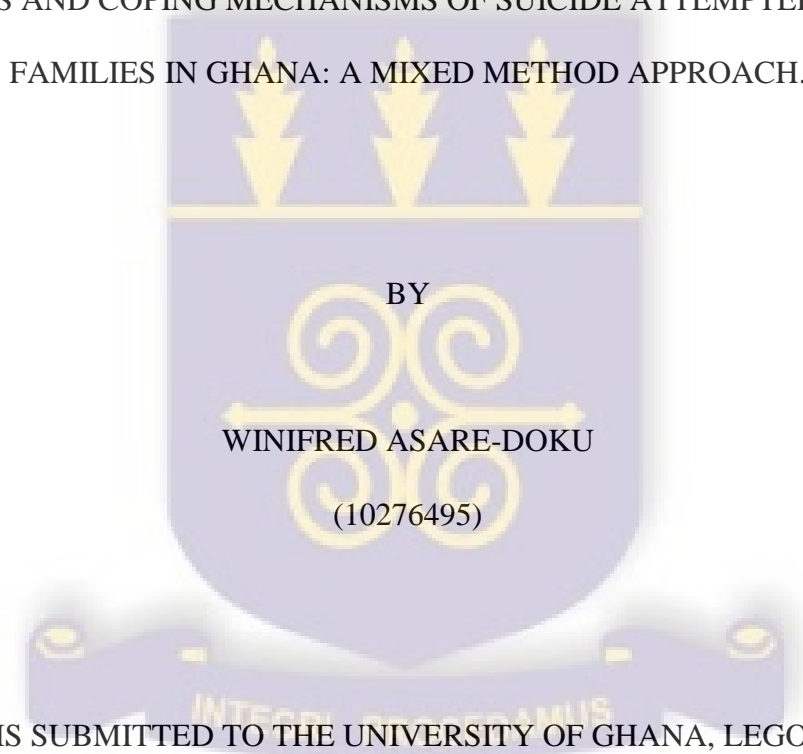


DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF GHANA, LEGON

EXPERIENCES AND COPING MECHANISMS OF SUICIDE ATTEMPTERS AND THEIR
FAMILIES IN GHANA: A MIXED METHOD APPROACH.



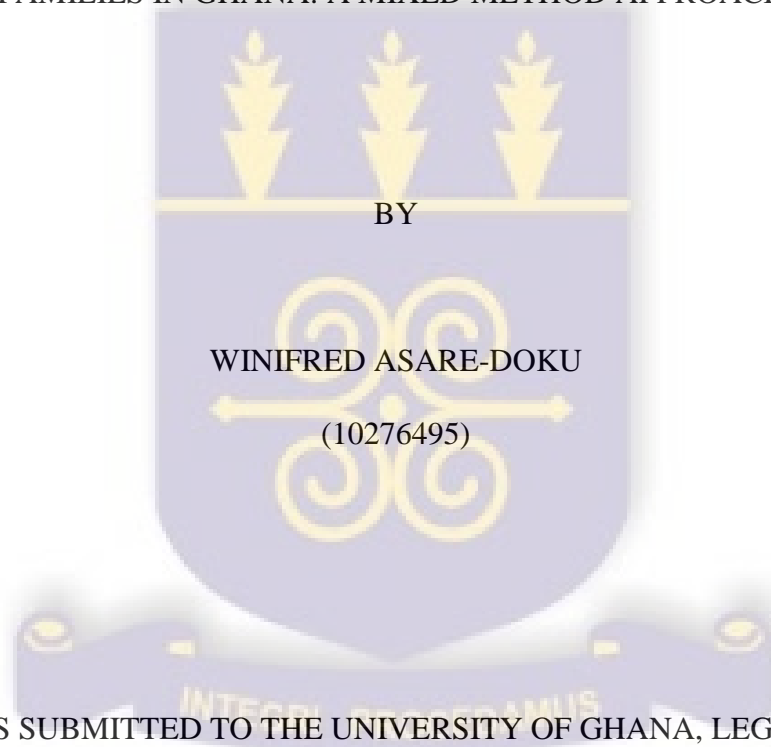
BY
WINIFRED ASARE-DOKU
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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL
FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MPhil PSYCHOLOGY DEGREE.

JULY, 2015

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Declaration

This is to certify that this thesis is the result of research carried out by WINIFRED ASARE-DOKU under supervision towards the award of the MPhil Psychology Degree in the University of Ghana. This work has never been submitted to any other institution by anyone for any award.



.....

Dr. Joseph Osafo
(Principal Supervisor)

Date.....

.....

Prof. Charity Akotia
(Co-Supervisor)

Date.....

Abstract

To understand the experiences and coping mechanisms of suicide attempters and their families in Ghana, 20 (10 attempters and 10 family members) persons were sampled in the aftermath of suicide attempts at the Psychiatry Department of the Korle-Bu Teaching Hospital. The convergent parallel design was used and participants were interviewed on their experiences and coping mechanisms after the suicide attempt. For the quantitative section, participants were administered the aficultural coping inventory and DASS scales and independent t test were used to analyze the data. The major coping mechanism was cognitive/debriefing coping followed by spiritual coping, however supportive network was generally weak and depression was high for suicide attempters. As regards the qualitative section, Interpretative Phenomenological Analysis was used to analyze the data. Findings showed that the precipitants for suicide were largely interpersonal. Further attitudes towards suicidality were a mixture of condemnation and support. Finally, suicide survivors largely utilized spirituality in surviving the stress of the crisis following suicide. In conclusion the experiences of attempters and their families during suicidal crisis present a potential risks for completion. Suicidality thus continues to be influenced by cultural dynamics. Sociocultural theory, aficultural coping theory and learned helplessness are used to explain some of the findings of this study. Implications for suicide prevention and clinical practice are also addressed.

Dedication

I dedicate this thesis to God and my family.



Acknowledgement

Better is the end of a thing than the beginning thereof (Ecclesiastes 7:8). I am very grateful to God for the strength He gave me to finish this work.

I am highly indebted to my supervisors Dr. Joseph Osafo and Prof. Charity Akotia for their great assistance and guidance in helping to complete my thesis despite their busy schedules. God richly bless you.

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Many thanks to Dr. Samuel Ohene and staff of Psychiatry Department (Korle-Bu Teaching Hospital) for the assistance offered me before, during and after the data collection. I am also grateful to my loved ones and friends for all their support during the course of my programme. God bless you all.

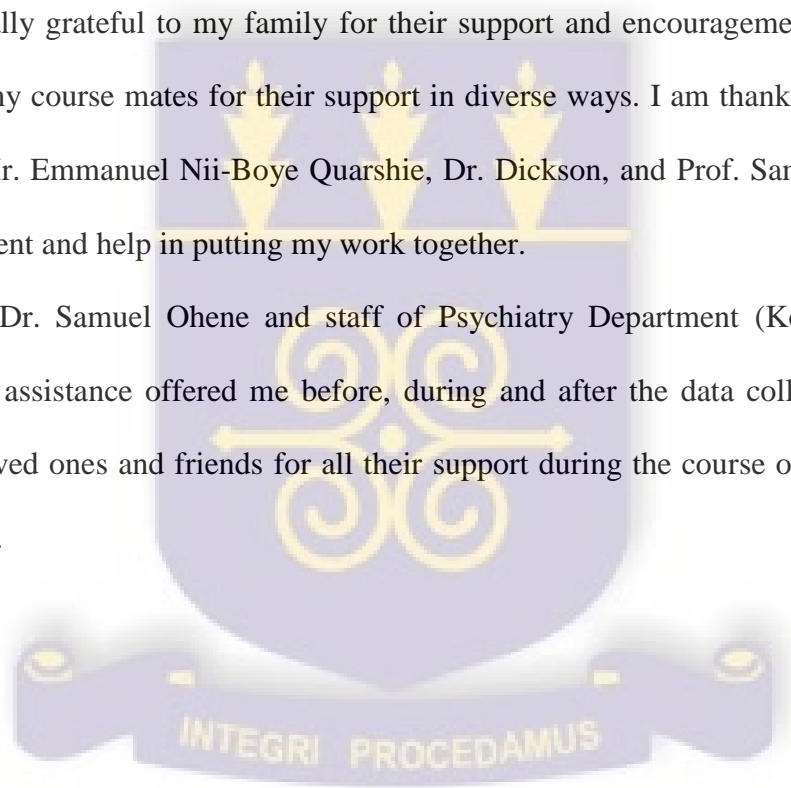
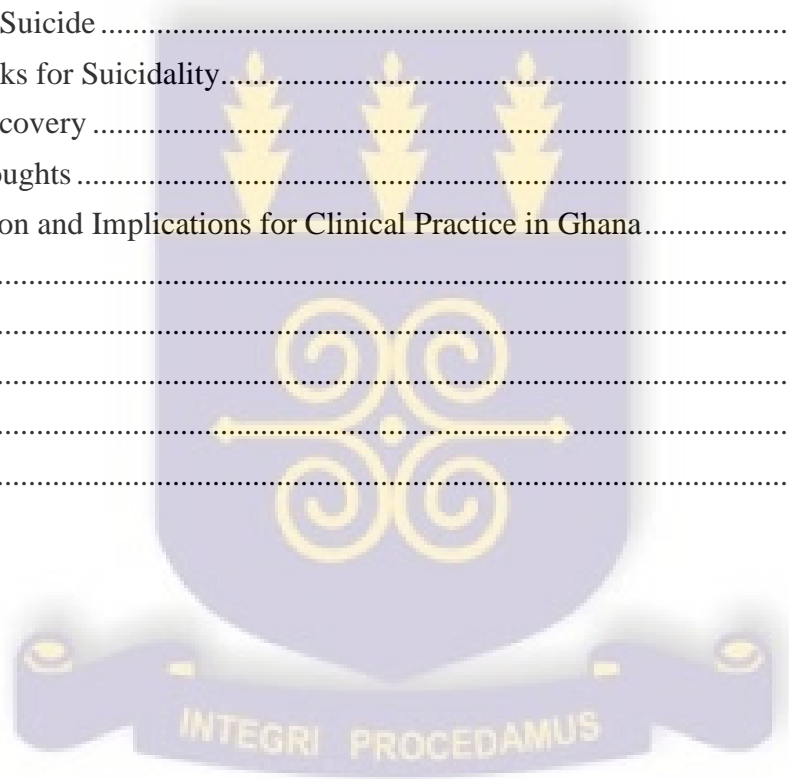


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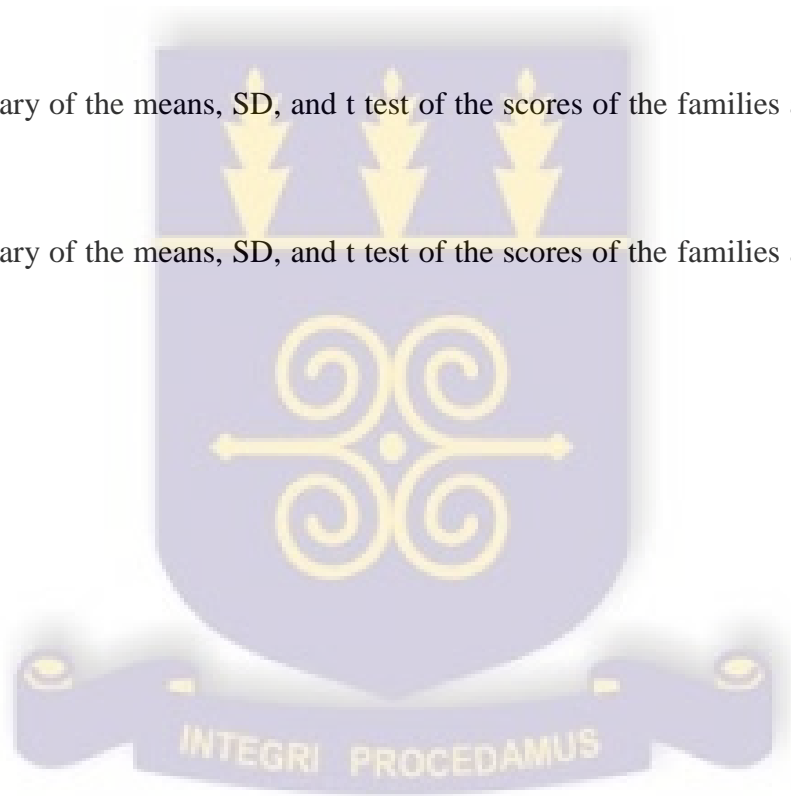
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List of Abbreviations

IPA	Interpretative Phenomenological Analysis
DASS	Depression, Anxiety, Stress Scale
WHO	World Health Organization
INSERM	French Institute of Health and Medical Research



CHAPTER ONE

INTRODUCTION

Background to Study

Shneidman (2004, p. 203) defined suicide as “a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution”. Suicide is an act of deliberately killing oneself or consciously taking one’s life (WHO, 2014). It is therefore an intentional act of ending one’s life and leaves surviving families and friends dumbfounded as they try to ascertain the cause of death. Suicidal behavior refers to a range of behaviors that includes thinking about suicide, planning for suicide, attempting suicide and suicide itself (WHO, 2014). Suicidal behavior is also usually referred to as a whole variety of conducts that include suicide attempt and suicide and can be classified according to the suicidal ideation, means of suicide, degree of lethality, the degree of alteration of cognitive function, triggering circumstances, and the presence of psychiatric or other comorbidities (INSERM, 2005).

