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Attitudes of psychologists and nurses toward suicide and suicide prevention in Ghana: A qualitative study

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ABSTRACT

Background: One way of preventing suicide has been increasing awareness among health care professionals of their own attitudes and taboos toward suicide and its prevention.
Objective: The purpose of this study was to understand the attitudes of health professionals toward suicidal behavior and its prevention in Ghana.
Methods: A total of 17 informants (9 clinical psychologists and 8 emergency ward nurses) in an urban center were interviewed using a semi-structured interview guide. Interpretative Phenomenological Analysis (IPA) was used to analyze the data.
Results: We found that the attitudes of these health workers toward suicide and suicide prevention seemed to be transiting between morality and mental health. The psychologists generally saw suicide as a mental health issue, emphasized a caring and empathic view of suicidal persons and approached suicide prevention from a health-service point of view. Mental health education and improvements in primary health care were reported as practical approaches toward suicide prevention. The nurses on the other hand, held a moralistic attitude toward suicide as a crime, viewed suicide persons as blameworthy and approached suicide prevention from a proscriptive perspective. Informal approaches such as talking to people, strengthening the legal code against suicide and threatening suicidal persons with the religious consequences of the act were also indicated as practical approaches to suicide prevention. Educational level, clinical experience with suicidal persons, and religious values, are discussed as influencing the differences in attitudes toward suicide and suicide prevention between psychologists and nurses.
Conclusion: Health workers in Ghana need training in suicidology to improve both knowledge and skills relevant for suicide prevention.

What is already known about the topic?

- Health professionals are key players in suicide prevention in all countries.
- To effectively engage them, it is important to examine their attitudes toward suicide and how it could either enhance or impede suicide prevention programs.

What this paper adds

- The attitudes of psychologists and nurses toward suicide and suicide prevention in Ghana seem to be in transition from morality toward mental health.

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- The idea that suicide is condemnable and the suicidal person blameworthy seemed to make nurses approach suicide prevention from a proscriptive approach.
- The view that suicide is pathology and the suicidal person a needful individual seemed to make psychologists approach suicide prevention from a health-service approach.
- A closer move toward the mental health view, has better implications for caring attitudes toward suicidal persons in Ghana.
- Contributes to knowledge on the relationship between culture and suicide and demonstrates the need to understand health professionals' attitudes toward suicide and suicide prevention.

Suicide is a major cause of death in many countries and a considerable public health problem both to individuals and society in general (Suokas et al., 2009; Samuelsson and Åsberg, 2002). Globally, the urgent need to coordinate and intensify actions aimed at preventing suicide has been pointed out by the World Health Organization (WHO) (WHO, 2004). One of the recommended ways of preventing suicide has been increasing awareness among health care professionals of their own attitudes and taboos toward suicide and its prevention (WHO, 2007). Consequently, their attitudes toward suicide and its prevention have received attention from several researchers around the world. For instance a study by Sethi and Uppal (2006) in India among 50 medical doctors working on accident and emergency wards reported the doctors viewed suicide as unlawful and manipulative. Negative attitudes toward suicidal attempters included avoidance, rejection, hostility and anxieties, with the consequence of low quality care. In another related study general practitioners in the UK reported more negative attitudes toward suicide than psychiatric and community nurses (Herron et al., 2001). In another study in the UK, psychiatrists were reported as perceiving attempted suicide as not punishable, not immoral and the suicidal person as needing care (Platt and Salter, 1989). Additionally, a study in Taiwan that examined casualty nurses' attitudes toward suicide attempters reported that suicidal attempters who survive the act require therapy and that training in interpersonal skills could be beneficial in the care for such patients (Sun et al., 2006).

Compared to other health professionals, the attitudes of nurses have received considerable investigations (e.g., Berlim et al., 2007; Botega et al., 2007; Samuelsson and Åsberg, 2002) with conflicting results Some studies have reported negative attitudes of nurses toward suicidal patients (e.g., Herron et al., 2001) whereas other studies have reported positive attitudes (e.g., Sun et al., 2006). Socio-demographics such as level of nursing education, religion, and experience of suicide care, have been found to influence nurses' attitudes toward suicide (Sun et al., 2006; Botega et al., 2007). Negative attitudes are those attitudes which reinforce the patient's feelings of worthlessness and hopelessness such as judgment and rejection; whilst positive attitudes refer to those attitudes which are protective, making the patient feeling loved and cared for (Aish et al., 2002).

Few studies have examined the attitudes of psychologists toward suicide, and have reported that they accept suicide under certain circumstances (e.g., pain, terminal illness) and those with more years of clinical experience showed more acceptability for suicide than those with less clinical experience (Hammond and Deluty, 1992; Werth and Liddle, 1994). Additionally, psychologists' empathic understanding of suicidal patients has been found to reflect their psychological orientation toward health (Swain and Domino, 1985).

