**Title:**

**Between moral infraction and existential crisis: Exploring physicians and nurses’ attitudes to suicide and the suicidal patient in Ghana**

**Abstract**

*Background*: Negative attitudes of health professionals toward suicide may hamper their willingness and skills to work with attempt survivors.

*Objective*: The purpose of this study was to explore the attitudes of physicians and nurses toward suicide and the suicidal patient.

*Methods*: A semi-structured qualitative interview was conducted on Twenty five (25) health professionals: (15 physicians and 10 casualty nurses) from five hospitals in Accra, the capital of Ghana.

*Results*: Findings showed that while majority of physicians viewed suicide as an existential crisis*,* most of the nursesviewed it as a moral infraction.Three key attitudes towards suicide and the suicidal patient were observed: stable, dissonant and transitioned. The findings are discussed under three main themes: *Contexts, Theorizing suicide, and Shades of attitudes.*

*Conclusion*: Nurses and Physicians are key gatekeepers in suicide prevention in Ghana. Training is however, needed to improve both attitudes (especially for nurses) and competence towards suicide prevention in the country.

Key words: Moral infraction, existential crisis, physicians, nurses, suicide, Ghana

1. **Introduction**

Suicidal behaviour is a public mental health issue in Ghana (Osafo et al, 2017c). Although there are no reliable national data, some studies have reported a standardized annual rate of 3.1% for Ghana in 2012 (Mishara & Weisstub, 2016); a figure lower than the global rate of 11.4% (WHO, 2014). Some police data in Ghana show that between 2006-2008, recorded cases of suicidal behaviour across the country was 287 with 243 fatalities (Adinkrah, 2012). A retrospective descriptive autopsy study has established that a proportion of 0.34% (148) of 44,000 of deaths in a10-year period (2003-2013) was due to suicide (Der et al., 2016). Among secondary school students, prevalence rates of 18.2%, 22.5% and 22.2% have been reported for suicide ideation, plans and attempts respectively, with risk factors including anxiety, loneliness, bullying and truancy among others (Asante et al., 2017). These numbers as reported above may be a tip of the iceberg, since negative attitudes toward suicide in the country do inhibit reporting (Adinkrah, 2012).

Some qualitative studies consistently continue to report psychosocial strains including conflictual relationships, poor school work, economic hardships, marital difficulties, neglect, shame, lack of social support, partner’s infidelity, social taunting and hopelessness as some of the reasons for suicidal behaviour in the country (Adrinkrah, 2012, 2013; Quarshie et al., 2015: Osafo et al., 2015). Suicide attempt continues to be criminalised under Ghana’s criminal code (1960, Act 29) and attempt survivors are vigorously prosecuted (Adinkrah, 2013). In Ghana, nurses and doctors, working in casualty departments are at the frontline when attempt survivors seek help in the hospital (Osafo et al., 2012). An earlier study has reported consistent negative attitudes of some nurses towards suicidal patients in Ghana compared with psychologists (Osafo et al., 2012). This was the first study which demonstrated the need to further examine the attitudes of health professionals towards suicidal patients in Ghana.

Hospital staff working in accidents and emergency units become extremely important when suicide attempt results in some serious injury that requires admission for intensive care. Primary care and specialist settings are therefore important help-seeking avenues which also present opportunities for early identification and assessment for the at-risk clinical population such as suicidal patients (Chan et al., 2013; Michail & Tait, 2016). Consequently, the majority of individuals who die by suicide do make contact with primary care providers, with some reports showing that in northwest of England 91% of individuals do consult their GP’s for instance on at least one occasion in the year before death (Pearson et al., 2009). Other studies also showed that about 1 in 5 suicide victims sought mental health services from health professionals before the attempt (Luoma et al., 2002).