Suicidal behavior happens among both genders, with men more likely to commit suicide than women and also, use more lethal methods of committing the act compared to women (Adinkrah, 2011; Peden, McGee, & Sharma, 2002). From 2006-2008, it was recorded by the Police Department that 287 persons engaged in fatal and non-fatal suicides in Ghana by the Police Department (Adinkrah, 2011). Records show that males engaged in suicidal behavior more than females. For example from 2006-2008 about 96.2 % and 3.8% of males and females engaged in suicidal behavior (Adinkrah, 2011). There are a myriad of problems and predisposing factors that influence suicide which includes; depression, family conflicts, sexual abuse, economic system, unemployment, tragic loss among others (Agerbo, 2003; Anderson, Tiro, Price, Bender, & Kaslow,

2002; Lee, Wong, Chow, & McBride-Chang, 2006; Overholser, 2003). Other risk factors include sense of isolation, abuse, violence, previous suicide attempts, mental disorders, chronic pain, financial loss and a family history of suicide (WHO, 2014).

Suicide attempt is any non-fatal suicidal behavior and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent (WHO, 2014). Suicide attempts are far more frequent than suicides and an individual can attempt suicide multiple times (Buus, Caspersen, Hansen, Stenager, & Fleischer, 2014). It is estimated that about 800,000 people die through suicide every year and it is the second leading cause of death among 15-29-year-olds; and in 2012, suicide accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death (WHO, 2014). In Ghana the age group with the highest record of suicide is from 20-39 years (Adinkrah, 2011).

In Ghana suicide is considered a taboo (Osafo, Hjelmeland, Akotia, & Knizek, 2011a) and according to Act 29 of Ghana's Penal Code (1960), "whoever attempts to commit suicide shall be guilty of misdemeanor" (section 48). Thus the individual who completes the act of suicide is apprehended and prosecuted. The Ghanaian society also proscribes suicide and tends to have a negative attitude towards it (Osafo et al., 2011c).

According to Kahn and Lester (2013), in Ghana, if an individual kills him or herself, the belief is that ancestors would drive the person's spirit back to earth, and that spirit would roam about threatening surviving relatives. In all ethnic groups in Ghana, suicide is abhorred and condemned although the beliefs and practices concerning death caused by suicide are different among the ethnic groups (Adinkrah, 2014). Dali stated that "among some ethnic groups in Northern Ghana, when suicide occurs inside a house or an apartment, the corpse must be removed through a

window or a specially created aperture in the wall because conveying the body through the doorway permanently desecrates the doorway for the living” (cited in Adinkrah 2010, p. 8).

The stigma suicide carries affects not only the suicidal individual involved but significant others and even future generations (Hjelmeland, Akotia, Owens, Knizek, Nordvik, Schroeder, & Kinyanda, 2008). Among all ethnic groups in Ghana, suicide is considered a “bad death” and physical contact with the person’s body is avoided at all cost. The act is perceived as bringing dishonor onto the lineage in which the suicide occurred (Adinkrah, 2012a). In some African countries like Uganda, suicide is considered a bad omen needing cleansing rituals (Knizek, Kinyanda, Owens & Hjelmeland, 2011).

Most times, a person attempting suicide is often so distressed that they are unable to see that they have other options. **In most cases of suicidal attempt**, individuals may have tried to communicate their intention before the attempt. One common myth of suicide is that people who tend to talk about suicide do not mean to do it (Sue, Sue, Sue, & Sue, 2015). Research has shown that people who attempt suicide or kill themselves talked about the act and it was a form of reaching out for support or help from significant others (Buus et al., 2014; Shilubane, Ruiter, Bos, Reddy, & Van Den Borne, 2014). According to Sue et al. (2015), a significant number of people contemplating suicide maybe experiencing anxiety, hopelessness, depression, and they think suicide is the way out. It has also been found out that in most cases mental illness preceded the suicide act.

Experiences and Psychological Distress after Suicide Attempt

After a suicidal behavior, families and significant others go through a lot of negative emotions and pathologies such as pain, shame, and distress, in the society. According to Shneidman (cited in Dyregrov & Dyregrov, 2005, p.1), “the person who commits suicide puts his psychological

skeleton in the survivor's emotional closet". When suicide occurs, families experience a significant loss because they are those who are closest to the victim. The experiences they go through may in the long term affect their mental health and their life as a whole. Families suffer from emotional sequel and are at risk of depression, suicidal ideation and other forms of distress (Vawda, 2012).

Precipitating factors in a study conducted by Holtman, Shelmerdine, London, and Flisher (2011) in South Africa found that in event of suicide attempt there was the presence of depression, hopelessness and violence. Others have cited chronic physical illness, death, divorce or separation and stressful life events (Overholser, 2003).

Research indicates that some suicide survivors develop post-traumatic stress disorder (PTSD) and grief reactions, which are anxiety disorders that can become chronic if not treated (Bartik, Maple, Edwards, & Kiernan, 2013; Dyregrov, Nordanger, & Dyregrov, 2003; Mitchell, Kim, Prigerson, & Mortimer, 2005). The emotions they experience can be devastating and they may even not be able to function (Dyregrov & Dyregrov, 2005). Life seems to come to an end for them especially when the person was very close to them. **For most families who have experienced a suicide attempt,** shock is the first and immediate reaction. Guilt feelings are existent in such situations and this occurs when the person regrets things they did, said or didn't do. They burden themselves of how they could have prevented the attempt. Survivors feel that they directly caused the death, feel guilt and blame themselves for not preventing the suicide (Jordan, 2001). In some situations, the families' members express intense fear of other members committing suicide or attempting it. Yet other people's emotional experience may be evident in physical symptoms like weight loss or gain, insomnia, pains and aches among others (Buus et al, 2014; Dyregrov & Dyregrov, 2005). These symptoms can to lead to psychological distress. Thus the aftermath of the attempt is likely to affect their mental health (Sveen & Walby, 2008). In a study by Buus et al., (2014) parents who had their

children attempt suicide expressed feelings of isolation, shame, guilt, and lived in fear of repeated attempt making them anxious as they cannot tell when such an incident might occur again.

Shame has also been shown to be one of the experiences that characterize the aftermath of a suicide attempt (Sveen, & Walby, 2008; Wiklander, Samuelsson, & Åsberg, 2003). After the event the person is filled with anxieties about the actions and possible consequences to him/herself and others, associated with depressive behaviors. Preoccupation with thoughts about what others will think about them increases their anxieties (McGinley & Rimmer, 1993). For some of the individuals, having attempted suicide and survived is perceived by them as another failure compounding to previous failures they have in life (Wiklander et al., 2003). It is reported that some suicide attempters worried excessively over the fact that significant people in their lives will discover what they had tried to do.

Alienation was consistently experienced by suicidal individuals in Canada after a suicidal behavior (Everall, Bostik, & Paulson, 2006). In school, relating with peer groups was also difficult thus reinforcing feelings of loneliness and abandonment; coupled with these feelings and experiences many put it as being sad or depressed. (Everall et al., 2006; Vatne, & Nåden, 2013; Wiklander et al., 2003). Others had feelings of being exposed as everyone now knew what they tried to do, yet others also experienced guilt feelings after the suicidal act because they felt they had sinned against God (Akotia, Knizek, Kinyanda, & Hjelmeland, 2013).

Coping after Suicide Attempt

There are many ways in which individuals cope with stress and **how they respond in stressful situations**. Suicide attempt is a stressful situation especially when the reason for attempting remains and situations have not changed. Individuals who are faced with any form of stressful

situation and find no leeway may resort to suicidal act and as a result may develop some coping mechanisms to cope with the situation. Lazarus and Folkman (1984) suggested two types of coping resources which are emotion focused which is trying to alleviate negative emotional responses and problem focused coping targets practical ways to solve the problem. Individuals in Canada reported maladaptive coping strategies after suicide attempts which included thinking about suicide, visualizing and planning about suicide, eating disorders, abusing drugs, chaotic lifestyles among others (Everall et al., 2006). Depression was reported as an aftermath of suicide attempt and this could be due to inappropriate coping mechanisms after the act (Ortíz-Gómez, López-Canul, & Arankowsky-Sandoval, 2014). A recent study conducted by Akotia et al. (2013) shows that suicide attempter's experiences include spiritual struggles: the perception that, they have sinned against God by attempting suicide. According to their study the suicide attempter consequently seek forgiveness from God which brings them solace knowing that the Supreme Being is able to forgive them for the act. Due to the communal nature of Ghanaians, they tend to explain their actions in light of the broader society. Gyekye (2003) writes that in the African community society, people hold that the welfare of each individual is dependent on the welfare of all, thus in the event of suicidal behavior the community becomes a protective shield to the individual.

The primary goals of this study are to examine the experiences of suicide attempters and their families and their coping mechanisms after a suicidal attempt. This will bring out culturally specific meanings of suicidal behavior and pave way for culture specific suicide prevention strategies. The study therefore seeks to explore through a mixed method approach the experiences of suicide attempters and their families after a suicidal behavior and their coping resources and how the plethora of experiences may lead to psychological distress.

Statement of problem

A single most important risk factor to suicide is previous suicide attempt (WHO, 2014). Therefore individuals who have attempted suicide before are more likely to attempt again and may succeed with further attempt. This is possible if precipitating factors that led to the attempt continue unabated and they develop maladaptive coping mechanisms in dealing with problems. **When the attempter perceives that their experiences after the attempt are unpleasant and negative, they are more likely to attempt again and succeed. It is also plausible that inadequate coping resources may trigger further suicide completions. Little work has been done on the experiences of suicide attempters and their families in Ghana (Akotia, Knizek, Kinyanda, & Hjelmeland, 2013; Osafo, Akotia, Andoh-Arthur, & Quarshie, 2015). The impact of suicidal behavior on the family ranges from pain and grief to various health consequences and may take many years to subside (Vawda, 2012).**

In Ghana, there is stigmatization attached to suicide (Osafo et al., 2011) and this stigma also affects families associated with the suicidal person. There is also stigma associated with seeking help for suicide attempts and this further compounds the difficulty, leading to inappropriate access to mental health care and to higher suicide risk (WHO, 2014). Sadly, because of low mental health literacy, family members are faced with odds of providing care for the suicide attempter. The primary professional caregivers of mental health, especially doctors and nurses who are the first-contact in event of suicide attempt lack adequate training to provide adequate care for this group. Usually, the medical condition is dealt with while the psychosocial factors are left unattended which include their experiences and how they are coping after the attempt. As such family members have to deal with the

stigmatization and also provide caregiving role for the suicide attempter which may be a stressor

The suicide attempt may also affect the relationship that existed between families and the victim because families consider the image of the family tarnished bringing a strain in family relationship after the event (Osafo Hjelmeland, Akotia & Knizek, 2011c). This may lead to alienation of the individual in the family which is a risk for further suicide attempt by the individual. Hence this current research seeks to explore experiences and how families and victims survive the stress associated with suicide attempt.

Aims of the study

The main aim of the study was to explore the experiences of suicide attempters and their families after a suicidal attempt and also to understand the coping strategies they use to deal with the associated challenges. **There is a need to examine the differences between victims and families as both groups experience guilt and shame over the attempt. Also caring for the attempter initially may be comforting yet it may later become burdensome for the family. The broad aim therefore is to make comparison of their experiences and ways they are coping to manage the stress.**

Specific Objectives

1. To explore experiences of suicide attempters and their families after a suicide attempt.
2. To examine coping mechanisms of suicide attempters and their families.
3. To examine differences in coping of suicide attempters and their families.
4. To ascertain the depression and anxiety levels of suicide attempters and families.

Relevance of the study

The present study will highlight the experiences of **suicide attempters**, their families and significant others after a suicidal behavior. **This study is critical because** such experiences are sometimes ignored in most cases since the suicide behavior may have occurred already. The experiences are mostly hushed for fear of stigmatization.

It will provide families the opportunity to be educated about suicide and suicidal behavior and how they can help prevent suicide. Based on the findings, they will be educated on the signs and triggers of suicide and how they can identify suicide warnings and help prevent suicide before it occurs.

The research will provide an outlet for families and attempters to ventilate painful emotions resulting from the suicidal behavior. Aftermath of suicide attempt brings shame and hurt to families. This can further lead to more suicide attempts upon which the individual might succeed with time. It is hoped that the study will restore broken relationships between attempters of suicide and their families if any exist. It may help facilitate the resolution of conflicts between attempters and their families which can be a risk factor for further attempt.

This research will also help identify positive and negative coping mechanisms of individuals and its influence on well-being. This will help counsellors and psychologists promote positive coping strategies to help improve psychological well-being of suicidal persons and their families.

Findings of the study will guide policy formulation on culturally sensitive suicide prevention in Ghana for suicide survivors. Thus prevention policy will be evidenced based.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents a review of some theoretical underpinnings of experiences and coping methods of suicide attempters and their families. The chapter also reviews related studies in relation to the variables being studied.

THEORETICAL FRAMEWORK

Africultural Coping Theory

Coping can be viewed as an effort to maintain a sense of harmony and balance within the physical, metaphysical, collective and spiritual realms of existence. It is a universal concept however it is culture specific as different cultures cope with stressors in different ways. Africultural coping is defined as the extent to which individuals of African descent adopt coping behaviors specifically derived from the African culture (Utsey, Adams, & Bolden, 2000). They conceptualized Africultural coping behaviors in terms of four dimensions and these include cognitive/emotional debriefing which represents adaptive reactions by individuals of African descent as a result of efforts to manage stressors. In this dimension, individuals hope for things to get better. They have the belief that everything will get better with time and this hope gives them strength to move on despite the challenging situations confronting them.

