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LIVED EXPERIENCES OF SURVIVORS OF SUICIDE IN THE KASENA-NANKANA MUNICIPALITY, GHANA

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DECLARATION

Student's Declaration

I, ROSEMARY KADUA AWIAH, declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted either in part or whole, for another degree elsewhere.

Signature: ……

Date: ……

Supervisor's Declaration

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba.

Mr. Samuel Richard Ziggah (Supervisor)

Signature: ……

Date: ……

DEDICATION

To my brother, Rev. Fr. Emmanuel Awiah for his unceasing prayers and directions, my mother, Matilda Seidu and my children; Michelle, Michael, Lucy and Annabel.

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ABSTRACT

Suicide survivors in most cases develop post-traumatic stress disorder (PTSD) which can become chronic if not treated. The emotions survivors of suicide experience can be devastating and this situation can negatively affect the way they function. The study sought to explore lived experiences of survivors of suicide in the Kasena-Nankana Municipality (KNM), Ghana. The study adopted phenomenological design within the qualitative research approach. Ten survivors of suicide were selected using purposive sampling technique. Interviews were used to gather data. Data were analysed in themes. It was found that psychosocial problems, psychiatric problems, previous suicide attempts and access to means of suicide were the themes to suicidal thought among survivors of suicide in the KNM. Also, isolation and regression were the effects attempted suicide survivors face on their social life. Again, positive and negative coping strategies were used by survivors of suicide to cope with the aftermath of their attempted suicide. Then more so, mass education and the establishment of community counselling centres were the preventive measures that can be put in place to minimize attempted suicide among suicide survivors in the KNM. It was concluded that survivors of suicide do experience emotional distress which may degenerate and create further distress for the attempters with risks for suicide completion. Also, coping behaviours of suicidal persons are largely influenced by cultural dynamics. It was recommended 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.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Shneidman (2004) 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" (p. 203). Furthermore, suicide is an act of deliberately killing oneself or consciously taking one's life (WHO, 2014). Hence, 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 behaviour refers to a range of behaviours that includes thinking about suicide, planning for suicide, attempting suicide and suicide itself (WHO, 2014). Suicidal behaviour 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).

Suicide is a major public health problem in most countries. Most recent available data find that a suicide completion occurs every 12.8 minutes (Centers for Disease Control and Prevention (CDC), 2018). Nationally, suicide is the second leading cause of death for youth aged 10-24 (CDC, 2018). Statistics compiled from the National Youth Risk Behaviour Surveillance (YRBS) in 2018 found that 47% of people especially students seriously considered attempting suicide in the previous 12 months and nearly 24% of these people made a plan about how they would attempt suicide in the previous 12 months. Moreover, 16% of them attempted suicide one or more times in the previous

12 months (CDC, 2018). All these data represent an increase since the last YRBS in 2018.

Suicidal behaviour generally refers to ideations, communications, and behaviours that involve some degree of intent to die (Van Orden, 2017). People who struggle with suicidal thinking or behaviour often exhibit unhealthy thought patterns due to mental health issues such as depression (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Thoughts of hopelessness, helplessness, and worthlessness are common thought distortions associated with suicidal behaviour (SAMHSA, 2016). This can lead to significant impairment (Klein, Kujawa, Black & Pennock, 2015).

Also, suicidal behaviour 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 behaviour more than females. For example, from 2006-2008 about 96.2 % and 3.8% of males and females engaged in suicidal behaviour (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; Lee, Wong, Chow & McBride-Chang, 2006; Overhosler, 2003). Other risks 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 behaviour 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). Also, 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 misdemeanour" (section 48). Thus, the individual who completes the act of suicide is apprehended and prosecuted. The Ghanaian society also prohibits suicide and tends to have a negative attitude towards it (Osafo, Hjelmeland, Akotia & Knizek, 2011a.).

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.

After a suicidal behaviour, families and significant others go through a lot of negative emotions and pathologies such as pain, shame, and distress, in the society. According to Dyregrov and Dyregrov (2015) "the person who commits suicide puts his psychological skeleton in the survivor's emotional closet" (p. 1). 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, 2013; Mitchell, Kim, Prigerson & Mortimer, 2005). The emotions they experience can be devastating and they may even not be able to function (Dyregrov & Dyregrov, 2015).

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 did not 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, 2011).

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, 2015).

These symptoms can lead to psychological distress. Thus the aftermath of the attempt is likely to affect their mental health (Sveen & Walby, 2015). 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 characterise the aftermath of a suicide attempt (Sveen, & Walby, 2008; Wiklander, Samuelsson & Åsberg, 2013). After the event the person is filled with anxieties about the actions and possible consequences to him/herself and others, associated with depressive behaviours. Preoccupation with thoughts about what others will think about them increases their anxieties (McGinley & Rimmer, 2013).

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., 2013). 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. There are many ways in which individuals cope with stress and how they respond in stressful situations.

The climate conditions of the Municipality are characterized by the dry and wet seasons. During such periods, rainfall is virtually absent due to low relative humidity. This makes most of the youth in the municipality idle during the dry seasons (November to April). During this period, those without alternative sources of income, have no option than to migrate to the south for greener pastures.

Most of the people in the Municipality are predominantly Christians and this is followed by traditionalist. There also exist religion other religions such as Islam, non-believers and others. Festival is a significant cultural practice in the Municipality. The people of Kassena Nankana predominantly celebrate the Fao festival. This festival is celebrated to thank the gods for bumper harvest and ensuring food security (GSS, 2010).

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 (as cited in Gyekye, 2013) suggested two types of coping resources which are emotion focused (trying to alleviate negative emotional responses) and problem focused (targets practical ways to solve the problem).

For example, individuals in Canada reported maladaptive coping strategies after suicide attempts which included thinking about suicide, visualising and planning about suicide, eating disorders, abusing drugs, chaotic lifestyles among others (Everall, Bostik & Paulson, 2016). 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).

Therefore, it was upon this foundation that the study sought to explore lived experiences of survivors of suicide in the Kasena-Nankana Municipality, Upper East Region, Ghana.

1.2 Statement of the Problem

Key facts from World Health Organization (2019) on suicide indicates that, more than 700,000 people die due to suicide. For every suicide, there are many more people who attempt suicide. Suicide is the 4th leading cause of death among 15 to 29year olds. In Ghana, about 1500 suicide cases are reported annually, and in each reported case of suicide are 4 unreported cases, summing the number of unreported cases to almost 6000 yearly. In Ghana, suicidal behaviour is considered criminal and carries legal as well as social sanctions. According to the Ghana Criminal Code (1960, Act 29), nonfatal suicidal behaviour is a crime. Section 57 of the code stipulates that "whoever attempts to commit suicide shall be guilty of a misdemeanour." Consequently, persons who engage in nonfatal suicidal behaviour in Ghana are subject to criminal apprehension and prosecution, and on conviction, receive criminal penalties. In addition to the strong legal stance against suicidal behaviour, a strong social stigma has surrounded suicidal behaviour in Ghana.

In Pennsylvania, suicide is the leading cause of death for youth ages 10-14 (Lester & Walker, 2016). Included in this age group is the target population for the current study. Although little is known about the reasons why those at risk do not seek assistance (Calear, Batterham & Christensen, 2018; Pandey, 2017), some research suggested that suicide and related behaviours are heavily stigmatised and that public attitudes toward suicide and mental illness in general may decrease the likelihood of

help-seeking behaviour (Batterham, Calear & Christensen, 2016b; Calear et al., 2018). Interestingly, none of these studies was conducted in Ghana.

Kassena Nankana Municipality-Navrongo Mental Health Unit (MHU) annual performance review from 2016-2020 showed that the rate of suicide had increased sharply for the past three years. The MHU report showed that in 2016, a total of 18 cases of suicides were reported, comprising 5 males and 13 females. In 2017, the number of cases increased from 18 to 39. Out of the 39 cases of suicide reported, 18 of them were males and 21 were females (Kassena Nankana Municipality-Navrongo MHU report, 2020).

Again, in 2018, the cases increased to 111, which comprised 44 males and 67 females. Further, in 2019, 132 cases were recorded of which 22 were males and the rest (110) were females. These individuals fall within the age bracket 18-40 years. In the first quarter of 2020, 12 cases had been recorded of which 3 were males and 9 were females. They also fall within the age range 11-87 years (Kassena Nankana Municipality-Navrongo MHU report, 2020).

In general, the MHU report showed that more females (220) attempted suicides than their counterparts (92). This suggests that women who are most of the time bread winners in the Kassena Nankana Municipality are committing suicide the more. Also, majority of them are single parents. These infer that, their children are likely to be vulnerable/orphanage if no extended family member extend a helping hand to their children. In this sense, it can adversely affect the growth and development of these children.

Though interventions such as giving talks to community members during community durbars and home visits have been made by the Psychiatric Nurse and the Social Welfare Officers to help reduce this challenge, yet the problem still persists. However, it seems little empirical studies have been conducted on the causes of high rate of suicides cases in the Kassena Nankana Municipality.

From the MHU (2020) report, it could be deduced that majority of the victims are in their youthful stage. If no measures are put in place to curb this situation, the youth who are the future leaders may lose their lives via suicide and this situation can adversely affect the victim's family members, the society and the nation at large due to loss of human capital in the Kassena Nankana Municipality.

Meanwhile, the 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 or they develop maladaptive coping mechanisms in dealing with problems. Again, when the attempter perceives that their experiences after the attempt are unpleasant and negative, they are more likely to attempt again and may 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 behaviour on the individual ranges from pain to various health consequences and may take many years to subside (Vawda, 2012). In Ghana, there is stigmatisation attached to suicide (Osafo et al., 2011c) 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 compound 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 at odds with providing care for survivors of suicide. The primary professional caregivers of mental health, especially doctors and nurses who are the first-contact in event of failed suicide attempt, sometimes lack adequate training to provide adequate care for survivors of suicide. 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 these survivors have to deal with the stigmatisation and its aftermath consequences on their own.

Survivors of suicide 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 et al., 2011c). This may lead to alienation of the individual in the family and society which is a risk for further suicide attempt by the individual. Hence, this study sought to explore lived experiences of survivors of suicide in the Kasena-Nankana Municipality, Ghana.

1.3 Purpose of the Study

The purpose of the study was to explore lived experiences of survivors of suicide in the Kasena-Nankana Municipality, Ghana so as to help reduce the rate of suicides and its aftermath consequences.

3.4 Research Objectives

The objectives formulated to guide the study were to:

1. Find out the causes of suicidal thoughts among survivors of suicide in the Kasena-Nankana Municipality.
2. Explore how attempted suicide affects the lives of survivors in the Kasena-Nankana Municipality.
3. Explore how survivors of suicide in the Kasena-Nankana Municipality cope with the aftermath of their attempted suicide.
4. Explore preventive measures that can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality.

1.5 Research Questions

The following research questions guided the study:

1. What are the causes of suicidal thoughts among survivors of suicide in the Kasena-Nankana Municipality?
2. How attempted suicide does affects the lives of survivors in the Kasena-Nankana Municipality?
3. How do survivors of suicide in the Kasena-Nankana Municipality cope with the aftermath of their attempted suicide?
4. What preventive measures can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality?

1.6 Significance of the Study

The current study holds much promise to contribute to the growing body of research in the areas of people's attitudes toward suicide, suicide stigma, and help seeking for self and others. It directly addresses the goal of increasing help-seeking behaviours

for at-risk individuals by decreasing stigma. Also, findings of the study can be used by guidance and counselling coordinators in giving talks to the youth especially on the need to seek for professional counselling instead of using suicide to end their life. Again, findings of the study can be used by other researchers as a baseline for future studies.

1.7 Delimitations

The study was limited to survivors of suicide from Kasena-Nankana Municipality. Themes covered were: The causes of suicidal thoughts; how attempted suicide affects the lives of survivors; coping strategies used by survivors of suicide; preventive measures that can be put in place to minimise attempted suicide in the Kasena-Nankana Municipality. Survivors of suicide within the Kasena-Nankana Municipality were used for data collection.

1.8 Limitation

The sample size used for the study was inadequate although the population was a bit large sample. Therefore, results generalisation to other suicide attempters need to be considered with caution.

1.9 Operational Definition of Terms

Attempted Suicide: It refers to any intentional and potentially dangerous effort to commit suicide. Thus, it refers to engagement in potentially self-injurious behaviour in which there is at least some intent to die.

Families: Any member related to the suicide attempter by blood or lives in the household with the attempter.

Psychological Distress: Depression, anxiety and stress that survivors of suicide go through.

Suicidal behaviour: This means a suicide attempt by an individual.

Suicidal Ideation: This refers to an individual having thoughts of wanting to end his/her own life. Thus, it refers to thoughts of engaging in behaviours intended to end one's life.

Suicide Plan: It refers to the formulation of a specific method through which one intends to die.

Survivors of Suicide: People who tried committing suicide but did not succeed.

1.10 Organisation of the Study

The study covers five chapters. Chapter One presents the introduction which is discussed under the following themes: Background to the study, statement of the problem, purpose of the study and research objectives. Moreover, it further discusses the research questions, significance of the study, delimitations, limitation and organisation of the study. Chapter Two deals with the review of the related literature. Chapter Three deals with the research methodology adopted for the study. It discusses the research paradigm, research approach, research design, study area, population of the study, sample and sampling techniques, data collection instruments, trustworthiness of the interviews, data collection procedures, data analysis procedures and ethical considerations. Chapter Four deals results or findings of the study. Chapter Five deals with the summary, conclusions and recommendations based on the findings of this study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter deals with the review of the related literature of the study. The following subheadings are discussed:

1. Theoretical Framework;
2. The Concept of Suicide;
3. Perceived Causes of Suicidal Behaviours;
4. Consequences of Attempted Suicide on the Lives of Survivors;
5. Coping Strategies used by Survivors of Suicide;
6. Protective Measures for Suicide;
7. Summary of the Related Literature Reviewed

2.1 Theoretical Framework

The study was guided by two Psychological Models and these were the Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB). Among the many predictors, behavioural intention has received intense attention from social psychologists. Intention-based approaches primarily focus on behavioural intention to predict human behaviours and explore diverse factors that directly or indirectly influence behavioural intention (Fishbein & Ajzen, 1975). This framework of understanding human behaviour has proved useful in explaining a wide range of human behaviours. The conceptualisation of human behaviours as a function of behavioural intention is derived from social psychological theories.

For example, the Theory of Reasoned Action (TRA) proposed by Fishbein and Ajzen (1975) and its extension, the Theory of Planned Behaviour (TPB) commonly emphasise the importance of social psychological variables, such as attitudes toward the behaviour and subjective norm (thus, learners' perceptions of significant others' opinions), as antecedents of behavioural intention. These social psychological models have been successfully utilised in the study of diverse human behaviours, such as voting, weight loss, consumer and tourist behaviour, and educational decisions (Fishbein & Ajzen, 1975). The study will use Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975) and Theory of Planned Behaviour (TPB) (Fishbein & Ajzen, 1975).

2.1.1 Theory of Reasoned Action (TRA)

Based on the assumption that humans are highly motivated and eager to utilise information from a variety of sources to reach a rational decision to perform certain behaviour, Ajzen and Fishbein (1975) propose a model of social behaviour to systematically account for the influences of social psychological factors on their behaviour. TRA, originally resulting from an attitude-based model of social behaviour (for example, expectancy-value model), is a theoretical attempt to consider the discrepancies between attitude and behaviour. As briefly mentioned in the introduction, a key element in TRA is behavioural intention, which represents a person's motivational drive or a conscious plan to perform the behaviour (Fishbein & Ajzen, 1975).

Based on the idea that the shorter the temporal distance between intention and the actual behaviour, the stronger the correlation between intention and the actual behaviour, Fishbein and Ajzen (1975) argue that accurately measured intention is the

best predictor of behaviour. Thus, according to TRA, intention causes behaviour, given an opportunity to act. The significant relationships between behavioural intention and actual behaviour have been confirmed through empirical studies (Fishbein & Ajzen, 1975).

TRA further posited that behavioural intention is a function of attitude toward the behaviour and the person's subjective norm. The first antecedent, attitude toward the behaviour, reflects the influence of the expectancy-value model, whereas the second antecedent is a new addition unique to TRA. According to Ajzen and Fishbein (1975), attitude refers to "a given person's general evaluation or overall feeling of favorableness or unfavourableness toward the behaviour in question" (Fishbein & Ajzen, 1975, p. 55).

On the other hand, subjective norm pertains to the perceptions that significant others think an individual should perform the behaviours in question. Significant others include those persons important to the individual, such as parents, siblings, friends, teachers, and relatives. Thus, subjective norm is reflective of the individual's perceptions of the social pressures made onto him or her. Previous empirical studies based on TRA indicate that attitudes and subjective norm made a significant and independent contribution to various behavioural intentions, as noted by Ajzen and Fishbein (1975).

2.1.2 Theory of Planned Behaviour (TPB)

TPB is an extended version of TRA with the added element of perceived behavioural control, which refers to an individual's perceptions about his or her ability to perform the behaviour in question. This non-volitional control factor is a measure of how competently a person can execute the actions required under specific situations

(Fishbein & Ajzen, 1975). Perceived behavioural control reflects an individual's perceptions of the situational factors that may facilitate or impede the performance of the behaviour (Fishbein & Ajzen, 1975).

The need for behavioural control is justified, given that TRA is based on the assumption that behaviours are voluntary and under volitional control. This suggests that without taking behavioural control into consideration, TRA may not be applicable to the behaviours with non-volitional control, hence compromising the predictive power of TRA (Fishbein & Ajzen, 1975). Therefore, attitudes, subjective norm, and behavioural control act as the core variables of TPB, and this triadic framework as an antecedent of behavioural intention is an effort to enhance the utility of TRA to better deal with a variety of social behaviours (Fishbein & Ajzen, 1975).

2.2 The Concept of Suicide

The word "suicide" was first introduced in the 17th century, said to be derived from the Latin words sui (of oneself) and *caedere* (to kill). Apparently, Sir Thomas Browne–a physician and a philosopher-was the first to coin the term suicide in his Religio-Medici (Minois, 2016). The new word reflected a desire to distinguish between the homicide of oneself and the killing of another (Minois, 2016). The conceptualisation of suicuside has changed throughout history with popular perception, and this has shaped what is currently defined as suicide. In antiquity and the early Roman culture *mors voluntaris* was not only accepted but at times recommended. It has to be noted, however, that especially in Rome, the rules were in force only for free citizens, thus, slaves were not allowed to kill themselves (if a newly bought slave killed himself, the new owner was entitled to have his money back).

A first important cultural shift happened with the coming of Christianity and the increasing numbers of martyrs (the so-called "Donatists"), who turned out to be a more serious threat to the young Christian community than the cruelest persecution by the Romans. As Alvarez wrote: "It culminated in the genuine lunacy of the Donatists, whose lust for martyrdom was so extreme that the Church eventually declared them heretics" (Alvarez, 1972, p. 111). In fact, in 348 AD the Council of Carthage condemned voluntary death for the first time in history because of Donatism, which praised the practice (Minois, 2016).

After the Council of Arles, in 452 AD, the Church also condemned the suicide of all famuli (slaves and domestic servants), giving ground to procedures such as the confiscation of all goods of the suicided person. This negative view continued, spurred by both law and religious influence, and the Councils of Braga and Auxerre ended by condemning all types of suicide and forbidding commemorative offerings and masses for suicides (Minois, 2016). Harsh penalties for suicides and their families existed during the middle Ages. Suicide was viewed as a criminal act and those who attempted suicide were placed on trial. Courts of the time distinguished between two verdicts, non-compos mentis for the innocent madman, and *felo de se* for those "felons of themselves" judged to be in violation of the laws of Godandman (MacDonald, 1989).

However, the popular conception of suicide shifted progressively away from criminality. Influential thinkers such as Durkheim (1951) led to an emphasis on the impact of external influences and the embrace of a more sociological and psychological concept of suicide. Since then, there have been many attempts to reach

a consensus on the definition of suicide, yet, thus far, there is little agreement on what aspects are important for inclusion in a definition of suicide.

A number of common key aspects emerge from these definitions: The outcome of the behaviour, the agency of the act, the intention to die or stop living in order to achieve a different status, the consciousness/awareness of the outcomes. In addition, two important conceptual issues emerge, namely, the impact of a theoretical orientation and of cultural influences. The cross-cultural design of the WHO/EURO Multi Centre Study heightened the importance of these characteristics of the definition.

Numerous suicidologists from varied backgrounds constituted the group responsible for implementing this project; the definition settled on must have reflected and allowed for this diversity. In the same vein, retaining a culturally neutral definition served to facilitate the intended international comparisons. Some of the differences in the definitions outlined in Table 1 stem from the distinct theoretical approaches of the authors. For example, Durkheim's (1951) characterisation of suicide is sociological; this is distinct from that of Shneidman (2014) who focuses on the psychological dimension and Baechler (1980) who emphasised the existential one (Maris, Berman & Silverman, 2010). The theoretical perspective explains the basis of the behaviour. However, definitions are a description of the concept rather than an explanation, and should not be guided by theory (Maris et al., 2010).