The frontline role of health professionals in suicide prevention is as important as the dynamic relationship between them and suicidal patients (Devries et al., 2013). For instance, suicidal patients may evoke positive feelings such as empathy and negative feelings such as distancing, aggression, guilt, anxiety and fear in health professionals (Høifødtn & Talseth, 2006). These feelings (especially the negative ones) from health professionals have been reported to affect therapeutic engagement and management (Thompson et al., 2008). The attitudes of these health professionals toward suicide and suicidal patients therefore, become important to investigate, especially when we know that attitudes may predict future behaviour towards the suicidal patient and perhaps interfere with the healthy working relationship between the health professional and the patient (Friedman et al., 2006; Öncü et al., 2008). Understanding the attitudes of health professionals towards suicide and suicidal patient can thus inform their training needs in suicide prevention (Kato et al., 2010; Smith et al., 2014). The purpose of this present study is to examine the attitudes of physicians and nurses toward suicide, attempt survivors and the criminalization of suicide attempt in Ghana.

**2. Methodology**

*Approach*: Qualitative method was adopted for this study. Our interest was to understand and allow the participants as meaning making persons, to engage their context, share their experiences, views and interpretations about suicidal behaviour (Willig, 2008; Yin, 2015). The usefulness of qualitative approach in suicidal research in recent times has been highlighted (Hjelmeland & Knizek, 2010).

*Participants and procedure*: Physicians and nurses from one government hospital, a quasi-government hospital, a university hospital and two private hospitals all in Accra were sampled by use of purposive and snowball technique. An introductory letter including clearance for ethics was presented to the hospital authorities. After permission was granted, nurses working in the casualty unit were approached. Participants who gave consent, were scheduled for an interview. Similar approach was used to recruit physicians. Interviews were conducted in locations of the participants’ convenience such as consulting rooms and communal offices. Interviews which took place in consulting rooms were conducted at the end of consultations for the day. All interviews (except one) were conducted in English by the fourth author. The only interview conducted in Twi was translated into English and back-translated by lead author. All participants who were approached accepted to be interviewed. Interview took a period of 8 weeks due to the work overload and tight schedules for this population. Data saturation was determined to have been reached after the interviewer observed that responses of participants did not show much variations. A total of 25 health professionals (made up of 15 physicians at all levels = 4 specialists, 2 principal medical officers, 3 senior medical officers and 3 house officers) and 10 casualty nurses were interviewed. All those who were approached accepted to participate.

*Instrument:* A semi-structured interview guide was developed based on previous attitude studies in Ghana (Osafo et al., 2012, Osafo et al., 2015). The interview guide had seven (7) main sections including general question about attitudes towards suicide, reasons for suicide and factors that protect, health professionals’ experiences with suicidal patients and the law. Interviews lasted between 45-60 minutes. They were audio-recorded and transcribed verbatim. Field notes were made only after interviews since interviewer did not want anything to interfere with the conversation which was being audio recorded. The table below shows other relevant demographic details of participants.

Table 1. Some relevant demographics of participants

|  |  |  |
| --- | --- | --- |
|  | **Frequency** | **Percent**  |
| Gender: male  | 12 | 48 |
|  female | 13 | 52 |
| Profession: Nurses(male) | 2 | 8 |
|  Nurses (female) | 8 | 32 |
|  Physician (male) | 10 | 40 |
|  Physician (female) | 5 | 20 |
| Tenure: nurses  | 25.4 years  |  |
|  Physician | 13.3 years |  |
|  Average tenure | 18.2 years |  |
| Age: Nurses  | 48.8 years |  |
|  Physician  | 39.3 years |  |
| Mean age  | 43.5 years  |  |
| Religion: Christian  | 21 | 84 |
|  Muslims | 2 | 8 |
|  Agnostics  | 2 | 8 |
| Family condition: married with children | 18 | 72 |
|  Married without children  | 2 | 8 |
| Single living alone | 3 | 12 |
| Widow living with children  | 1 | 4 |
| Living alone with children | 1 | 4 |
|  |  |  |

*Ethics*: Ethical clearance for the study was obtained from the Ethics Committee for Humanities (ECH) under the large project dubbed “Suicide, Risks and the Law in Ghana” from the University of Ghana. To address anonymity during analysis, we have only reported the participants’ gender, profession, numerical code and age (e.g., *FN2, 45yrs*, where F is female and N is nurse)

Transcribed interviews were analysed using thematic analysis (Braun & Clarke, 2006). The analysis was led by the first author. First we read the transcripts independently, as authors. This was done along listening to the audio-tapes to check for omissions and misprints and also examining field notes on each interview. At this level of analysis, initial ideas and thoughts were noted. These initial thoughts were formulated into codes independently and discussed by all authors. Agreed codes which were considered relevant to the purpose of the present study were searched throughout the transcripts and similar ones were formulated into themes to help explain larger sections of the data (Braun & Clarke, 2006). The next level was to analyse the connections between the emerging themes. Clearly identified and defined themes were discussed by all authors. Finally, typical quotes which represented aspects of the themes were selected to support analysis (Braun & Clarke, 2006).