Studies on attitudes toward suicide and suicide prevention among health professionals are scarce in Ghana. The only studies which come close to the present one are those that have examined the attitudes of psychology students (who are potential health professionals in the future) toward suicide and suicide prevention in Ghana (Knizek et al., 2010–2011; Hjelmeland et al., 2008a,b; Osafo et al., 2011a), which is part of a broader study of which this present study is an aspect. In these studies the students' negative attitudes toward suicide were reported to be strongly influenced by religious values, but they were also found to be endorsing the need to prevent suicide.

In the context of Africa, health care professionals are key opinion leaders in their communities and in most social settings are in a power category whose attitudes can affect the views held by society (Awusabo-Asare and Marfo, 1997; Dodor et al., 2009). For instance in Ghana, it has been reported that the way health workers' relate with tuberculosis patients such as shouting at them and standing at a distance when talking to them contributes to the stigmatization of such patients (Dodor, 2008; Dodor et al., 2009).

The focus on emergency nurses and psychologists in this study is important. Like elsewhere in the world, nurses are the first point of contact when a suicide attempter seeks attention at a health facility (McCann et al., 2007). In Ghana most suicide attempters are first sent to the emergency wards of general hospitals for medical attention and nursing care and then later referred for psychological attention. Thus the emergency nurse is likely to encounter a considerable number of suicide attempters and their role becomes central in the initial management (Suokas et al., 2009). The psychologists thus become equally central in the treatment and management of suicide attempters due to the referral chain (E. Dickson, personal communication, October 10, 2008).

The attitudes of health care professionals can be detrimental to suicide prevention (Lang et al., 1989) and as long as these two groups are active and key handlers of suicidal patients, it becomes essential to examine their attitudes toward suicide and suicide prevention in Ghana. Additionally, it will be noted that emergency nurses and psychologists belong to different health perspectives; medical and mental respectively. It is also therefore important to have a comparative analysis of how each views suicide and reacts toward suicidal persons. The purpose of this study is to examine the attitudes of psychologists and emergency ward nurses toward suicide and suicide prevention and examine the implications for suicide prevention in Ghana.

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1. Method

The few studies that have examined attitudes toward suicide in Ghana have been predominantly quantitative (e.g., Eshun, 2003; Hjelmeland et al., 2008a,b). However, we need to understand the perceptual experience and meaning/s behind the statistical explanations offered for the kind of attitudes people express toward suicide. For instance, what meaning does the act of "suicide" constitute for a person who is reported to have a negative attitude toward it? An answer to such a question requires a method which is meaning-driven, such as a qualitative method (Silverman, 2006). Moreover, the need to consider the local cultural context as a step toward understanding suicide has been emphasized by various authors (Boldt, 1988; Colucci, 2006, 2009; Hjelmeland, 2010). One way of doing this is to conduct studies that allow the cultural context to emerge as people share their opinions of certain phenomena. Qualitative studies are regarded useful in such endeavor (Malterud, 2001; Hjelmeland and Knizek, 2010).

Ghana: the study setting. Ghana lies on the Gulf of Guinea in the Western coast of Africa as a sovereign state. Mental health care continues to be constrained by several problems including underfunding, low man power and poor professional standards (Read et al., 2009; Roberts, 2001). Stigma remains a challenge to mental health patients and services in the country (MHAPP, 2008). Although attempts are underway to improve mental health care and services (WHO, 2007), the mental health bill which is one of such attempts is still yet to be passed into a law. The 1960 Criminal Code of Ghana criminalizes attempted suicide and whoever is found guilty can be jailed for about three years. Furthermore, suicide as an act is socio-culturally prohibited in Ghana (Adinkrah, 2010; Hjelmeland et al., 2008a,b; Osafo et al., 2011a,b). There are no national statistics on suicide in the country, but estimations based on college students' knowledge of people who have attempted suicide in Ghana does seem to indicate that suicide is a considerable public health problem that necessitates prevention efforts (Hjelmeland et al., 2008a,b).

Location. Accra, the capital, was the site for the study. It has a population of about four million, with several suburbs. There are three main public hospitals, two psychiatric hospitals and several other private owned health centers.

Informants. The sampling was purposive as such an approach can grant us access to a particular view on the issue of interest: suicide (Smith et al., 2009). We selected a general hospital and private health facilities as sites for data collection. This is because the stigma attached to mental health issues does influence people to access services from such sites rather than the traditional psychiatric facilities. Two groups of informants participated in this study. Each group was sampled using snowball technique; thus those who had participated introduced new participants and they were interviewed. The first group was nurses and the second psychologists. In all a total of 17 informants were interviewed; 9 clinical psychologists (3 men and 6 women) and eight emergency ward nurses (4 men and 4 women).