A similar approach guided the choices of the WHO Working Group stated that a theoretical basis for the definition of suicide should have not been the driving force, as for at least two reasons it could have actually hindered the goal of communication (Maris et al., 2010). First, those not adhering to the particular theoretical perspective

would have been less likely to accept the definition. In fact, for a nomenclature to be useable, it must be applicable across all theoretical perspectives.

Second, if the theory is superseded, or becomes less popular, then the definition also becomes obsolete and the desired definitional consistency is disrupted. The most valuable definition is, thus, one that is theory neutral. Similarly, a definition for suicide should also be free of value judgment and remain culturally normative. Both of these characteristics serve to facilitate effective and precise communication. Exemplary of such value judgments is, for example, the German word for suicide, *Selbstmord*, which translates literally to "self-murder" (the same holds true for Scandinavian countries).

If suicide is defined as a crime, or as immoral, then the way toward unbiased discussion and research practice is impeded (Mayo, 2012). Cultural differences can also imbue a definition of suicide with a value judgment. For example, Stack (2016) explains that in the Japanese culture, suicidal behaviour is generally accepted, particularly in the face of shame. Such cultural differences in the attitudes toward suicidal acts clearly question the adequacy of a universal definition.

A workable solution is retaining a culturally normative definition for suicide. This should be broad enough so as to be applicable to a range of belief systems and concurrently, specific enough to give an adequate description of the characteristics involved. The WHO Working Group proposed to adopt a standard definition to be implemented in each site for the study in an attempt to take these issues into consideration. The definition of suicide adopted was as follows:

> Suicide is an act with a fatal outcome which the deceased, knowing or expecting a fatal outcome had initiated and carried out with the purpose of provoking the changes he desired (WHO, 1986).

Also, Shneidman (2014) defines suicide as "a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defined an issue for which the suicide is perceived as the best solution" (p. 203). 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 behaviour refers to a range of behaviours that includes thinking about suicide, planning for suicide, attempting suicide and suicide itself (WHO, 2014).

Furthermore, according to Sudak, Maxim and Carpenter (2015), suicide is regarded as the most severe loss that anyone can experience and the effects of suicide that are covered in the literature spans not only the experiences of individuals, but also as well as how the family units function post-loss. In particular, studies reveal those suicide survivors' experiences of emotions, namely guilt and depressed mood following the loss, occurred frequently and to such an intense degree that the way in which they experienced daily life was dramatically altered (Schneider, Grebner, Schnabel & Georgi, 2011).

2.2.1 Methods of suicide

The main methods used by persons to commit suicide are firearms, hanging, drug overdose, drowning, asphyxia (Van Orden, Cukrowicz, Witte & Joiner, 2012). It is important to highlight that trends in the methods used are liable to national differences (national policy in restriction of firearms) and to the types of residence (community versus long-term care) (McLaren, Gomez, Gill & Chesler, 2015). Trends in time have been observed as well: Despite a reduction in prescription of benzodiazepines, drug overdose suicides have increased (Chan, Draper & Banerjee, 2014). A gender effect

has been observed as well: men tended to use more violent methods (Erlangsen, Jeune, Bille-Brahe & Vaupel, 2013). The use of more violent methods increased by age (Erlangsen et al., 2013).

Studies (Lapierre, 2015; Moore, 2013) on suicide attempts reported drug overdose as the main method, followed by hanging and self-injury. Also, Stanley, Hom, Rogers, Hagan and Joiner (2015) in comparing the methods used in suicide attempts and completed suicides revealed no differences and the majority of persons with a history of a suicide attempt used the same method in their final act as in their last attempt (Sher, 2011).

The suicide intent in attempted suicides of older persons was found to be higher in comparison to younger attempters (Dyregrov & Dyregrov, 2015): two-thirds had significant higher intent scores (Wiklander et al., 2013). Suicidal intent of the attempt is correlated to attempt lethality (Sveen & Walby, 2008). Attempt lethality was found to be higher in older men and in younger women in later life (Sveen & Walby, 2008).

In view of the changed ratio of suicide attempts versus completed suicides (8:1 compared to 29:1 in adulthood (Wiklander et al., 2013) one can make an indirect assumption that suicide attempts increase in lethality by age (Stanley et al., 2015). Research data confirmed this assumption: in a sample of suicide attempters, aged 50 years and over, higher age was indeed associated with higher attempt lethality in men (Wiklander et al., 2013) and higher degree of attempt planning overall (Chan et al., 2014).

Also, while numerous factors contribute to the choice of a suicide method, societal patterns of suicide may be understood from basic concepts such as the social acceptability of the method (thus, culture and tradition) and its availability (thus,

opportunity) (Buus et al., 2014). Methods used vary with access and availability but also with gender and age (National Confidential Inquiry [NCI], 2013; Windfuhr, Bickley, While, Williams & Hunt, 2015).

The report by the NCI (2013) showed that the most common methods of suicide were by hanging or strangulation (44%), self-poisoning (23%), and jumping from a height or in front of a moving vehicle (10%). Less frequent methods were drowning (5%), carbon monoxide (4%), cutting or stabbing (3%), and firearms (2%). Over the period 2001 to 2010 there were changes in method of suicide. Suicide deaths by hanging increased, although they have fallen since the peak in 2008. Deaths by self-poisoning, drowning and carbon monoxide decreased and those by jumping did not change.

Furthermore, men are more likely to use violent methods such as hanging and shooting; women tend to use either prescribed medication or over-the-counter medications such as paracetemol (Gunnell, Middleton & Frankel, 2010). Varnik, Kolves and van der Feltz-Cornelis (2015) studied suicide rates, trends and methods among youths aged 15 to 24 years in 15 European countries. The findings showed a very high proportion of hanging in youths, which is a difficult method to restrict. The fall in carbon monoxide suicides is due to the introduction of catalytic converters in 1993 and firearm suicides are low due to the unavailability of guns in the United Kingdom.

Methods have also been associated with factors such as suicide hot spots [geographical areas frequently used as a location for suicide (National Institute for Mental Health in England [NIMHE], 2016). Many well-known locations seem to act as magnets, drawing suicidal individuals to them. In the UK, Beachy Head cliffs in Sussex and the Clifton Suspension Bridge in Bristol are notorious as suicide sites.

However, there are also many less well-known locations, and every local area will have sites and structures that lend themselves to suicide attempts. In many cases, the place itself provides the means of suicide (NIMHE, 2016).

Few studies have examined the characteristics of people with mental illness in relation to suicide methods (Hunt, Windfuhr, Swinson, Shaw, Appleby & Kapur, 2010; Kelly, Shim, Feldman, Yu & Conley, 2014; Kapur, Murphy, Cooper, Bergen, Hawton, & Simkin, 2015). Those that have investigated methods with regard to psychiatric morbidity have generally focused on one particular diagnostic group such as schizophrenia (Kapur et al., 2015; Kelly et al., 2014) and found that individuals may use more dangerous methods than the general population. Awareness of the methods of suicide employed in those with mental illness may contribute to prevention strategies in this high risk group. However, given that 25% of people who die by suicide are in contact with mental health services (NCI, 2013), there is a need for broadly based population initiatives, restricting access to means more generally, and measures to improve population awareness of potential benefits of help seeking in times of crisis.

In furtherance, while no single source or statistics were available to provide a recent global overview of preferred methods for completed suicide, the work carried out by Hepp, Stulz, Unger-Koppel and Ajdacic-Gross (2012) did provide some insight into the matter. The study found that violent and highly lethal methods such as suicide by firearm and hanging are more frequent among men, whereas women often choose poisoning or drowning, which are less violent but sometimes less lethal as well. Hanging was observed as the major method of suicide in most countries. The highest proportions were around 90% in men and 80% in women, observed in Eastern Europe

in countries such as Estonia, Latvia, Lithuania, Poland and Romania. Firearm suicide was the most common method in the United States, but was also observed in Argentina, Switzerland and Uruguay. Jumping from a height was noted in Hong Kong, Luxembourg and Malta. Pesticide poisoning was found to be a major problem in rural Latin American countries such as El Salvador, Nicaragua and Peru as well as in the Asian countries such as the Republic of Korea and Thailand, in addition to Portugal. Poisoning or overdose on prescription drugs was common in both men and women from Canada, Nordic countries and the United Kingdom. New methods such as charcoal burning were also noted in urban Taiwan, China and Hong Kong.

However, the most important observation from this study was that methods vary more from country to country, than between genders. Thus, both culture and the availability of technical means to cause death play a major role in determining the acceptability of a specific method and, indirectly, on suicide in general. Therefore, the higher the obstacles in using a particular method, the lower the acceptability of the method and the greater the proportion of suicides associated with psychosis and other severe mental disorders. This would, hence, suggest that the use of fire or self-immolation, for instance, could be associated with severe mental disorders, depending on the context or country.

2.2.2 Suicidal behaviour among teenagers

Studies (Mpiana, Marincowitz, Ragavan & Maleta, 2014; Wasserman, Cheng & Jiang, 2015; Hur, Kim & Kim, 2011) reported suicide as an increasingly important cause of death among both teenagers and young people worldwide. Wasserman, Cheng and Jiang (2015) estimated that suicide was the fourth leading cause worldwide of death among those aged 15-19, with 9.5% of all the 132,423 deaths

reported for that particular age group, and is currently the third leading cause of death for those aged 10-24 in the U.S. according to the Centre for Disease Control and Prevention (CDC) (2014). As far as gender differences are concerned, girls are believed to be more likely to attempt suicide than boys who go for more violent methods (hence, more effective ones), as seen in adults.

Some of the risk factors mentioned previously would apply to teenagers, as well as to adults, as seen by some of the risk factors identified by the (CDC, 2014):

1. History of previous suicide attempts;
2. Family history of suicide;
3. History of depression or other mental illness;
4. Alcohol or drug abuse;
5. Stressful life event or loss;
6. Easy access to lethal methods; and
7. Exposure to the suicidal behaviour of others.

However, it would appear based on existing research, that the 13-19 age group does have some distinct risk factors which are more focused in the social/psychosocial and psychiatric/biological categories. Adolescence is also a period where children experience some significant physical and mental changes as a result of puberty. It is also a time of self-discovery and experimentation which take several forms and can go several ways, including risky behaviour ranging from substance abuse to promiscuity, violence, self-harm and suicide. Moran, Coffey, Romaniuk, Olsson, Borschmann, Carlin and Patton (2012) did note the same risk factors usually associated with suicide among young people reporting self-harm during their teens such as symptoms of depression and anxiety, anti-social behaviour, high risk alcohol

use, smoking cannabis etc. When danger is not an issue, most experts view adolescent experimentation and environmental exploration as integral to the development of a healthy and individuated sense of self (Hazen, Scholzman & Beresin, 2015). While self-destructive behaviour is not universal among teenagers, a potential explanation for this may lie in differential brain development during adolescence.

2.2.3 Stigma surrounding suicide

Stigma surrounding suicide has been pervasive and persistent (Tadros & Jolley, 2011). Stigma refers to negative or inaccurate stereotypes about a specific group of people that stems from "poorly justified knowledge structures that lead to discrimination" (Corrigan & Penn, 2016, p. 766). For the broader category of mental illness, these knowledge structures and the stigmatising behaviours they illicit are widespread (Pescosolido, Martin, Long, Medina, Phelan & Link, 2010). This often connote beliefs that individuals with mental illness are (a) dangerous and should be feared, (b) irresponsible and should not be allowed to make their own decisions, or (c) childlike and need to be under the guidance of others (Brockington, Hall, Levings & Murphy, 2013).

Stigma specifically toward suicide can occur in the form of social disapproval, isolation, or shunning (Scocco, Castriotta, Toffol & Preti, 2012). Two studies conducted decades apart both found that stigmatising attitudes were more pronounced toward suicide than toward ethnic and religious groups (Lester, 1993). Other studies by Batterham, Calear and Christensen (2013) and Lester and Walker (2016) have identified specific expressions of stigma. For example, roughly half of American university students said they would not date someone who had attempted suicide in the past year (Lester & Walker, 2016). Adjectives used to describe people who die by

suicide also reveal stigmatising beliefs; those adjectives include arrogant, attention-seeking, pathetic, selfish, and weak (Batterham et al., 2013).

Additionally, beyond identifying stigma towards suicide, these examples also exemplify how existing suicide stigma research, although valuable, primarily examines the stigmatising attitudes that non-attempters have toward attempters (Batterham et al., 2013; Scocco et al., 2012) or that family members who have had a relative die by suicide experience (Sudak et al., 2015). Reports of stigma encountered by attempt survivors and those with past experiences of suicidal ideation (hereafter referenced together with the term attempt survivor) can be a valuable learning resource that has thus far gone largely untapped by suicide researchers (Lester & Walker, 2016).

Furthermore, studies (Cerel, Currier & Conwell, 2016; Emul, Uzunoglu, Sevinç, Güzel, Yilmaz, Erkut & Arikan, 2011) that have examined the experiences of individuals with suicidal behaviour fail to examine stigma perpetrated by non-professionals, such as family and friends. Therefore, the current study examines stigma experienced by attempt survivors from both treatment providers and individuals in one's social and family networks. The existing literature regarding sources of stigma and how these sources relate to stigma types were reviewed next.

2.3.4 Sources of stigma

Suicide stigma has been perpetuated from a religious and legal standpoint for centuries (Tadros & Jolley, 2011); yet few studies have specifically examined the source of suicide stigma (thus, the individual or group from which another person perceives stigma). Some researchers have explored stigma perceived through interactions with treatment providers. One study in Turkey found that up to 80% of

medical students displayed socially distant attitudes toward attempt survivors (Emul et al., 2011). Another study found that over half of patients with suicidal behaviour who presented at an emergency department in the United States did not feel that the staff listened to them, explained the nature of treatments, or took their injury seriously (Cerel et al., 2016).

Moreover, more than half also felt that the emergency department staff directly punished or stigmatised them. Although valuable, these studies only examined emergency department providers and medical students. No other studies to date have examined the extent to which attempters feel stigmatised by other treatment providers or have compared rates of stigma by mental health versus non-mental health providers (for example, emergency department personnel, family physicians, pharmacists and many others).

Mental health providers are specifically trained to work with individuals struggling with mental illness. Licensing boards for marriage and family therapists (American Association of Marriage and Family Therapy, 2014), psychologists (American Psychological Association, 2014), psychiatrists (American Psychiatric Association, 2014), and social workers (National Association of Social Workers, 2014) require professionals to have training in the epidemiology, symptoms, and treatment of mental health problems. This requirement does not exist for non-mental health providers.

In addition to interactions with treatment providers, attempt survivors may also interact with friends or family members following suicidal behaviour. However, research on suicide stigma has often failed to consider the role of the family environment in perpetuating or assuaging stigma among individuals contemplating

suicide (Gould, 2011). Consequently, little is known about suicide stigma from treatment providers relative to suicide stigma from one's social network. One study compared social network stigma and perceived stigma from mental health treatment providers experienced by individuals struggling with general mental health concerns: Stigma from mental health providers were reported more often than from employers and friends, but less often than from co-workers, family, and the general community (Wahl, 2016).

However, Wahl's study did not account for whether the individuals disclosed suicide information to all of these individuals. Certain individuals may be more likely to know about a history of suicidal behaviour and thus have more opportunity to exhibit stigma. For example, family members may be more likely to discover evidence of suicidal behaviour compared to friends or employers with whom one does not reside.

2.3.5 Types of stigma

Research on stigma has indicated that stigma has multiple dimensions. The two dimensions most commonly referenced in the literature are public stigma, which refers to the awareness of stereotypes held by the general public (Link, 1987), and anticipated self-stigma, which occurs when an individual adopts those stereotypes in their beliefs about themselves and often results in disempowerment and devaluation of self (Corrigan, 2012). Although these two forms of stigma frequently co-occur, individuals are capable of recognising stereotypes without agreeing with them (Jussim, Nelson, Manis & Soffin, 2015), and these two forms of stigma can produce different effects on attitudes about treatment (Pattyn, Verhaeghe, Sercu & Bracke, 2014) and treatment seeking behaviours (Corrigan & Rüsch, 2012).

For example, Pattyn et al. (2014) found that individuals struggling with mental illness who experienced higher levels of self-stigma viewed professional treatment as less important than did their counterparts who experienced lower levels of self-stigma, and those with higher levels of public-stigma were more likely to view informal help-seeking as less important than did their counterparts who experienced lower levels of public-stigma.

Pattyn et al.'s (2014) study also examined the effects of stigma type, but it seems there is scanty published studies have addressed whether and how those effects vary according to source of stigma. Because suicidal ideation often stems from interpersonal components of feeling that one does not belong and is a burden to others, attempt survivors may be more likely to value the opinions of individuals in their social network (thus, friends, family and many others) than the opinions of professionals (for example, treatment providers). In other words, an attempt survivor who hears a loved one explicitly state that the survivor is loved and valued might be able to rid oneself of thoughts that he or she is a burden to others. In contrast, stigmatising interactions that reinforce previously-held ideas of burdensomeness and a lack of connection might be more likely to agree with those thoughts as well.

2.3.6 Effects of stigmatisation

A study by Link, Struening, Neese-Todd, Asmussen and Phelan (2011) indicated that experiencing mental-health stigma is linked to lower self-esteem poorer life satisfaction (Rosenfield, 2014), and a smaller social network (Link, Cullen, Stuening, Shrout & Dohrenwend, 1989) in individuals coping with mental health issues. The impact may be cyclic for attempt survivors because these factors also increase the

likelihood of another suicide attempt (Van Orden, Witte, Cukrowicz, Braithwaite, Selby & Joiner, 2010).

However, no published studies to date have examined whether distinguishing among sources of stigma increases the ability to predict an attempt survivor's mental health, and specifically depression, which is experienced by most individuals who attempt suicide (Joiner, 2015). Given the negative impact of stigma on those who have general mental health issues and research showing the importance of interpersonal relationships for suicide risk (Van Orden et al., 2010). The ultimate result of negative attitudes towards suicide from the family/community, religious groups, and the law code is the intensification of stigma towards suicidal persons. Stigma is a mark that denotes a shameful quality in the person who has been so marked (Pompili, Lester, Grispini, Innamorati, Calandro, Iliceto, & Girardi, 2013). The sources of the stigma are varied and may include beliefs and prejudices (Pompili et al., 2013; Sabatelli & Shehan, 2015), ignorance (Joiner, 2010) and careless use of diagnostic labels (Sabatelli & Shehan, 2015).

Stigma till date, continues to be a major obstacle to quality of life of several persons suffering from one form of mental distress or another. Although mental illness is stigmatised, the stigma of suicide continues to be unique one and as a special domain of mental distress (Sudak et al., 2015). This implies that suicide stigma has serious consequences which must be tackled (Sudak et al., 2015). In an editorial, Rusch, Zlati, Black and Thornicroft (2014) have shown three ways in which stigma can be related to suicidality. First, suicide stigma can lead to social isolation and impaired social network. Secondly, suicide stigma can create structural discrimination. This implies that there will be poorer funding of mental health care and this will eventually reduce

access to quality mental health care services. Thirdly, stigma can lead to self-stigma which may lead to a sense of worthlessness, hopelessness and a threat to coping resources. Stigma is one likely obstacle when planning effective intervention for warning signs of any type including suicide (Sudak et al., 2015).

Warning signs are useful indicators for public health education and awareness which eventually may lead to early detection and effective intervention of suicidal persons (Rudd, Goulding & Carlisle, 2013). The stigma attached to suicide may become hurdles in lowering enthusiasm to provide help to person who are experiencing suicidal crisis (Sudak et al., 2015). For example, in one study that examined the impact of stigma on participants' readiness to provide urgent help and their degree of comfort and trust in their helping efforts, participants showed readiness to respond urgently towards heart attack patient than someone in suicidal crisis (Sudak et al., 2015). Suicide stigma can also lead to people distancing themselves from the suicidal individual and potentially compounding the sense of isolation, loneliness, and burdensomeness (Van Orden, Joiner, Hollar, Rudd, Mandrusiak & Silverman, 2016).

In one study in Uganda, the stigma attached to suicide is so deep that at the instance of a suicide, the family, lineage, and the entire clan detach themselves from the suicidal person as a way of ritually managing the fear of collective social stigma (Mugisha, Hjelmeland, Kinyanda & Knizek, 2011). The labels of suicidal ideations and persons as weak, shameful, sinful and selfish may prevent them from seeking early help in the suicidal process and those within their social network may also pull way for fear of shared stigma (Pompili, Mancinelli & Tatarelli, 2003; Rusch et al., 2014).

The emerging literature (although inconclusive) is beginning to show some support for the hypothesis that stigma variables contribute to suicidality (Rusch et al., 2014). For example, in a study, that examined patients views about suicide prevention efforts, 83% of patients were conscious of the stigma associated with mental illness when feeling at their worst, with 59% indicating that this stigma had contributed to their feeling at their worst (Eagles, Carson & Begg, 2013). In a study in Ghana reported that attempters indicated that the stigma following suicide was traumatic for them with one ending up killing himself from social taunting a few weeks after the interviews (Osafo et al., 2015). Stigma reduction has thus been considered as a one of the suicide prevention efforts (Pompili et al., 2013; Rusch et al., 2014). In fact, stigma reduction is a recommended national prevention method by the WHO as means of globally combating the suicide menace (WHO, 2014).