In qualitative research, the researcher is primarily the instrument for the research (Creswell, 2007). Consequently, the values and attitudes of the researcher can influence data analysis and interpretations. In the present study, the background of the interviewer as a medical doctor could influence the interview process and analysis. Being mindful of this, data analysis and interpretation were conducted and guided by the views of all the authors. The lead author led the analysis and the rest provided critical analysis of the themes. Themes were carefully scrutinized and agreed upon or sometimes discarded. Further, during data collection, the views of participants were summarised to make sure they have been correctly captured or recorded. This was also helpful since their work overload and schedule would not allow a second visit to validate their views after transcription. These communicative and cross-validation steps can minimize bias, subjectivity and improve the trustworthiness of the analysis and findings (Creswell & Miller, 2000; Steinke, 2004).

**3. Findings**

**3. 1 Contexts:**

 Analysis started by examining participants’ general perceptions about suicidality in Ghana on issues such as perceived prevalence, number of suicidal patients seen in the past one year, and awareness of how religiosity influenced their attitudes towards suicide. These background issues provided a context within which their attitudes were carefully examined.

Majority of the participants viewed suicide trends in Ghana as public health concern. A total of 14 participants (7 doctors and 7 nurses) viewed the act as increasing, compared to 11 of them (8 doctors and 3 nurses) who thought otherwise. Further, on average, each of them had seen at least two suicidal patients (totaling 50) in the past year. More than half of the participants reported having either close relatives or friends engaged in suicidal behaviour. Five of the informants reported close family relatives attempting suicide and 6 others reported other relations such as friends, colleagues or schoolmates who were suicidal.

Religion provided interpretative grid within which the participants expressed their attitudes towards suicide, with majority (n= 23) of them reporting that, their religious beliefs proscribed suicidality as expressed in dogmas such as ‘*life belongs to God*’ and ‘*thou shalt not kill*’. Unequivocally, they indicated that the religious consequences of engaging in such behaviour was suffering in hell. Only 2 physicians did not have any religious reflection on suicide. No differences in attitudes were observed in terms of where they worked, tenure or gender. But we observed differences in terms of professions.

The analysis further investigated participants’ specific attitudes toward suicide, the suicidal patient and the law criminalizing the act. Key contextual issues including religious beliefs and experiences while working with suicide patients were closely examined to see how they influenced participants’ overall attitudes towards suicide. The analysis is conducted under two main themes with sub-themes: Theorizing suicide(subthemes: *etiological conceptualisation*, *consequential conceptualisation*)and Shades of attitudes *(*subthemes: *stable attitudes, dissonant attitudes,* and *transitioned attitudes).*

**3.2 Theorizing suicide:**

This theme addresses the attitudes of the health professionals toward suicidal behaviour in general. It represents their ‘lay theories’ on what the act represents and is based on two formulations: 1) *etiological conceptualisation* (i.e., why people engage in such act), and 2) *consequential conceptualisation* (i.e., the negative impact of the act on others and the victim in the netherworld). More nurses held a consequential and thus a moral view (7 out of 10) compared to the physicians who expressed an existential view (12 out of 15).

