition. I fell for you and couldn't resist you when I saw the nurse cleaning you up. I promise to pay all bills up and marry you. I really love you Missy". (Dr. XT sent on 30-08-2013)

Clearly this is a serious ethical breach and superficially his promise is a cover-up gesture of his unethical behaviour. Implicitly there is an ideology of perceived love (irresistible attraction towards the patient) as a motive which drives the caring he is ready to demonstrate by paying all bills and marrying the patient. At this juncture, the caring (which he is supposed to provide by virtue of his profession) becomes

sexualized- an instrument with serious ethical implications. When FA advised patient to take a legal action against the physician, he ran into serious opposition from sections of the medical fraternity. This is a typical posture in medical profession of collegial support to prevent revocation of licences and salvage the image of the profession (Edwin 2009).

Some Prospects?

There is evidence of some prospects of collaboratively working with other professionals in managing cases of suicide. The evidence is found in the increased *readiness to refer cases* to psychologists, *readiness to work together*, and *commitment to ethics*.

Readiness for Referral

One principle undergirding referral in therapeutic relationship is that one refers patient to another professional he or she adjudges competent and qualified to be within the professional social network of support (Nelson-Jones 2008). The referrals therefore demonstrate some level of acceptance of a Suicidologist/psychologist within the physician's and clergy's professional space of practice. Physicians continue to refer suicidal cases and FA has had countless productive working relationships with them for the overall wellness of the client.

Readiness to Work Together

Related to the above is the willingness among professionals to work together on particular cases. From the experiences presented so far, this can be amply seen in the attitude of the clinical psychologist who invited a community psychologist/suicidologist (SA) into an ongoing therapeutic session, as well as SA's subsequent involvement of the police in managing the same patient. With respect to the police, SA viewed the police as having operated seemingly from a crisis, rather than crime orientation because the police, after the first suicide attempt, released the 'offender' and further encouraged him to be of good behaviour. From such a posturing, it was easier for the territorial barrier to be disrupted

Commitment to Ethics

One major way a profession may continue to validate its acceptance is the continuous upholding of strict ethical principles and codes, which goes to raise service users' confidence in the providers of the services (Spielthener 2015). In our professional working experience with other health and allied health professionals, when there was a genuine breach of ethics some professionals had a quick overview of this and sought to correct this. Others rendered apologies

to clients and the interprofessional collaboration team members and demonstrated new learnings in the case management. This is a clear indication of hope that the error has been acknowledged and thus potential lessons for improved service provision considered in future clinical work. The medical profession is a human institution and is liable to errors of all kinds (Edwin 2009) and when errors are committed, some physicians might have dysfunctional ways of handling them (Goldberg et al. 2002; Wears & Wu 2002). One finds in some of these doctors, genuine regrets that are pro-collaborative and restorative in the furtherance of learning to improve self and professional experience.

Discussion and Conclusion

This brief report has highlighted some tensions and prospects involved in collaborating with multiple professionals in treating and managing persons with suicidal crisis in Ghana. There are increasing reports concerning the importance of collaboration in managing several health problems by team instead of a single professional approach. For example, Pape and Rafiullah (2005) have proposed a collaborative approach between psychologists and physicians in the management of pain. Others have also called for collaboration between ethnomedicine traditional healers and biomedical practitioners in the management of HIV/AIDS in both Tanzania and Namibia (Kayombo et al. 2007; Chinsebu 2009). There are numerous calls for collaboration between the clergy and mental health professionals such as psychiatrists and psychologists in the management of mental illness (Oppeneimer et al. 2004; Farrell and Goebert 2008). In Ghana, recent studies are documenting the crucial need for collaboration between mental health professionals and the clergy (Asamoah et al. 2014; Arias et al. 2016; Osafo 2016; Ofori-Atta et al. 2018; Read 2019). One reason for such collaboration is to deliver effective and culturally relevant services to service users (Queener and Martin 2001) and the other is to improve inter-professional learning which will eventually affect the delivery outcomes.

Further, across the breadth of the African continent calls are coming from everywhere regarding the need to collaborate with traditional healers (e.g., that as Ghana's health landscape widens to accommodate other health workers, training of all health practitioners is required to provide continuous understanding of the multi-sectorial nature of health workers and help promote collaboration.

Worth noting is a new layer of collaboration that concerns the engagement of non-health professionals such as the police in suicide management, prevention and research in proscriptive suicide contexts as Ghana as partly evidenced in Case 3. It must be noted, however, that professional collaboration in healthcare in the manner evinced so far in this article, does not

happen by chance. It must be consciously created and nurtured based on a healthcare model that makes interdisciplinary and multisectoral collaboration relevant. Narrowing health issues to professional silos—say biomedicine and neglecting the psychological, spiritual and sociocultural dimensions creates boundaries to treatment for allied professionals. Further, having a keen sense and understanding of holistic health makes one more likely to allow other professionals to come into existing treatment in providing holistic health care. Based on the preceding points, we advocate an increase mental health education for biomedical practitioners. Given the increasing need for the integration of mental health into primary health, equipping biomedical practitioners with some amount of mental health education, particularly in the areas of detection of suicidal signs, basic treatment and communication with suicidal patients will be useful for screening and treatment purposes. Further, the sheer size of the number of faith based practitioners in Ghana who continue to receive cases involving mental health related challenges, implies a certain congruity between their care model and people's lay conception of mental illness. Even though some abuses have been reported in some faith based care practices (Osafó 2016), equipping them with mental health education can improve their practices and promote task shifting in mental health care in general. It is against this background that we also recommend periodic training for police officers on their responsibilities so far as mental health gatekeeping is concern (as enshrined in Ghana's Mental Health Bill) and more specifically in the handling of persons who might be undergoing suicidal crisis.

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Data Availability Data has been made available within the manuscript and is the main subject of analysis.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict interest.

Ethics Approval and Consent to Participate The study received approval from the Ethics Committee for the Humanities (ECH) of the University of Ghana, Legon. All procedures were in accordance with the 1964 Helsinki declaration and its later amendments”.

Consent for Publication All the participants consented to participation on the strict condition of anonymity and confidentiality.

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