2.3.7 Institutionalising stigmatisation towards suicide in Ghana

Hjelmeland, Knizek, Akotia, Owens, Knizek, Nordvik, Schroeder and Kinyanda (2015) and Osafo et al. (2011b) consistently reported a generalised negative attitudes towards suicide in Ghana these negative attitudes are often expressed towards the suicidal person (Osafo et al., 2015). It is argued in this section that these negative attitudes appear symbolic and institutionalised.

When members live in a community, as Nwosu (2014) explained, they become culture-bound enough to accept certain rules by which they relate to one another and interpret certain actions as an attribute of morality and adopt rules which guide their conduct as people; and once these rules become guide to their conduct they will acquire a moral value within that context. Consequently, certain behaviours might be normalised and practiced over time as part of the moral fabric of the people. The

harsh negative attitudes toward suicide in the Ghanaian society therefore might achieve a symbolic nature as a social reality in the way the act is construed and the shared meanings established among a group of people.

In furtherance, Ibáñez (2014) argues that "Nothing is social if it is not instituted within the sphere of shared meanings which belongs to a collective of human beings" (p. 30). The negative attitudes towards suicide might be established within the sociocultural moral fabric of people to the extent that they receive unscripted social backing. For example, viewing suicide as social evil might have received a strong societal backing through the convergence of the ethics of social welfare and respect for human life. Plausibly, over the long haul, such condemnable view of suicide is functionally thought to be preventive as we have begun to observe from some of our studies (Hjelmeland, Osafo, Akotia & Knizek, 2014). Instinctually, humans are wired towards self-preservation and so suicide does not resonate with our innate make up (Tang, Yu, Wu, Du, Ma, Zhu & Liu, 2011).

Negative attitude expressed towards a suicidal person to suppress self-destructive desires might consequently be thought of as suicide preventive. But such view is simplistic as in most cases people tend to expressed negative attitudes towards the person going through the suicidal crisis and not the behaviour. In about 8 years' studies of suicide in Ghana, a consistent observation is that people have found it difficult to decouple the suicidal person from the act. They hate the act, condemn the act, but are unable to express empathy towards the victim. The social reactions towards suicide attempters therefore become traumatic for them in Ghana (Osafo et al., 2015). These negative attitudes toward suicide, it is argued, are products of the Ghanaian sociocultural set up which has created a value system of what constitutes

good death and bad death. It is argued that such moral view of death is facilitated by three influential institutions. The first institution is the family/community, the second is religious organisations and the third is the law that criminalises suicide.

The family and community: The social arrangement of Ghana is patterned along interdependence. Sociological analysis has revealed that the family is a social insurance in Ghana and therefore socialisation of members are patterned along moral lessons that are geared toward reducing loses and maximising success (Assimeng, 2016, Nukunya, 2013). Children are socialised to avoid any behaviour considered image damaging since the damage inflicted by acts of misconduct is shared by all members.

Similarly, a personal act therefore has serious social consequences for the rest of the family and by extension the community. Suicide in Ghana is, thus viewed by most communities as an anathema, with molestations of the body of the suicide, the destruction of anything or method used in the process and the memory of the suicides destroyed (Adinkrah, 2012a; Osafo et al., 2011c). Thus socioculturally, beliefs and practices in Ghana are all proscriptive of suicide (Osafo et al., 2011c).

Research on the meaning/s of suicide in Ghana has discovered that suicide as a phenomenon has been conceptualised as an act with serious consequences for the family. For example, suicide is conceived by lay persons in both rural and urban Ghana as a waste of potential, an act of cowardice, a threat to conjugal opportunities and a social injury for the family (Osafo et al., 2012). African families (much as Ghana) value honour. It is an attribute that gives families a stake to participate within the social space of human interaction. A loss of this honour as a result of suicide is considered a threat to social survival.

In certain tribal groupings it is even considered a curse, with serious future consequences for the family. The suicidal attempter then has an uphill task of survival because his or her first tormentors might be from the immediate family and the community at large. In one of our studies, a suicide survivor indicated that the inhumane treatment meted out to him by the community was severer than the pressures which pushed him to consider suicide (Osafo et al., 2015). Such harsh attitudes reflect a view of the suicidal person as an outcast and antisocial person to the collective survival of the family and community.

In the African moral space any conduct that is nonaligned to the collective good is an "anti" entity and might have to be re-aligned through social sanctions and punishment. There are complexities of stigma that exude from suicidal behaviour in interdependent societies. Mbiti (1989) asserted that in such societies personalities are intensely naked as life is shared with each other. From that basis, the act of suicide might represent a pain of betrayal and abandonment for the family and at the same time a threat to their social image (Osafo et al., 2011a, 2011c). The suicidal person consequently, might be a target of anger and strong antagonism.

Religious groups: Ghana is rated as a very religious nation (Gilani, Shahid & Zuettel, 2012). In recent times Pentecostal, charismatic and neo-prophetic ministries have turned the religious landscape into a vibrant one. Religion thus has been deeply infused into Ghana's cosmology and sociocultural practices. Descriptions of Ghanaians as incurably and notoriously religious lend support to this assertion (Gyekye, 2010; Pobee, 2012). It is important however to draw a distinction between religion as a basis for morality and religion as exerting impact on moral behaviours. Gyekye (2013) subscribed to the naturalistic basis of African morality but does admit

the influence of religion in the moral beliefs and practices of the African. Others subscribe to a supernatural basis of African morality (Mbiti,1989; Menkiti, 1984).

What appears to be common in these perspectives is that religion influences African moral discourses (Ikuenobe, 2016; Gyekye, 2013) and this conclusion resonates within the morality-religion discourses in Ghana. For instance, studies have confirmed that religion facilitated negative attitudes towards suicide in Ghana through strongly held religious views such as the sanctity of life, "thou shalt not kill" and the equation of suicide with murder (Osafo et al., 2012). As the moral community theory stipulates, individuals are nested into a community of likeminded persons and this can reinforce religious ideals and behaviours (Stark & Kposowa, 2011a).

Most people in Ghanaian communities might be living in religious moral space which enforces certain moral behaviours and sanctions immorality. It is an everyday experience to see various church groups in almost every community in Ghana openly expressing religious lifestyle through prayer and other rituals. Within such intensely charged religious environment, suicide was viewed by our informants as faith-failure, an idea that expressed incapacitation on the part of a religious person to deploy intrinsic religious resources in coping with life's challenges (Osafo, Knizek, Akotia & Hjelmeland, 2011b).

To deploy religious resources during distressing circumstances also appears to be a measure of one's successful religious lifestyle. Suicide persons are viewed as having failed in their religious lifestyle. Such commitment to core religious beliefs and the pervasiveness of the experience of living in highly religiously moral communities normalises the negativity toward suicide. Accordingly, it may be normal to perceive the suicidal person as a sinner and transgressor before the religious community.

Legal code: Although efforts are intensifying to decriminalise suicide and improve mental health services around the world, attempted suicide continues to be criminalised in some countries. In an extensive review on the legal status of suicide from 192 countries by Mishara and Weisstub (2015), 25 countries still do have penal codes against attempted suicide with additional 20 countries proscribing attempted suicide under Islamic law where the victim could suffer jail sentences. In some African countries such as Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda, including Ghana attempted suicide is penalized (Adinkrah, 2013; Kahn & Lester, 2013).

The 1960 Criminal Code of Ghana indicates that "whoever attempts to commit suicide shall be guilty of a misdemeanor." (Act 29, section 57). Widespread stigma towards suicide in Ghana appears to lend some credence for criminalising it and thus difficult to change this law (Kahn & Lester, 2013). In the meantime, the code is not dormant but active. There are reports indicating that suicide attempters in Ghana are being aggressively prosecuted and fined with majority pleading guilty and receiving sentences ranging from incarceration to fines (Adinkrah, 2013).

However, other reports show that some professionals such as Police, Nurses, Psychologists and Medics are calling for the repeal of this law though others support it (Osafo et al., 2015; Hjelmeland, Akotia, Owens, Knizek, Nordvik, Schroeder & Kinyanda, 2014). Those in favour of the repeal of the law viewed the suicidal person as sick and unwell, whilst those who support the law viewed the suicidal person as a criminal and a potential murderer. They thus validated the need to use the law as means of deterring people and preventing suicide in the long run (Hjelmeland et al., 2014). The institutionalisation of criminal code against suicide might prime the value

of life and living and accentuates the criminal view of suicidal behaviour and persons. This can contribute towards deepening social stigma towards persons as criminals who deserve punishment.

2.3 Perceived Causes of Suicidal Behaviours

Suicide is a multi-factorial problem which cannot be viewed unidimensionally for example, mental disorders equal suicidal behaviour or tragic life events equal the same (WHO, 2012). While suicidal behaviour can be viewed from different academic/disciplinary angles, as seen in the previous sub-section, there appears to be some established causes of suicide termed "risk factors" to which the theories seen previously give different weights when trying to account for suicidal behaviour (WHO, 2012). Based on the factors suggested by the WHO (2012), these can be grouped according to: societal/stressful events or "psychosocial problems", psychiatric problems, access to means and a history of past attempts.

2.3.1 Social/Psychosocial problems

Psychosocial problems are events with the potential to act as triggers of stress and/or induce mental disorders such as depression, anxiety and many others. Such events can put individuals at increased risk of harming themselves and, thus, act as risk factors for suicidal behaviour (WHO, 2012). Examples of psychosocial problems and interpersonal factors include living in poverty, unemployment, loss of loved ones, arguments with family or friends, breakdown in relationships, financial, legal or work-related problems.

While such events are common experiences, only a minority of people are driven to suicide because there are also other factors which appear to protect people against suicidal feelings or acts referred to as "protective factors". They include personality

traits such as constant high self-esteem and good social networks and relations with close ones (family and friends) allowing for social support. A stable and happy marriage and commitment to a religion, are believed to form part of such protective factors.

2.3.2 Psychiatric and biological problems

To act as precipitating factors, or ‘‘triggers’’ to suicide, the stressful events seen must happen to someone who is predisposed, or otherwise especially vulnerable to self-harm. Predisposing risk factors include alcohol and drug abuse, a history of physical or sexual abuse in childhood, as well as social isolation. Psychiatric problems, such as depression and other mood disorders, schizophrenia and a general sense of hopelessness also play important roles. Physical illnesses, especially those which are painful or disabling, are also important factors (Mpiana, Zhu & Liu, 2014).

Access to means

Having access to the means to kill oneself (most typically guns, medicines and agricultural poisons) is both an important risk factor in itself and an important determinant of whether an attempt will be successful or not (Mpiana et al., 2014).

Previous Suicide Attempts

Having made a previous suicide attempt is a powerful predictor of subsequent fatal suicidal behaviour, particularly in the first six months after the first attempt (WHO, 2014).

2.4 Risk Factors

Much of the research on college student suicide and suicide at large has focused on the identification of factors or personal characteristics that increase the likelihood that an individual will commit suicide (Wasserman et al., 2015; Lamis & Lester, 2011).

Wasserman et al posit that the recognition of individuals who are most at risk for suicide (via the identification of a cluster of predictors) should be translated into the saving of at-risk lives due to prevention and intervention efforts. Documenting the risk factors for suicide should not only lead to earlier identification of at-risk individuals, but also inform treatment for those individuals who have survived a suicide attempt (with hopes of decreasing the chance that they will attempt again).

Unfortunately, even with extensive research in this area, college student suicide rates have fluctuated little with suicide still being a major health concern (Drapeau & McIntosh, 2015; Schwartz, 2011). This, of course, could be the result of many forces and does not undermine the importance of identifying risk factors in furthering the understanding of college student suicide. Research has indicated that the following risk factors are most relevant to the college student population and will be reviewed: previous attempt(s) (Wasserman et al., 2015), a mental health diagnosis (Pompili, Venturini, Montebovi & Innamorati, 2011), depression (Konick & Gutierrez, 2015) hopelessness (Wasserman et al., 2015) substance use (Lamis & Bagge, 2011), physical and/or sexual abuse (Martino, 2011), and personal identifying factors (Drapeau & McIntosh, 2015; Centers for Disease Control and Prevention, 2012; Schwartz, 2011).

Even though official statistics on suicide attempts are not available, the AAS estimates that for every young person in 2014 who completed suicide in the United States, 100-200 additional young people attempted and survived suicide, which makes suicide attempt survivors a much larger segment of the population than those individuals who die by suicide (Drapeau & McIntosh, 2015). Directly related to the necessity of the present study, one of the greatest risk factors of suicide is the history

of one or more unsuccessful suicide attempts (Rogers & Soyka, 2014; Schwartz, 2016a).

Groholt, Ekeberg and Haldorsen (2016) conducted a study with 71 Norwegian adolescents who had attempted suicide and found that 44% of the participants had experienced repeated suicide attempts when contacted approximately nine years after their initial attempt. Similarly, Beautrais (2014) found that among 302 New Zealander adults who made a suicide attempt that warranted medical attention, 44.5% either attempted suicide again or died by a subsequent attempt within five years of their initial attempt.

Maris (2012) found that 30-40% of individuals who commit suicide have made at least one prior attempt. While these data are not specific to the population of college students, they indicate the risk that increases when an individual has a history of one or more suicide attempts. While it is important to remember that not every college student who has attempted suicide will attempt again, the presence of such history increases one's risk.

Also, a student who enters college with a mental disorder (or develops one during his/her college experience) is at a greater risk of committing suicide (Hjelmeland et al., 2014; Pompili et al., 2011). Similar to a previous suicide attempt, it is important to remember that not every student with a mental disorder will go on to attempt suicide. More specifically, vast research documents that the presence of depression, in particular, is a mental health condition that is closely related to suicide (Konick & Gutierrez, 2015; Wasserman et al., 2015).

In a study of 345 undergraduates, Konick and Gutierrez (2015) found that when compared to other empirically supported risk factors, symptoms of depression were most correlated with suicidal ideation. Suicidal ideation, in turn, is a strong predictor of both suicidal attempts and completions (Maris, Berman & Silverman, 2010). Closely related to the experience of depression is that of hopelessness, another important factor that has long been identified as increasing one's propensity to commit suicide (Stephenson, Pena-Shaff & Quick, 2016; Wasserman et al., 2015). This loss of hope eliminates one's ability to see beyond the bleakness of the present moment experience, which is often what pushes one to consider suicide as a viable option.

Heisel, Flett and Hewitt (2013) explored the different dimensions of hopelessness and discovered that the presence of social hopelessness (as opposed to simply general hopelessness) is particularly risky for college students and correlated with suicidal ideation among this population. This was the first study to document the importance of assessing for a student's degree of social hopelessness when evaluating for suicidal risk. It is most likely the interpersonal emphasis of college environments that makes social hopelessness an especially relevant suicide risk factor for college students (Heisel et al., 2013). Moreover, the use and abuse of substances has been found to increase a college student's suicidal risk (Wasserman et al., 2015; Lamis & Bagge, 2011). A 13-year study with students at Oxford University, for example, documented that 44% of students had consumed alcohol within six hours of engaging in suicide-related behaviours (Mahadevan, Hawton & Casey, 2010). Lamis and Bagge (2011) discuss how even though much is unknown about both the direct and indirect ways a college student's alcohol involvement can lead to a suicide attempt (warranting further research in this area), it is clearly a risk factor.

Broadening the scope beyond just alcohol use, Brener, Hassan and Barrios (2016) found that those students who reported considering suicide on the 1995 National College Health Risk Behaviour Survey (NCHRBS) were more likely to also use alcohol and/or drugs. Similar to how the likelihood of any risky behaviour increases when one is under the influence of substances, suicide is no exception. A history of physical and/or sexual abuse also appears to increase the likelihood that a college student will attempt suicide (Hjelmeland, Osafo, Akotia, Kinyanda & Knizek, 2011; Mann & Currier, 2011). Among two large undergraduate samples (958 and 1520 students) at a large, mid-western university, Hjelmeland et al., (2011) found that experiences of rape and childhood physical or sexual abuse were associated with an increase in suicide attempts. Wasserman et al. (2015) highlighted the importance of completing a thorough background assessment with potentially at-risk students to help uncover past experiences of abuse, if present. In addition, students that become victims of physical or sexual abuse while enrolled in college should also be recognised as being especially vulnerable to suicidal tendencies.

Again, specific personal identifying factors inevitably place some students at a greater risk for suicide due to known trends in the general population. Even though females, for example, are more likely than males to attempt suicide, males are more likely to actually die by suicide (Sudak et al., 2016). More specifically, for every one male who attempts suicide, three females will also attempt and conversely, for each female who dies by suicide, 3.4 males will also die by suicide (Drapeau & McIntosh, 2015). So, while males are more vulnerable to make fatal suicide attempts, females are more likely to exhibit suicidal behaviour, in general.

Thompson, Vivino and Hill (2012) conducted a study on racial and ethnic differences related to suicide in college students is minimal and is an area in need of further exploration to understand if individuals who identify with certain groups are more vulnerable. National data, however, support that Native American/Native Alaskan youth report the highest rate of suicide for young people (Centers for Disease Control and Prevention, 2012). Although this is not specific to the college student population, in terms of sexual orientation, a study (with 14,433 participants) found that lesbian, gay and bisexual young people were more likely to report suicidal ideation and behaviour (and for different reasons) than their heterosexual peers (Sartorius, 2013). In terms of age, students who are 25 years or older (who commonly also identify a graduate students) are at a greater risk of for suicide (World Health Organization, 2014).

Thus, while identifying with a particular demographic group does not automatically mean a student will commit suicide, it is important to remember that identifying with certain groups may increase a student's vulnerability, even though further research in this area is warranted. More so, risk factors for suicide that are especially pertinent to the college student population have been well-documented within the empirical literature. Previous suicide attempt(s), a mental health diagnosis, depression, hopelessness, substance use, physical and/or sexual abuse, and personal identifying variables are all factors that appear to interact to increase a college student's susceptibility for a suicide attempt (and successful completion of suicide). These factors are important to continually consider and evaluate when working with college students who may be at risk.

The interpersonal theory of suicide and Durkheim's (1951) Suicide Typology highlights the role of a social component in the development of suicide behaviours; yet there is not one simple explanation for suicide, as Hegerl, Althaus and Stefanek (2013) explain: "… we may never know the real reason a person commits suicide. This is a multifaceted problem with a serious consequence, and social isolation, lack of personal or intimate relationships, depression, and/or lack of adequate coping skills may all play some roles in a person's decision to commit suicide" (pp. 150-151). Studies by Blumgart, Tran and Craig (2014) and Christensen, Batterham, Mackinnon, Donker and Soubelet (2014) have indicated that mental health issues such as depression, anxiety, and others should be heavily considered when investigating suicide. When considering the symptoms or actions related to those behaviours, though, it should be worth considering that risk factors and these "behaviours" within these symptoms should be similar to social integration concepts.

Aldridge (2015) also attempted to explain potential individual problems that are considered "risk factors" predicting suicidal behaviour. One of the factors is considered as "personal motivation" such as crying for help/not crying for help, to be out of the way, did not want to be around anyone, no longer belonged anywhere, and avoiding stigma. Another factor was "isolation", which consisted of being alone/having no one to talk to or situational factors such as being a single parent or not having any sex in your life. Other factors include personal stress and death of a loved one as potential risk factors of suicidal behaviour (Aldridge, 2015).

Rudell and Curwen (2015) assessed risks of suicide by creating a list of potential factors individuals may have that link towards suicidal behaviour, which includes psychological/mental health problems, marital problems, physical illnesses, social

isolation, employment problems, loss/bereavement, recent trauma and many others. Some of the factors that Rudell and Curwen (2015) have mentioned can be related towards feelings of thwarted belongingness or perceived burdensomeness, which in turn influence likelihood of suicide ideation.

After Aldridge (2015) created a list of risk factors that may result to suicide behaviour, Rudell and Curwen (2015), a decade later, proposed similar risk factors that confirm that people could have the same problems/risk factors. Previous research has investigated the relationship between the above risk factors and interpersonal theory of suicide. A study conducted by Christensen et. al., (2014) investigated the factors associated with the three components of the Theory of Suicide (thwarted belongingness, perceived burdensomeness and capability of suicide). The researchers hypothesised that suicide attempt risk is higher among people who have a longer history of self-harm, have more methods, and report a lack of physical pain during self-harm. There were 1,167 participants who participated in the original study and returned the follow-up surveys. These results revealed that mental health was significantly related to all three constructs in the Theory of Suicide, whereas various social support measures (such as a strong relationship or a weak relationship from friends/family) were differently significantly related with the three constructs. For example, poor support from family and friends was positively correlated with perceived burdensomeness, but not correlated with thwarted belongingness.