The nurses were qualified Registered Nurses (RGN) working in the emergency ward in a general hospital. The majority ($n = 6$) held a diploma (considered as a lower qualification) certificate in nursing and the rest with a degree in nursing and seeking further studies. The clinical experience of the nurses ranged from two to forty years and three had been in practice for less than three years. They altogether reported to have seen between one to 25 suicidal patients in their entire clinical practice till the time of the interview. Their ages ranged from 25 to 60 years.

The majority of the psychologists were working in private settings whereas two were working in a general hospital. Their ages ranged from 26 to 70 years. Educationally, all the psychologists had at least a Master's Degree, with four holding PhD qualifications. The clinical experience of the psychologists ranged from three to forty years, with four in practice for less than four years. These young clinicians do private practice under the supervision of experienced psychologists. The psychologists indicated that they had seen more than 45 suicidal patients in the past year with some even reporting seeing suicide cases almost every week.

All the informants were Christians (3 Catholics, 6 Protestants, 8 Pentecostal/Charismatics) living and working in Accra.

Instrument and procedure. Permission was sought officially from the authorities of the general hospital where the nurses and the two psychologists work. They were informed personally that those who wished to participate could do so. The rest of the psychologists who were in private practices were informed about the study and requested to participate. Everyone approached agreed to participate. The interviews were conducted in 2008 and took place in the offices, common sitting rooms or homes of the informants. A semi-structured interview guide was used to examine the informants' experience and attitudes toward suicidal behavior. The semi-structured interview is flexible and allows for a deep exploration into the social and personal worlds of the participant, allowing the researcher to create a rapport with the participant and engage in meaningful dialogue. It is in such a context that a co-creation of meaning between interviewee and researcher on events and experiences related to health issues such as suicide becomes possible (DiCicco-Bloom and Crabtree, 2006)

Some of the items on the guide were: What is your own principal attitude toward suicide? Do you think suicide should still be considered a crime? How do you feel about suicidal persons, and how do you react when you discover that your patient/client is suicidal? Do you think suicide should be prevented? What kind of treatment do you think is the most appropriate for suicidal persons?

The interviews were conducted in English by the first author who is a Ghanaian psychologist. All interviews lasted for 45 min with the exception of one which lasted for 25 min for lack of time on the part of that informant. We obtained informed consent of the informants and the interviews were audio-recorded and later transcribed verbatim. The study was approved by the Regional Research Ethics Committee in Central Norway and the Noguchi Memorial Institute for Medical Research Institu-

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tional Review Board (NMIMR-IRB) at the University of Ghana. Suicide is a sensitive issue in Ghana and being seen participating in suicide research is in itself not too pleasant for some people. Therefore, for purposes of anonymity age, gender, and the names of the specific health facility of informants are not reported. Only professions with numerical superscripts appear in the narrative quotes during analysis. For example Psy[1] represents "psychologist1" and Ns[2] represents "nurse2".

Analysis. Interpretative Phenomenological Analysis (IPA) was used (Smith et al., 2009). Since the sample size was large (from an IPA standpoint) the emphasis in the analysis was on assessing the key emergent themes for each group; then eventually the whole group (Smith et al., 2009). The first step in the analysis was to read and get an overview of each transcript, thus assessing the key emergent themes for the whole group. This involved reading to gain an overview of each transcript, noting important recurrent statements and phrases. This was iterative as it involved closer interaction between reader and text (Smith and Osborn, 2003).

The second step was to illustrate the group level themes with typical examples of quotes from individual participant's experiences linking them with other recurrent themes. In the third step themes were verified, summarized and analytical connections were established across them (Smith et al., 2009).

Validity of interpretations. Validity of interpretation is a key issue in qualitative studies (Whittemore et al., 2001). One way validity was ensured in this study was through communicative validation where during interviewing the researcher often summarized and checked whether the views of informants' had been correctly recorded (Kardoff, 2004). Another way validity was ensured was through group interpretation. The research group discussed and scrutinized every theme until consensus was reached. For instance, the other three members (two Norwegians and one Ghanaian) of the research group have queried the assumptions and beliefs of the first author (who is a Ghanaian). In keeping with Creswell and Miller's (2000) recommendation, they have also challenged the interpretations of the data during the analysis. Such cross-validation and group-interpretation could enhance inter-subjective comprehension and increase the analytic rigor and trustworthiness of the interpretations of the findings in this study (Steinke, 2004; Whittemore et al., 2001).

2. Findings and discussion

Four major themes emerged: (1) *Suicide: Pathology or a Moral Issue?* This theme describes the principal attitude (in theory) of the informants about suicide as a phenomenon. (2) *Between Care and Crime* is anchored on theme one and assesses (in practice) the informants' attitudes on how society should view suicide as they reflect on the criminal code against the act. In the light of their reflections on how society should view suicide, we follow up to examine the informants' view of the suicidal person and how they relate with them under theme (3) *A Needful or Blameworthy Person?* The final theme (4) *Prevention: Health Service and Proscriptive Approach*, examines the informants' views toward suicide prevention and how it should be approached. Each of these themes are described and discussed below.