***3.2.1. Etiological formulation: Existential crisis***

Physicians generally perceived suicide as existential crisis (12 physicians and 2 nurses n= 14). It is a conceptualization of suicidal behaviour as stemming from various negative life circumstances such as poverty and distressed conditions as illustrated:

*A lot of the people who commit suicide, mention something like: ‘life is not worth living’, ‘I am tired of living’ etc. I think it’s as a result of failure of society in identifying people who are in one crisis or the other. It’s something small that somebody may have been able to help…Sometimes it’s about school fees…and because of that embarrassment the person ends his life (MP011)*

The explanation of the existential crisis is blamed on external forces in life. Many of the narratives reflected such conception. Consequently, suicidal behaviour was perceived as a reaction to external negative psychosocial stressors, accentuated by lack of supportive networks around people. This view is corroborated by a nurse: *“Hmm. I think errm, people think about suicide, attempting to commit or thinking about it or actually committing it because they are at their wits end, in some crisis, where they need support” (FN014)*

***3.2.2. Consequential conceptualisation: Moral infraction***

Several nurses, compared to physicians perceived suicide as a moral infraction (7 nurses, 3 physicians). This view refers to the ideology that suicide constitutes a breach of some religious rules, beliefs or norms governing life, and this comes with dire consequences:

*From my religious point of view, suicide is not permitted. Anyone who commits suicide would go to hell! So if you know this and go ahead then it’s your own business! So I would not pity anyone who does that (MN013).*

*I frown on it because first of all as a Christian, I don’t think that anybody should take their own life. …God is the giver of life so no matter how bad it is you don’t have any right to take your life away (*MP022).

The first quote from a male nurse (MN13) proscribes suicide on grounds of consequences: that the person will go to hell. This, he perceives, is enough deterrence. The second view (PM022) from a male physician, postulates however that, the immorality of suicide is based on the ideology that the act usurps God’s prerogative over life. The moral view was predominantly influenced by religious dogmas and lay theological interpretations. A further and important dimension of the moral view also was the tendency to inhibit the expression of empathy towards the suicidal patient as illustrated in the first quote above. In the voice below, the impact of such moral position and the proclivity to abuse the patient can be gleaned:

*I take them to the nurse’s room. Especially if they have to wait for an appointment before they see the psychologist or psychiatrist. I ask them what their problem is and then I advise them. Sometimes I blast them because the story they recount is all foolishness! They don’t own their life. The psychologist told me to desist from doing that but sometimes you just can’t help it. Aaah! Foolishness! (FN001)*

 This nurse spends the time (which is rather needed to perhaps reduce the perturbation of the patient), on escalating it. Her moral position on suicidality leads her to resort to insults and ultimately perceives the patient in condemnatory terms. A caution from a mental health professional does not change her moral condemnation of the patient.

Thoughts and beliefs may affect attitudes and action. It was therefore very important to carefully delineate how these lay theorizing about suicidality from the participants related to their beliefs about the suicidal patient and the law that criminalizes them in the next theme.

3.3 **Shades of attitudes:**

This theme addresses three kinds of attitudes observed from the health professionals toward the suicidal patient and the law that criminalizes them. They are *Stable, Dissonant,* and *Transitioned attitudes*.

***3.3.1 Stable attitudes***: There were two dimensions of this set of attitudes. The first is the *negative stable attitude* and the second is the *positive stable attitude*. The negative stable attitude refers to a consistent link observed between a conception of suicide as a moral infraction, a demeaning view of the person and a strong support to criminalize the act. This attitude was reported by some nurses (n=4) but none of the physicians expressed this attitude. In the conversation below a nurse held a moral view of the suicidal act, judged the suicidal patient and supported the law that condemned attempt survivors:

*Interviewer: Tell me your attitudes about suicide*

*Participant: Errm, we know that it is not good to think that ‘I would kill myself’ because it is against God’s rule (FN023)*

*Interviewer: what does this represent for you then?*

*Participant: I think it’s a coward kind of behaviour. You don’t want to face the realities in life that’s why you killed yourself.*

*Interviewer: mmmm. You said it is a cowardly act?*

*Participant: Yes. If you are brave, you would face the problems (FN023)*

*Interviewer: what’s your view about the law that criminalizes the act?*

*Participant*: *Yeah it is a crime, because thinking that ‘I’m going to kill myself ...’ you shouldn’t think like that. Even in… in my Koran it’s a crime to commit suicide because you’re killing a soul also (FN023)*

She refers to the attempt survivor as coward and someone who kills a soul. Religious beliefs played a major role in her views about the attempt survivor and the law that criminalizes the person. Religion seemed to have shaped an inflexibly negative view of suicide as antagonistic towards divine ethics.