As for acquired capability (ability to kill self or not), results show that there was a connection between stressful life events and lifetime traumas as well as higher levels of psychoticism and receiving negative support from friends and family (Christensen et al., 2014). However, given that the definition of belongingness was not clear for

this study, further investigation would be needed to clarify the association between social concepts and the components of interpersonal theory of suicide.

Moreover, to achieve the goals of assessment, prediction, and prevention, much suicide research has focused on identifying individual correlates of suicide and suicidal behaviour. The predominant methodology has been to compare suicidal and non-suicidal individuals. The underlying assumption is that comparisons of groups of suicidal and non-suicidal persons can provide critical insights that might not be apparent on an individual level. Some researchers (Lester, 2016; Linehan,1986) asserted that suicidality is best represented as a continuum ranging from having never thought about suicide to contemplating suicide to attempting suicide to committing suicide. Others assert that individuals who attempt suicide are distinctly different from people who merely consider suicide, both of whom are different from those who never even consider suicide (Linehan,1986). The empirically identified risk factors in the first part of the following section, therefore, were obtained from comparisons of suicidal and non-suicidal groups or from analyses assessing individuals across the suicide continuum. Note that age, gender, ethnic, and sexual orientation subgroups may share the general risk factors, but they also have specific statistically based risk factors.

2.5 Personality, Cognitive, Environmental, Alcohol/drug use, Behavioural, and Physical Illness Factors

Suicidality is associated with many psychological problems. Suicidality correlates relatively highly with a number of disorders, including depression (Black & Winokur, 1986; Evans & Farberow, 1988); schizophrenia and other disorders involving psychosis (Gilliland & James, 2013); personality disorders (Duberstein & Conwell,

2014; Kullgren, Tengstroem, & Grann, 2015), particularly borderline personality disorder (Duberstein & Conwell, 2014), even without using the repeated suicide attempts that are part of the criteria for this diagnosis (Linehan, 1987b); neuroticism (Beautrais, Joyce & Mulder, 2016); and panic disorders (Bongar, 2011).

2.5.1 Personality

In terms of affect, suicidal individuals are relatively more depressed (Harrington, Fudge, Rutter, Pickles & Hill, 2010) and anxious (Chance, Kaslow & Baldwin, 2014) than their non-suicidal peers. Temperamentally, they are more unpleasant, submissive, and particularly more arousal than their non-suicidal peers (Mehrabian & Weinstein, 1985). Compared with others, suicidal individuals also have reduced ability to regulate their affect (MacLeod, Williams & Linehan, 2012).

2.5.2 Cognitions

In terms of cognitions, suicidal individuals are relatively more hopeless (Cole,1989), more perfectionistic (Blatt, 2015), and more irrational in their beliefs (Woods, Silverman, Gentilini, Cunningham & Grieger, 2011) than their non-suicidal peers. Suicidal individuals have relatively weaker reasons for living (Westefeld, Cardin & Deaton, 2012). They have a more external locus of control (Bendixen, Muus & Schei, 2016). Their attitudes toward life and death are different: They are less attracted to life and more repulsed by it, and at the same time they are less repulsed by death and more attracted to it (Cotton & Range, 2016).

They tend to be less skillful at generating alternative solutions and anticipating negative consequences (Schotte & Clum, 1987); they are more likely to come up with inappropriate solutions to problems (Kehrer & Linehan, 2016). They display over-general retrieval of autobiographical memories and reduced ability to remember

specific positive experiences (MacLeod, Williams & Linehan, 2012). They are less future oriented than non-suicidal individuals (MacLeod et al., 2012). Thus, their ineffective belief systems and weak problem-solving skills mean that suicidal individuals lack the personal resources they need when they experience strong negative feelings. Hopelessness and helplessness are two cognitive/affective states that are often present in suicidal clients. The feeling that things will never change and that there is nothing that can be done about it can be overwhelmingly distressing. Hopelessness is a particularly bad sign, is a better predictor of suicidal risk than depression (Weishaar & Beck, 2012), and is one of the best long-term predictors of eventual suicide (Beck, Kovacs, & Weissman, 1979).

Interested readers should see Beck, Rush, Shaw and Emery (1979); beyond the pharmacological and interpersonal effects (Flavin, Franklin & Francis, 2010). "Rather, it's association may additionally be a function of its capacity to restrict attention to immediate situations, inhibit the ability to solve current problems, and to limit hope for the future" (Rogers, 2012, p. 541). Alcohol and substance use and abuse exacerbate other environmental problems and lessen the ability to cope.

2.5.3 Behaviours

In addition to personality issues, negative emotions, cognitive distortions, and drug and alcohol involvement, some specific behaviours are associated with suicide. A past history of suicide attempt(s) is a danger sign for eventually committing suicide (Nordstroem, Asberg, Aberg-Wistedt, & Nordin, 2015). High lethality in previous attempts correlates with increased current risk level (Suokas & Loennqvist, 2011). In addition, the more recent the past attempt, the higher the current risk (Bongar, 2011). Finally, the opportunity for rescue is also of importance-fewer opportunities for

rescue are associated with higher risk. Verbal communication of intent is also critical. Intent is the individual's desire to die and expectation that death would result from action (Moscicki, 2016). One of the best predictors of suicide is how the client answers the following question: "Have you been feeling so badly lately that you have thought about harming yourself?" (Lester, 2012, p. 91).

Most clients will answer this question honestly, although the ambiguity of the answer (thus, "I don't know," or "Not right now") is often a problem (Maris, 2012). "Although the relation of ideation to action is not isomorphic, sometimes the best predictor of suicide is simply to ask people whether they are thinking about killing themselves" (Maris, 2012, p. 11). Thus, an expression of verbal intent in response to a direct question can alert the intervening counseling psychologist to any plan, method, and potential time of occurrence of possible suicide behaviour. However, the absence or denial of intent in response to a direct question regarding suicide may mask true suicidal intent (Shea, 2015). Therefore, counselling psychologists should be cautious in relying on verbal communication alone.

2.5.4 Physical illness

Across age groups, but particularly among the elderly, physical illnesses also correlate with suicidal risk (Draper, 2016; Duggan, Sham, Lee & Murray, 2011; Runeson, Eklund & Wasserman, 2016), particularly chronic physical illnesses and/or illnesses involving chronic pain (Hitchcock, Ferrell & McCaffery, 2014). Specific physical illnesses associated with increased suicide risk include epilepsy, malignant neoplasms, gastrointestinal problems, musculo skeletal disorders (Maris, Berman, Maltsberger & Yufit, 2012), history of migraine headaches (Breslau & Davis, 2013) and HIV (Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu, & Mann, 1988). Suicidal

individuals, compared with their non-suicidal peers, have personalities that are more disturbed; affect that is more depressed and anxious; cognitions that are more negative; environments that are more adverse; and patterns of substance use and abuse that will depress them, lower their inhibitions, and impair their judgment. They suffer from hopelessness and helplessness, depression, anxiety disorders, and schizophrenia and are lonely, isolated, and physically ill to a greater extent than non-suicidal individuals. They have histories of previous suicidal behaviours that increase their risk for future suicide and further distinguish them from their non-suicidal peers. They will probably communicate to others that they are suicidal.

2.6 Group Factors

Groups of people of different ages, genders, ethnic backgrounds, and sexual orientations face some unique situations and risks for suicide. Therefore, counselling psychologists need to be aware of various subgroup (such as age, gender, race and sexual orientation) risk factors for suicide in addition to the general risk factors (Hitchcock et al., 2014).

Age

Age groups differ in their rates of suicide. Adolescents and adults older than the age of 65 are two groups that have significantly higher suicide rates as compared with the general population. Suicide is the third leading cause of death for adolescents (Goldman & Beardslee, 2018), but diminishes in the list of causes of death among the elderly because, although the risk for suicide increases with age (Moscicki, 2016), other causes of death also increase as people age.

Adolescents: Among children and adolescents, suicide rates have risen in the past two decades. For adolescents (ages 15 to 24), the suicide rate was 12.2 per 100,000 in 1996; for children ages 10 to 14, the rate was 1.6 per 100,000. These rates made suicide in 1996 the third leading cause of death for young people between the ages of 15 and 24.

Furthermore, there are an estimated 8 to 25 attempted suicides to 1 completion, with the ratio even higher in women and youth (National Institute of Mental Health [NIMH], 2016). Although this section primarily discusses adolescents, children share many of the same risk factors. Suicide risk factors unique to adolescents can be divided into four categories, including demographic, psychosocial, psychiatric/ medical, and miscellaneous (Jacobs, Brewer & Klein-Benham, 2016).

Demographically, married adolescents commit suicide more than unmarried adolescents. Psychosocially, suicide risk factors include being pregnant and unwed, experiencing parental absence and abuse, and having academic problems. Psychiatrically, suicide risk factors include attention deficit hyperactivity disorder, epilepsy, conduct disorders, impulsivity, explosiveness, disciplinary crisis, and humiliation (Jacobs et al., 2016).

In terms of miscellaneous factors for individual adolescents, exposure to suicide and presence of fire arms in the home are risk factors (Jacobs et al., 2016). Reasons for the higher suicide rate among youth include increased rates of alcohol abuse and depression; increased access to lethal methods, particularly fire arms; and changes in family structure and practices such as divorce, mobility, and de-emphasis on religion (Goldman & Beardslee, 2016). Cultural factors may exacerbate or ameliorate individual factors in contributing to an adolescent's suicide.

Elderly: Suicide risk increases with age. The elderly has the highest suicide rates of all age groups (NIMH, 2016). Though rates for persons 65 and older dropped between 1940 and 1980, there was a 36% increase from 1980 to 1992 (Steffens & Blazer, 2016). This increase did not affect older adults between the ages of 65 and 74. Rather, there were increases of 11% for adults 75 to 79, 35% for adults 80 to 84, and 15% for adults 85 and older (Steffens & Blazer, 2016).

Elderly European American men older than the age of 85 had the highest prevalence of completed suicides among age and ethnic groups, with a rate of 65.3 per 100,000 (NIMH, 2016). It is particularly risky to be an elderly, isolated, European American man with a history of past attempts and drug or alcohol abuse. Reasons for the high suicide rate among the elderly include physical illness, functional disability, chronic pain, and dependency on others for care (Steffens & Blazer, 2016).

Suicidal elderly individuals experience increased hopelessness, loss of pleasure or interest in life, and cycling from a depressed mood to a feeling of well-being. Furthermore, these individuals have enacting-out coping style as opposed to being able to express personal distress (Steffens & Blazer, 2016). By contrast, factors such as living alone, financial problems, and death or illness in the family have been in consistent in predicting suicidal behaviour in the elderly (Steffens & Blazer, 2016). Compared with younger individuals, the old openly communicate their suicidal intent less frequently, use more violent and lethal means and less of ten attempt suicide decide as a means of gaining attention or as a cry for help (Osgood & Thielman, 2010).

Elderly individuals are less ambivalent about their own suicide than adolescents. The high rates of suicide in both adolescents and older adults speak to unique and specific concerns and problems facing these age groups. Identifying specific risk factors can be a convoluted task, but by increasing the understanding of the complex interactions and contributing factors that lead a person to attempt or commit suicide, counselling psychologists will be better equipped to help suicidal adolescents and elderly individuals.

Gender

Gender differences exist in suicide rates. Men commit suicide 4.5 times as often as women (NIMH, 2016). However, women in most Western countries have a higher incidence of suicidal ideation and attempts than do men (Canetto, 2014; Canetto & Sakinofsky, 2015). Two possible explanations for these gender differences have been espoused, though there are inconclusive data to support either notion. First, it is possible that suicide attempts and ideation in men are under reported and that fatal suicidal behaviour in women is misreported as "accidents" or "deaths from undeterminable causes" instead of suicides.

Second, biological or sociocultural factors may actually result in the observed gender differences. For example, there are differences in how American men and women perceive suicide in general and how people in general perceive suicidal behaviour in men and women: American families are more likely to hide a woman's suicide than a man's, perhaps out of fear that the suicide will cast aspersion upon the woman (Kushner, 1985). Furthermore, a woman's non-fatal suicide attempt is more likely to be seen as an acceptable cry for help (Langhinrichsen-Rohling, Sanders, Crane &

Monson, 2015), whereas similar behaviour in a man is seen as weak and in appropriate given societal norms for men (Canetto & Sakinofsky, 2015).

Thus, social norms may mitigate against nonfatal suicide attempts for men or provide some level of permission for nonfatal suicidal behaviour for women, or both. Men and women display differences in help-seeking behaviour that could contribute to the differences in suicide rates. Men who kill themselves usually do not consult a mental health professional beforehand (Shneidman, 1985). Relatedly, men are more uncomfortable than women being around a person they know to be suicidal (Dahlen & Canetto, 2016).

Men's problems in coping with their own emotionality may lead to marked psychological distress with no source of comfort (Rabinowitz & Cochran, 2014). This unease is a concern in correctly identifying suicidal ideation and risk for self-harm among men, especially when these men are seen by male physicians, psychologists and researchers, or when their intent is noticed (and disregarded) by male peers (Canetto & Sakinofsky, 2015). Cultural norms not only impact suicide and reporting of suicide, but help seeking in general. Culture may interact with gender relevant norms to impact suicide (Canetto, 2014; Canetto & Sakinofsky, 2015).

One example is society's expectation regarding personal accomplishment. When a man is unable to meet culture-bound expectations regarding achievement, his self-esteem and sense of meaning in life may suffer. This phenomenon is likened to the "warrior ethos" that exists in some cultures, such as the American Plains Indians and some Asian cultures (Andriolo, 2015). The sense of honor that comes from accomplishment can extend beyond the individual to the family. When a man fails, he can deal with the disgrace to the individual and the family by suicide. In such cases,

the suicide is expected; cultural ceremonies exist that even glorify the suicide (Andriolo, 2015).

Such "good" suicides were by their very nature restricted to cultural warriors, usually men. Any suicidal act by a woman was "bad," considered to be deviant. Thus, some women and men in specific cultural groups (discussed in more detail in the next section) who attempt or succeed in suicide may do so because of their perceived inability to accomplish culturally defined gender-specific norms. Furthermore, culture can impact whether and which kind of suicidal behaviour is viewed as permissible (Canetto & Lester, 2015).

Ethnicity

Ethnic background makes a difference in suicide rates. Cultures undergoing major periods of change have higher suicide rates than more stable cultures (Jilek-Aall, 1988), but change is not the complete explanation. Countries such as the United States, Japan and Sweden that are highly competitive and goal directed have appreciably higher rates of suicide than countries such as Norway, which has been characterised as less competitive and less goal directed (Jilek-Aall, 1988). Culture may interact with other variables in increasing or reducing suicide risk. There is, of course, considerable difficulty in formulating a global approach to counseling suicidal individuals that encompasses all cultures.

Each culture has its own particular stresses that can influence either a person's suicidality or the manner in which it needs to be addressed. In the following sections, some aspects of the four largest racio-cultural groups in the United States (African Americans, Hispanic Americans, Asian Americans, and Native Americans) are reviewed to illustrate these issues. Note that distinguishing between groups of people

is important in gaining an overview of broad categorical differences. However, there are many more differences within ethnic groups than differences between groups (Range, Leach, MacIntyre, Posey-Deters, Marion, Kovac, Baños & Vigil, 2016). Obviously, membership in any group is not a definitive clue about suicide risk. Individuals may be suicidal regardless of their ethnic background.

African Americans: African Americans have a suicide rate lower than European Americans. In 1996, the suicide rate was 6.46 per 100,000 compared to 11.65 per 100,000 for all groups (NIMH, 2016) and lower than most other ethnic groups (Gibbs, 2014). Though under reporting of suicide among African Americans may occur (Phillips & Ruth, 2013), with suicides perhaps being misinterpreted as accidents or homicides, the differences are too great to be the result of underreporting alone.

Sex differences in suicide exist among African Americans. African American men have higher rates of suicide (11.44 per 100,000) than African American women (1.95 per 100,000). This sex difference in rates is comparable to European American seven though European Americans have higher levels of suicide overall (NIMH, 2016). Furthermore, although African American women attempt suicide as often as European American women and even more than European American men and although they frequently experience high levels of stress and psychological problems, their level of completed suicide is the lowest of all major ethnic/gender groups in the United States (Nisbet, 2016).

This ethnic difference is interesting given the history of poverty and discrimination that African Americans as a cultural group have faced (Gibbs, 2014). Age differences in suicide also exist among African Americans. Inner city African American adolescent men are at greater risk of suicide than individuals of other ages (Maris,

2012). The peak ages for suicide among African American men in general are 20 to 24 years old (NIMH, 2016). Age and gender differences in suicide rates among African Americans are somewhat distinct from the majority culture.

Experts asserted that the reasons for the overall lower rates of suicide among African Americans include a history of resilience and life-affirmation in the African American culture (Billingsley, 2012); a belief that suicide is unacceptable no matter what the life circumstance (Early & Akers, 2013); a strong system of family and community support (Gibbs, 2014); heavy reliance on the extended family, especially family elders (Gibbs, 2014); and participation in a church or religious community (Early, 2012).

There is empirical support for some of these assertions. For example, African Americans have stronger reasons for living than European Americans (Ellis & Range, 2011). Marriage is a protective factor for some African American women (Nisbet, 2016), though it appears to protect European American women against suicide even more (Nisbet, 2016; Stack, 2016). Though the mechanism is not entirely clear, the African American culture appears to provide some protective buffers against suicide as compared with the dominant culture.

Hispanic Americans: Hispanic Americans, likely to be the largest ethnic minority group in the United States in the next century (Portes & Rumbaut, 2010), have a lower suicide rate than non-Hispanics (9.2 per 100,000 compared to 19.2 per 100,000). Suicide is reported as most prevalent among Hispanic Americans between the ages of 15 and 24 (Earls, Escobar & Manson, 2010). Hispanic Americans may experience high levels of stress as a result of their minority status, even though they have a lower suicide rate than non-Hispanics. High stress levels result from difficulty with the English language, poverty, low levels of education, unemployment, poor

housing conditions, low social and political status and living with prejudice (Leong, Wagner & Tata, 2015).

In addition, Hispanic Americans as a group tend to under utilise mental health services (Leong et al., 2015), perhaps because such services lack relevance to them, are financially out of reach to them, are discouraged to them, or because they have alternative resources within the Hispanic American community. Culture may contribute to this lower than expected rate of suicide for Hispanic Americans in several ways. First, Hispanic Americans have a relatively high level of reliance on family, extended family and friends, so that individuals have a well-developed social network.

Second, Hispanic Americans typically have a high trust in religion, which includes the belief that suicide is unacceptable no matter what the circumstances. Third, Hispanic Americans have an emphasis on fatalismo, the belief that divine providence rather than personal control regulates the world, so the individual must strive to accept life's circumstances rather than railing against them (Range et al., 2016). As is true for African Americans, cultural buffers may contribute to the lower than expected suicide rate among Hispanic Americans.

Asian Americans: Asian Americans in the 1980 to 1990 decade were a fast growing group in the United States (Asia Central, 2014). They too have a lower suicide rate than the majority culture and have sometimes been overlooked in the study of suicide (Shiang, Blinn, Bongar, Stephens, Allison & Schatzberg, 2014). Furthermore, although the overall rate is low, suicide is kin this group rises steadily with age. A cultural force that may impact the suicide rate is the de-emphasis on the individual as

opposed to the group, with a corresponding emphasis on inter dependence or inter connectedness (Shiang et al., 2014).

Thus, suicide is viewed as disrespectful or harmful to the entire group, as selfish, as in appropriately passionate and/or as shameful to the family. When suicide occurs, it may be tied to acculturative stress. For example, acculturative stress may occur when an Asian woman comes to live with her family in the United States and discovers that the elderly is not revered or venerated as much as they were in Asia. Acculturative stress may also occur among men who come to America without their families and feel isolated and removed from their culture (Baker, 2014).

Native Americans: Overall, Native Americans have suicide rates 1.6 to 4.2 times the national average (Echohawk, 2014). However, among the diverse Native American culture, there are more than 300 federally recognised tribes who are represented in 278 reservations (Earls et al., 2010), and the tribes vary widely in suicide rates. One possible explanation for the overall high suicide rate is the high rate of alcohol abuse among some Native American youth (LaFromboise & Bigfoot, 1988).

In addition, culturally related risk factors, such as the breakdown of social cohesion and pressures against acculturation by tribal elders, may partially explain this high rate. Furthermore, the personal identities of some Native Americans, especially the young, have been somewhat ambiguous (LaFromboise & Bigfoot, 1988). Some young Native American shave little understanding of their tribal traditions and those who choose to leave the reservation leave behind their sense of identity.

In rejecting their native identities, attempting to acculturate into the majority culture, and being unable to find total acceptance among the majority, an identity crisis occurs for some. Though it is unclear whether acculturative stress raises the risk of

suicidality or exacerbates preexisting stress and problems, Native American tribes with a stronger sense of cultural cohesion have lower suicide rates than other tribes (Lester, 2014b). In any minority culture, unsuccessful acculturation could result in increased stress, depression and suicide (Hovey & King, 2014).