2.1. Suicide: Pathology or a Moral Issue?

The views of the informants toward suicide lay between psychopathology and morality. Starting with the psychologists, those younger in practice ($n = 4$) appeared to be more judgmental (moralistic) toward suicide whilst those older in practice held the view that the suicidal act is pathological. Religious considerations underpinned the moralistic attitude of the younger psychologists who conceptualized suicide as constituting a religious transgression. For instance:

> *I know that I have a purpose to live on earth, and I know that my life is given to me by God and at the time he chooses he would take it. So until that time comes, I have no right to do that. I personally will see it as a sin, because the Bible says thou shall not kill (Psy[3]).*

The attitude of the older psychologists ($n = 5$) toward suicide reflects more of a view that suicidal behavior is a mental health issue. Suicide was viewed as either a psychiatric illness: "People need to understand that suicide is a mental health disease, you know" (Psy[5]), or an act following depression as illustrated below:

> *I know that it is a risk factor with depression. Therefore, I ask people who are depressed or who have serious anxiety problems or pain, "Have you had thoughts of killing yourself"? Then I admit them for treatment. That is how I see it (Psy[7])*

In this quote, there is an attempt to assess the risk of suicide in the patient where suicide ideation is considered symptomatic and thus warranting admission for proper clinical attention. There is an implicit indication that such a mental health conception of suicide provides this participant a framework for understanding the act.

Similar to the younger psychologists, all except two of the nurses were quite moralistic, thus appeared judgmental in their attitudes toward suicide as a phenomenon ($n = 6$). Generally, religion exerted a strong influence over the seeming judgmental attitudes of the nurses. Their view of the act was conceptualized within a religious universe which ascribed ownership of life to God: "Life doesn't belong to me. It belongs to God and therefore you cannot take your life" (Ns[3]). Within the nexus of such a religious worldview life was seen as invaluable and the vicissitudes of life viewed as constructive to the overall meaningfulness of a person's life. Such a religious view strongly proscribed suicide:

> *I don't think anybody should think of suicide. It is a taboo because all the religions in Africa see it as such. You should not take your life because life is precious. Everything that happens builds you up. As the religions say, you take it as part of life, that there is light at the end of the tunnel (Ns[8])*

Also implicit in the quote is the expectation that the religious value and view of life should provide some level

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of hope in the future. That way there is a normative expectation for the suicidal person to cope with life's circumstances through religious prescriptions rather than destroy it (see an overview in Osafo et al., 2011b).

Two of the nurses who seemed non-judgmental viewed suicide from a pathological perspectives rather than a moral one. For instance one of them said:

> *I personally see it to be problem that needs solution. That is how I see it. As I said earlier we should see it as a psychiatric problem and call on those responsible to take care of them. We nurses say "every behaviour is purposeful", before anybody will act in a particular way . . . he has a purpose, there is a meaning to it. So it's better for us to delve deeply into it and find solution to it than seeing as an evil behaviour (Ns[5]).*

This nurse holds a degree in nursing and in the past had worked closely with a psychiatrist on suicidal persons. Suicide as indicated is a health issue but also goal-oriented that requires helpers with expertise to handle it. Such an understanding of suicide might facilitate the seeming non-judgmental attitude toward the act as expressed above.

2.2. Between Care and Crime

To further our understanding of the informants' principal attitude toward suicide, their personal reflections on the existing criminal code against suicide was analyzed. Although the psychologists were divided over their theoretical view of suicide as indicated earlier, in this theme, they unanimously ($n = 9$) emphasized that society should view suicide as an act that requires *specialized care* rather than criminalization. For instance a young psychologist responding to a question on the current criminalization of suicidal behavior in Ghana said:

> *It is wrong to criminalize suicide because these are people who are at their wits end; they need all the support, treatment and management to be able to get out of it rather than locking them up. (Psy[5])*

The suicidal person is perceived as *unwell*, a state of vulnerability that necessitates their need for specialized care. Such a specialized form of care decries criminalization and is projected as a better alternative to dealing with the perturbation present during suicidal crisis. This is illustrated in the preference for healing and helping the suicidal person by some older psychologists as better ways of viewing suicide:

> *I think anybody who tries to commit suicide does it in pain or in anger; you know there is extreme emotions involved in a suicidal attempt, or successful suicide. So I would prefer to see it as something that needs healing or needs help, rather than as a crime to be punished (Psy[8]).*