The second dimension is spiritual-centered coping and refers to behaviors that reflect a spiritual sensibility like praying that things will work themselves out during a stressful situation. Spiritual coping helps as people connect with their Creator as they pray for an intervention for their problem (Vandecreek & Mottram, 2011). Being and belonging to a group brings psychosocial support that can promote mental health. Africans are perceived to be very religious and believe in their religion (Mbiti, 1990). In Africa for example, people believe in a Supreme Being to help them deal with

situations they are faced with. “To be without a religion amounts to a self-excommunication from the entire life of the society, and African people do not know how to exist without religion” (Mbiti, 1990, p.2). According to Mbiti (1990) religion is African’s whole system of being for which reason an individual cannot detach himself or herself from the religion of his group. For to do so is to be severed from his roots and kinship. Since Africans are such ingrained **in** their religion, they see everything in the light of religion thus when problems arise, they turn to their religion for direction and strength to deal with it. One of the basic assumptions of Eriksson’s (2002) theory of health, caring and suffering is that the human being is fundamentally a religious being, therefore in relation to the experiences of suicide attempters and families after an attempt, they are more likely to resort to their religion to help them cope.

The third dimension is collective coping and it represents a reliance on in-group to manage stressful situations and seek comfort from members of the group. Proverbially, it is said “a problem shared is half solved”, therefore as an individual shares his or her problems with someone, they feel better and are able to deal with the situation. The last dimension is the ritual-centered coping. This involves African cultural practices for example burning incense for strength or guidance in dealing with a problem or stressful situation (Utsey, 2000). People use one or more of this type of coping mechanisms during a stressful event and in this instance, suicide attempt is a stressful event. Society proscribes the act and thus such victims are more likely to turn to a deity to help them survive this period of their lives. They pray to a spiritual being and hope that things will turn around for them.

Sociocultural Theory

The socio-cultural theory postulates that in order to understand an individual, you need to understand their cultural context and social experiences and how they influence their development (Vygotsky, 1981). Experiences in the environment shape the behavior and attitudes of people. This helps to know how the interactions within the environment affect the life of individuals in the society and how society contributes to this development. Suicide is stigmatized in the Ghanaian culture (Hjelmeland et al. 2008) and as part of an individual's development, this belief is formed and learned. Stigmatizing suicide can be said to be a learned experience from the environment thus making it part of the person's development and growth. This implies that as a person grows and interacts in the society, s/he learns from the society. Thus an individual who attempts suicide is faced with harsh treatments from the society and this has an impact on their experiences and development. **Their experiences after an attempt may depend heavily on how society appraises suicide.**

Chun, Moos and Cronkite (2006) attempt to describe the role of culture in stress and coping and how collectivistic and individualistic systems influence coping. The authors used five panels to explain how individualistic and collectivistic cultures deal with stress. The panels include environmental system, personal system, transitory conditions, cognitive appraisal and coping skills and health and well-being. For the purpose of this research the cognitive appraisal and coping skills will be employed to help understand coping. When faced with a stressful event, the individual first appraises the nature of the stressful event and the available coping options. The appropriate coping resources are then used based on the appraisal made. Within this theory, collectivism (interdependence) and individualism (independence) are viewed as the most salient cultural dimensions that have a bearing on cultural variations in coping patterns and outcomes

(Kuo, 2011). The culture influences the individuals' appraisals and their choice of coping mechanism. According to Gyekye (2003) Ghanaians are collectivistic, thus there is interdependency and in the event of any situation like death, marriage, festivals, unemployment among others, families are brought together to assist in whatever way they can (Adjibolosoo, 1995). People who attempt to kill themselves and are not successful might therefore rally around friends and family to help cope with the situation. Families and significant others may provide more support for such individuals to prevent future attempt.

These negative experiences that families and attempters may have can be alleviated by people and significant others who show care and support for them. Eriksson's (2002) theory of health, caring and suffering asserts that by caring for a patient's needs, their suffering will be decreased and their strength returned to help them cope with the situation

Learned Helplessness Theory

Seligman and his colleagues in 1965 discovered accidentally an unexpected phenomenon known as learned helplessness. This theory was chanced upon while studying the relationship between fear and learning in dogs (Peterson, Maier, & Seligman, 1995). The theory **is being used to explain** why some people become **anxious, stressed and** depressed and may adopt inappropriate behaviors. Humans need to feel they have some level of control over their lives. Therefore people become helpless when they feel they can no longer control the situation they are in. The learned helplessness theory helps understand that a person's thinking style is a factor that determines whether learned helplessness would occur. **It also arises when a person's negative experiences in a situation are generalized to their broader situation and that person thinks there is no way out.** It is therefore inevitable for people who are depressed for example to think that nothing

will ever change their situation and thereby feel trapped in an inescapable or intolerable situation. When people lack control over things happening to them, they develop maladaptive thoughts and inappropriate coping behavior and suicide may seem as the appropriate choice or coping method. **They perceive suicide as the last solution to their problems. This is because a person attempting suicide mostly is distressed and is unable to see other options that may be available.**

Review of Related Studies

Suicide has been a menace in society and many efforts have been and are being made to reduce the prevalence of suicide globally. Despite interest in suicide survivors, it is surprising that little empirical research has actually been conducted on the topic in Ghana. The few studies conducted on suicide in Ghana include attitudes toward suicide (Knizek, Akotia, & Hjelmeland, 2010; Hjelemland, Akotia, Owens, Knizek, Nordvik, Schroeder, & Kinyanda, 2008), criminalization of suicide (Adinkrah, 2012a; Hjelmeland et al., 2013; Kahn & Lester, 2013) among others. This section reviews studies that highlight the experiences of families and attempters of suicide after a suicidal behavior.

Using a sample of 200, Purushothaman, Premarajan, Sahu, and Kattimani (2015) interviewed the participants over a period of one year. The focus of their study was to examine the socioeconomic status, bio-psychosocial detail, and precipitating factors that led to the suicide attempt. Findings revealed that the major precipitating factor was verbal abuse. The most common stressful life event was family conflict, followed by large debt. Also the most common mode of suicide attempt was by consumption of poison. Another finding also revealed the presence of psychological distress among participants. Although the

authors' methodology was not detailed, it can be seen that a quantitative approach was used for the study which draws attention to examining suicide intent even after an attempt.

Lim, Lee, and Park (2014) sought to compare and analyze the difference between suicide attempters and completers in terms of the suicide methods used. Their findings showed that drug poisoning was the most frequent method in suicide attempters, whereas hanging was the most common method among suicide completers.

Suicide and coping experiences

Buus et al. (2014) sampled a total of 14 parents of sons or daughters who have attempted suicide in Denmark. A focus group approach was used to interview two groups of parents on their experiences after their children had attempted suicide and its psychosocial effects on the family. Thematic analysis was used to generate two central themes: “emotional response and stress” and “effects on families and relationships”. According to Buus et al. (2014), a common reaction was shock, panic and fear at the behavior of the child. This fear can be characterized as being in a state of anxiety although no assessment was done to ascertain that. In the current study however, anxiety will be assessed to determine whether the suicide attempt causes victims to live in fear of future attempt. It was also reported that parents expressed feelings of isolation, shame, guilt, lived in fear of repeated attempt and stigmatized among others after a suicidal attempt of their children. They also found out that some parents were apprehensive in disclosing their story to others for fear of stigmatization. This according to the research led to more emotional strain for the parents and their families which did not allow them to cope well with the situation. **The authors used thematic analysis which is the commonest form of analysis in qualitative research and identifies patterns that are important to the phenomenon, the use of focus group discussion may be**

considered inadequate. This is because suicide is a sensitive topic and focus group discussion may not capture individual feelings and emotions about the phenomenon as confidentiality may be breached. Ideally, individual interviews will capture the individual experience and provide a deeper understanding of the phenomenon.

Vante and Nåden, (2013) conducted a study and interviewed 10 participants in Norway on their experiences in the aftermath of suicide attempt. The study revealed three themes which were “experiencing and not experiencing openness and trust”, “being met and not met by someone who addresses the matter” and “being met on equal terms versus being humiliated”. Their themes suggested that healthcare personnel do not necessarily help client after a suicidal experience but rather reinforce their suffering and discourage any form of hope in them. It was reported in their study that others experienced humiliation and reported feeling more depressed, lonely, ashamed and guilty. It was discovered that when health personnel listened and empathized with them, they experienced a sense of trust and openness towards them. This gave some of the patients some resurgence of hope and to get better and live their life. **Their study was based on** Eriksson (2002) theory of health which explains how suffering can be alleviated when people do good, therefore in this case when caregivers did good to patients (suicide attempters) it helped to alleviate their pain and suffering. **The authors used a semi-structured interview which explores particular themes and responses of participants to get an in-depth view of their experiences after the attempt.**

Some studies however take a different approach in examining the experiences of significant others in event of suicide completions. Siblings’ and parents psychosocial situation and needs for assistance were explored by Dyregrov and Dyregrov (2005) in Norway after a suicidal act. They used a mixed method approach and questionnaires used include general health questionnaire, impact of event scale and assistance questionnaire. Results showed that parents reported higher

psychosocial distress reflected through anxiety, somatic symptoms and depression. According to their findings siblings and parents alike reported post-traumatic stress disorder which left them in shock and disbelief. Feelings of stigmatization, guilt and blame were eminent. In this current study however experiences of suicide attempters and their families will be explored to compare differences and similarities in their experiences. Their study reported anxiety and depression as psychosocial distress of participants however they did not measure these constructs objectively, these constructs will be explored quantitatively in this current research. Their finding is consistent with findings by Buus et al. (2014) and Holtman et al. (2011). This research is relevant and contributes to knowledge on suicide experiences and how siblings can be ignored after suicide.

Using a qualitative study and a semi-structured interview approach, Holtman et al. (2011) interviewed suicide attempters and their families in South Africa. The aim for their study was to explore whether living conditions in the community precipitated the suicide attempts of farmers. A total of five participants aged between 20 to 33 years participated in the study. **A semi-structured interview was used and this qualitative method of inquiry provides the opportunity for the interviewer to explore further particular responses of participants.** It was documented that three of the participants had attempted suicide before but didn't succeed and tried again. Themes generated included perceived predisposing factors **included abuse of alcohol, chronic illness, violence, poor socio-economic conditions and dysfunctional family**; precipitating factors to suicide attempt included **depression, helplessness and violence**; methods of self-harm and support provided after attempt. According to their findings, only one individual received a form of support from a social worker. However in their study, there was no record of the experiences of the families of the suicidal attempters although it was stated as part of the research question. **Thus, it does not give a clear picture of the experiences from the perspective of the families as**

suggested by their study and also there was no discussion on whether families and significant others provided forms of support for the victims.

A focus group study was conducted using adolescents on exploring their knowledge and experience with a peer who committed or attempted suicide in South Africa (Shilubane et al., 2014). Six focus group discussions were done using 56 high school students between the ages 13 and 19 years of age. Their findings revealed that majority of the students blamed themselves after their peer attempted suicide. Others according to the results lived in fear of their friend attempting again and it is consistent with Buus et al.'s (2014) findings on experiences in the aftermath of suicide attempt.

Hirsch, Webb, and Kaslow (2014) reported from a cross-sectional survey of 148 African-American female attempters from an urban hospital that, there was a weaker relationship between hassles, suicidal thoughts and spiritual well-being. Spiritual well-being moderated the relationship between suicidal thoughts and hassles, thus individuals who were spiritual did not experience suicidal thoughts. They also found out that depressive symptoms were positively associated with daily hassles and suicide ideation and negatively associated with spiritual well-being. **Their study throws light on experiences of adolescents after a peer has attempted or committed suicide. However the use of focus group limits the depth of the study as participants may not be able to express themselves.**

Osafo et al. (2015) interviewed 10 people in the community of Asuogyaman District (Eastern Region of Ghana) where they explored the experiences of suicidal persons after a suicide attempt. All the participants were males between the ages of 30 and 41 years. Their experiences included physical molestation and ostracism by their families. According to Osafo et al. (2015), the family which is to serve as a refuge for comfort turned against such victims in event of suicidal behavior.

Their findings however showed that families isolated themselves from the victim's thereby saving face while others expressed that they received negative reactions from their families and friends as they shunned their company. It also showed that the society's harsh attitudes compounded the initial problem as was confessed by some of the participants, which maybe a risk factor for further attempts in the future. They found that the coping mechanisms used by the victims included religion and social support, and although some experienced harsh reactions from families, others received social support from their families and friends which served as a protective factor. **Their study portrays an aspect of the families' experiences after suicide attempt although they were not the focus of their study. It appears that stigma associated with suicide may have led to their reactions.** The current study seeks to explore through mixed method the coping mechanisms of families and victims using the Africultural Coping Systems Inventory (ACSI) to determine whether there will be a difference between coping methods of families and suicide attempters.

Based on the literature reviewed, few studies appear to have a direct focus on experiences and coping resources of both attempters and families which is a gap in suicide studies, hence the purpose of this study is to develop a deeper understanding of the experiences of not only the suicide attempters but their families and understand the coping mechanisms they employ to deal with the situation. Psychological distress will be measured in the current study to determine the mental health of the participants.

Rationale

Literature on suicide in Ghana have centered on attitudes towards the suicidal act, criminalization of suicide, religion in suicide, prevention of suicide and among other related ones (Adinkrah, 2014; Hjelmeland, Osafo, Akotia, & Knizek, 2013; Osafo, Hjelmeland, Akotia, & Knizek, 2011a).