Several factors that could mediate successful acculturation include a supportive community of one's own culture present within the new culture, a tolerance for diversity by the majority culture, the minority person's knowledge of and comfort with the majority culture, the reasons behind the person's migration or attempts to acculturate, and the individual's coping skills, self-esteem, and other aspects of psychological health (Williams & Berry, 2011). Acculturative stress, which can occur when individuals attempt to fit into cultures outside their own, results in an increased risk for suicide (Lester, 2014b).

2.7 Sexual Orientation

Again, the literature investigating the relationship between sexual orientation and suicide suggested that gay and lesbian individuals may be at a greater risk for suicidal behaviours than heterosexual individuals (Remafedi, Farrow & Deisher, 2013; Remafedi, French, Story, Resnick & Blum, 2015). For example, Remafedi et al. (2015) suggested that gay and lesbian adolescents were 2 to 3 times more likely to commit suicide than heterosexual adolescents.

Similarly, Remafedi et al. (2013) report that one third of their gay and bisexual adolescents ample had made a suicide attempt with more than half of the attempters reporting multiple suicide attempts. In a more recent population-based study using 1987 data, Remafedi et al. (2015) report that 28.1% of male adolescent and 20.5% of female adolescent homosexuals and bisexuals had attempted suicide.

Finally, Remafedi et al. (2015) further indicated that sexual orientation was a factor in contemplating or attempting suicide in three fourth soft he cases they studied, and Remafedi et. al. (2013) concluded that sexual orientation is a greater predictor of a decision to commit suicide than either ethnicity or socioeconomic status. Although this literature has been interpreted as providing strong evidence of a link between sexual orientation and suicidal behaviour (Remafedi et al., 2015), have argued for a more tentative interpretation (McBee & Rogers, 2014; Moscicki, 2016).

Moscicki (2016) suggested that there is now a biased evidence that clearly implicates sexual orientation as "an independent risk factor for completed or attempted suicide outside the context of mental or addictive disorders" (p. 48). Similarly, Faulkner and Cranston (2015) highlight typical limitations in the research on sexual orientation and suicide as including small and convenience-based samples, self-selection, and the absence of appropriate comparison groups. Although it may be premature to conclude that sexual orientation in and of itself is an independent risk factor for suicidal behaviour, research in this area has identified a number of factors that seem to place some gay and lesbian individuals at a higher risk.

According to McBee and Rogers (2014) many of the suicide risk factors for gay men and lesbian women overlap with those for heterosexuals, although these factors may take a somewhat different form. For example, substance abuse, which is linked to attempted and completed suicide in general Rogers (2012) is 3 times more prevalent among gay and lesbian adolescents than in the general population (Gibson, 1989). Possible reasons include using alcohol/drugs to cope with the hatred, physical abuse, fear, and isolation experienced by some gay men/lesbian women and using gay bars as socially acceptable places to meet others (McBee & Rogers, 2014).

Similarly, family dysfunction, including paternal alcohol abuse and physical abuse, may be another predisposing factor for gay and lesbian suicide (Schneider, Farberow, & Kruks, 1989). Identity confusion is also a significant contributing factor to the risk of suicide for gay men and lesbian women (McBee & Rogers, 2015). The stress of coming out (Schneider, Taylor, Hammen, Kenneny & Dudley, 2011) exacerbates the typical stresses related to adolescent development (Rotherman-Borus, Hunter & Rosario, 2014).

In addition, the younger the age at which a gay man or lesbian woman becomes aware of his or her sexual orientation, the higher the risk for suicide (Gibson, 1989). Thus, alcohol abuse, family dysfunction, identity confusion and the stress of coming out- rather than sexual orientation per se may be contributing to the suspected relationship between sexual orientation and suicidal behaviour. In addition, disrupted social ties also contribute to suicide risk for gay men and lesbian women in Western Society (McBee & Rogers, 2014) with the risk becoming greater with increased disruptions in social networks (Saunders & Valente, 1987).

This disruption may involve parents' rejection of the gay or lesbian individual, loss of support from family and friends and increased verbal and physical abuse from others (Gibson, 1989). The disruption may lead to low status and limited social integration of gay men and lesbian women (Saunders & Valente, 1987). Additionally, since gay and/or lesbian relationships are not socially condoned or accepted by some, gay and lesbian individuals who experience a termination in an intimate relationship may have less social support than heterosexuals (Saunders & Valente, 1987).

Finally, the social inequity faced by gay and lesbian individuals may increase risk of suicidal behaviour (McBee & Rogers, 2014). Examples of social inequity include denial of access to social benefits, lack of police protection, heterosexuals, lack of job security, with holding of the same rights as married heterosexuals, religious condemnation, physical victimisation, and low status due to the stigma associated with AIDS (McBee & Rogers, 2014). Thus, disrupted social ties may increase stress and diminish the coping resources of gay, lesbian, and bisexual individuals.

2.8 Demographic Factors

There are a variety of miscellaneous demographic factors that may relate to suicidal risk and these will now be briefly discussed. Demographic factors associated with increased suicidal risk include being unemployed (Norstrom, Asberg, Aberg-Wistedt, & Nordin, 2015), being unmarried (Bongar, 2011) or being unpartnered (Mastekaasa, 2015). Suicide rates also seem to vary by geographical location, with the suicide rate higher in urban, metropolitan areas as compared to rural locations (Garrison, 2012).

However, geographic differences in suicide rates may result from other factors such as inaccurate reports, accidental misidentification of death as in determinate and fewer autopsies being per formed to determine cause of death in rural areas (Garrison, 2012). There is some evidence that suicide runs in families (Egeland & Sussex, 1985; Roy, Segal, Centerwall & Robinette, 2010). For example, among Old Order Amish families in Pennsylvania, about 75% of 26 suicide victims clustered in four families (Egeland & Sussex, 1985).

However, whether this association is due to modeling or a genetic link is uncertain (Platt, 2013; Rogers & Carney, 2014). Family history of psychopathology and/or suicidal behaviour, disrupted family environments, negative parenting, and physical

and sexual abuse within families correlate with an increased risk of suicidality (Moscicki, 2016). Whatever the mechanism, families are clearly the source of many shared vulnerabilities and stressors (Moscicki, 2016).

2.9 Consequences of Attempted Suicide on the Lives of Survivors

Internal psychosocial problems, or psychological components, include dominant personality components such as high or low self-esteem, hopelessness, hostility and many others are some of the consequences of attempted suicide on survivors (Hur, Kim & Kim, 2011). These may lead to depression, excess stress and anxiety as well as other mental disorders. Consistent with other studies, four psychosocial factors were found among a study of 100 adolescents aged from 17 to 19 years. The study conducted by Rutter and Behrendt (2014) focus on the overall suicide risk in New York. The study examined suicidal ideation, suicidal behaviour, and history of attempt among the adolescents and found hopelessness, hostility, negative self-concept, and isolation as the root causes of attempts. Hur et. al. (2011) report self-esteem, defined as the evaluation of one's personal traits, as being the strongest predictor for attempts.

Research has shown that self-esteem shows a negative correlation with suicide attempts, and researchers have identified that low self-esteem predicts attempting suicide, usually when related to depression (Wilburn & Smith, 2005; Hur et. al., 2011). Hur et. al. (2011) confirm that positive self-esteem, coupled with social resources (for social support), mediated the relationship between depression anxiety and suicidal probability from a sample of 1586 secondary school students in South Korea, where the importance placed on academic achievement can be extremely stressful for teenagers. Also, Gould, Fisher, Parides, Flory and Shaffer (2016) note

that there was a significant independent impact of social and psychosocial factors on increasing suicide risk among children and adolescents beyond the risks linked to psychiatric illnesses. Some of the examples given included school problems, a family history of suicidal behaviour, poor parent-child communication among others. Such stressful events, consist of events having either occurred in the past, or happening in the present, which may act as triggers and lead vulnerable teenagers to feel depressed and develop suicidal thoughts.

Lewisonh, Rohde and Seeley (2014) found that besides a history of past attempt and current suicidal ideation, other predictors of suicide included attempts by a friend (exposure to suicide leading to potential copycat behaviour) and having been born to a teenage mother (single parent family unit). Results, which were obtained from a sample of 1,508 high school students aged 14-18 years old, suggested that teenagers who are depressed and those who attempt suicide share many psychosocial risk factors. Such risk factors are, however, not universal and are likely to vary from culture to culture and, thus, to change over time. Besides the risk factors previously identified by the CDC for young people, other more recent risk factors for teenagers noted during the literature review include:

1. Violence and Bullying, including cyber or online-bullying;
2. Sexual Orientation;
3. Online media and social networking sites impacting on risky behaviours;
4. Self-harm (mutilation, ingesting toxic substances, self-beating and many others);
5. The breakup of a relationship with a girlfriend or boyfriend;
6. Humiliation;
7. Parental divorce;

8. Victim of Sexual Abuse;
9. Dating Violence;
10. Problems with the law;
11. An unplanned pregnancy;
12. Causing injury or death to another person; and
13. Anniversary of a tragic event

Depending on the context and how vulnerable the individual is, such factors could potentially lead to mental disorders and suicidal behavior, as noted by Hur et. al. (2011) many researchers have pointed to depression as a crucial factor in suicide and described depression symptoms among young suicide attempters (Kandel, Ravies & Davies, 2011). Thus, depressed teenagers may use avoidant and affect-oriented coping behaviours, as opposed to problem oriented behaviours, as a means to escape from their problems, hence, it is not unlikely for such teenagers to choose suicide as a method to escape problematic situations that make them depressed (Kandel, Ravies & Davies, 2011).

In some cultures, adolescents experience life stress associated with peer relationships and achievement that has vast and intense effects. It is, thus, not unheard of that the constant pressure in such contexts causes teenagers to develop mental pathologies, besides depression, such as anxiety and other personality disorders. While mood disorders such as depression, bipolar disorder, and dysthymia are the disorders most commonly associated with suicide and serious suicide attempts. The Clinical Advisory Services Aotearoa (CASA, 2009) from New Zealand has noted the presence of the following additional mental disorders among teenage victims of completed suicide/attempted suicide:

1. Substance use disorders: alcohol, cannabis and other drug abuse and dependency, are also linked with suicidal behaviour. Substance use disorders often occur with mood disorders, anxiety disorders, and antisocial disorders. Additionally, the disinhibiting and facilitating effects of alcohol increase the likelihood of impulsive suicide attempts.
2. Anxiety disorders, schizophrenia, and eating disorders are also associated with elevated risks of suicide.
3. Personality disorders and traits, especially antisocial and borderline, are also associated with higher risks of suicide
4. High rates of co-morbidity, co-occurrence of two or more mental disorders, are also found in those engaging in suicidal behaviour.

Additionally, suicide is a serious health and social issue whose aftermath can be particularly devastating for those left behind. The latter are usually referred to as "survivors", and are intimately and severely affected by it (Davis & Hinger, 2015). For every suicide that takes place, there are several other individuals who are impacted by it. Among those survivors, members of immediate family, extended family, friends, colleagues and acquaintances can be found. Campbell (2014) has estimated that there are about 28 different survivor relationships for every suicide occurring in the U.S. This does not even take into consideration larger families, extended families and social networks existing in some Asian and African countries where the remaining survivor relationships could potentially be much higher.

Again, Campbell (2014) found that the trauma inflicted upon survivors can increase the risk of complicated grieving, which can potentially lead to greater morbidity in terms of physical illness, depression, anxiety, Post-Traumatic Stress Disorder (PTSD),

substance abuse, family and work disruption, as well as further suicide in some cases. It is important to note that the consequences of suicidal behaviour may differ depending on whether the attempt made has resulted in death or not.

In broad terms, the consequences of attempted suicide appear to be more concentrated on the surviving victim. The consequences of successful attempts, or completed suicides, on the other hand, affect survivors the most. Subsequently, according to the existing literature the consequences of suicidal behaviour can be classified according to the following categories:

1. Physical health impairment of victims (in cases of attempted suicide);
2. Mental health impairment of victims (in cases of attempted suicide);
3. Mental health impairment of survivors (in cases of completed suicide);
4. Financial implications (in cases of both attempted and completed suicide);
5. Stigmatisation of victims and family members (in cases of both attempted and completed suicide); and
6. Societal impact (in cases of both attempted and completed suicide).

Furthermore, Campbell (2014) found that victims of suicide attempts themselves suffer from the severe consequences of their act(s), even years afterwards. In cases where there was a significant desire to die, very often the after effects are irreversible. In this case, the impact of the attempt would be milder for family, friends etc. as compared to cases of completed suicides. To make matters worse, in the case of both attempted and completed teenage suicide, the greatest consequence of all would be the loss of a potentially better, if not more promising future, because of a temporary lapse in judgment. The sub-sections that follow, therefore, examine the impact of attempted suicide and completed suicides.

Attempted Suicide: Physical Health Impairment

Suicide attempts usually include parasuicides and real attempts to die. The former is mostly done to attract attention, with no real intention to die, while the purpose of the latter is to end life. In the two cases, the method used, and as such the extent of the damage caused to the individual's health, will differ. In the former, and the most prevalent, suicide method used is swallowing pills whilst for the latter, an "attempter" can go as far as using a shot gun.

A primary consequence of suicide attempts is the harm caused to the body or physical health impairment, following the method used (Campbell, 2014). Following the absence of data on the direct physical consequences of suicide attempts in teenagers, the potential health consequences of these acts are summarised as follows:

1. Overdosing on pills: Internal organ damage such as kidney, stomach and liver.
2. Wrist cutting: Blood loss, infection, tendon and nerve damage, sensory loss, brain damage and the possibility of permanent loss of motor function.
3. Firearm: traumatic brain injury, damage to internal organs, massive blood loss, loss in motor function, possibility of life-long physical and mental handicaps.
4. Jumping from height: spinal injury, traumatic brain injury, shattered bones, paralysis, possibility of life-long physical and mental handicaps.
5. Hanging: damage to the neck and/or spine, arteries resulting in brain damage and loss of motor function.
6. Absorbing noxious substances: sometimes irreversible internal organ damage to the kidney, stomach and liver, among others (Campbell, 2014, p. 121).

While initial emergency treatment may work in the short-term, victims may still die of complications at a later stage (Campbell, 2014).

Attempted Suicide: Mental Health Impairment of Victims

In most cases, a mental health disorder is a common condition in individuals with suicidal tendencies. Following the suicide attempt, mental health impairment is further amplified and the risk is recurrent or relapse is possible. A failed suicide attempt can potentially affect an individual in many different ways, ranging from a sense of shame, helplessness and failure, as well as making the initial reason, and/or related mental disorder, for attempting appear even worse (Brent, Bridge, Johnson & Connolly, 2016). Such emotions can potentially lead to further attempts, or relapse, if the appropriate help is not provided or available. Moreover, a previous suicide attempt has been found to be a leading cause of suicide. Evidently, the need for both emotional and psychological support is crucial after such an event.

Attempted suicide: Mental Health Impairment of Kins

Following a suicide attempt, guilt and blame are often experienced by the close family circle. When the motive of the attempt is poorly understood, or when the act was not expected, the issue of blame is heightened and is coupled by a strong sense of perplexity. It is common that family members and close friends feel that they could have prevented the act. This mixture of feelings can give rise to serious psychological problems including depression and Post-Traumatic Stress Disorder (PTSD). Moreover, it is believed that exposure to suicidal behaviour whether in form of suicide attempts or completed suicide, is linked to increased risk of depression and similar suicidal behaviour in the long term (Brent et. al., 2016). Hence, this is why it is recommended that after such an event, not only the victim, but his/her close entourage, seek psychological help.

Attempted Suicide: Financial Implications

In cases of attempted suicide, the financial cost incurred is both the medical, physical and mental care required for victims. Such costs are usually incurred by the immediate family as opposed to the victim herself/himself and can range from just a few months to being lifelong financial commitments for health and social care.

Attempted Suicide: Stigmatisation

In certain societies, stigmatisation associated with suicide is present to such an extent that victims of suicide attempts and their families prefer to pass the attempt off as an accident. Rejection as well as avoidance by friends and society are feared, since victims of suicide attempts are often regarded as weak and selfish individuals instead of an individual in need of medical care. Stigmatisation, thus, instigates a feeling of shame which is experienced by both suicide victims and the family of victims. As seen previously, in some countries, stigmatisation by society is reflected through the fact that suicide is considered as a crime and attempters are fined and penalised. However, of late, suicide appears to be less and less stigmatised than before (Cerel, Jordan & Duberstein, 2015).

Attempted Suicide: Consequences on Society

The substantial economic burden of suicide attempts significantly affects any society. For this reason, the costs associated with suicide and suicide attempts cannot be ignored (Platt, McLean, McCollam, Blamey, Mackenzie, McDaid, Maxwell, Halliday & Woodhouse, 2016). Direct costs to society are health care costs, in instances where these costs are incurred by the government. Indirect costs to society are productivity losses as a result of disability or premature death of those who have attempted suicide.

As per the Centre for Suicide Prevention (2010) indirect costs are classified as: (1) human capital, which quantifies the value of time lost due to absence from work or reduced productivity; (2) friction cost which estimate the cost of replacing workers temporarily or permanently disabled with other existing workers; (3) willingness-to pay which estimates what individuals are willing to pay either (a) to avoid being victimised or (b) the cost preventive measures to avoid exposure to or mitigation of the effects of injury (Butchart, Brown, Khanh-Huynh, Corso, Florquin & Muggah, 2015).

The media-related impact of suicide concerns the unethical and sensationalistic reporting of attempts, depending on how it is done, such reporting can negatively influence the stigma and taboo surrounding such acts for victims and the public at large. In some cases, the consequences of such reporting may go even further than that and can potentially impact culture in other ways by contributing to the exposure of suicide and making an acceptable option (Brent et. al., 2016).

Completed Suicides: Mental Health Impairment of Survivors

Barrett and Scott (2010) made reference to the 'parent survivor' in their study. This term describes parents who lost a child as a result of suicide and who are left with intense feelings of guilt arising from not protecting their child. Parents, siblings and friends suffer tremendously from their loss. When the suicidal act happens unexpectedly and suddenly, the survivors are brutally faced with a harsh and unexpected reality. In the US, there are 36,000 suicides every year and it is estimated that for every suicide there are at least six survivors. It is believed that this number of survivors varies depending on who defined themselves as a survivor (Berman, 2011).

These survivors of suicide also represent "the largest mental health casualties related to suicide" (Edwin Shneidman, Ph.D., Founding President of the American Association of Suicidology (AAS). Family members and close friends of the victims are deeply impacted by the tragic event, and experience a range of complex grief reactions including, guilt, anger, abandonment, denial, helplessness, and shock (Jordan, 2011; American Association of Suicidology [AAS], 2015), which often lead to psychological stress. Survivors may face the added psychological stress of societal blame and reduced social support (Cerel et al., 2015). During the bereavement process which is often painful, psychological help and support are highly recommended. Moreover, as for suicide attempts, exposure to completed suicide, is linked to the risk of personal suicidal attempt in the long term (Brent et al., 2016).

Completed Suicides: Impact of suicide on social relationships. Suicide can have a profound effect on the social network of survivors (Cerel et al., 2015). Blame for the death of the victim can be expressed through social withdrawal and results in the rupturing of the cohesion in a family or a social network (Barlow & Coleman, 2013).

Another factor responsible for the distortion of communication, and eventually to the disruption of family networks, is the secrecy surrounding the cause of death. The long term effects of secrets (or lies) in families and other social systems can cause dysfuntions and impact on the psychological development of all family members, particularly children (Jordan, Kraus & Ware, 2013; Walsh & McGlodlrick, 2011). Both blame and secrecy after suicides, in turn, give rise to further social isolation and self-isolation of survivors, which are forms of communicational distortion (Cerel et al., 2015).

2.10 Coping Strategies by Survivors of Suicide

This subheading discusses the coping mechanisms adopted b survivors of suicide.

2.10.1 Peer support groups for coping with suicide loss

In light of the distinctive bereavement issues and experiences of stigma that suicide survivors face, they are also placed in a predicament of finding the "right fit" in the professional help that they seek in order to cope. As it turns out, a substantial number of suicide survivors have found solace in joining peer-facilitated/suicide survivor-led groups. In fact, these groups are the preferred model of help, relative to treatment from the medical-psychiatric profession (Feigelman & Feigelman, 2015).

In a systematic analysis of these groups, Feigelman and Feigelman (2015) explore the unique nature of peer-facilitated suicide survivor support groups as they played the role both of researchers and of participant-observers. In their analysis, they utilised Schulman's dynamic principles as a framework from which to articulate how suicide survivor support groups assist in the therapeutic process of their members. Specifically, the following 10 principles of mutual aid were demonstrated to be of help in addressing the multifaceted needs of group participants: (1) The "All-in-the-Same Boat" phenomenon, (2) Discussing a Taboo Area, (3) Mutual Support, (4) Individual Problem Solving, (5) Sharing Data, (6) The Dialectical Process, (7) Mutual Demand, (8) Rehearsal, (9) Universal Perspective, and (10) The "Strength-in-Numbers" Phenomenon.