The majority of the nurses ($n = 6$) on the other hand, following from their moralistic principal attitude toward suicide, seemed to prefer a *criminality view* of the act. Thus they expect society to view the act as law breaking and condemnable. They offered three major reasons for this view. The first is the religious ideology of the divine ownership of life and its invaluableness which prohibits suicide: "yea, my religious view affects my view of suicide; it does, because life is precious and belongs to God. That is why I agree with even the law against suicide in Ghana" (Ns[8]). The second is the social hazard ideology, the view that suicide is a risky behavior that affects others: "I see it as a very dangerous crime that can affect others and so we should not tolerate it" (Ns[7]). The third is the deterrence ideology of suicide, the view that social proscription of the act discourages others from engaging in it: "yes, it should be considered a crime so that when you attempt and you don't die you are put into jail to deter others" (Ns[6]). However, the nurses who were non-condemning still emphasized care rather than crime by looking at the consequences of the criminal response toward suicide:

> *If you say it is a crime, then you need to punish the person. But the punishment is going to give him more stress, so it is not the best option. Rather the best option, I think is that he needs professional care (Ns[4])*

Such a view is similar to the psychologists in the sense that it demeans the crime view by exposing the inherent complications, whilst endorsing the care ideology.

2.3. A Needful or Blameworthy Person?

Consistently, the psychologists ($n = 9$) viewed the suicidal person as someone in need and thus deserve empathy: "I am empathic of them because I see them as those who really need help" (Psy[6]). They found empathy instrumental in understanding the suicidal person: "I feel empathetic toward them because it helps me to understand what they might have gone through" (Psy[1]). Additionally, empathy was perceived as a useful therapeutic tool for the management of the suicidal patient:

> *If you show that sign of empathy, it is an initial step that helps the person to know that somebody understands his situation and then he or she would be able to open up to this person. So as you show more empathy it helps the client to open up the more. Then of course once you know the details of the problem, it helps with management easily. (Psy[4])*

As indicated in the quote, empathy is seen as creating the atmosphere for building rapport and fostering attachment. Within such an atmosphere, the suicidal client becomes empowered to ventilate without a sense of feeling condemned. This strong therapeutic alliance that is produced through empathic responding, as implied in the quote, is a basis for effective management of the suicidal patient. This is consistent with the evidence that the attachment the therapist develops with the patient is crucial in dispensing effective psychotherapy to suicidal patients (Leenaars, 2004, 2006; Paulson and Worth, 2002).

Some younger psychologists ($n = 3$) expressed some level of anxiety during their first clinical encounter with suicidal persons. However, over time, an empathic

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responding seemed to have prevailed. This further strengthens the view of the suicidal person as vulnerable to life's circumstances and it prioritizes the importance of empathy. For instance:

> *The first time I saw one, I was a bit scared, worried, and I was asking myself so many questions. But with time, I see them as every other person; anybody in their position could do what they did. So I just empathize with them more than I would with other people. (Psy[3])*

The issue of worry as indicated in the quote is an expected reaction of young clinician's first encounter with suicidal patients (Reeves, 2003). However, the reference to the bothersome questions during the initial encounter with a suicidal patient could perhaps signal lack of knowledge with regard to how to handle a suicidal person. Plausibly, the gradual development of empathy during the psychotherapeutic relationship reflects improvement in knowledge on how to deal with suicidal persons.

The nurses ($n = 6$) on the other hand, consistently expressed a seeming judgmental attitudes toward suicidal persons. For instance, a nurse said:

> *To me when I think about suicidal persons, I think they are wicked. Once they are able to kill themselves they can do any other thing; any crazy other thing. So I think they are wicked, yea that is what I think about them. (Ns[3])*

Here, the decision to end one's own life is moralized as a murderous tendency which makes suicidal persons fearsome and blameworthy. Such a blameworthy view of the suicidal person seems to place the working relationship of the caregiver with the patient within the framework of morality rather than health. Therefore, though some nurses attempted to project a view of the suicidal patient as someone in need, such a view seemed overshadowed by moral imperatives. For instance a nurse said:

> *"I feel protective of them, but I insult them. The insult is to kick them out of the depression. I give them the guilt syndrome. I make them feel guilty that what they are doing is a criminal offence" (Ns[8]).*

Clearly, the patient is perceived as in need of professional attention, however serious effort is made to draw the patient's attention to his or her culpability. The health worker completely steps out from the ethical obligation and regulation of the profession and relies purely on personal moral values in relating to the suicidal person. This demonstrates how crucial the principal attitude of the suicidal person as blameworthy could determine the ethical mode of behavior of the health professional toward the patient. The nurses who seemed non-judgmental however, did view the suicidal person as needing help: "I think people like this need a special help, giving them much attention and care" (Ns[5]). A closer examination of the demographics of these nurses revealed a regular engagement with psychologists. Perhaps, the working relationship with some psychologists has facilitated such seeming non-judgmental attitude toward suicidal persons.