Dimensions like the experiences and coping mechanisms of suicide attempters and their families have not been captured much in the literature. This study therefore explores the experiences of suicide attempters and their families after a suicidal attempt and also the coping mechanisms they employ in such periods. Also, their psychological distress will be assessed to determine their current mental health state. Assessing their mental health currently is relevant because a major predictive factor of future suicide attempt or completion is the presence of psychological distress (WHO, 2014). The choice of methodology is important because it will give objective and subjective accounts of individual differences on how they cope during stressful situations like suicide. In Ghana, there is little or no research on families and how they cope after a suicidal behavior, hence their experiences will help build on the knowledge of suicide, prevention of suicide and seeking help for the survivors of suicide attempt after a suicidal behavior.

Hypotheses

- 1. Suicide attempters will be more depressed than families.**
- 2. Families will experience higher levels of anxiety compared to attempters.**
- 3. Suicide attempters will use more spiritual coping compared to families.**
- 4. Suicide attempters will use cognitive coping more than families**

Research questions

1. What environmental factors precipitated the suicide attempt?
2. What are the emotional experiences of suicide attempters and their families after the attempt?
3. How do suicide attempters cope in the aftermath?

4. What forms of support are available after a suicidal behavior for both attempters and significant others?

Operational Definitions

1. Suicide attempters: people who tried committing suicide but did not succeed
2. Suicidal behavior: this means a suicide attempt by an individual.
3. Families: Any member related to the suicide attempter by blood or lives in the household with the attempter.
4. Psychological distress: depression, anxiety and stress.

CHAPTER THREE

METHODOLOGY

This chapter discusses the research methodology that was used in investigating the experiences and coping resources of suicide attempters and their families. The research design, population and sampling are described, followed by the materials that were used, and procedure.

Research Setting

The location for the research was in Accra, the Greater Accra Region of Ghana. Participants were recruited from the Psychiatry Department of Korle-Bu Teaching Hospital, the leading national referral center in Ghana. Interviews were conducted at the Psychiatry Department and the homes of participants. These locations were chosen based on convenience of the participants. As such people with diverse background were represented in the study. The department was chosen because all suicide attempt cases that come to the emergency unit of the hospital are referred to the department for management.

Population / Sample

The population for the study consisted of suicide attempters and their families. The sample consisted of 10 family members and 10 suicide attempters. For each suicide attempter, one member of the family was interviewed. In all, 20 informants participated in the study. Smith, Flowers and Larkin (2009) recommends between five and 10 participants when using IPA (Interpretative Phenomenological Analysis) due to commitment to a detailed interpretative account in IPA. IPA studies are conducted on small sample sizes (Smith & Osborn, 2003) as large sample sizes might prove to be too time-consuming and lengthy in terms of analysis. **A family consisted of any member of the household or one who is related by blood** to the suicide attempter who

has lived with the suicidal person for at least 2 years. The participants who were interviewed for the qualitative method were the same participants used for the quantitative study.

Inclusion Criteria

1. Participants should be 18 years and above as according to the Ghanaian law, an individual is considered an adult if they are 18 and above.
2. Suicide attempters should have made a suicide attempt one time in their life.

Exclusion Criteria

1. Individuals who are below 18 years of age.
2. Families who have had someone in their family completing suicide

Sampling Technique

Sampling of participants was purposive and convenience sampling. Purposive sampling focuses on specific characteristics of the population people who will better be able to assist with answering the research questions. **Thus to meet the criteria for the study, one should have attempted suicide at least once.** Convenience sampling method relies on data collection from people who are readily available to participate in study. The convenient sampling technique was used in sampling the respondents for the study because the number of suicide attempters available was relatively few. Thus those who were available were recruited for the study.

Research Design

The design for the study was a mixed method design, specifically the convergent parallel design. This design occurs when researcher collects and analyzes both qualitative and quantitative data during the same phase of the research process and merges the two sets of results into an overall interpretation (Creswell & Clark, 2007). Qualitative method helps explore the motivations for a phenomenon and it gives a rich detail of information including contextual factors that have to be

explored in relation to the phenomenon under study (Creswell, 2013). This was therefore influenced by the empirical focus on subjective experiences after of victims' suicide attempt. This method is also used when a limited number of cases are to be used. For example the suicide attempters who were participants for the study are clinical cases; therefore, only a limited number was available for the research. Qualitative was used to explore individual experiences after the suicidal behavior to understand the meaning of the behavior and how they make sense of the experience which cannot be captured in numerical data. Quantitative method was used for hypothesis testing. According to Kral, Links, and Bergmans, (2012) enhancing the strength of research can be done by employing multiple methods. The use of mixed methods has been encouraged by Kral et al. (2012) and Rogers and Apel (2010) in suicidology, as mixed methods will be able to integrate objective and subjective accounts on constructs that will be measured. **The combination of qualitative and quantitative is critical to the current study to explore experiences, coping and psychological distress. These two approaches will ascertain differences in the constructs being used for the study.**

Measures

This section describes the instruments used to collect data. The Africultural Coping Systems Inventory (ACSI) (Utsey et al., 2000) was used to assess the coping resources of the participants. The ACSI is a 30-item, 4-point, Likert-type (0 =does not apply or did not use, 1= used a little, 2= used a lot, 3= used a great deal) scale that measures culture-specific coping behaviors used by African Americans during stressful situations. There are four subscales which are cognitive/emotional debriefing (11 items), spiritual-centered coping (8 items), collective coping (8 items), and ritual-centered coping (3 items). Scores were obtained by adding the responses to the items. Items on the questionnaires include, "Tried to forget about the situation"

(cognitive/emotional debriefing subscale) and “Sought emotional support from family and friends” (collective coping subscale). Cronbach’s alpha ranges from .76 to .82 for the four subscales (Utsey, 2000).

The DASS 21-item scale, a short version was also used to measure depression, anxiety and stress of participants. This is a self-report scale designed to measure the negative emotional states of depression, anxiety and stress. Each of the three scales contains 14 items divided into subscales. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The stress scale assesses difficulty relaxing, nervous arousal and easily agitated. Cronbach alpha is 0.93 (Henry & Crawford, 2005). It is measured on a 4 point Likert scale ranging from “never” to “almost always”. A score of 14 and above indicates extremely severe depression, a score of 10 and above is extremely severe anxiety and 17 and above indicates an extremely severe stress.

The use of DASS and ACSI are appropriate for the study because the psychological distress for participants will be measured using DASS which is sensitive in identifying psychological distress in a population. The ACSI has four dimensions of coping based on African descent which makes it sensitive to the Ghanaian culture and appropriate for the study. In addition to the scales, an interview guide was also used to gather data for the qualitative study. The interview guide was in two different parts, one for the suicide attempters and the other for the families. Some items on the interview guide for the attempters included “Can you say something about why you tried to kill/harm yourself”, “At the time you harmed yourself/attempted suicide, did you consider any consequences this act might have”. An item on the interview guide for the families is “How does it feel to hear a close relation has attempted suicide”.

Procedure

Approval was obtained from University of Ghana Ethics Committee for the Humanities (ECH) for study to be conducted. Subsequently, an introduction letter was sent to the unit head at the Psychiatry Department of Korle-Bu Teaching Hospital. The records of suicide attempts were taken and contacted, those who expressed interest were recruited for the research and booked for appointment. The participants were contacted a day before the appointment and asked if they had any further questions and if they would still like to participate. Afterwards a family member of the suicide attempter was contacted after approval given by the **latter**. The study's aim was explained to the family member. Family members who expressed interest were later recruited for the study.

Interviews were conducted anytime from two weeks after the suicidal behavior occurred. In event where any participant felt distressed, the interview was halted and continued later. Participation was voluntary and freedom to withdraw was emphasized at the beginning and during the interview. Participants were assured of confidentiality of the information they would provide and prior to being interviewed participants were asked to sign a consent form. The data collection were interviews and questionnaires administration. A semi-structured interview guide was used. The interview took place at the residence of participants and the premises of the Psychiatry Department. The interview sessions lasted between 40 min to an hour with the exception of one which lasted for 17 min for lack of time on the part of the informant (family member). Each person was interviewed separately although one interview was conducted in the presence of the relative who had attempted suicide. The researcher attempted to establish rapport with all the participants to gain their trust and to ensure truthful and open responses. Despite attempts to recruit more participants, difficulties were encountered. Reasons for this might reflect the topic being researched, in that it is a sensitive topic and is heavily stigmatized. Six suicide attempters and four

family members declined and refused to participate in the research, they were therefore not followed up. Of those who agreed, there were six females and four males for suicide attempters and six males and four females for families. After data collection, interviews were transcribed verbatim and analyzed.

CHAPTER FOUR

RESULTS

The purpose of this study was to examine the experiences and coping resources of suicide attempters and their families in Ghana. Specific objectives of the study were to examine; the depression and anxiety levels of suicide attempters and their families and to determine the coping resources of families and suicide attempters. Based on these objectives, four hypotheses were generated and tested. To further explore the experiences of suicide attempters and their families, qualitative interviews were conducted and analyzed using Interpretative Phenomenological Analysis (IPA) approach. Hypotheses were analyzed using Independent t test. This section presents the analysis and the results of the study.

Interpretative Phenomenological Analysis

Participants were asked to talk as widely as possible about their experiences of the suicide attempt and their coping mechanisms. Three major themes emerged with sub-themes under each. The first theme is Precipitants for Attempt (with sub themes: *Dyadic Contexts; Mental Health dimensions, and Diabolical Interference*). The second theme is Social Reactions to the Attempt (with sub-themes: *Supportive Network; Stigmatization*). The third theme is Surviving the Stress of Suicide (with sub-themes: *Engaging in religious activities, Social support, Avoidance; Distractive activity, Personal survival efforts*). For the purpose of anonymity, only participant's gender, age and whether participant is a suicide attempter (SA) or family (F) will be stated for direct quotes.

Precipitants for Attempt

This theme examines explanations participants gave as being responsible for driving them to attempt the act. Five main reasons emerged from the analysis which are discussed as sub-themes

Dyadic Contexts

This sub-theme deals with the interpersonal difficulties which were cited as motivations for attempting suicide. It was the major reason that was generated during analysis. The relationship problems transcend particularly to familial and intimate relationships. Participants had problems with their family and this according to them, led to the attempt. In examining suicidal attempts cases that have been prosecuted, Adinkrah (2012a) realized some motivations for suicide included interfamilial discord. Family conflicts were mostly misunderstanding between family members. For instance, an informant reasoned that:

“My husband and I were not on good terms then. My cousin was asked to come stay with us to school...she was very disobedient. No one could control her...she started misbehaving. I was against some of the things she did but my husband supported her so she took me for granted. One morning she misbehaved and I called my brother to inform him that I want the girl to leave our house...when I look at the behavior of the girl who is going to live with us for three years before she completes school, I can't stand it. And since my brother said if I do not allow her to stay, he ceases to be my brother, I had to make a decision. ... My brother told me that if I don't keep quiet and let the girl stay with us and finish her school, then he ceases to be my brother and I should not call him again. So I hanged myself on a rope in our bedroom” (SA, woman, 34).

This quote shows that the woman may have interpersonal and adjustment problems or perceives aspects of the relatives behavior distressing to her. People who do not have good coping

mechanisms are more likely to adapt to other unhealthy methods of solving problems they face (Furnham & Traynar, 1999). *“I don’t also want to divorce because I hate divorce so if am not around my husband should take care of the children and if he will replace me with the girl, that’s his problem”* (SA, woman, 34). In seeking after peace in the household and with the brother, the participant took the decision to end her life as she could not continue living with the cousin based on the condition and threat by the relative.

Among predictors of suicide attempts, interpersonal conflicts with spouse/partner has been found to be one of such predictors (Marangell et al., 2006). Participant was having conflicts with husband and cousin as she could not adjust to the new living conditions at home. Divorce was not an option, as no relative understood her situation, therefore her plan was to end her life *“Me I wanted to die so when I woke up at the hospital, I asked my husband why he brought me to the hospital and didn’t allow me to die. I was angry that he didn’t allow me to die. It was not a small thing I was going through that time”* (SA, woman, 34).

For some informants they expressed self-blame due to their relationship with their family as they felt they were the cause of everything that happened at home. Participant had an agreement with relative that she will give him GHC ₵ 50 (\$ 15), and when he could not get the money:

“I told her that if she doesn’t have the money for me am going to burn the clothes as repayment ... So that was when my uncle, the one I’m not close to came around... my uncle asked me whether I was the one burning my mum’s cloth and I said yeah and he slapped me and pushed me...So I went to my mum’s room and started thinking about stuffs, like all the things that I have done and every time are people talking about me ...so I was like okay, if I end my life I won’t be blamed for everything and no one can complain... Everyone will have their peace of mind. It’s like every time something comes up, am the reason and

everyone keeps talking about it. I went to the kitchen, took a knife and started slitting my wrist. During my sister's wedding there was misunderstanding between my father and my uncles and even though I was not there at that time, I was told I was also part of the reason for the misunderstanding. All these were part of the reasons why I wanted to kill myself" (SA, Man, 20).

Participant considers that he was the reason for almost anything that happened at home either he was present or absent at home. All these emotions could have led to the participant deciding to end it all as everything was pointed at him in the end. This informant had a misunderstanding with uncles at home. He confirms that he has not been talking to one of the uncles for some years now. He employs a metaphorical description of not seeing "eye to eye" with the uncle to express the difficult and unhealthy relationship that exists between them.

Individuals who attempt suicide are more likely to have experienced a higher number of stressors which may include interpersonal conflicts and these conflicts may lead to suicide attempts (McFeeters, Boyda, & Siobhan, 2015).