Of note, these groups are successful because they allow suicide survivors to voice their feelings openly and authentically. Members are also provided the opportunity to offer help to one another, allowing the participants to identify their similarities and work collaboratively to form a natural therapeutic setting, complete with mutual trust.

Furthermore, these groups are valuable in supplying the bereaved individuals with peer examples of coping and survival as well as affording them the opportunity to advocate within the community and reduce stigma (Clark & Goldney, 2010).

2.10.2 Importance of communication and cohesiveness

In terms of coping within the bounds of family, grief is best handled when family members work as a group, speak openly about their feelings, and are thoughtful, sensitive and responsive to the needs of their surviving family members (Callahan, 2010; Nelson & Frantz, 2016; Schoka Traylor, Hayslip, Kaminski & York, 2013). In this regard, suicide survivors noted that being surrounded by supportive others with whom they were well-acquainted was helpful in handling the immediate shock (Lindqvist, Johansson & Karlsson, 2015) and that the construct of expressiveness was related to the closeness that a family reported during their time of grief (Nelson & Frantz, 2016). In fact, Dyregrov and Dyregrov (2015) emphasise open communication about loss and a "shared experience of the loss within the family" for the ultimate health of the family (p. 721).

However, the core features of expressive, open communication and family cohesion are difficult for some families to achieve. In this regard, family therapy is regarded as a viable option to help families cope with loss; however, the effectiveness is dependent on the strength of the family bonds, on their social support networks, the ability to communicate with one another, and the members' self-esteem (Kaslow & Aronson, 2014). Communication appears to be a core feature in working through loss as a unit; however, it does not simply improve in time (Nelson & Frantz, 2016).

Rather, despite the general decrease in overt conflict observed in surviving families, improved communication patterns and a tightening of relationships within the family appear to be something that families need to work on actively in order to achieve healing (Nelson & Frantz, 2016). Conversely, if families experience less cohesion and they struggle as a result to adapt to change, then they are at relative risk for further attempted suicides amongst their members (Compton, Thompson & Kaslow, 2015).

2.10.3 Typologies of family coping styles in the context of natural loss

Research studies conducted by Kissane, Bloch, Onghena, McKenzie, Snyder and Dowe (2016b) sought to uncover whether there were any patterned responses amongst surviving family members who had lost either a parent or a spouse to cancer. The surviving family units participated by filling out questionnaires that addressed issues such as preferred coping patterns and co-occurring risk factors. As a result, the families were categorised according to a model containing the dimensions of expressiveness, conflict, and cohesiveness. Kissane, Bloch, Dowe, Snyder, Onghena, McKenzie and Wallace (2016a) discuss the fact that cohesiveness stood out as a core factor in what defines a resilient family.

Specifically, it is because the individuals in the family enjoy a genuine closeness with one another, are open to expressing the continuum of emotions (including negative emotions associated with grief), and share a balance of support across members that they experience success in coping. These families (who constitute about 1/3 of the families studied) do not display open disagreement and are referred to as supportive (Kissane et al., 2016a).

In contrast, these researchers associated conflict with destructive family dysfunction and identified a grouping in which anger, aggression, poor communication and organisation, and disconnectedness were prevalent; this is the hostile maladaptive family grouping (Kissane et al., 2016a). They also defined a sullen grouping which shared some characteristics with the hostile group, but they usually had a domineering family member who mandated prescriptively how the family was going to function (Kissane et al., 2016a).

The remaining two groupings of families were the conflict-resolving and intermediate ("ordinary") families because they represented intermediary points on the continuum. The conflict-resolving families demonstrated some level of dysfunction but also possessed the quality of cohesiveness and the intermediate families possessed some cohesiveness but did not struggle with the conflict underlying dysfunction; rather, the results suggested they are likely to allow overarching societal rules, rather than their family's consensus, to dictate the decisions they make as a family (Kissane et al., 2016a). In terms of the implications of these typologies on clinical factors, Kissane et al. (2016b) found that the hostile and sullen groupings experienced more depressive symptoms and suffered more psychological anguish in comparison with the other groupings. Intermediate families were slower to re-engage with their social networks, but the supportive and conflict-resolving families did not display problematic patterns of behaviour in relation to bereavement and social adjustment or endorse symptoms associated with a wide-range of psychopathological disorders (Kissane et al., 2016b).

Of chief importance, the supportive families experienced intense levels of grief; however, the ability they had to unreservedly express and share their distress surrounding their loss, as a collective group, enabled them to work through their

sorrow and preserve their mental health (Kissane et. al., 2016b). Thus, the support they provided one another as a cohesive, expressive group who was open to sharing a multitude of emotions and thoughts in bereavement fared well despite all foreseeable risks. The authors discuss the resulting utility of classifying grieving families according to these dimensions because it allows interventionists a foothold into comprehending the process through which a particular family is going to grieve. Furthermore, this understanding reveals optimal places in which a family would benefit from targeted support in order to help facilitate their grief process in an effective, adaptive manner (Kissane et. al., 2016b).

2.10.4 Typologies of family patterns within the context of suicide loss

In contrast to the work with families and the grief they suffer, in the context of natural loss, Cerel et al. (2015) sought to investigate the parental and family functioning of children and adolescents who experienced bereavement as a result of losing one of their parents to suicide. Participants were interviewed one month after the death of the parent and the authors categorised the suicide-bereaved families into one of three categories. Their defined category, functional families, showed no evidence of psychological problems or family difficulties prior to the loss. The majority of suicides in this category occurred as a result of chronic medical hardships and physical illness. Conversely, chaotic families demonstrated characteristics of psychopathology and family conflict prior to the suicide event. Within these families, there was evidence of physical abuse and general dysfunction within the family. Encapsulated pathology families, on the other hand, included families in which the decedent suffered symptoms of psychopathology, but the other family members were deemed to be psychologically intact and displayed healthy patterns of interaction.

In Cerel et al.'s (2015) study, approximately half of the participating families were regarded as chaotic according to their descriptive categories, suggesting that families who lose members to suicide may experience a generally elevated level of dysfunction and conflict prior to the event of suicide. It is noteworthy, however, that in addition to a relatively small sample size, the methods used in this investigation included semi-structured interviews. As a result, it is unclear what the particular nature of the dysfunction resembled, in terms of how the surviving family members perceived it or would choose to describe it in relation to their life experiences.

2.10.5 Suicide survivors' family interaction

Patterns in relation to healthy coping regardless of the familial risk factors specific to suicide survivors discussed in the previous section, there is a body of research, indicating that some surviving families experience a fortification of the family post-loss and that those who overtly address pain and grief in a shared fashion can experience this increased closeness with family members (Clark & Goldney, 2015; Dyregrov & Dyregrov, 2015; Nelson & Frantz, 2016).

Specifically, some research has uncovered the fact that a number of the suicide survivors that were interviewed ended up restructuring their lives so that they were able to work toward the goals that the deceased held, ultimately creating new purpose and meaning in their own lives after their loss (Clark & Goldney, 2015). In light of our knowledge of constructive, healthy forms of coping (for example, cohesiveness and expressiveness as discussed in Kissane et. al., (2016a) and Kissane et. al., (2016b) that have been restorative to grief stricken families, it is unclear about how to best support this process in surviving families. In this regard, despite the conception that suicide is a profound experience that could be negatively life altering to a family, the

way in which a family's style of functioning factors into an anticipated prognosis is unknown.

In terms of the resilience that interventions are aimed to promote within families, it is an open question about whether or not there are family profiles (akin to what has been observed in non-suicide grief in the work of Kissane et al. (2016b) that would help or hinder a family's ability to heal and cope constructively with its loss. In order to address this question, systematic analysis of family interaction patterns and management of stressful situations both prior to and post the suicide loss are essential. However, the general level of family functioning prior to the suicide event is not commonly addressed, so direct comparisons between pre-loss patterns of functioning and the family structure and dynamics post-loss have not been widely explored (Cerel et al., 2015).

2.10.6 Pre-existing family interaction patterns

Some research evidence implies that family patterns of poor attachment and troublesome interactions as observed in families affected by suicide prior to the loss, are unique (Jordan, 2011). However, in regard to the findings that each family member's individual response to the loss transformed the family dynamics as a whole (Clark & Goldney, 2015), the fluid nature of these dynamics appears to be influential within a family. Presumably, these dynamics could also have shifted in response to other events that the family experienced prior to the loss and may have proved powerful in forming the psychological/interpersonal state that the family was in upon receipt of the news that a member died due to suicide. Regardless, there is scant research in the literature that explores the interaction patterns of the family both prior to and following the suicide loss.

In one such attempt, Nelson and Frantz (2016) investigate the effects of the death of a child by suicide on the family dynamics of affected families as they compared with families who grieved because of losing a child to illness or accident. They uncovered the fact that there was much consistency in the interaction patterns observed amongst the participating families both prior to and post-loss, suggesting that families' levels of perceived disengagement, conflict, expressiveness, and cohesion were unaffected by the type of death. These results suggest that the more expressive and sharing the family members were with one another prior to experiencing the death, the more likely they would be to continue that supportive pattern of interaction during challenging times of bereavement.

Another approach to uncovering core family interaction patterns involved interviewing individuals who have survived a personal suicide attempt, in regard to how they viewed their family's characteristics. Summerville, Kennedy, Mather and Carstensen (2014) argue that a majority of the urban adolescents who have attempted suicide report that their family's style of functioning was disengaged and was marked by low cohesion, as well as low levels of perceived warmth. It is noteworthy that the perception of support may play a larger role than the actual availability of support (Compton et. al., 2015), suggested that if families are at the very least present and attentive to some degree, a member who is struggling may not feel entirely isolated, helpless, and vulnerable.

Furthermore, in another investigation that utilised predictive statistical modeling, Weich, Patterson, Shaw, and Stewart-Brown (2016) concluded that maternal psychological unavailability early in life (prior to age 5) predicted attempted suicide (by the age of 16) and was associated with thoughts surrounding suicide. Having said

that, the general pattern of research findings revealed that families whose structure is defined by low cohesion and disengagement are problematic for coping with loss and co-occur with suicide-relevant factors. However, it is unclear about when in the family's history such destructive patterns were adopted. A goal of the present study is to investigate whether or not disengagement and poor communication accurately described the family's style of interaction prior to experiencing a suicide or if these were resulting responses to the trauma of suicide loss.

Furthermore, in light of the highly personalised bereavement experiences that could influence subsequent interactions with others (for example, if the loss involved a parent versus a lover; Barrett & Scott, 2010), a research method that could effectively and authentically probe the intricacies of loss and family problem solving is warranted.

2.11 Protective Factors for Suicide

Research reports have been published, aiming to explore which variables have a protective function in the development of suicidality when confronted with risk factors. Sense of belonging: "Sense of belonging" has been defined as the experience of being personally involved and integrated within an environment or system (Heisel, Neufeld & Flett 2015a). Two dimensions have been discerned: an antecedent dimension (a person has the energy, interest and potential to develop a sense of belonging) and a psychological dimension (a person has to feel valued, needed and significant within the environment).

Both components of sense of belonging were protective in the development of suicidality (in a sample of retired home-dwelling older people), although they operated in different ways (McLaren, Merrill & Owens, 2014). High scorers on the

antecedent dimension of sense of belonging expressed less suicidality than low scorers independently of the effect of depression, whereas high scorers on the psychological dimension of sense of belonging seemed to be protected against suicidality even when they expressed a high level of depression.

Positive future orientation: "Future orientation" has been defined as "a predisposition to think about and have a positive mood about the future and to strive toward achievement of identified goals" (Heisel et al., 2015a, p. 101). Heisel et al. (2015a) found that in patients with Major Depressive Episode [MDE] (50 years and over), having a positive future orientation was associated with lower reports of suicidal ideation, although this association might be due to an interaction effect with functional status: the association between functional status and the presence of suicidal ideation is weaker for patients with higher levels of future positive orientation (Heisel et al., 2015a).

Positive affect: The trait Positive Affect was shown to distinguish older primary care patients (65 years and over) reporting suicidal ideation from those who did not (Heisel et al., 2015b). Agency measured as "socially desirable masculine traits" was found to be related to suicidal ideation in Australian men, not women, aged 65 years and above (Hobbs & McLaren, 2014). Older depressed men with low levels of agency have a greater increase of level of suicidal ideation compared to depressed men with high levels of agency.

Reasons for living: Patients with MDE (aged 50 years and over) who reported higher levels of fear of suicide was less likely to report suicidal ideation (Hobbs & McLaren, 2014). Concerning reasons for not committing suicide, moral objections and child-related concerns were raised by older people (Hobbs & McLaren, 2014).

Happiness: Happiness was shown to have an attenuating effect on the relationship between the number of self-reported diseases and the report of suicidal distress in primary care patients (60 years and over): persons with chronic medical problems who also exhibit positive emotions are less distressed by thoughts of suicide (Heisel et al., 2015b).

In addition to the study of preventive factors discussed, some researchers (Hobbs & McLaren, 2014) have also emphasised the added importance of also looking at factors that protect against suicide. Just as it is important to know what factors may contribute to suicide, knowledge of what may keep that same person alive is especially critical to inform intervention efforts. Conceptualising suicide through the combined evaluation of risk and protective factors seems to provide a more complete picture than looking at either risk or protective factors alone. To that aim, the following protective factors were reviewed: social support, reasons for living and personal factors (which includes self-esteem, problem solving skills, and religiosity/spirituality).

Similar to how social hopelessness has recently been identified as a particularly important risk factor for college students (Heisel et al., 2015b), the presence of social support is one of the most well-documented protective factors against college student suicide (Heisel et al., 2015b). Defined by Westefeld, Cardin and Deaton (2012) as "an individual's sense of belonging, the presence of an important relationship with another individual, and an understanding that this relationship is meaningful to all parties involved" (p. 171), social support spans relationships with family, peers and mentor-like older adults.

The director of the University of Iowa's University Counseling Service, Sam Cochran (as cited in Westefeld et al., 2012), believed that peer relationships are the most influential type of social support for college students, especially as students are oftentimes breaking away from family in developmentally appropriate but challenging ways. Westefeld et al. (2012) recognised that if a suicidal student has a well-established peer network, they might also be more likely to disclose their suicidal thoughts (and hopefully allow for an appropriate intervention).

In addition, because social interactions are especially emphasised in college, it seems obvious that the presence of secure and trusting relationships would help to insulate one from suicidal activity. The paradigm shifts of thinking about reasons to live (as opposed to reasons to die) has been identified as a protective mechanism for college students after it was first developed and applied to the general adult population (Westefeld et al., 2012).

This parallels the importance of focusing on what keeps suicidal college students alive for example, protective factors) versus what propels them into a suicide attempt (for example, risk factors). In extending the reasons for living research to college students, Westefeld et al. (2012) identifies six areas that represent college students' rationale to choose life over suicide. They include survival and coping beliefs, moral objections, responsibility to friends and family, fear of suicide, fear of social disapproval, and college and future-related concerns. The sixth category is the only one that differed from the original work done by Westefeld et al. (2012), which replaced child-related concerns, highlighting developmental differences between adult and college student populations. In a study on suicidal risk assessment with 211 students at a Midwestern university, Weishaar and Beck (2012) found that protective reasons for living

included fear of social disapproval, fear of suicide and responsibility to family. Westefeld et al. (2012) acknowledged how being mindful of reasons for living that could have protective power with suicidal students can be a key component of suicidal interventions, helping students realize that there are things worth living for, making suicide a less desirable choice.

Personal factors that can deter a college student from suicidal action include high self-esteem, adaptive problem-solving skills and religiosity/spirituality (Westefeld et al., 2012). The relationship between high levels of self-esteem and reduced likelihood of suicidality has clearly been established empirically (Suokas & Loennqvist, 2011). College students with higher levels of self-esteem and confidence are less likely to turn to suicide in times of crisis. It can be helpful for clinicians to focus on boosting a people's self-esteem (even in small ways) if suicide seems like something a student may be considering.

In general, providing individuals with opportunities (via classes, student organisations, university events and many others) to develop self-esteem is recommended (Westefeld et al., 2012). Students who have developed effective problem-solving skills are also more protected from suicidal behaviour (Moscicki, 2016). Westefeld et al. (2012) believes that "helping students develop healthy and positive ways of relating to and conceptualising setbacks would not only reduce their risk of suicide but will also contribute to their overall psychological health" (p. 176).

Also, a student who holds religious or spiritual beliefs appears to be an additional personal factor that protects against suicide (Gould et al., 2016), although more research is needed in this area. Thus, the identification of protective factors provides an important contribution to the empirical literature on college student suicide.

Specifically focusing on and fostering college students' social support, reasons for living, and adaptive personal factors can lessen their suicidal risk and should be utilised within both clinical and higher educational contexts.

It is clear that much research has been done on the importance of identifying both risk and protective factors related to college student suicide in an attempt to reduce the likelihood of the phenomenon from occurring in the future. Much of what is known about suicide is related to the study of risk and protective factors, that is why the author chose to open the literature review with an explanation of these factors.

2.12 Summary of the Related Literature Reviewed

The summary of the related literature revealed that majority of suicide being committed are due to victims' inability to cope with the challenges they were going through in live. The review suggested that social/psychological problems, psychiatric and biological problems and others were the main causes of suicide. The review also showed that majority of survivors of suicide were faced with stigmatisation either from family relatives, community members or health professional. This situation in most cases made survivors of suicide to attempt committing another suicide. It was deduced from the review that stigmatisation goes a long way to affect survivors of suicide. The review further indicates that majority of the studies were done in developed countries with very few in developing countries like Ghana.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter deals with the research methodology of the study, which includes the research paradigm, research approach, research design, study area, population of the study, sample and sampling technique, data collection instrument, trustworthiness of the interviews, data collection procedures, data analysis procedures and ethical considerations.

3.1 Research Paradigm

The study used interpretivism research paradigm. A research paradigm intends to define approaches to social science research (Ary, Jacobs & Sorensen, 2010). According to Creswell and Creswell (2018), participants seek understanding of the world in which they live so the use of interpretivism paradigm allowed the participants of the study to view their world through the perceptions and experiences they have concerning attempted suicide. The study then used these experiences gathered from these participants to construct and interpret their understanding from the gathered data. An understanding of the context in which this research was conducted is critical in the interpretation of the data gathered as suggested by Gall, Gall and Borg (2010) based on the belief that reality is socially constructed.

3.2 Research Approach

The study aimed at gathering data using words hence, the use of qualitative research approach. The reason was that the aim of qualitative research is to illuminate an experience or understanding for others, but, unlike quantitative research, not to generalise from it (Cohen, Manion & Morrison, 2013). Creswell and Luketic (2013)

define five features of qualitative research approach which help put this debate into perspective. The features are as follows: Qualitative research has actual setting as the direct source of data and the researcher is the key instrument, qualitative research is descriptive. The written results of the research contain quotations from the data to illustrate and substantiate the presentation, qualitative researchers are concerned with process rather than simply with outcome or products.

Qualitative researchers tend to analyse their data inductively. They do not search out data or evidence to prove or disprove hypotheses they hold before entering the study, rather through emergent data collection, they are constructing a picture that takes a particular shape and qualitative researchers are concerned with what are called participant perspectives. How different people make sense of their lives is their major interest (Hammersley, 2013).

Also, Dudovskiy (2016) suggested that qualitative approaches are not presented as statistical summations, but rather in a more descriptive style. Dudovskiy (2016) further argued that the close connection between qualitative research and teaching might inspire educators to become involved in research so that the results of studies might lead more expediently into new decisions for action. This added further weight to the researcher's decision to use a qualitative methodology, because the aim was to explore lived experiences of survivors of suicide in the Kasena-Nankana Municipality, therefore it was ideal to use qualitative research approach which gave participants the opportunity to share their experiences without been restricted. In furtherance, qualitative approach was used because the study was concerned with developing explanations to social phenomena. Thus, it sought to find answers to questions relating to how suicide and its interventions affect people. Qualitative

approach also helped in providing a unique opportunity to explore and elicit unlimited perspectives and opinions from participants on suicide.

Additionally, the study aimed at understanding situations in their uniqueness as part of a particular context and the interactions there. This understanding was an end in itself, so that it was not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting-what it means for participants to be in that setting, what their lives were like, what was going on with them, what their meanings were and what the world looked like in that particular settings.

3.3 Research Design

Phenomenological research design was used for the study. Patton (2002) state that phenomenological studies have become an important research method, especially in instances when one needs to understand specific phenomena in depth. Dudovskiy (2016) also argue that:

> Researchers in the phenomenological approach do not assume, they know what things mean to the people they are studying but attempt to gain entry into the conceptual world of their subjects in order to understand how and what meaning they construct around events in their daily lives (p. 23).

They believe that multiple ways of interpreting experiences are available to each of us through interacting with others. The reason for using this design was that the study sought to interpret the meaning of lived experiences of survivors of suicide in the Kasena-Nankana Municipality. The design was considered because it helped the researcher to focus on descriptions of causes of suicidal thoughts, how attempted suicide affects the lives of survivors, coping strategies used by survivors of suicide and preventive factors that can be put in place to minimise attempted suicide in the

Kasena-Nankana Municipality. The design also helped participants to share experiences on the topic without been limited.