2.4. Prevention: Health Service and Proscriptive Approach

Though the psychologists and nurses differed in their attitudes toward suicide and suicidal persons both in theory and practice, there was a general consensus ($n = 17$) among them to prevent suicide. This consensus is however driven by different motivations. For instance, the psychologists who generally viewed the suicidal person as in need of care and empathy ($n = 9$), seemed to emphasize the relevance of intervening in the internal attitude of ambivalence which is often present in the suicidal state as typified in the following voice:

> *We should prevent it because in my own experiences, lots of people who attempt suicide do not want to die so badly. They want to die and they want to live. So we give them help when we prevent it. People have come back and they are thankful that they weren't allowed to kill themselves at the time that they felt like it's the only way out. So then, it's worth preventing suicide, just as its worth saving lives physically (Psy[8])*

This informant highlights the effectiveness of support by the indication that the eventual self awareness that emerges after an intervention provides a strong reason for the need to prevent suicide. In that case, suicide prevention is based on the premise that the person is in an *illness state* and thus needs help for a cure that restores him or her unto an optimal level of health, a level at which the suicidal tendency becomes reduced if not totally extinguished. The psychologists ($n = 9$) thus emphasized mental health education and improvements in primary health care as practical approaches to suicide prevention.

Mental health education focuses on improving peoples' knowledge of the psychological basis of mental health issues (e.g., depression) and that when people see such persons they should provide help rather than condemning them. For instance: "if people are sensitize enough about suicide, or even depression then when they see others go through the struggle, they easily recognize and provide help" (Psy[5]). Shneidman (1985) finds public education as the ultimate means of preventing suicide and indicated that, "perhaps the main task of suicidologists lies in the dissemination of information especially about the clues to suicide: in the schools, in the workplace, and by means of the public media" (p. 238). In low income countries such as Ghana and where mental health services are deficient, such an approach to suicide prevention could be cost effective as indicated by some studies (Hoven et al., 2009). Improvement in primary health care approach involves the detection of early warning signs and treating those at risk for suicide: "so we should be able to really put up preventive measures against depression, especially in the schools. We should be able to screen them and treat them as early as possible" (Psy[6]). This approach has also been viewed as useful in South Africa to curb the incidence of suicide (Meel, 2003).

Those nurses who seemed non-judgmental toward suicide and suicide persons did mention mental health education as an important way of preventing suicide, for instance: "we have to educate people about the

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psychological basis of why others engage in suicide" (Ns[4]). The majority however, had a more informal approach toward suicide prevention (e.g., talking to a suicidal person, asking a suicidal person to share with others). Strong moral considerations (reflected in the religious unacceptability of suicide and the fear of the social consequences of the act) underlie such an approach as illustrated below:

> *We should prevent suicide because religiously you are not supposed to take your life. Also when you take your life you damage the image of others as your whole house will be stigmatized. So we should talk to people that it is not the best (Ns[1])*

Explicitly, the motive underlying the need for suicide prevention is to commandeer *moral obedience* for people to stay within moral boundary. Some of the nurses seem to step out of their professional domain and recommend the use of religious and legal threats as preventative of suicide. The religious threat highlights the unpardonable nature of suicide transgression in the hereafter thereby pointing to the weight of its consequences:

> *Like the way I talk to my children, you can say that if you take your own life it's a sin that God will never, never, never forgive you, when you are dead. When they are judging you, whatever you do can be forgiven, but when you take your own life God will never forgive you. You know when you use such threatening words to advise, you can, can prevent suicide (Ns[7]).*

The legal threats called for a review of the legal code against suicide by strengthening it: "If the punishment for suicide is flexible, then it should be more toughened, so that people will be aware that when I attempt and I don't succeed this or that is my punishment" (Ns[2]). Generally, the obligation to prevent suicide is mixed up with moral imperatives such as religion and societal values. This is consistent with a recent study of psychology students' attitudes to suicide and suicide prevention in Ghana in which the students were reported to be mixing religion with professional skills in suicide prevention (Knizek et al., 2010–2011). Perhaps, low level of professionalism (in mental health issues) among the nurses and the psychology students is what separate them from the psychologists in this present study.

3. General discussion

The objective of this study was to understand emergency nurses and psychologists' attitudes toward suicide and suicide prevention in Ghana. The analyses have showed that generally, two perspectives for understanding suicide seemed to determine the attitudes of the informants toward the act. These perspectives are moral imperatives and mental health. The former could be thought of as representing a cultural view of suicide and the latter representing the professional view of the act. The kind of attitude expressed toward suicide, suicidal persons and suicide prevention seemed to be determined by the perspective on which it is based. For instance the seeming generalized judgmental attitude of the nurses toward suicide consistently manifested in their view of the act as criminal, the suicidal person as blameworthy and suicide prevention from a prohibitive angle. Similarly, a non-condemning attitude of the psychologists toward suicide also manifested in their view of suicide as an act requiring care, the suicidal person as a needful person who requires support through empathic responding and thus viewed suicide prevention from a health-service perspective.