Another participant also had conflict with the step mum and was always beaten and insulted by the step mum. This created tumultuous relationship between them:

"My step mum used to beat me and insult me. When it happened, I run away to my grandparents place in the Volta Region, so that my parents can have peace at home" (SA, woman, 18).

According to her report, she left home when the parents were not around and was brought back by the grandfather to the house. Problems that existed was sorted out between them, however according to participant, the situation still did not change at home as she continued the narration:

"But I told my grandparents that am not going back to my dad because of the way the woman was treating me in the house. So my granddad accompanied me to Accra and they

talked about everything but still she didn't change. The woman was always saying that the man am living with is not my dad so I shouldn't say he is my dad... So one day I went to a certain woman's kitchen and picked the parazone (detergent) and drank it". (SA, woman, 18).

Participant begins using a personal reference of “my step mum” but this later change in the narrative to “the woman”. This change in voice and reference might be pointing towards a strained relationship and distancing from the step mum which is very evident in many people with step mothers as they find it difficult adjusting (Fine, 1986). This act of insult became unbearable for the participant that led her to run away to the grandparent's house in another region to seek shelter and escape from such daily predicaments.

For another participant, it was pressure from family members that made him attempt suicide. His cousins and aunties were always giving him pressure at home. However he mentioned he used to be close to his relatives and shared secrets together, *“I used to share all my secrets with her and I don't know how things changed”*. Participant described himself as someone who cannot take pressure so when this pressure was mounting, he couldn't take it anymore and wanted to end it all as illustrated in this voice:

“Pressure...In the house they trouble you and in the house they treat you as if you are nothing .to them... They don't respect you and anyone at all speaks anyhow to you. They took me for granted because they feed me so they speak anyhow to me and want to tell you what to do. Because I don't contribute anything at home, my friends can't even visit me unless I visit them. And my sister was also worrying me, casting insinuations and insulting me all the time and spoke anyhow to me, always complaining...Meanwhile at home I don't worry

anyone and have no problem with anyone. I'm always in the room watching TV. The moment you go out of the room then she will be casting insinuations at you. So to cut all these short and everybody will know that you are not needed and not important, I drank parazone. The first thing that came to mind before I drank it was that, I mean nothing to these people and they don't appreciate anything I do for them, my plan was to leave and join my dad". (SA, man, 21).

What the participant describes as pressure can be viewed as a harassment involving insults, incessant complaints, excessive control, insinuations and perceived disrespect from home. He perceives the home as turbulent and discouraging. One potential reason he perceives as contributing to this harassment (what he refers to as pressure) is his unemployed status. Adomako Ampofo and Boateng argued that men generally lose face and become socially stigmatized within the family and community whenever there is a significant role reversal, with the woman as the economic provider (as cited in Adinkrah. 2012b, p.6). In this instance, his relative feeds him so that is a role reversal. He does expect to be respected despite his present predicament. His suicide attempt seemed to have stemmed up from the incessant harassment from the people he was living with at home.

Intimate relationships issues were cited by two participants as a reason for their suicide attempt.

One participant said:

"I was having a disagreement with my girlfriend ... She felt I had embarrassed her in front of our colleagues, so that's what happened. I didn't think that what I said was any big deal. I didn't expect her to get hurt about it. It's like every time something happens to me, the very next thing I do is to think about all the different things that has happened before and is like...I think I overreact...It's like one small problem and next thing I know is I will make it

really huge...so that was the trigger. Already I have a whole lot of back load things already. I just don't like to have problems and is like if it comes I get all agitated, why is this happening, that kind of thing... for a moment I didn't know what I was doing. Next thing I was doing...I drank savlon.”(SA, Man, 24).

For this participant disagreements between him and his girlfriend were the trigger to the suicide attempt. However from the participant's point of view, the disagreement of which he did not disclose what it was, should not have caused any problems in the relationships. Previous happenings also compounded the decision to attempt suicide.

This other participant ignored attempts by the relative to connect her to someone to marry and decided to stay with the man who helped her in diverse ways especially in areas of finance “...because when I started learning how to learn how to sew no family member helped me and he was the one helping me through out. In this life, he is the only one who has been helping me”. Threats were also issued and this reinforced the decision to stay with him. As time progressed that man changed and she became disappointed because she perhaps reasoned that she had ignored other choices of marital partner and this caused her emotional pains.

“My uncle was trying to link me up with a white man so I marry him and leave Ghana with him. However because my husband had helped me a lot and gives me money and feeds me, I didn't want to disappoint him by going to take another man. He also threatened me that I shouldn't leave him because of all that he had done for me. So my uncle said that if that's what he want, I should stay with him like that. Then all of a sudden he packs his things and goes to stay with another woman whiles we are living together. So it was like he didn't allow me to go with my uncle and his side too, he is chasing another woman so it was like I had lost both. So it was during that time that I felt the pain and anguish and we had

disagreements most times. So as someone will say I didn't think twice and took the parazone (detergent) and drank. ” (SA, Woman, 28).

The expression of a loss appears to be exhaustive- loss of better option of a partner and a husband she loved. This loss was a basis for her pains as she was left with nothing in the end to hold on to. This indicates a form of cheating whereby the man denied her the opportunity to be with who the relative arranged for her. Participant also felt cheated by the man she was living with as he was seeing another woman.

Mental Health Dimensions

In this sub-theme, participants cited various psychiatric and psychological problems accounting for the suicidal attempt. These included mental illness, hopelessness and loneliness. For instance a participant found mental illness as a reason for a wife's suicide attempt as illustrated below:

“I was really confused and suspected it was a mental problem when it happened. I didn't think she could go to that extreme to kill herself. I spoke to some people a long time ago about it and told them I suspected my wife had a mental problem. They didn't believe me. People thought I was only trying to demonize or make my wife appear bad. I once suggested we go to see a psychiatrist and she got angry with me. She said am thinking she is mad. So when she attempted to kill herself, I told the people that my suspicions were right” (F, Man, 44).

As indicated in the narrative, social stigma attached to mental illness seemed to have delayed the early help seeking. Although the partner observed signs of potential illness, the social environment hampered early intervention. Further, the patient also equated seeking help from a psychiatrist to being mad. After the attempt by the relative, it was confirmed by a Psychiatrist the relative was suffering from borderline personality disorder comorbid with depression. Mental illness is known

to be a precursor to suicide (Hiroeh, Appleby, Mortensen, & Dunn, 2001). Borderline personality disorder is characterized by intense fluctuations in mood, self-image, and interpersonal relationships and poor coping skills (Sue, Sue, Sue & Sue, 2015). They are more likely to exhibit recurrent suicidal behaviors, have a higher probability of suicide than average and suicide attempts are mostly triggered by interpersonal conflicts in people with borderline personality disorder (Duberstein & Conwell, 1997; Welch, Shaw, & Linehan, 2002; Yen et al., 2003, cited in Sue, Sue, Sue & Sue, 2015). Feelings of loneliness were the most commonly reported factor in a research conducted by Söderberg, Kullgren, and Renberg (2004) on precipitating factors of suicide attempt by patients with borderline personality disorder.

Some participants further indicated that hopelessness was a precipitating factor for their suicidal attempt. In one case a lady who needed help moved in to stay with someone she was hopeful could provide help but did not happen as expected. She felt abandoned and hopeless as illustrative in the narrative below:

“Since then no one spoke to me again in the house. The guy later began to change. Sometimes he will frown at me and not talk to me for no reason... I was having arguments with him and that day my daughter went to do something she shouldn't have done so I was really angry and the insults was too much. I said to myself that the guy who brought me here is giving me problems and my own daughter too is giving me problems. As for the guy I knew he was dating that's why he was treating me like that...Because of that I went to drink acid ” (SA, woman, 34).

This narrative shows that the participant put her hopes in the man she went to stay with because they were in a relationship. However, his behavior changed towards her after she moved in to the house.

In another case, feeling of dejection and hopelessness was imminent as participant's husband moved out of the house to stay with another person. There was nothing to look forward to in the future as all her aspirations were dashed:

“When I became pregnant it became worse but when I was not pregnant he was not worse like this. He doesn't sleep at home and doesn't mind me. I don't know where he is even now, he hasn't been home in 3 days. He doesn't pick calls and he will rather call. So when he calls I pick and he will tell me whatever he wants me to know” (SA, Woman 28).

This participant was due to give birth the following week at the time of the interview and had not heard from the husband or seen him.

In another case of hopelessness, a participant lost money that was to be used to start a business with his partner, he was robbed at home. He could not come to terms to explain to the friend, otherwise he would be said to have cheated the partner. He realized there was no hope anywhere as he searched for the money for three days but could not find it.

“Money got missing at home. Thieves came to steal the money at home. It was money for me and someone else. I searched and searched for the money but couldn't find it. The money was 5,000 cedis. When I couldn't find the money after three days, I went to buy poison and drank it. I knew that so long as the money was missing, my life had ended. I didn't tell the person that this was what had happened. When I couldn't find the money after three days, I went to buy poison and drank it” (SA, Man, 27).

Fear of being accused that he had taken the money suggests why he attempted suicide. The statement “my life has ended” implies that the participant had no reason to live if he could not find the money as that was for him and his friend. It also reflected a feeling of hopelessness as there was no means of coming out of the situation.

Two participants expressed that emotional loneliness was the reason why they attempted suicide. They had no one to talk to and they felt alone. One participant reported that

“I will call it depression and isolation. That’s the most general term I can give you. I had a series of things bothering me. I’m all alone taking care of me and fending for myself. Nobody supports me, no friend. The love from outsiders just went off automatically. I didn’t have the zeal to move on again. I will scroll through my phone over and over again and there was no one to talk to. Before it happened I was complaining of insomnia. I was not sleeping and I come to school with heavy eye buds.” (SA, woman, 24).

Participant mentioned that she was living alone and although there were other house mates she does not see them as they are equally busy with school work too. This sense of isolation and loneliness according to participant made her depressed. Finding no one to talk to on the phone suggest that participant felt no one could make her happy. She describes her experience further, saying:

“A night before I went to this particular guy’s house, people were saying it is because of him but it’s not. But he also added to it. The whole talk of us had just opened up and that day he had already made me angry in the morning... When I got to the house my room was looking so strange. Everything was just different. It’s not sadness, I think its bitterness. I was extremely bitter. I have never cried that much before. I cried for like three hours non-stop. I was having severe headache... I was not sleeping for a very long time too. It just

happened and I drank Dettol. Before that I was crying and scrolling through my phone. Like who am I supposed to call and who is supposed to care? Even if I tell you will you care or make me feel better?" (SA, woman, 24).

This narrative depicts a person in severe emotional pain who was experiencing loneliness and is bitter towards a guy. All these emotions combined made her depressed and when asked whether she felt any pains before the attempt reported “*yes emotionally I was drained badly*”. All these emotions show that it was a gradual process and had accumulated overtime.

Another participant also experienced loneliness as the person he was close to got married and left the house.

“I also felt in a way that my sister had neglected me because we were not taking as much as we used to talk. She is married now and with her husband so right now her main focus will be her husband...So I just went to the kitchen and I saw a knife and took it and was slitting my wrist” (SA, man, 20).

This participant was close to the relative and when she got married, their interaction reduced; something which the participant was not expecting. His hope was that there would still be frequent interaction after she had left the house. There is a need for a one-to one relationship between people as reported by Shneidman (2004). He confessed that he sent an anonymous text to her the night he attempted suicide which said, “*She should never ever call me again and that she is dead to me*”. The text message sent depicts how close they were and how her absence at home affected him. Attention seeking can also be demonstrated as a need for these participants. They wanted attention but could not get it from anyone therefore it could be that the act was to seek attention from their family.

Interaction is fundamental for most people and when there is deprivation of access to people, some individuals may experience loneliness. Isolation, little hope for future and loneliness have been found to be risk factors for suicide (Muehlenkamp, & Gutierrez, 2007; Spirito & Overholser, 2003).

Diabolical Interference

This sub-theme examines the perception of the spiritual dimensions of the motivation to attempt suicide. One participant attributed the suicide attempt to spiritual cause. According to this participant a dream she had the night before in which she saw dead mother beckoning her to come towards her influenced the suicide attempt:

“I think it was spiritual or something because I wasn’t having any problem with anyone. Like my dad didn’t do anything to me and it was not like I was pregnant or what people normally do or broken heart or something...Before that day I was having series of nightmares and I saw my mother calling me to come to her although she was dead. But what really happened that day before I went to take in the turpentine, I can’t tell”. (SA, woman, 21)

The reason given by the participant reflects that in her opinion, what could make someone kill him/herself is probably likely to be diabolical intervention.

Social Reactions to the Attempt

This major theme addresses both the feelings and behavior of the immediate family towards the attempt, as well as the report from the suicidal person on how families, friends and neighbors in the community reacted towards the suicide attempt. Generally, families expressed painful negative emotions such as sadness, shock, surprise following the attempt. Some were ignorant about the

reasons for the act and thus became sad: Some responses of families included: *“I felt very pathetic, very pathetic. It’s very sad...very very”* (F, woman, 56). Another reported *“At that time I was very very sad. I was even crying. I came to Korle Bu (hospital) and was crying. I was sad and surprised how it happened”* (F, man 25). Shocks and surprises also came up: *“My mum was shocked and was hurt in a way and was asking why I had done that”* (SA, man, 20). *“Actually I was shocked when it happened... I was shocked and till date I haven’t fully recovered from the shock”* (F, man 44).

Some described the physiological stress reactions they experienced when they saw the act occurring. They even sense a rush of emotions of wanting to also die with the attempter: *“I became scared and my heart skipped a beat. I was shouting and wanted to kill myself too when I went to meet him at the kitchen cutting his wrist”* (F, woman 56).