The phenomenological design again was considered the most appropriate for the study because it helped the researcher to detach her own presuppositions from the study and not to pretend otherwise (Gall et al., 2010). Thus, the intention of this research, at the outset (preliminary focus), was to gather data regarding the perspectives of survivors of suicide about the phenomenon of causes of suicide, how it affected their lives, coping strategies and preventive factors. Since, the study sought to gather data on lived experiences on these variables, phenomenological design was found to be the appropriate design to use in the study (Gall et al., 2010).

3.4 Study Area

The Kassena Nankana Municipality is one of the fourteen (14) districts in the Upper East Region of the Republic of Ghana. It shares boundaries with Burkina Faso and with West Mamprusi District (in the Northern Region) (Ghana Statistical Service [GSS], 2010). The population of the Municipality according to the 2010 Population and Housing Census is estimated to be 109,944 people with a female population estimated to be 56,268 representing 51.2% while the male recorded 53,676 representing 48.8% of the population (GSS, 2010). The total age dependency rate is about 54.35 percent of the total population in the municipality which falls within the potential labour force (59,751); out of this figure 28% are females and 26.35% are males (GSS, 2010).

The climate conditions of the Municipality are characterized by the dry and wet seasons. During such periods, rainfall is virtually absent due to low relative humidity. This makes most of the youth in the municipality idle during the dry seasons

(November to April). During this period, those without alternative sources of income, have no option than to migrate to the south for greener pastures.

Most of the people in the Municipality are predominantly Christians and this is followed by traditionalist. There also exist religion other religions such as Islam, non-believers and others. Festival is a significant cultural practice in the Municipality. The people of Kassena Nankana predominantly celebrate the Fao festival. This festival is celebrated to thank the gods for bumper harvest and ensuring food security (GSS, 2010).

The main employment opportunity for the municipality is farming and animal rearing with very few people in the public and private sector. The Municipality has 59 Primary Schools, 39 Junior High Schools, 5 Senior High Schools, 3 Vocational Training Institutions, 2 Training Institutions and 1 University (GSS, 2010). The municipality have one hospital (War Memorial Hospital) with other 24 health facilities for health care delivery. The hospital has been the only center in the municipal where conditions like the attempted suicide cases are been referred (GSS, 2010).

From this description, it could be deduced that folks of Kassena Nankana who are not gainfully employed depend on the few people who are gainfully employed for their survival. This could infer that when these dependents are unable to meet the financial needs of those who are unemployed, it could add to the stresses they are going through. When they are unable to resolve or overcome this stress, it could compel them to attempt suicide as a way of escape to those unmet needs. Next is the map of Kassena Nankana municipality.

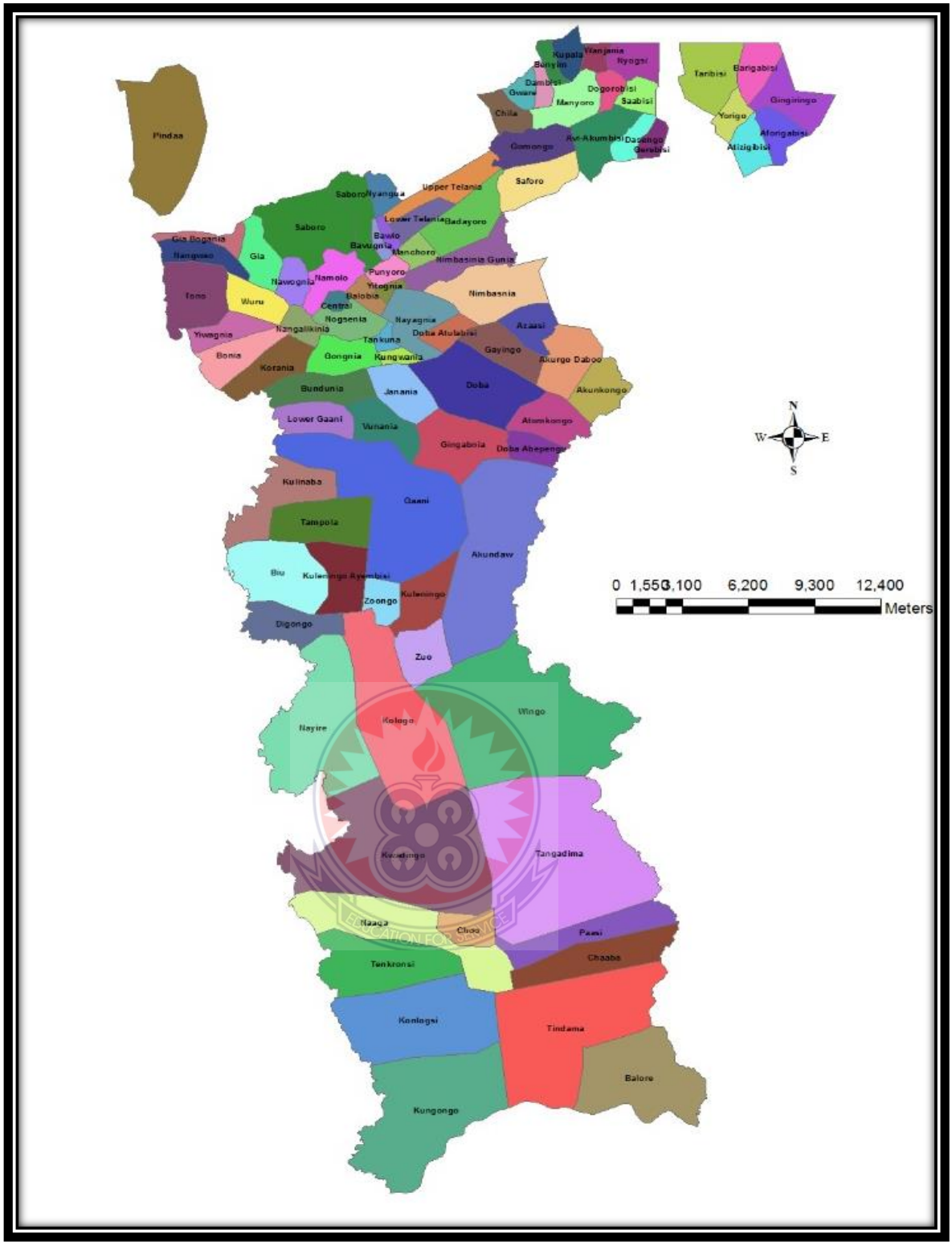

Figure 1: Map of Kassena Nankana Municipality

Source: GSS (2010)

3.5 Population of the Study

The target population of the study were survivors of suicide in the Kassena Nankana Municipality of Ghana. The MHU in their report estimated that there were 38 survivors of suicide in the Kassena Nankana Municipality. These individuals were used for the study because they have experience the situation, therefore have knowledge about the topic under investigation and for that reason can help gather needed information in order to address the research objectives.

3.6 Sample and Sampling Technique

Creswell and Creswell (2018) posited that five to twenty (5-25) participants can be used for qualitative research. As a result, 10 participants were used for the study, comprising five males and five females. They were selected using purposive sampling technique. This was used to select survivors who went through attempted suicide. This suggested that information–rich participants were being selected. This people had the needed information in order to help address the research questions.

In this study, it was not difficult for the researcher in identifying survivors of suicide. Thus, this technique was used because potential participants were not difficult to find. Meaning, in using the purposive technique, the psychiatric nurse assist of the MHU identified participants for the study. For this reason, the first survivor of suicide was identified. Afterwards, this identified participants assisted in identifying other participants he or she had come into contact with and were having similar experience. Through this method, other survivors of suicide identified. Hence, the total sample was 10 survivors of suicide.

3.7 Data Collection Instrument

Interview guide was used to collect data from participants . It has two sections: Sections A and B. Section A, presented questions on the demographic information of participants . Section B had questions that helped in gathering data so as to address the research questions. The study used interview guide due to its benefits. They included: It encouraged two-way communication, provided opportunity to participants to clarify they stories shared, gave participants time to open up about sensitive issues concerning their stories (Kusi, 2012).

3.8 Trustworthiness of the Interview

Trustworthiness of the interview guide was discussed under the following sub-headings: Credibility, dependability, transferability and confirmability.

3.8.1 Credibility

The researcher employed probes to elicit detailed data and interactive questioning, in which the researcher returned to matters previously raised by an informant and extracted related data through rephrased questions. Again, the researcher gave opportunities to course mates and research supervisor to scrutinise interview guide for the study. Feedbacks provided by the course mates and research supervisors offered fresh perspectives that enabled the researcher to refine some of the questions. Similarly, member checks were employed. Thus, the audio recordings were played to the participants after each interview for their confirmation. This allowed the participants to consider whether their words matched what they actually intended to share.

This is in line with what Lee (2013) posited. Lee (2013) argued that member checking is an important technique that qualitative researchers use to establish credibility. Lee (2013) further argued that in using this technique, the data, interpretations and conclusions of the study were shared with participants. It allowed participants to clarify what their intentions were, correct errors and provided additional information where necessary.

3.8.2 Dependability

In order to address the dependability issue more directly, the processes within the study were reported in detail. This enabled a future researcher to repeat the work, if not necessarily to gain the same results. The study also provided a description of the research design and its implementation, describing what was planned and executed on a strategic level; the operational detail of data gathering, addressing the details of what was done in the field; and reflective appraisal of the thesis and evaluating the effectiveness of the process of inquiry undertaken.

This support what Lincoln and Guba (1985) postulate the idea of dependability emphasises the need for the researcher to account for the ever-changing context within which research occurs. To achieve dependability, researchers can ensure the research process is logical, traceable, and clearly documented (Kusi, 2012). When readers are able to examine the research process, they are better able to judge the dependability of the research (Lincoln & Guba, 1985).

3.8.3 Transferability

In this study, a sufficient thick description of the phenomenon under investigation was provided which allowed readers to have a proper understanding of the work. This

would enable them to compare the instances of the phenomenon described in the research report with those that they have seen emerged in their situations.

This confirm what Kothari and Carg (2014) indicate that transferability means the extend of degree to which the results can be generalised or transferred to other contexts or settings. Transferability refers to the generalisability of inquiry. In qualitative research, this concerns only to case-to-case transfer (Kothari & Carg, 2014). The researcher cannot know the sites that may wish to transfer the findings; however, the researcher is responsible for providing thick descriptions, so that those who seek to transfer the findings to their own site can judge transferability (Lee, 2013).

3.8.4 Conformability

The researcher took steps to help ensure as far as possible that the study's findings were the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher. To this end, beliefs underpinning decisions made and methods adopted were acknowledged within the research report. Also, the study gave reasons for favouring one approach when others could have been taken and weaknesses in the techniques actually employed were admitted.

The study also provided an in-depth methodological description which allowed the integrity of research results to be scrutinised. This is in line with what Denzin and Lincoln (2013) indicate that audit trail can be used to grant the conformability of an interview. To achieve this, the researcher detailed the process of data collection, data analysis and interpretation of the data. Also, the study recorded issues that were unique and interesting during the data collection, wrote down the researcher's thoughts about coding, provided a rationale for merging some of the codes together

and also explained what the themes meant. Audit trail was used since it is the most popular technique used to establish conformability because it is incredibly useful when writing up the results chapter (Denzin & Lincoln, 2013).

3.9 Data Collection Procedures

An introductory letter from the Head, Department of Counselling Psychology, University of Education, Winneba was obtained to enable approval from the gate keepers (partners and parents/care takers of participants) and participants . Participants were given explanation to the purpose of this research, aspects of confidentiality and the intended use of the data. Measures such as were taken to ensure that the settings for the interviews helped in promoting confidentiality by way of ensuring that the participants were not overheard. English and the local languages (Kasena-Nankana) were used for the interviews. Also after the MHN introduce the researcher to each participant the researcher created rapport. This made participants to interact freely and share rich information with the researcher.

The interviewer used audio taped after permission had been granted by participants . This helped to ensure a more accurate picture of the questions and answers and also helped to improve the credibility of the interviews. In the same way, the recorded interviews helped the researcher to focus more on the interviewee's non-verbal utterances, attitudes and even body language then to be concentrating more in the taking of field notes. Further, important information (field notes) were written which served as backup in case the recorder develops a fault.

3.10 Data Analysis Procedures

Data was analysed in themes. The interview was audio-recorded, transcribed verbatim and analysed by the researcher using thematic analysis. The transcribed data was read over and over again which helped in identifying words, ideas, concepts and themes that appeared frequently. Themes, concepts and words that frequently appeared in the interviews were compared and cross-checked with other interviews so as to find out the consistent that existed from the data (Denzin & Lincoln, 2013).

Furthermore, thematic analysis involved searching through data to identify any recurrent patterns. Thematic analysis for the study attempted to represent a view of reality via systematically working through text to identify topics that were progressively integrated. It involved the preparation of data to be analysed by transcribing the interview into text and reading the text to note items of interest in order to acquire a sense of the various topics embedded in the data. Again, the text was read thoroughly by way of examining text closely, line by line to facilitate a micro analysis of the data (Denzin & Lincoln, 2013).

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

The name, definition and supporting data were also re-examined for the final construction of each theme, using all the material relating to it. Finally, each theme was reported with its description in addition to illustrating it with a few quotations from the original text to help communicate its meaning to readers. Qualitative study is highly interpretative and must have structured measures to minimise errors that might compromise the trustworthiness of the explanations are vital (Denzin & Lincoln, 2013). The quality and rigour of interpretations in this study went through a thorough discussion with the research supervisor. Themes that emerged were thoroughly scrutinised and direct quotes that could typically represent them were cross validated by the researcher's supervisor.

3.11 Ethical Considerations

Access, informed consent, confidentiality, anonymity and plagiarism were the ethical issues the study considered and how they were ensured in this study:

3.11.1 Access

An introductory letter from the Head, Department of Counselling Psychology, University of Education, Winneba was obtained to enable approval from gate keepers and participants . Thus, a copy of the introductory letter was sent to the gate keepers and participants to seek approval for data collection. After permission had been granted at that level, dates, time and venue were fixed for data collection.

3.11.2 Informed Consent

The researcher clearly spelt out the purpose, the intend use of the data and its significance to the participants . Afterwards, each participant was allowed to willingly decide as whether to take part in the study or not. This suggested that participants were not forced to take part in the study.

3.11.3 Confidentiality

Participants were assured that data would be kept confidentially. For example, audio-recordings of the interviews were not shared to the general public. Also, the interviews were undertaken at a conducive environment where no one heard the voices of the participants . Further, apart from my supervisor, no one had access to the field notes and audio-recordings of the interviews.

3.11.4 Anonymity

Participants were encouraged not to mention any noticeable information (such as name of school, participant 's name, email address, house number and contacts) when sharing their stories. For that reason, no identifiable information of participants was stated in the reports or findings of the study. This made it very difficult for a third party to trace the responses to the specific participant who shared it. Furthermore, codes were assigned to the interview data and were kept from the reach of other individuals.

3.11.5 Plagiarism

The study tried it best to acknowledge all in-text references under the reference column. Besides, the study ensured that no text was cited in the work without acknowledging its source.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.0 Introduction

The chapter deals with the results or findings of the study. It has two sections: Sections A and B. Section A presents the results on demographics information of participants. Section B presents results for the research questions and discussions. Below are the themes generated from the findings.

Table 4.1: Main themes Tthemes from the Four Research Questions

Research Question	Theme
Research Question 1: What are the causes of suicidal thoughts among survivors of suicide in the Kasena-Nankana Municipality?	• Psychosocial and Psychiatric problems • Access to means suicide
Research Question 2: How does attempted suicide affects the lives of survivors in the Kasena-Nankana Municipality?	• Isolation • Regression
Research Question 3: How do survivors of suicide in the Kasena-Nankana Municipality cope with the aftermath of their attempted suicide?	• Positive and negative coping strategies
Research Question 4: What preventive measures can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality?	• Mass education • Establishment of community counselling centre

Section A

4.1 Results on Demographics Information of Suicide Survivors

Items 1-7 on the interview guide deals with the demographic information of suicide survivors. They were sex, age, level of education, marital status, number of children/ dependents, kind of job/career and source of income. Frequency counts and percentages were used to analyse the data. Results are presented on Table 2.

Table 2: Demographic Information of Suicide Survivors

Item	Categories	Frequency	Percentages (%)
Sex	Male	5	50
	Female	5	50
Age (in years)	15 and below	1	10
	16-20	2	20
	21-25	1	10
	26-30	2	20
	31 and above	4	40
Level of Education	No Formal Education	1	10
	Basic	2	20
	Secondary	4	40
	Tertiary	3	30
Marital Status	Single	4	40
	Married	2	20
	Separation	1	10
	Divorced	1	10
	Widow/Widower	2	20
Number of Children or Dependents	1-3	3	30
	4-6	5	50
	7 and above	2	20
Kind of Job/Career	Dispatch Riding	3	30

	Hair Dressing	2	20
	Farming	2	20
	Trading	1	10
	Teaching/Nursing	2	20
Source of Income	Earned Income	8	80
	Business Income	2	20

Source: Field data, (2020) (Total Number of Suicide Survivors =10)

Table 2, shows that there are 5(50%) male and 5(50%) female survivors of suicide. This means that equal opportunity was given to the participants on the bases of sex thus the researcher hopes to get and balance information for the study. The result further reveal that only 1(10%) of the survivors of suicide was 15 years and below, 2(20%) of the survivors of suicide indicated that they were between 16-20 years. More so, 1(10%) of the survivors of suicide was between 21-25 years. Further, 2(20%) of the survivors of suicide indicate that they are between 26-30 years. Again, 4(40%) of the survivors of suicide are of the view that they were between 31 years and above. The result further reveals that majority of the survivors of suicide were within 31 years and above. It could be inferred from this result that these survivors of suicide were in their middle age which is the productive age group.

Table 2 further shows that 1(10%) of the survivors of suicide had no formal education. Also, 2(20%) of the survivors of suicide are basic school leavers. Moreover, 4(40%) of the survivors of suicide were secondary school leavers. Furthermore, 3(30%) of the survivors of suicide were tertiary school leavers. The results suggest that majority of the survivors of suicide used for the study were secondary school leavers. The results also indicate that survivors of suicide across different educational background.

Table 2 again that shows that 4(40%) of the survivors of suicide are singles. Also, 2(20%) of the survivors of suicide were married. Further, 1(10%) had separated and 1(10%) had divorced while the rest 2(20%) were widows/widowers. It could be realised from these results that majority of the survivors of suicide are not married (singles).

Again, Table 2 show that show that 3(30%) of the survivors of suicide had 1-3 children or dependents and 5(50%) of the survivors of suicide had 4-6 children or dependents. Further, 2(20%) of the survivors of suicide indicate that they had 2 children or dependents. Additionally, Table 1 shows that show that 3(30%) of the survivors of suicide were dispatch riders and the 2(20%) of the survivors of suicide were hair dressers. Furthermore, 2(20%) of the survivors of suicide were farmers. Again, 1(10%) of the survivors of suicide confirmed that he/she was a trader. Also, 2(20%) of the survivors of suicide claimed that they were teachers or nurses. The results indicate that all the survivors of suicide used for the study had jobs/careers that ended them some form of income. Lastly, Table 1 show that majority 8(80%) of the survivors of suicide reveal that they earned income and the rest 2(20%) declared that their source of income was through the businesses they were running. In general, results on demographic information of the survivors of suicide suggest that they had varied background information.

Section B

4.2 Research Question One: What are the causes of suicidal thoughts among survivors of suicide in the Kassena-Nankana Municipality?

The objective of this question was to find out the causes of suicidal thoughts among survivors of suicide in the Kassena-Nankana Municipality. Responses from survivors

of suicide suggested that psychosocial problems, psychiatric problems, previous suicide attempts and access to means suicide were main causes to suicidal thoughts among survivors of suicide in the Kassena-Nankana Municipality. Subsequently these statements were made by some of the survivors of suicide.

> *"I have two wives and six children but I am not working. So, anytime they come to me for money either for their schooling or housekeeping, I have not been able to get money for them in this direction. Therefore, I decide to end my life so that all these problems will end"* [SS: 5].

Likewise, one survivor of suicide shared a similar view by saying:

> *"I think because of the work I don't have that is why I wanted to end my life. It all started when the request from my wife and three children kept increasing. So, I thought of killing myself by committing suicide"* [SS: 1].

Comments from SS: 1 and 5 suggest that they were not working as at the time they attempted suicide. This situation suggests that these participants could not provide for their families. It could have been deduced from these responses that they were under stress to provide for their families but as a result of the situation they found themselves (being unemployed) they could not honour the financial responsibility to their families.

Other participants commented that breakdown in relationships is the cause to their attempted suicide. The following comments were advanced to support this claim:

> *"Hmmm. I had dated this guy for close to ten years. I have supported him from his secondary school to the tertiary. Upon conclusion of his tertiary education, he told me that he was no more interested in the relationship. Meanwhile, while we were dating, I received lots of proposal from guys I think they were far better off than him. However, I remained faithful to him. Aooo. Hmmm. This condition made me to attempt suicide*" [SS: 9].