The attitudes of the health workers toward suicide seemed to be in transition from morality toward mental health where the movement toward the latter could reflect a development of a non-condemning attitude toward suicidal persons. Factors such as level of education, clinical experience with suicidal persons, and religious values seemed to influence this transition and thus the differences observed in the attitudes toward suicide and its prevention.

Although nursing education in Ghana has come very far and now includes courses in the social sciences, there is little integration of mental health into primary health care (MHAPP, 2008; Opare and Mill, 2000). General nursing education in Ghana therefore does not receive adequate knowledge about the psychological basis of behavior and ill health and the opportunity for advance nursing education in Ghana is limited (Talley, 2006). In Taiwan, Sun et al. (2006) for instance has reported that casualty nurses who have higher level of mental health education had more positive attitudes toward suicidal patients than those who did not. They therefore reasoned that the more knowledge nurses have about suicide, the more open their minds and favorable their attitudes toward suicidal patients (Sun et al., 2006). The nurses in this study compared to the psychologists have a low educational exposure to mental health and this seems to be reflected in their divergent attitudes toward suicide and suicidal persons.

On clinical experience with suicidal persons, the attitudes of general hospital nurses compared to psychiatric nurses have been found to be influenced by level of contact with suicidal persons. More frequent contact with suicidal patients was related to more positive attitudes among the psychiatric nurses than among the general hospital nurses (Samuelsson et al., 1997). Psychiatric nurses by virtue of their profession do contact and relate with suicidal persons, similar to psychologists. In the present study, the psychologists had more contact with suicidal persons than the nurses and perhaps the respective positive and negative attitudes toward suicidal persons reflect the effect of contact or lack thereof with such persons.

Cultural context in which people live can provide a salient set of assumptions and facts that affect their attitudes (Oskamp and Schultz, 2005). In Ghana, the sociocultural environment is deeply infused with religion (Gifford, 2004; Meyer, 2004). In African societies including Ghana religion and morality appear inseparable (Gyekye, 1997; Mbiti, 1989; Verhoef and Michel, 1997). Gyekye (1997) has said that "*For the African people, to do the right thing is primarily a moral obligation; but it is, in some sense, also a religious obligation. A moral value thus becomes also a*

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religious value (p. 19). It is within the nexus of such ideology of interrelatedness between religion and morality that we discuss how religion appeared to influence the attitudes of both nurses and young psychologists toward suicide.

The nurses appeared to rely more on religious values in their conception of suicide than the psychologists. Such reliance on religion reflects how close they are to the moral imperatives perspective (which views suicide as negative). Some studies have indicated that religious values among emergency ward nurses are contributing factors toward their negative attitudes expressed toward suicide (Herron et al., 2001). The report that religion prohibits suicide and thus religious people are found to be considerably more intolerant toward suicide than less religious people (Koenig, 2008; Koenig et al., 2001) is thus consistent with the attitudes of the nurses in this study.

Although religion equally exerted some influence over the attitudes of the young psychologists, unlike the nurses, they however did separate such an attitude from the suicidal person. Religion therefore perhaps does not have a far reaching influence on how the psychologists in this present study viewed suicidal persons. Furthermore, Swain and Domino (1985) for instance found that the empathic attitude of psychologists toward suicide is influenced by their psychological orientation to health. Perhaps, it is empathy that helps in this separation of negative attitudes toward suicide from the suicidal patient.

However, the 'pathologization' of suicide by the older psychologists demands a closer look. Although some mental disorders such as depression, schizophrenia, conduct disorder and others are risk factors for suicide (e.g., Apter et al., 2009; Bertolote et al., 2003; Jenkins et al., 2005;), this does not make the act a mental disease. Such a view makes suicide a mere symptom of illness and implies that the health worker has to find the cause of the pathology and treat it (Michel and Valach, 2001). Suicide is nevertheless an intentional act involving planning and decision making by a conscious agent and thus could be a communicative or goal-directed to achieve a purpose (Hjelmeland et al., 2008a,b; Knizek and Hjelmeland, 2007; Michel and Valach, 2001). For instance in Ghana suicide has been reported among women as a measure to escape or oppose oppressive patriarchal society, whilst to men, it is an act to avoid shame or dishonor (Sefa-Dede and Canetto, 1992; Adinkrah, 2010). The 'pathologization' of suicide is thus simplistic and fails to consider broadly other complexities (e.g., cultural factors) in understanding the phenomenon. Additionally, in Ghana mental health problems are already stigmatized (Quinn, 2007; Read et al., 2009), and thus this view could further deepen stigma toward suicidal persons.