The second set of stable attitudes is the *stable positive attitude.* This was expressed by all physicians (n=15) and some of the nurses (n=6). Such attitude was found to be akin to the view of suicide as arising from existential/health crisis. If the act of suicide was conceptualized as a life struggle or crisis, the health professional empathized with the suicidal patient and did not find them blamable as illustrated in the conversation below:

*Interviewer: what is your view about suicide?*

*Participant: I feel empathetic towards them because the person desperately needs help. So for me, I simply want to help. I treat it with urgency (MP018)*

*Interviewer: ok, so how do you view the suicidal patient?*

*Participant: I think they need compassion and understanding to be managed properly… I mean see how difficult it is and what pain you go through when you’re cut by a sharp object or even when you get pricked by a needle. It takes bravery to be able to do something like that. I would describe them as desperate and needing help (MP018).*

*Interviewer: I see. So what is your view about the law that condemns the suicide attempter?*

*Participant: I think it should be scrapped off our books. Yeah. You know people who commit need help…They are desperate and calling for help. Those who made that law, have no knowledge of mental health (MP018).*

As can be deduced from the conversation, the physician’s position on the law is consistent with his view about suicide as crisis, and the suicidal patient as someone in desperate need. He expatiates that the formulation of the law on suicide attempt is traceable to ignorance about mental health issues on the part of the framers of that law.

***3.3.2 Dissonant attitudes***: It was observed that some participants maintained two conflicting attitudes towards suicide and the suicidal patient. This was only observed among the physicians and became apparent when they encountered a suicidal patient in their line of work. The following narrative is from a male physician with 25 years of practice who responded to the question ‘*how do you view suicide, and the suicidal patient?*

*Errm. It’s mixed. In the sense that, yes it’s sad that they actually attempted suicide but sometimes it’s annoying…some of the people come in and you wonder ok ‘what is wrong with you? Because whatever the person is supposedly trying to die over, seems not worth it. So in that vein, it’s annoying. But at the same time it’s also sad that somebody could have so little self-esteem that they want to take their life over something so seemingly trivial* (MP003).

He admits that painful emotions flare up during suicidal crisis but reasons for the act could also irritate the health worker. Perceiving the reason for the act as worthless provided impetus for such negative attitude. The mixed emotions of irritation and sadness might represent the undercurrent of a collision between the moral infraction ideology and professional ethics of the health worker.

In another voice, a young physician with only two years of medical experience expressed such dissonant attitude:

*In instances where I have come across someone like that, I do pity them. Well I must be frank here that sometimes too when you hear the stories behind their act or attempt at suicide you wonder why people do that. Not as the trained person but as an ordinary person... you just, instinctively criticize and ask ‘why did you do this?’ So sometimes I know I go overboard* *but generally I pity them (MP21)*

In the narrative, he is alternating between professionalism and lay ideology, probably because the act does not make sense to him. He explains, that sometimes he discards professional ethics and applies morality in making judgment about the act.

In another scenario, social injury, a view that suicide creates unpalatable consequences for the family of the suicidal patient was a key factor in the formulation and expression of the dissonant attitude:

*Erm. Sometimes hurt, sometimes anger. It’s a myriad of them especially when you know people’s lives are dependent on you and you just decide to take the easy way (suicide). I understand you’re sick but why is everybody not taking the easy way out? I mean sometimes this get me a bit angry. Do you know how much it is going to hurt everyone else? I mean that is a bit selfish. But sometimes it’s also like you understand. It’s like you see the whole situation and wonder ‘hmmm, what would I do if I were in his shoes?’ So, as and when, the feelings differ, but I try not to let my own feelings get into the way. I just try to get to understand their side. (MP020)*

 The impact of the act on others is a key factor in the way he moralizes the act and condemns the attempt survivor’s action as reflecting selfishness. On the flip side, he universalizes and personalizes the suicidal crisis in an attempt to empathize with the patient. Key in such alternating mode is the temporal dimension and perhaps context-specific factors alluded to: “*as, and when, the feelings differ*”. This may suggest that, this physician does maintain more than two attitudes related to specific situations and his emotions.