Shameful emotions also made it difficult for others to share the news of the attempt with other relatives for support: *“Actually I was ashamed, that if this thing would have happened. That’s why I find it very difficult ... to tell you, I have never ever told any of my family people, I have never”* (F, man 59).

Some other family members alienated themselves from the suicide attempter. They dissociated themselves from them and some also experienced accusations. Alienation was a common perception after suicide attempt from both family and peers of suicidal individuals in a research by Everall et al. (2006) as illustrated by this participant:

“Some of my family members said if I can poison myself in terms of me committing suicide, then it means I can kill them. So from the hospital, I didn’t get close to them anymore. My auntie’s children say behind my back that I can even kill them because I tried to kill myself” (SA, man, 21).

Health professionals who are expected to be supportive of the act were also negative towards the suicidal act. According to one,

“I saw some doctor passing and I was passing too. And a group of doctors about 4-5 of them and one was telling them, he said that he wanted to commit suicide because of a girlfriend. They were gossiping. They were insulting him. You see. Why should you do that? I don't know whether she saw me but she has already said it. She is a doctor. She is a female doctor but a male doctor attended to my son. Some of them were gossiping about him and pointing fingers at him and saying he is a bad boy” (F, woman 56).

Further negative reactions including insults from neighbors were reported by: *“My son's friend came and said that we should leave him and if he dies we will bury him. I know people will say he is a bad boy and they will insult him and all that”* (F, woman 56). *“My friends were all insulting me, they were asking whether am a fool”* (SA, woman 18).

Suicide is stigmatized in Ghana and from past to present, social stigma surrounds suicidal behavior in Ghana. (Adinkrah, 2012a). It is considered a bad death in all ethnic groups in Ghana and people mostly avoid marrying from such families (Osafo, et al 2011b).

“People were not happy at all and some withdrew from us and the stigma associated is not easy (sighs heavily). We are still in a small community and such rural communities the stigma is great unlike urban areas. The signs of the attempt are still there so we are still living with the stigma. The sign I mean refers to the scar on the neck. It is prominent and everywhere she goes people see the scar and it reminds them even when they have forgotten. Some people in the community even try to provoke her and ask her about it. The act is an abomination in our community...I sometimes feel rejected by people because they didn't understand why such a thing should happen in our family” (F, man, 44).

The physical injury from the attempt appears to have been indelibly marked on the attempter's body, providing constant reminder or validation for neighbors to perpetuate stigma reactions towards the victim. Some community members retreated from them and rejected them.

Families, friends and neighbors constituted the community of people around the suicide attempter. In the event of the attempt, suicidal persons also shared their experiences on how they perceived the reactions of family, friends and neighbors as expressed towards them. Some of these reactions included alienation, insults, anger, and some also were apprehensive:

“My friends talked down on me. Some said they were going to cut off from me and they actually did. That's why am saying that it made me stronger. Even my closest friend in school, I was expecting her to be supportive but she wasn't. She is the only person. Those ones that cut me off, I never expected them to do that. I was really surprised” (SA, woman, 24).

This participant's friends broke away from her. They refused to get closer to her because of what she did. Perhaps when she saw her social support system were all failing she had to fall on her internal support system to move on. Her psychological resolve to survive was further provoked and strengthened.

For one participant who was living in the guy's family house, she experienced insults even after she was discharged although she was expecting to be sympathized with. The experience could be said to have escalated when the guy's mother returned the cloth she had bought for her. This suggests the extent to which the mother did not want to have anything to do with her:

“The guy's family insulted me all the more after I came home when I was discharged. The guy's mother had travelled and when she came back, she came to insult me and called me a

murderer. I bought her a cloth, she gave it back to me. She said I can kill a human being”

(SA, woman, 34).

Some family members were angry to the extent that they wanted their relative to move out from the house just in case he tried to attempt again as illustrated by this participant: “*Even some were saying that I should be sacked and go to my mother’s house because I can do that again*” (SA, man, 21). Some family members were angry and spoke harshly with insults as reported by this participant: “*My cousin called me once and also said it was a foolish thing I did and if I had died, he won’t have come to my funeral*” (SA, woman 34).

Community reactions and perceptions of the attempter as a murderer is rife in Ghana (Osafo et al, 2011b). The idea behind such views is that the courage to ignore natural inclination for self-preservation is a dangerous act and could break boundaries and be extended towards others. Such thinking is further given validation by the presence of murder-suicides phenomenon which is almost a public health problem in Ghana (Adinkrah, 2008; Adinkrah, 2010). Strong condemning reactions from community folks often ensue after the act and some communities in Ghana could provide further provocations for suicide (Osafo, Akotia, Andoh-Aurther, & Quarshie, 2015).

Surviving the Stress of Suicide

This last major theme examines how participants managed the various reactions from both the family, community and their own emotions after the attempt. It included the attempters and their families and how each managed the aftermath of the suicide attempt. Analysis showed that coping mechanisms included: *engaging in religious activities, social support, avoidance; distractive activity, personal survival efforts.*

Engaging in religious activities

This was the common activity both families and attempters used in coping with the occurrence of suicide. Most resorted to going to church, praying and reading the Bible. Ghanaians are known to be religious and to engage in various religious activities. When participants were asked in a study on how they cope with crisis, prayer was the common theme as well as engaging in religious activities (Osafo, Knizek, Akotia, & Hjelmeland, 2013). The major elements in the religious coping are the use of prayer and participating in church services as means of distracting their distressing thoughts:

Some participants reported: *“I go to church and pray too. I am more focused on my work now”*- (SA, Man 27). *“Like I said I pray a lot and I just try to forget about it”*- (F, Man 59). For some, the prayer is a sign to convince them that they are obeying a religious norm to seek spiritual solutions and not human focused ones, when they are stressed as expressed in this case:

“I pray too, as for prayer, prayer is the key. I tell my God, I don’t tell human being. That is what we have been taught to do. They said we should talk to our God” (F, woman 56). Some also expressed that anticipating a brighter future by God’s help: *“I have the faith that in the near future God will do something for me”* (SA, woman, 43), increased church attendance and commitment: *“I went to church more regularly”* (SA, woman, 21), *“...I became very serious with church afterwards”* (SA, woman, 18years), *seeking inspirations using spiritual songs: “I also prayed and sang songs to encourage myself”* (SA, woman, 28). Church attendance and participating in religious activities are perceived as protective during life crises (Akotia, Knizek, Kinyanda, & Hjelmeland, 2013,) as well as various negative emotional experiences (Dervic, Oquendo, Grunebaum, Ellis, Burke, & Mann, 2014; Vandecreek, & Mottram, 2011). Almost all participants

did not inform their religious leaders about the act, they engaged in religious activities for their own personal spiritual coping.

Social support

Other participants relied on assistance given by families and friends after the attempt. They surrounded themselves with such supportive network to help them manage the situation. This is typified in some of their quotes:

“I’m having a best friend, his name is Ebenezer, he was coming to visit me and making funny comments so I laugh and forget about the situation. He comes to me always” (F, man, 25).

“I sought support from my family and friend and this helped me during that period and took my mind off what had happened” (SA, man 24)

“The only friends I have are just casual friends, “boys boys”. But don’t really have a tight friend. I told them about it and they encouraged me that it will be well” (F, man 46)

“Anytime am surprised or sad over something, I discuss it with somebody close to me. So the day I heard it, I discussed it with my mum when I went home because she is the closest to me” (F, woman 31). *‘Only my two daughters and mum were helping me to cope, they call every day and assist me in many ways’* (F, woman 56).

For this informant who was living with the suicide attempter, the mother and children were the close confidantes so shared what they were feeling with them. This helped them cope with the situation.

This informant was not used to sharing what she was feeling or experiencing; however, after the attempt she resorted to talking to people who will help her with the situation. *“I used not to share my problems with people but after the incident I talked to people and this was a way I used to*

cope. This helped me share my problems with people I thought could help me. So they gave me advice and helped me to cope” (SA, woman, 28)

Some participants were not fortunate to have experienced such support from their social network.

“Life was not going all that well but as time went on they realized because of what they were saying I wasn’t getting closer to them. I didn’t mingle with the people in the house and didn’t engage in any of their conversations. Even when it happened before Christmas, I used to go out and come in the evening when my brother closed from work” (SA, man, 21).

For some other participants, their situation was worsened when they tried to seek solace from friends:

“Although I went to a friend’s place. He even worsen my situation because this person was always talking down on me, like no wonder you tried to commit suicide, no wonder you tried to kill yourself. I was enduring, tolerating and managing it. At a point I just said to myself that what am I doing, just because I want to be around somebody I have to go through all these? I just left his house and that was all” (SA, woman, 24).

The distressing social relationships and stigma that may further provoke painful emotions for the attempter are attested in the narrative above. It is a harassment and condemnation instead of providing empathic support. The major decision for the participant at that point was to decide to move away to save herself. For this participant the family was not supportive *“My siblings don’t call me or check up on us after the incident” (F, woman 56).*

Avoidance

Avoidance was used by some families as means of coping where they avoided mentioning the suicide attempt so as not to cause further attempts by the victim. It was also a mechanism to avoid discussing the pain and shame the family has experienced due to the attempt, as this could lead to difficult relationships with the attempter. Further, their impression is that it may trigger the idea of attempting suicide again. Emotion focused coping is coping that is directed towards changing the individual's emotional response to the problem and this includes strategies such as wishful thinking, minimization, or avoidance of the problem (Folkman, & Lazarus, 1988).

One participant reported *"I called her and asked her what is wrong with her and if she was having any problems at home. She said nothing is bothering her. So I decided not to probe further to cause any other problems since she said she was okay"* (F, Man, 62). This participant was the father of one of the attempters. To avoid further problems, it was better not to keep on asking again whether she was okay. This other participant coped by avoiding talking about it to people. According to the participant *"Me naturally that's how I train myself. When I have a problem, I don't tell anybody. I cope by not telling people. When people hear of it eh, they will be gossiping and in future they will be insulting you"* (F, woman 56). Society's reaction to the attempt alone which is mostly negative affects her, therefore this participant will avoid talking about it to anyone. Other participants resorted to withdrawal from their family as a form of avoidance coping after the attempt. He voiced that:

"I didn't mingle with the people in the house and didn't engage in any of their conversations. Even when it happened before Christmas, I used to go out and come in the evening when my brother closed from work. Even still I'm not able to chat with them freely unless my brother is around before I engage in conversation with them" (SA, man, 21).

This participant adopted avoiding the members of the family at home except his brother who he felt comfortable with and this is evidenced in the narrative. In his perspective, avoidance helped and protected him from further verbal abuse from others and he chooses rather to while away time away from home waiting for his confidante.

Distractive activity

Pearlin (1959) argues that people tend to watch television to escape from stressful situations. In a research by Tway, Connolly, and Novak (2007), 69% of the parents with autistic children watched television as a coping response. Some participants did not engage in religious activities or get support from their social network, but engaged in distractive activity such as watching television to take their minds off the situation. It is “more likely they use it simply to forget intermittent and brief times of their troubles and worries. Thus it appears that one of the functions of television is to offer to its audience an opportunity to withdraw periodically from whatever strains and unpleasant experiences they might have” (Pearlin, 1959, p. 259). “*I used to watch Agya Koo and the others films to make me forget about it*” (SA, woman, 18). In Ghana Agya Koo is a celebrated comedian and his movies are full of comedy for which reason most people patronize them. The hope of this participant is that as she watches it, her mind will be taken off what happened. Another participant informed that “*I like playing games and watching movie. So that helped me so that I don’t become lonely. I have decided to also do something to take the idleness away*” (SA, man 20). To displace the idleness, the participant resorted to watching television and playing games as that made him busy.

Personal survival efforts

Some participants resolved to take personal responsibility in their recovery and coping process. Intrinsic motivation was key for a participant as she was determined to continue living her life: “*I*

was just moving on because I have to” (SA, woman, 24). One other participant researched and sought for information to help him understand the relative’s condition: “I made a detailed research and downloaded materials and what I saw there helped me to understand and positively manage the situation. So am living a positive life. The research helped...” (F, man, 44).

Quantitative results

Table 1: Descriptive of Suicide Attempters

Suicide attempters	Frequency	Percentage %
Gender		
<i>Males</i>	4	40
<i>Females</i>	6	60
Age range		
18-25	6	60
26-34	4	40
Occupation		
<i>Student</i>	5	50
<i>Dispatch rider</i>	1	10
<i>Businessman/trader</i>	2	20
<i>Seamstress</i>	2	20
Method used		
<i>Antiseptic</i>	2	20
<i>Rope</i>	1	10
<i>Detergent</i>	3	30
<i>Turpentine</i>	1	10
<i>Slit wrist</i>	1	10
<i>Poison</i>	1	10
<i>Acid</i>	1	10

Table 2: Descriptive of Families

Families	Frequency	Percentage %
Gender		
<i>Males</i>	6	60
<i>Females</i>	4	40
Age range		
25-45	5	50
46-62	5	50
Occupation		
<i>Technical officer</i>	1	10
<i>Civil servant</i>	1	10
<i>Accountant</i>	1	10
<i>Teacher</i>	2	20
<i>Carpenter</i>	1	10
<i>Security officer</i>	2	20
<i>Dispatch rider</i>	1	10
<i>Trader</i>	1	10

Hypothesis testing

The objectives of the study were to examine differences in the depression and anxiety levels of suicide attempters and their families and also to determine the coping mechanisms of families and suicide attempters. Based on these objectives, four hypotheses were generated.