However, the view that suicide is pathology does seem to necessitate a positive attitude toward the suicidal person. If the suicidal person is viewed as suffering from pathology, then fundamentally the patient is not responsible for the suicidal act, and might receive empathy and care from the public. The pathology view of suicide is thus double-edged, in that on one hand, it presents both a knowledge gap and a risk (for suicide prevention) that needs to be addressed to improve the health professional's overall understanding of the act. On the other hand, it presents an opportunity to push an alternative position that could compete with (if not break suicide away from the clutches of) the prevailing moralistic perspectives and its condemnatory consequences. Suicide prevention is a responsibility of everyone, but perhaps health professionals have more responsibility due to their training and duty to preserve life (Anderson and Caddell, 1993; Kassiner, 1997). Therefore, the consensus expressed toward the need to prevent suicide, albeit there are differentials in the underlying motivations, could reflect a positive attitude toward suicide prevention and thus a commitment to this responsibility of life preservation. The illness ideology of the suicidal person as emphasized by the psychologists places their attitudes to suicide prevention in a care and educational approach. This involves commitment to a professional duty to recognize patients' need and provides a professional intervention (Upanne, 2002) as well as educating the public to change their attitudes toward suicide. The nurses' moralistic standpoint from which they construed suicide and the suicidal person as culpable seemed deterministic of their approach toward suicide prevention. The tendency among them to engage contextual moral issues such as religious beliefs and societal values in suicide prevention reflects a *proscriptive* and *normative approach* to suicide prevention.

3.1. Limitations and future research

We have demonstrated through qualitative method, for instance, varied constituted meanings of suicidal behavior and its prevention. The findings in the study contribute to the overall view that culture affects attitudes toward suicide and health professionals are no exception; thus necessitating continuous training of health professionals on suicide and its prevention. However, this study has some limitations. There are various categories of nurses in Ghana. Therefore further studies should consider the views of other categories of nurses. For instance, the views of psychiatric nurses could be studied and compared to the nurses in this study in order to further our understanding of attitudes toward suicide. The same view applies to extending the study to include psychiatrists in the country. There are few qualified and practicing psychiatrists in Ghana and their views of suicide and suicide prevention could help further our understanding of attitudes toward the act.

4. Implications for suicide prevention

The findings in this study have implications for training in suicide prevention in the country. Religion appears to affect health workers' (especially nurses) attitudes toward suicide and suicidal persons. To the extent that religious prohibition of suicide can reduce suicide rates (Dervic et al., 2004; Greening and Stoppelbein, 2002), the negative attitudes toward the act per se is not a problem. However, when the negative attitude is extended to the suicidal person, as reflected in the attitudes of the nurses in this study, then it becomes problematic as it could lead to stigmatization of the suicidal patient. The suicidal person in turn might interpret that as a rejection and that could further affect both the content and effectiveness of treatment (Anderson et al.,

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2000; Neimeyer et al., 2001; Suokas and Lönnqvist, 1989). Since experience as a caregiver does not provide sufficient skills to manage and prevent suicides (Scheerder et al., 2010) training of health workers in suicide and suicide prevention must be of paramount importance. For instance, training in suicide-specific skills such as suicide risk assessment impact and stigma of suicide behavior, assessing and managing a suicidal patient has proven very effective (Botega et al., 2007; Herron et al., 2001).

Starting with the nurses, suicide and suicide prevention education could be organized to improve their knowledge about suicide as well as their relationship with suicidal persons. Some studies have already showed that educational training on suicide prevention for nurses in general hospital can improve their attitudes toward suicide patients and help them develop a new outlook on care (Berlim et al., 2007; Chan et al., 2009).

The training program in clinical psychology in Ghana does not specifically include skills in dealing with suicidal persons. However, it is recommended that suicide training begins early in the training program and even throughout internship and post doctoral experience of students (Westefeld et al., 2000). The indication in this study that young clinicians experience some anxieties working with suicidal persons, and the ideology of pathologizing suicide do provide us with areas for suicide training where requisite skills for handling suicidal individuals and knowledge to improve understanding of suicide could be organized (Fenwick et al., 2004; Westefeld et al., 2000). From this perspective, caution must be exercised in training professionals to appreciate the implied nuances of the pathology ideology in order to expand their view of the act within the Ghanaian contexts.

Training these health professionals should go hand-in-hand with the development of useful guidelines to educate the public on how to help suicidal persons. For instance, Colucci et al. (2010) have developed mental health first aid guidelines in India on how the public could provide help to a suicidal person. Similar guidelines could be developed to enhance both the training of mental health practitioners as well as empowering them on how to extend such training toward public education on suicide in the country. In conclusion, attitudes toward suicide and suicide prevention have differed between psychologists and nurses. The principal attitudes toward suicide seemed to have greatly influenced the attitudes of the health professional toward suicidal persons and suicide prevention. The kind and extent of the influence depended on the perspective on which it rested. More negative attitudes were based on a moral perspective, whilst positive rested on a mental health perspective. Thus among psychologists and nurses attitudes toward suicide lie between mental health and morality respectively, the implications of which must be addressed to inform any suicide prevention program in the country.

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