***3.3.3 Transitioned attitudes***: Some of the physicians (n= 8) and a few nurses (n= 2) expressed a changed attitude from an earlier held negative attitude to a new positive attitude. This is what we refer to as transitioned attitude. As observed, the participants changed from a strong moralistic (negative) view of suicide and suicidal patients to a more empathic view. Such change appeared to have resulted from experiences with suicidal crisis involving friends or relatives. The account below is illustrative:

*In the past I used to say to myself, ‘I can’t get depressed’, that’s not an illness. We want to see pneumonia,… malaria and stuff. But depression? No! But now I understand, because my life is a little more complex and I understand that there are complexities in life. In the past, I use to look at people who committed suicide as cowards. They can’t face the problem at hand so they are cowards. I now look at it a little differently. I just think that some of them have a chemical imbalance that can actually be reversed or treated and the others have a longstanding emotional problem that perhaps may have been ignored. So, it’s a problem. It’s not cowardice. I think they are sick…just like the schizophrenics are sick (MP005).*

Two views about suicide and the suicidal patient can be deduced from the narrative above: 1) the conception of illness from a pathogenic-based perspective. In this regard, he viewed mental illness (i.e., depression) as non-serious debility compared to pneumonia and malaria. This view is more reductionist. 2) The view that suicidal patients have a weakness in character, and observed as cowards who fail to survive existential struggles. As evident in the narrative, there is a temporal dimension, suggesting a transition from such pathogenic-based knowledge about health to a state of holistic understanding of what he calls the ‘*complexities in life’*. On the basis of this new perspective, he claims to have discarded the previous poor attitude and replaced them with a rather improved one. Although the present improved attitude is presumed to be superior in quality to the previous, it also appears narrow and much more neuro-psychiatric. However, such new view seems to promote empathy for the suicidal patient, an important attribute needed in their management (Lenaars, 2004). As pointed by Marsh (2010) such contemporary pathologization of suicide may reduce feelings as rejection, guilt and anger toward suicidal patients. The above participant indicated that this change in attitude towards suicide and suicidal patients is partly due to his experiences with colleagues who went through suicidal crisis:

*Interviewer: Do you think these personal experiences you have had, influenced your attitude towards suicide?*

*Participant: Yes (said without hesitation). Long pause*

*Interviewer: How?*

*Participant: I don’t think they are crazy. Now I don’t think they’re cowards. No! I just know that at that time, just because I haven’t experienced it...... what happened to them was so overwhelming that they found no way out (MP005)*

As he explained, such experiences have shaped the current empathic attitude he expresses toward the act and the suicidal patient.

In another case, a physician indicated how his moral view toward suicide and the suicidal patient transitioned. His new attitude appeared to have been influenced largely by developmental outcomes including personal experiences:

*Well, at first I used to look at them with scorn but I changed my mind as I grew up. Personal experiences and so on make one change you know. They need to be pitied. We have to show mercy and try and bring them on board and let them know that people around them love them and they don’t want to see their demise. So I personally now have changed my mind from (laughing) scorn to compassion… (MP06).*

His initial moral view was derogatory but as he indicated, this transitioned from ‘*scorn to compassion’.* Such a change as he explains was intentional than accidental. One of the physicians indicated that training in Medical School accounted for this transitioned attitude:

*If you’re looking at it from the angle of the law, the person is a murderer, from the angle of religion, he is a sinner. But if am looking at it from the context of being a doctor, then the person is a sick person who needs help. The person is a patient who needs help. I used to think of them only as sinners and criminals but now after my medical training, I think it’s been watered down by the knowledge that I now have that they need help and not condemnation (FP08)*

This participant presents multiple views about the suicidal patient in terms of the law, religion, and health. The first two views fostered moralistic condemnations of suicidal patients as criminals and sinners. These profiles are in sharp contrast to the health perspective of the person as a patient. Knowledge gained from medical school might have moderated this moralistic view to such empathic attitude.