Similarly, another participant said:

> *"I will not encourage any youth to go into relationship if he/she is not ready to marry. The reason is that I did and it did not help me at all. My fiancé told me he was not interested in the relationship again after I caught him having sexual intercourse with my best friend. This situation nearly made me to go mad. For this reason, I attempted the suicide"* [SS: 7].

Comments from SS: 7 suggest that due to breakup in a relationship, she attempted suicide. This comment implies that she trusted the guy she was in a relationship with to the extent that he would not disappoint her. However, this trust did not end in marriage; hence, causing this participant to attempt suicide.

Furthermore, comments from some participants indicate that psychiatric problems were the causes of their suicidal thoughts. For example, one participant , SS:4 said:

> *"I have become addicted to drugs for the past 15 years. Because of this, my father had passed away since his attempt to stop me from the drugs become unsuccessful two years down the lane, my mother too died out of the same situation. This made me to attempt suicide since I thought that will help save other family members of mine" [SS: 4].*

Comments from SS: 4 shares that he is a drug addict. Because of this his father became so worried about him and that contributed to his father's death. Similarly, this participant 's mother also got worried over her son's addiction to drugs and also died. According to this participant , in order to prevent future occurrence of other family member dyeing, he attempts suicide. Again, SS: 3 states that social isolation was the cause to his suicidal thought:

> *"I don't have friends because anytime I make an attempt, they reject my offer. This condition really affects my emotions negatively. For example, most of the time I become sad and do not have anyone to share my problems with. So, I thought it wise to end my life since no one wants to be my friend"* [SS: 3].

The comments from SS: 3 indicates that she does not have friends to socialise with. According to this participant , several attempts have been made to make friends but in

all instance, she did not succeed. Another participant SS:6 shares her experience by saying that:

> *"I was sexually abused by a mad man in my area. After the incidence, anytime I go out, then, my neighbours will be pointing their finger at me. In fact, it got to a point that I could not control it again, therefore, I resorted to suicide but failed to succeed*" [SS: 6].

From this comment, it is clear that her that sexual abuse made her attempt suicide. The comments also reveal that the stigma attached to this situation was beyond her control and therefore decided to commit suicide. SS: 8 also shares his experience by saying that:

> *"I have witness that in this area, when someone has a problem, he or she will not get someone to attend to him or her. For this reason, people who go through problems most of the time had to commit suicide. For that matter I also adopted this approach by attempting suicide"* [SS: 8].

These comments suggest that community members' inability to assist individuals who go through problems contributed to suicidal thought among the people of Kasena-Nankana Municipality. SS: 2 also shared his experience by saying that:

> *"This area is a farming community. For this reason, one can easily get access to Dichloro-Diphenyl-Trichloroethane (DDT). So, when people feel like committing suicide, they can go and buy this DDT and use it. This what I did in my case"* [SS: 2].

Comments from SS:2 further reveal that this drug is available in community because it is mostly used by farmers. These comments further suggest that this participant had easy access to a drug which can be used to commit suicide.

Also, one of the participant said:

> *"I thing rejection was the reason for me attempting suicide. I don't have any friend and I don't have anyone to talk to when I face challenges in life. It was upon this basis that I told myself that I don't see the need to be in this world without having even a friend"* [SS: 2].

This comment suggests that isolation was the cause of attempted suicide according to participant 2, because he has no friend to discuss life issues with him or her.

In general, it is clear from these comments that living in poverty, unemployment, loss of loved ones, arguments with family or friends, breakdown in relationships, financial, legal or work-related problems are some of the psychosocial problems that contribute to suicidal thought among survivors of suicide in the Kasena-Nankana Municipality.

Also, psychiatric problems which include alcohol and drug abuse, a history of physical or sexual abuse in childhood, social isolation as well as depression and other mood disorders contribute to suicidal thoughts among survivors of suicide in the Kasena-Nankana Municipality. Again, previous suicide attempts and access to means suicide were other causes to suicidal thought among survivors of suicide in the Kasena-Nankana Municipality. This implies that psychosocial problems, psychiatric problems, previous suicide attempts and access to means to suicide are causes of suicidal thoughts among survivors of suicide in the Kasena-Nankana Municipality.

These findings concur with that of WHO (2014), when report that ingestion of pesticides, hanging and firearms are among the most common methods of suicide globally, but for this story, 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 behaviour (Beautrais, 2001; Beautrais, 2014) where it is reported that females attempt suicide more than males.

Also, Shneidman (2004) finds that 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) report 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.

Additionally, 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 behaviour.

Furthermore, WHO (2014) documented global risk factors of suicidal behaviour 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 (Taylor, Wood, Gooding & 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).

4.3 Research Question Two: How does attempted suicide affects the lives of survivors in the Kasena-Nankana Municipality?

The objective of this question was to find out how attempted suicide affects the lives of survivors in the Kasena-Nankana Municipality. Responses from survivors of suicide state that it affected them adversely. For example, one of them said:

> *"I still hear the negative thought ringing in my mind. Sometimes I don't even see where my life is going. I think am in a different world and there is no one to talk to concerning my problems*" [SS: 5].

Also, participant 1 said:

> *"I now feel shy to move out. This is because anytime I meet my friends, they want to find out more about what made me to attempt the suicide. However, the more they do, the more I remember the situation that made me to attempt suicide"* [SS: 1].

Another participant said:

> *"After taking the drug, I thought that was all until I found myself on the hospital bed. In fact, I was very said when I found myself in that state. But after some time now, I have regretted taking that step. This is because I cannot be free with my colleagues like before"* [SS: 10].

Again, participant 4 said:

> *"I will say it has negative influence on my life and career. After that bitter experience and I did not die, I cannot associate with my friends as I used to"* [SS: 4].

Also, participant 7 said:

> *"I don't like the way people are pointing fingers at me anytime I go to the market. Because of that I have to send some of the children in my house to buy ingredients for me"* [SS: 7].

Furthermore, participant 3, said:

> *"I will say, this experience is not good at all. Therefore, anyone who want to try it should stop"* [SS: 3].

Participant 8 said:

> *"I have stopped fellowshipping at where I used to. All because the way they used to watch me whenever I go to church, I did not like it. I know is because of the situation (attempted suicide) I went through"* [SS: 8].

It could be realised from these responses that attempted suicide had contributed to stigmatisation among suicide survivors in the Kasena-Nankana municipality. This results could be that the way folks in the municipality are perceiving suicide survivors, it is having negative influence on the social life. Also, it could be realised

from these responses that the situation they went through is adversely affecting their career life.

The comments further suggest that survivors of suicide do not have their freedom as they used to have. The responses again revealed that survivor's human relationship had been reduced because of the suicide they attempted. From these comments it was concluded that attempted suicide had negative influence on the social life of suicide survivors in the Kasena-Nankana Municipality.

These findings support findings of other studies. All the reactions towards suicide and the suicide attempter which were either reported by families or suicidal persons as expressed by a family member, neighbours or friend all reflect negative attitudes towards suicide in Ghana. These attitudes toward suicide and suicidal person in Ghana are confirmed by studies of (Osafo et al., 2011a, 2011b, 2011c). These negative attitudes reflect cultural issues and how they affect people's perceptions of suicidal behaviour in Ghana.

The act of suicide is considered a taboo and in Ghana as reported by 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) also report 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.

A study on attempted suicides in Ghana reports that post-suicide attempt experiences could be traumatic for attempters. The report added that the harsh reactions from people to suicide attempt including social stigma, alienation, social taunting and physical molestation may linger and even lead to completion of suicide (Osafo et al., 2015).

4.4 Research Question Three: How do survivors of suicide in the Kasena-Nankana Municipality cope with the aftermath of their attempted suicide?

The objective of this question was to identify how survivors of suicide in the Kasena-Nankana Municipality cope with the aftermath of their attempted suicide. Responses from survivors of suicide state that while majority of them had strategies they used to cope with their situations, few of them did not have coping strategies. For example, one of the participants said:

> *"When it happened that way, it was my friends who encouraged me till now. They did this by always checking up on me. In fact, it is their encouragement that had brought me this far"* [SS: 2].

Similarly, one participant emphatically said:

> *"Since day one, my friends had been my source of joy and encouragement. They were able to do this by using the challenges they have gone through and did not attempted committing suicide. I thank God I have such friends around me always"* [SS: 7].

Another participant indicates that:

> *"Had it not be the social welfare officer; I will not know where I will have been by now. Her motivational words had helped me to manage the situation till now. And I always thank God for their lives"* [SS: 8].

Again, one participant said:

> *"After my pastor got to know of my story, he kept on calling me to encourage me that all is not lost. Anytime he calls me, he encourages me not to give up and that God had good plans for me. Frankly speaking, he used the word of God to encourage me and this has*

helped me cope with the situation. So, I will say that I have come this far because of the words of encouragement from my pastor" [SS: 1].

Also, participant 4 said:

"Some people say that when they go through such situations, their parents reject them. However, in my case, is my parents who had been there for me since day one. Thus, my parents had been there for me since the beginning of my story. In fact, I can confidently say that their love for me had increased in these times than before. I thank God for their lives" [SS: 5].

Further, one participant said:

"It is my partner who keep encouraging me till now. Without that I am not sure I will be alive at this moment. The kind of love my partner had shown to me within this short period, it exceeds the one I have enjoyed so far from him since we got married. This had helped me to manage the situation" [SS: 9].

However, some of them were also of the view that they had not been able to cope with the situation till now. For example, one of them said:

"In fact, the health workers of whom I thought they will console me, they did not. They were rather giving me some kind of negative attitudes" [SS: 6].

Likewise, one participant said:

"I have not gotten anyone to share my problems with. So, each day and each night, I stay indoors and battle with issues within me" [SS: 3].

Moreover, participant 10 indicated that:

"Hmmm. I don't even know what to say. This is because I have no one who is ready to listen to my story. And this is eating me up gradually" [SS: 10].

Again, one participant said:

"I sometimes feel like trying it again. This is because I don't have anyone I can share my story with, in terms of what I am going through" [SS: 4].

Responses from these survivors of suicide imply that individuals within the community served as coping mechanism for these survivors. This implies that the caliber of individuals closer to the survivor of suicide is likely to determine whether the survivor would receive some words of encouragement which can lead to coping mechanism. For some of the participants , they had their friends, pastors, spouses, social work officers and parents in helping to cope with their situation.

However, others too expected individuals around them to better understand their situations but they did not see them to be so. For example, health workers. The researcher conceptualised that because suicide is against the law, that could be the reason why the health workers did not want to help these survivors. It could be realised from these responses that aside pastors and social work officers who have gone through some form of counselling, other individuals (parents and friends) who helped survivors to cope with the situation are likely not to have any background knowledge in counselling.

The comments again infer that none of these survivors was able to cope with the situation through a professional counsellor or clinical psychologist. From these responses, it was concluded that advice and motivational messages received from pastors, parents, spouses and friends were strategies used by survivors of suicide in the Kasena-Nankana Municipality to cope with the aftermath of their attempted suicide.

In Ghana religiosity and spiritual coping is utilised as relief from stressors, threats of death, suicide, chronic illness, unemployment among others (Akotia et al., 2013; Osafo, et al., 2015). These findings more consistent with the literature where spiritual coping and social cohesion was the primary coping resource in any distressing event in Ghanaians (Mukwato, Mweemba, Makukula, & Makoleka, 2010) and also for suicidal behaviour both in Ghana and elsewhere (Osafo et al., 2015).

Maple, Edwards, and Kiernan (2013) state that 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 but avoidance was the coping mechanism that helped some participants during such situation.

Again, according to Charlton and Thompson (1996), "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 (p. 526).

4.5 Research Question Four: What preventive measures can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality?

The objective of this question was to find out preventive measures that can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality. Responses from survivors of suicide revealed that education to the

general public on adverse effects of suicide, establishment of community counselling centre, support in diverse ways especially from parents and enforcement of law on suicide are key preventive measures that can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality. For example, one of the participants said:

> *"The law enforcement agency should intensify the law by arresting people who attempt suicide. This when done will help reduce this situation in this community"* [SS: 1].

Participant 3 said:

> *"Most of the people we the adolescent go through is as a result of the perceptions some parents have towards us. For example, some parents do not provide basic needs for their adolescent children. For this reason, we have to fend for ourselves. In an attempt to do so, we are likely to enter into relationship which may lead to broken heart one day and its consequences such as attempted suicide"* [SS: 3].

Again, one participant said:

> *"I believe that the general public must be educated on adverse effects of suicide. I think because most of us did not know how suicide can negatively affect us and our families, we attempted it. Therefore, I will suggest that experts on suicide issues must educate us using the community radio centre"* [SS: 5].

Participant 6 states that:

> *I am of the view that social work officers should make it a point to visit churches, schools and community gatherings to educate people that there are other better ways of solving problems as compared to committing suicide. Though this education, it will encourage people to seek help whenever they have problems"* [SS: 6].

One participant also said:

> *"When I read the bible, I find myself better. So, because of that if I have negative thought of committing suicide again, then, I go for my bible and read"* [SS: 8].

Furthermore, participant 2 said:

> *"If the local assembly can help establish a counselling centre in this municipality, it will encourage most people to seek for counselling when the need be. This will help individuals to be able to have the idea*

> *on how to deal with issues instead of using suicide as the only solution"* [SS: 2].

From these comments it is evident that survivors of suicide are of the view that suicide can be prevented. To them, this dream can be achieved when some preventive measures are put in place. The comments further suggest that individuals as well as the government should come on board to help prevent suicide in the municipality. Based on these results it was concluded that general education on adverse effects of suicide, establishment of community counselling centre, positive attitudes from individuals and parents towards adolescents and enforcement of law on suicide were major preventive measures that can be put in place to minimise attempted suicide among survivors in the Kasena-Nankana Municipality. The researcher took the opportunity and made referral of participants who were distress to get help from the psychiatric nurse of the Navrongo Mental Health Unit of the War Memorial Hospital.

However, social hopelessness has recently been identified as a particularly important risk factor for college students the presence of social support is one of the most well-documented protective factors against college student suicide (Heisel et al., 2015b). Westefeld et al. (2012) view social support as "an individual's sense of belonging, the presence of an important relationship with another individual, and an understanding that this relationship is meaningful to all parties involved and social support spans relationships with family, peers and mentor-like older adults" (p. 171).

The director of the University of Iowa's University Counseling Service, Cochran (as cited in Westefeld et al., 2012) believes that peer relationships are the most influential type of social support for college students, especially as students are often times breaking away from family in developmentally appropriate but challenging ways. Westefeld et al. (2012) recognise that if a suicidal student has a well-established peer

network, they might also be more likely to disclose their suicidal thoughts and hopefully allow for an appropriate intervention.

In addition, because social interactions are especially emphasised in college, it seems obvious that the presence of secure and trusting relationships would help to insulate one from suicidal activity. The paradigm shifts of thinking about reasons to live (as opposed to reasons to die) has been identified as a protective mechanism for college students after it was first developed and applied to the general adult population (Linehan, Goodstein, Nielsen & Chiles, 1983).

This parallels the importance of focusing on what keeps suicidal college students alive for example, protective factors versus what propels them into a suicide attempt example, risk factors. Also, Westefeld et al. (2012) identifies six areas that represent college students' rationale to choose life over suicide. They include survival and coping beliefs, moral objections, responsibility to friends and family, fear of suicide, fear of social disapproval, and college and future-related concerns. The sixth category is the only one that differed from the original work done by Linehan and colleagues (1983), which replaced child-related concerns, highlighting developmental differences between adult and college student populations.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The chapter presents the summary of the findings, conclusions and recommendations of the study.

5.1 Summary of the Findings

The study sought to explored lived experiences of survivors of suicide in the Kasena-Nankana Municipality, Ghana. The study reveals that psychosocial problems, psychiatric problems, previous suicide attempts and access to means were causes to suicidal thought among survivors of suicide in the Kassena-Nankana Municipality. Also, attempted suicide had negative influence on the social life of suicide survivors in the Kasena-Nankana municipality. For example, these survivors were stigmatised by people around them.

Again, advice and motivational messages received from pastors, parents, spouses and friends were strategies used by survivors of suicide in the Kasena-Nankana Municipality to cope with the aftermath of their attempted suicide and general education on adverse effects of suicide. Additionally, establishment of community counselling centre, positive attitudes from individuals and parents towards adolescents and enforcement of law on suicide were major preventive measures that can be put in place to minimise attempted suicide among suicide survivors in the Kasena-Nankana Municipality.

5.2 Conclusions

It was concluded that survivors of suicide do experience emotional distress which may degenerate and create further distress for the attempters with risks for suicide completion.

Also, findings of the study fill the gap on experiences of survivals of suicide and families after a suicide attempt. Another important finding of this study is that the coping behaviours of suicidal persons are largely influenced by cultural dynamics.

5.3 Recommendations

From the findings and conclusions of the study the following recommendations are made:

1. 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. Similarly, 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.
2. Another important recommendation for suicide prevention is for clinical practice. From the findings of this study, individualised 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.

3. Further, religious leaders and the clergy should be engaged in the prevention of suicide through 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 since this can play an active role in suicide prevention by fostering a sense of connectedness among individuals and the community as a whole.
4. Again, 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.
5. Moreover, 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. This study contributed to important gaps in the literature on suicide in the Kasena-Nankana Municipality and the country at large.

6. 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.
7. The study would contribute to existing literature on suicide in general.

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APPENDICES

APPENDIX A

Introductory Letter

UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF COUNSELLING PSYCHOLOGY
P. O. Box 25, Winneba, Ghana psychology@uew.edu.gh
030 298 0904

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION: ROSEMARY KADUA AWIAH

I write to introduce to you the bearer of this letter who is a student in the Department of Counselling Psychology of the University of Education, Winneba. She is pursuing a 2-Year Postgraduate Programme leading to the award of Master of Philosophy Degree in Counselling Psychology.

As part of the requirements of the programme, she is conducting a research titled: **LIVED EXPERIENCES OF SURVIVORS OF SUICIDE IN THE KASENA – NANKANA MUNICIPALITY, GHANA**. She needs to gather information on this subject to enable her obtain authentic data to be analysed for the said research and she has chosen to do so in your institution.

I would be grateful if she is given the needed assistance to enable her conduct this important academic exercise. Thank you.

Peter Eshun, PhD
Ag. Head of Department

APPENDIX B

Consent Form

UNIVERSITY OF EDUCATION, WINNEBA

DEPARTMENT OF COUNSELLING PSYCHOLOGY

FACULTY OF EDUCATIONAL STUDIES

TITLE OF RESEARCH: lived experiences of survivors of suicide in the Kassena Nankana Municipality, Ghana.

Researcher: Rosemary Awiah Kadua

INSTITUTIONAL CONTACT: University of Education, Winneba, **P. O. Box 25, Winneba**

I am currently caring out a study on the Topic stated above. Kindly provide your responses to assist in data collection.

Your responses are completely anonymous. Also your decision to participate in this study is complete voluntary. If you decide not to participate in this study, it will not affect the care, services, or benefits to which you are entitled.

If you decide to participate in this study, you may withdraw from your participation at any time without penalty.

I ……..... voluntarily agree to participate in this research program

Witness by: ……...

Signature: ……..

Person Obtaining Consent: ……..……

Signature: ……..……..……..

APPENDIX C

Interview Guide for Survivors of Suicide

This interview guide seeks to explore lived experiences of survivors of suicide in the Kasena-Nankana Municipality, Ghana. The study is part of the researcher's Master of Philosophy Degree at the University of Education, Winneba. Please, do not mention your name as no participant will be traced or identified from this study whatsoever, as confidentiality and anonymity are guaranteed. There are no right or wrong answers to the interview guide.

Please, note that the researcher is only interested in your own opinion in relation to the topic. All data and information generated from this study will be treated as strictly private and confidential. You are therefore, kindly requested to the questions as honest as possible. The interview has two sections: Sections A and B. Kindly respond to all the questions.

Thank you for accepting to participate in this study.

Yours sincerely,

Rosemary Kadua Awiah

University of Education,

Master of Philosophy Student

SECTION A

Demographic Information of Participants

1. Sex: Male [ ] Female [ ]
2. Age:
3. Level of education:
4. Marital status:
5. How many children/dependent(s) do you have?
6. What kind of job/career do you do?
7. What is (are) your source/sources of income?

SECTION B

8. Briefly describe your experiences in staying in Kasena-Nankana municipality?
9. How many times have you attempted suicide?
10. What do you think were some of the causes of your suicidal thoughts?
11. Describe what you did when these thoughts came in mind?
12. Describe how your suicidal attempt had affected your social life in this community?
13. How did you feel after attempting to commit suicide?
14. What kind of social support have you received after you attempted committing suicide?
15. How do you cope with the situation of your attempted suicide?
16. What measures do you think can be put in place to minimise attempted suicide in this community?
17. Please do you have any more comments based on what you have shared so far?