H1: Suicide attempters will be more depressed than families. The independent t test was used in analyzing the mean scores of families and suicide attempters.

Table 3: A summary of the means, SD, and t test of the scores of the families and attempters on depression.

	Variable	N	Mean	SD	df	t	p
Depression	Suicide	10	10.30	4.74	18	2.62	0.00
	Attempters						
	Families	10	5.20	3.91			

The results show that the mean difference between suicide attempters (M=10.30, SD=4.74) and families (M=5.20, SD=3.91) was found to be statistically significant. Thus $t(18) = 2.62$, $p < 0.00$. The hypothesis stating that suicide attempters will be more depressed than families was retained.

H2: Families will experience higher levels of anxiety compared to attempters. The independent t test was used in analyzing the mean scores of families and suicide attempters.

Table 4: A summary of the means, SD, and t test of the scores of the families and attempters on anxiety.

Anxiety	Variable	N	Mean	SD	df	t	p
	Suicide	10	8.20	4.18	18	1.85	0.04
	Attempters						
	Families	10	4.80	4.05			

The results show that the mean differences between suicide attempters (M=8.20, SD=4.18) and families (M=4.80, SD=4.05) was found to be statistically significant. Thus $t(18) = 1.85$, $p < 0.04$. The hypothesis stating that families will be more anxious than suicide attempters was rejected.

H3: Suicide attempters will use more spiritual coping compared to families. The independent t test was used in analyzing the mean scores of families and suicide attempters.

Table 5: A summary of the means, SD, and t test of the scores of the families and attempters on spiritual coping.

	Variable	N	Mean	SD	df	t	p
Spiritual coping	Suicide	10	12.80	4.80	18	0.44	0.33
	Attempters						
	Families	10	11.80	5.37			

The results show that the mean differences between suicide attempters ($M=12.80$, $SD=4.80$) and families ($M=11.80$, $SD=5.37$) was found to be statistically non-significant. Thus $t(18) = 0.44$, $p > 0.33$. The hypothesis stating that families will resort to spiritual coping compared to families was not supported.

H4: Suicide attempters will use cognitive coping more than families. The independent t test was used in analyzing the mean scores of families and suicide attempters.

Table 6: A summary of the means, SD, and t test of the scores of the families and attempters on cognitive coping.

	Variable	N	Mean	SD	df	t	p
Cognitive coping	Suicide Attempters	10	19.70	7.63	18	3.33	0.00
	Families	10	9.70	5.61			

The results show that the mean differences between suicide attempters ($M=19.70$, $SD=7.63$) and families ($M=9.70$, $SD=5.61$) was found to be statistically significant. Thus $t(18) = 3.33$, $p < 0.00$. The hypothesis stating that suicide attempters will use cognitive coping compared to families was supported.

Summary of Findings

Qualitative Analysis

1. The common method used in attempting suicide was self-poisoning followed by hanging and wrist cutting.
2. The recurring theme underlying precipitants of suicide attempt were dyadic context, mental illness and diabolical interference.
3. Social reactions to the attempt included stigmatization and supportive network.
4. Participants survived the stress of suicide by engaging in religious activities which was the common theme, followed by social support, avoidance; distractive activity, then personal survival efforts.

Quantitative Analysis

1. The first hypothesis stated that **suicide attempters will be more depressed than families. This hypothesis was retained.**
2. The second hypothesis which stated that **families will be more anxious than suicide attempters was rejected.**
3. **The hypothesis stating that families will resort to spiritual coping compared to families was not supported.**
4. **The hypothesis stating that families will use cognitive coping compared to families was supported.**

CHAPTER 5

DISCUSSION

The purpose of this study was to examine the experiences and coping resources of suicide attempters and their families using a mixed method approach. As part of this, their psychological distress was measured by the DASS to provide a common basis for comparison. Africultural coping scale was also used to examine coping mechanisms of both families and attempters.

Some Important Demographics on Suicide Methods

The suicide attempt for all the participants occurred between three months to one and half years as at the time of the interview. The methods by the participants in the study include ingestion of detergents, antiseptics, hanging (use of the rope), turpentine, wrist cutting and poison. According to the WHO (2014) report, ingestion of pesticides, hanging and firearms are among the most common methods of suicide globally. For this present research, detergent was the most common method used followed by antiseptics and this is probably due to easy availability of such in most homes. Self-poisoning (detergent and antiseptics) was the common method used by both males and females **which was also found to be one of the commonest methods in Lim, Lee and Park (2014) study**. Females attempted suicide more than males (F=6, M=4) and this is consistent with previous research on suicidal behavior (Beautrais, 2001; Beautrais, 2014; Canetto & Sakinofsky, 1998; Mościcki, 1994) where it is reported that females attempt suicide more than males.

Motivation for Suicide

Contextually, the motivations for attempting suicide revolved around mainly dyadic contexts and mental health dimensions. Interpersonal difficulties were cited as motivations for attempting suicide. These difficulties transcended particularly to familial and intimate relationships. According to Shneidman, (2004), suicide is commonly occurring in dyadic context and occurs in

relationship with significant others. In a study in rural China, Zhang, Conwell, Zhou, and Jiang (2004) reported that interpersonal difficulties in family (18.2%), marriage and dating accounted for over 30% of all the claimed causes of suicide and especially for the women. According to WHO (2014), families and friends can be an important source of social and emotional support which can buffer the impact of external stressors. For this study however, dyadic contexts provided the largest risks for suicide attempt as reported by the participants, as such familial and intimate difficulties was often reported by participants as reasons for their suicidal behavior.

There is burgeoning literature on protective role of the collectivist social arrangement of African and African-Americans families in dealing with life stressors (Compton, Thompson, & Kaslow, 2005; Constantine, Donnelly & Myers, 2002; Driscoll, Reynolds & Todman, 2014; Kuo, 2011). Ghana is a collectivistic society where a sense of mutual support and duties almost makes it obligatory for people to ask and receive help (Adjibolosoo, 1995). It is therefore paradoxical that this supportive network which is supposed to foster more healthy interactive relationships with the potential of improving mental health outcomes, also presents as a potential risk for suicidality.

The mental health dimensions of attempted suicide in this study included mental illness, hopelessness and loneliness. WHO (2014) has documented global risk factors of suicidal behavior to include hopelessness, isolation, relationship conflict and discord, lack of social support and mental disorders. Feelings of defeat and entrapment played a key role in the development of suicidality among people who reported some degree of suicidal ideation in a research by Taylor, Wood, Gooding, and TARRIER (2010). A sense of entrapment was observed in two of the narratives in the current study and the only route of escape was suicide according to participants. The suicidal person was seeking to escape pain which they considered unbearable and found suicide as the best solution in that intolerable situation (Shneidman, 2004). Entrapment has been described as a will

to escape with awareness that all escape routes are blocked; suicide may therefore be seen as the only viable escape route from aversive life circumstances (Taylor, Wood, Gooding & Tarrier, 2010). This sense of entrapment is consistent with Seligman's theory (1967) where people who have need for control feel they lack this control and this makes them helpless. **The implication is that** participants' feeling of being trapped and inability to escape led to helplessness, which further led to the suicide attempt.

There were reports on criticisms and insinuations as the trigger that propelled some people to attempt suicide. This finding is in accordance with a study conducted by Purushothaman, Premarajan, Sahu, and Kattimani (2015) where the commonest risk factor among young people who attempted suicide was verbal abuse and easily getting offended by criticism even from their own parents and family. Young people are sensitive to verbal abuse and they may lack some intrapersonal protective factors that would have prevented suicide attempt.

Adinkrah (2013) documents that suicidal behavior is mainly an impulsive act, cry for help, or mental illness in Ghana. Generally in the suicidological literature, mental illness is a risk factor for suicidal behavior (Van Niekerk, Scribante, & Raubenheimer, 2012) and in this study mental illness is the cause of suicide attempt for one participant with borderline personality disorder. Söderberg, Kullgren, and Renberg, (2004) have observed that the burden of mental illness and psychiatric symptoms is a risk factor for suicidal behavior in borderline personality disorder. They also document in their study that to escape a perceived unbearableness of the present situation or pressure, both borderline patients and the control group resorted to suicide as way of escape. Thus, individuals with no history of mental illness or psychiatric problems also used suicide as way of escape.

Feelings of loneliness is also reported as a factor that precipitated suicide attempt and this is in line with other studies that establish a link between loneliness and suicidality (Levi-Belz, Gvion, Horesh, & Apter, 2013; Söderberg et al., 2004). Loneliness leads to suicidal behavior (Levi-Belz et al., 2013) especially when the person to whom the individual is attached is absent for long periods. Heinrich and Gullone (2006) noted that loneliness signals that an individual's personal relationships are in some way inadequate and "the drive to escape isolation accounts for all our passion, thought, and action" as indicated by Mijuskovic (1988, p. 508). Hopelessness increases suicide risk (Masango, Rataemane, & Motojesi, 2009): some participants in the current study implicated hopelessness as undergirding their suicidal behavior. They had feelings of having nothing to do about their difficult situation and this led them to an all-or-nothing distorted mindset due to the tunneling of their minds (Shneidman, 2004). What is interesting about the motivations for suicide in this study is that they were predominantly psychosocial more than psychiatric (and mental illness). **The psychosocial factors include family conflict, financial problems, and relationship problems among others.** There is presently a generalized view that psychiatric illness may not be the major reason for suicidality in most low and middle income countries as suicidality has been demonstrated to be more of an outcome of psychosocial strains more than psychiatric illnesses (Conwell et al., 2010; Fleischmann, Bertolote, & De Leo, 2005; Naidoo & Schlebusch, 2014; WHO, 2014; Zhang et al., 2010).

Stigma, Psychological Distress and Risks for Suicidality

All the reactions towards suicide and the suicide attempter which were either reported by families or suicidal persons as expressed by a family member, neighbors or friend all reflect negative attitudes towards suicide in Ghana. These attitudes toward suicide and suicidal person in Ghana are confirmed by earlier studies (Hjelemland, 2008; Osafo et al., 2011a, 2011b, 2011c). These

negative attitudes reflect cultural issues and how they affect people's perceptions of suicidal behavior in Ghana.

The act of suicide is considered a taboo and in Ghana as reported by Hjelmeland and colleagues (2008) and Osafo and others (2011a, b, c), the act leads to serious social consequences for the surviving family. Generally, families expressed painful negative emotions such as sadness, shock and surprises following the attempt and suicide attempters were mostly sad before and after the attempt. Osafo and colleagues (2011c) have also reported that suicide is a social injury and may leave families traumatized as they perceived their honor dented by the act. This view informed the need to assess family members' current psychological distress following a member's suicide using the measures.

Recent study on attempted suicides in a community in Ghana has reported that post-suicide attempt experiences could be traumatic for attempters. The report added that the harsh community reactions to suicide attempt including social stigma, alienation, social taunting and physical molestation may linger and even lead to completion (Osafo et al., 2015). **In the current study, it was found that attempters were more depressed than their families and this could be possible because the problems that led to the suicide attempt may still be present and they also have to deal with having been hospitalized for the attempt.** It is, however, also possible that the higher scores on depression by the suicide attempters in this study might reflect ongoing trauma arising from these negative social reactions towards suicidal persons in Ghana. In hindsight, other psychosocial and environmental factors could also account for the depression reported.

Community reactions following suicide attempts were mostly negative due to stigmatization of suicide. This stigmatization may impede seeking mental health by victims affected by suicide in the community. Suicide attempters' experienced alienation and lack of social support by the

community who knew what had occurred. **According to the sociocultural theory, a person's development is based on their interactions in the environment; as such, suicide attempters experienced harsh treatments from the society due to stigma.** The stigmatization can be painful for suicide survivors whose guilt, shame, and blame can be intensified and reinforced by the lack of discussion about suicide within a community (Fine & Myers, 2003 cited in Barnes, 2006).

Altogether, it is possible that these negative attitudes towards suicide attempters and the bereavement experienced by the surviving family may conspire to produce in both the attempter and the social relations a psychological distress. The anticipation was that the attempters may have common psychological distress such as depression, anxiety and stress. Although the results showed no significant difference in psychological distress between suicide attempters and families, an inspection of the mean scores indicates a difference in the depression with the attempters experiencing more than families. An explanation for such finding could be attributed to the persistence and potential escalation of negative attitudes toward suicide following the act.

Firstly, social relations in Ghana bereave and feel morally offended by the suicide act since it constitutes for them a social injury (Osafo et al., 2011c). Secondly, this posture might create intense hatred, breeding interpersonal difficulties between the attempter and their social relations with fatal outcomes for the attempter. For instance in a recent study, the continuous social taunting (negative attitude) of a suicide attempter from community members eventually led to a completion of the act (Osafo, Akotia, Andoh-Arthur, Quarshie, 2015).

Individuals who have previously attempted suicide are more vulnerable to risk factors. A history of a past suicide attempt is one of the strongest predictors of a future suicide attempt (Hirsch et al., 2014). Although not formally hypothesized, three participants are known to have attempted suicide in the past before the current suicide attempt and if the link between persistent negative attitudes

towards suicide and completion as explained earlier is anything to go by, then the high scores of depression among the suicidal person are important clinical outcomes that may follow the persistent negative reactions towards suicidality. Negative attitudes toward suicide and suicidal persons in Ghana may continue to present serious risk for suicide attempters. This is an important finding in this study with important implications for early intervention for suicide attempters and their families in Ghana. In this regard, stigma reduction is thus an important area to be considered in suicide prevention in Ghana. The sociocultural theory (Vygotsky, 1981) which postulates that cultural contexts and social experiences of people affect development could shed some light on the cultural dynamics on attitudes towards suicidality in Ghana. The study has demonstrated largely that the experiences of suicidal persons, reactions and attitudes towards them and the coping mechanisms they adopt in managing the crisis of suicide are all cultural artefact that will require cultural competence in rolling suicide prevention programs in Ghana.

Survival and Recovery

In Ghana religiosity and spiritual coping is utilized as relief from stressors, threats of death, suicide, chronic illness, unemployment among others (Aikins, 2003; Aikins, Boynton & Atanga, 2010; Akotia, et al., 2013; Osafo, et al., 2011b; Osafo, et al., 2015). An important finding in this study was that, cognitive coping was adopted more than spiritual coping and collective coping **based on the measures used**. Nevertheless, in the qualitative section, the participant indicated falling on spiritual coping more than any other methods. Second, the finding is consistent with the literature where spiritual coping and social cohesion was the primary coping resource in any distressing event in Ghanaians (Knipscheer & Kleber, 2007; Kretchy, Owusu-Daaku, & Danquah, 2013; Mukwato, Mweemba, Makukula, & Makoleka, 2010) and also for suicidal behavior both in

Ghana and elsewhere (Akotia, et al., 2013; Osafo et al 2015; Hirsch, Webb, & Kaslow, 2014; Vandecreek & Mottram, 2011).

The inconsistent finding between the reported more frequent use of spiritual coping in the qualitative than reported in the quantitative could be explained. An explanation is that the items on the spiritual coping dimension of the afri-cultural coping measure used are slanted more toward a generalized spiritual coping (e.g., I went to church or other religious meeting to get help or support from the group, I asked for blessings from a spiritual or religious person, I asked someone to pray for me etc) than individual spiritual coping (such as prayers and meditation). Suicide attempters and their families might feel judged and condemned by their religious community and thus might not relate much after the act for support. This is especially so when the person views the act as a religious infraction or is viewed by the religious community as a transgressor. Cognitive coping therefore might be reported more than spiritual coping on this dimension. This explanation fitted in well with their responses on the qualitative which reflected more on personal spiritual coping (as they had the opportunity to express themselves by this method) than depending on others for spiritual coping. Thus the qualitative brought to the fore the fine details of spiritual coping and has showed that persons in suicidal crisis might fall more on personal spiritual coping more than collective spiritual coping in Ghana. Such personalized spiritual coping might reflect psycho-cognitive resources for suicidal persons in a context where there may not be readily available support services for them. In Ghana, religion is a major explanatory model that performs a doubled edged role-both as manufacturing empathic responses towards suicidal persons and also condemning and shaming them (Osafo et al, 2011b, 2015).

Findings of this study also revealed that most families avoided talking about the act to prevent triggers and further complicate the situation. This is consistent with findings on suicide by Bartik,

Maple, Edwards, and Kiernan (2013) where people who lost friends to suicide were more likely to use avoidant strategies and attempt to distract themselves to avoid dealing with stressful situations. It is also consistent with Chun et al.'s (2006) theory on cultural transaction theory of stress and coping where collectivistic cultures used more cognitive avoidance coping, due to their emphasis of harmony in such cultures. Avoidance was the coping mechanism that helped some participants during such situation. According to Charlton and Thompson (1996, p. 526), "a possible explanation is that distancing is more easily attempted when an event is over and clearly situated in the past", therefore till date the act is not talked about at home according to some participants and this is consistent with previous report that a major attitude towards suicide in Ghana is silencing (Osafo et al., 2011a).

To better understand the situation some participants also took the initiative to get more information on the present problem and motivated them to move on. These coping strategies were employed in the aftermath of the attempt to help them cope.

The recovery process in the aftermath of suicide attempt as shown by this study appears to be more of the survivor's own personal efforts than from institutionalized support and services. Recovery might thus be slow and arduous with the potential for risks. This also presents serious implications for providing support services for both suicide attempters and their families.

Concluding Thoughts

In conclusion, this study was exploratory in nature and the interpretation of the findings cannot be more than suppositional, serving as clues for further research in the context of suicidal behavior in Ghana. However, it has contributed to important gaps in the literature on suicidology in the country. A major finding of this study is that suicidal attempters and their families do experience emotional distress which may degenerate and create further distress for the attempters with risks

for suicide completion. **This finding fills the gap on experiences of suicide attempters and families after a suicide attempt.** Another important finding of this study is that the coping behaviors of suicidal persons are largely influenced by cultural dynamics. The provision of support systems in suicide prevention to help attempters recover should be tailored to meet these cultural dynamics. **This is because participants relied on personalized spiritual coping and cognitive coping to manage the situation. The study draws attention to the need to explore further other coping mechanisms in the Ghanaian context which might be used.** Risk factors or reasons for suicidal behavior in Ghana appear to reflect the generally held notion that in low and middle income countries, motivations for suicide reflect psychosocial factors more than psychiatric illnesses. This is in line with WHO (2014) report where in high-income countries, mental disorders present up to 90% of people who die by suicide than psychosocial factors in low and middle income countries. Suicidal behavior continues to be a cultural artefact and any prevention attempts should seriously consider cultural issues which permeate attitudes, reactions, and coping in order to provide culturally sensitive programs on suicide prevention (Colucci & Lester, 2013).

Recommendations and Implications for Clinical Practice in Ghana

A few recommendations for suicide prevention can be drawn from this study. The first is that there is the need to develop a national policy on suicide prevention that examines the broader social dimensions of people's lives and how these may lead to distress and provide support in the form of suicide helplines. These policy prevention strategies should be dependent upon Ghanaian cultural meaning of suicide. Ministers of health therefore have a critical role to play in providing leadership and bringing together stakeholders in suicide prevention to coordinate sectors including education, media, social welfare, and religion to effectively engage them in suicide education prevention activities.

Another important recommendation for suicide prevention is for clinical practice. From the findings of this study, individualized psychotherapy for only suicide attempters leaving out their families might not be useful. The difficult social relations that develop between attempter and family are critical indicators of rolling our family therapy sessions for suicides and their families in Ghana.

Religious leaders and the clergy should be engaged in the prevention of suicide and religious resources such as hope should be included in suicide prevention strategies since it was a major coping mechanism for victims of suicide attempt. Religious leaders should help people find meaning in their lives and since they can play an active role in suicide prevention by fostering a sense of connectedness among individuals and the community as a whole.

Religious leaders can also provide education on suicide prevention for members of their faith community and to encourage them to seek help for themselves and other people they know with suicidal thoughts or have noticed any warning signs for suicide. They can also give sermons or a presentation on suicide prevention by inviting a mental health professional to speak to their congregation or sponsor suicide prevention training for communities. Clergy should also demonstrate empathy and compassion toward the survivors of suicide as this will improve their spiritual and emotional wellness.

Finally, future research on coping and experiences of suicide attempters and their families should increase the duration for data collection to get more participants as this research was time constrained.

Limitations

The study, nevertheless, has some limitations. The sample size was inadequate although the population was a clinical sample; therefore, results generalization to other suicide attempters and

families need to be considered with some caution. There was limited time available for data collection therefore few participants participated in the research. Finance was a huge constraint in the study as some of participants that were contacted were living in the Northern part of the Ghana, therefore could not participate in the study due to insufficient funds to travel. Finally, there were no non-attempter clinical control subjects to compare the results of the suicide attempters and their families to ascertain differences in psychological distress to determine whether other factors account for depression, anxiety and stress.

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Appendix 1



UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

17th March, 2015

Ms. Winifred Asare-Doku
Department of Psychology
University of Ghana
Legon

Dear Ms. Asare-Doku,

ECH 040/14-15: EXPERIENCES AND COPING RESOURCES OF SUICIDE ATTEMPTERS AND THEIR FAMILIES IN GHANA, A MIXED METHOD APPROACH

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

Expiry Date: 3/09/15
On Agenda for: Initial Submission
Date of Submission:: 16/02/15
ECH Action: Approved
Reporting: Quarterly



Please accept my congratulations.

Yours Sincerely,

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

CC: Prof. C. C Mate- Kole, Dept of Psychology

Tel: +233-303933866

Email: ech@isser.edu.gh

Appendix 2

UNIVERSITY OF GHANA



Official Use only Protocol number

OFFICE OF RESEARCH, INNOVATION AND DEVELOPMENT
Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND
INFORMATION

Title of Study:	Experiences and coping resources of suicide attempters and their families in Ghana: A mixed method approach
Principal Investigator:	Winifred Asare Doku
Certified Protocol Number	

Section B- CONSENT TO PARTICIPATE IN
RESEARCH

General Information about Research

People are known to attempt suicide when they are overburdened with issues of this life although they may know that it is not accepted in the community. They therefore go through some form of experiences after the attempt and this may be negative or positive. These experiences may influence how they deal with circumstances after the suicide attempt. We would like to know what causes one to attempt suicide and their experiences after they have attempted suicide. We would also like to explore ways in which people manage and cope with life after the attempt. This knowledge might help other people who are also going through such similar problems to help them manage the situation.

Benefits/Risk of the study

There will be no direct benefit to you, but your participation is likely to help us find out more about the experiences after suicide attempts and the ways people cope with the situation. We are asking you to

share with us some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. In any event of you experiencing emotional disturbances or stress during the interview, we would take a break or stop and continue after you are stable. Also if the presence of anyone you would choose will help you through the interview process in offering emotional support, it will be allowed after you have given consent to that. You do not have to answer any question or take part in the interview and survey if you don't wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview.

Confidentiality

We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and the information will be kept private. It will not be shared with or given to anyone.

Compensation

You will not be provided any incentive to take part in the research, however your participation will be appreciated.

Withdrawal from Study

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the interview at any time that you wish without your job being affected. I will give you an opportunity at the end of the interview to review what I have written and you can ask to modify or remove portions if you do not agree with my notes or if I did not understand you correctly.

Contact for Additional Information

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact the principal investigator on any of the following:

Email: wasare594@gmail.com

Tel: 0242610595

Dr. Joseph Osafo
Department of Psychology,
University of Ghana,
Legon

Tel: 0244296435

Prof. Charity Akotia
Dean of Social Science,
University of Ghana,
Legon
Tel: 0208127695

This proposal has been reviewed and approved by Ethics Committee for Humanities of University of Ghana, which is a committee whose task it is to make sure that research participants are protected from harm.

Section C- VOLUNTEER
AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

Name of Volunteer

Signature or mark of volunteer

Date

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.

Name of witness

Signature of witness

Date

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.

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

Date

Appendix 3

QUESTIONNAIRE

Section A

Please the questions below carefully and tick as it applies to you. Please be candid in your opinion.

Demographics

1. Gender

Male ()

Female ()

2. Age

(.....)

SECTION B

Africultural coping systems inventory

Instructions: Please consider the strategies you use in coping with the stressful situations after the suicidal attempt. Tick each coping strategy by indicating whether you used it to cope with after the suicidal behavior.

	Did not use	Used a little	Used a lot	Used a great deal
1. I prayed that things would work themselves out.				
2. I got a group of family or friends together to help with the problem.				
3. I shared my feelings with a friend or family member.				
4. I remembered what someone once said about dealing with these kinds of situations.				
5. I tried to forget about the situation.				

6. I went to church (or other religious meeting) to get help or support from the group.				
7. I thought of all the people have had to endure and it gave me strength to deal with the situation.				
8. To keep from dealing with the situation, I found other things to keep me busy				
9. I sought advice about how to handle the situation from an older person in my family or community.				
10. I read a scripture from the Bible/Quran (or similar book) for comfort and/or guidance.				
11. I asked for suggestions on how to deal with the situation during a meeting of my organization or club.				
12. I tried to convince myself that it was not that bad.				
13. I asked someone to pray for me.				
14. I spent more time than usual doing group activities.				
15. I hoped that things would get better with time.				
16. I read a passage from a daily meditation book.				
17. I spent more time than usual doing more things with friends and family.				
18. I tried to remove myself from the situation.				
19. I sought out people I thought would make me laugh.				
20. I got dressed up in my best clothing.				

21. I asked for blessings from a spiritual or religious person.				
22. I helped others with their problems.				
23. I lit a candle / used other objects for strength or guidance in dealing with the problem.				
24. I sought emotional support from family and friends.				
25. I burned incense or use other objects for strength or guidance in dealing with the problem.				
26. I attended a social event (dance, party, and movie) to reduce stress caused by the situation.				
27. I sang a song to myself to help reduce the stress.				
28. I used a cross or other object for its special powers in dealing with the problem.				
29. I found myself watching more comedy shows on television.				
30. I left the matter in God's hands.				

SECTION C

DASS SCALE

Please read the questions below carefully indicate the presence of a symptom over the previous week. Each item is scored from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week).

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

	Never	Sometimes	Often	Almost always
1. I found it hard to calm down				
2. I was aware of dryness of my mouth				
3. I couldn't seem to experience any positive feeling at all				
4. I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
5. I found it difficult to work up the initiative to do things				
6. I tended to over-react to situations				
7. I experienced trembling (eg, in the hands)				
8. I felt that I was using a lot of nervous energy				
9. I was worried about situations in which I might panic and make a fool of myself				
10. I felt that I had nothing to look forward to				
11. I found myself getting agitated				
12. I found it difficult to relax				
13. I felt down-hearted and sad				
14. I was intolerant of anything that kept me from getting on with what I was doing				
15. I felt I was close to panic				
16. I was unable to become enthusiastic about anything				
17. I felt I wasn't worth much as a person				
18. I felt that I was rather touchy				

19. I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20. I felt scared without any good reason				
21. I felt that life was meaningless				