Although more of the physicians reported such transitioned attitudes, it was also observed among two of the nurses:

*Anyway, in Pantang (*a public mental health hospital) *what we usually used to do is that we used to whip them...because most of them...they don’t really know what they are doing. So you whip them and they come to their senses before you start talking. Yeah…but now I think the most appropriate thing is to sit the person down and find out the reasons why they did that and then you counsel them (MN13)*

The nurse presented a previous position of what ‘*used to be’* and how he has changed from that to ‘*the appropriate’ thing* to do in the present*.* As indicated, the insensate approach of handling suicidal patients is aimed at socializing them to accept the normative moral view that proscribes the act and emotionally stabilize them prior to the provision of help. Such crude mode of help, has transitioned to a view of suicidality as a condition that requires empathic response through counselling services. This is a more professional approach. He indicated that such transition is influenced by exposure to mental health education as illustrated further in the following conversation:

*Interviewer: mmmm. Ok. If you were to describe somebody who is suicidal in a few words how would you consider them?*

*Participant: If I hadn’t had any knowledge in mental health, I would have said the person is a sinner, but I think now I would say the person is sick. Yeah (MN13)*

As can be deduced, his moral conception of the suicidal patient as a ‘*sinner* (transgressor) has changed to a person who ‘*is sick’ (patient)*. This he indicates resulted from exposure to mental health literacy. His attitude has thus transitioned from a moral to a health perspective.

Another female nurse shared an experience of how her attitudes have transitioned from a moral position through personal experience as illustrated in the conversations below:

*Interviewer: If you were asked to describe somebody who is suicidal using a few words how would you consider them?*

*Participant: I used to think that, they are fools or stupid to think about committing suicide but now I think over the years I have changed that notion. They need care and help.*

*Interviewer: What in particular changed that notion for you?*

*Participant: Personal experiences I am unable to disclose now (FN14)*

This nurse has had close to 30 years in nursing care and although does not clearly show which experiences have shaped this new view, she reported that she sees between 10-15 cases of suicide attempt every month. She adds that, she is drawn closer to such persons to *“…find out which ways the person would feel comfortable... by helping” (FN14)*. Perhaps such encounters together with personal and undisclosed issues, facilitated the transition from the use of pejorative labels (e.g., fools) to a more humane view of them as needing *care and support*. Later in the interview she intimated that religion also influenced this transitioned attitude to a more spiritualized perspective as seen below:

*I have come to believe…that it is actually something more of a spiritual force which pushes you to commit suicide and so should I find somebody or even myself thinking about it, I just tell myself ‘no, this is another voice I’m hearing’ and whichever God I worship, I think would want me to go through this pain, this challenge, trials and tribulations and come out victorious; a better person (FN14).*

There is a transition from a previous viewpoint on suicidality. This is illustrated in the phrase ‘*I have come to believe’*, to the present spiritualized conception of the act as a consequence of diabolical intervention. However, she opines that, life’s struggles (including suicidal crisis) can be managed by self-instruction as well as a reconstituted meaning of crisis in life. She hopes such coping mechanisms should result in a sort of posttraumatic growth following such crisis.

**4. Discussion**

The purpose of this study was to examine the attitudes of nurses and physicians towards suicide and the suicidal patient. The health professionals, most of whom had interacted with suicidal persons (either as patients, colleagues or family folks) viewed suicide as a considerable public health problem in Ghana, arising from psychosocial crisis rather than psychiatric illnesses. This is consistent with previous studies that have reported the preponderance of psychosocial/sociocultural factors in suicidality in LMICs and Ghana in particular (Iemmi et al., 2016; Akotia et al., in press; Osafo et al., 2015)

Generally, suicide was conceptualized as crisis more than a moral infraction. This was manifested in the generalized positive attitudes of the health professionals towards suicidal patients. The physicians generally held a *crisis* view of the act and this is consistent with a study in which general practitioners were reported to view suicidality as crisis mixed with symptoms of acute depression (Zadravec & Grad, 2013). The few physicians who held a biomedical/psychiatric view of suicidality is also consistent with another study in Denmark, which reported that medical students viewed suicide as a psychiatric condition which can be treated with antidepressants; they were also more likely to believe that suicidal patients are not responsible for their actions (Wallin, & Runeson, 2003). But in one study which was not consistent with this finding in the present study, physicians often conceptualized the suicidal behaviour as attention seeking (crying wolf) rather than a suicide attempt (‘cry for help’) and this was found to affect the management of the patient (Saini et al., 2016).

Nurses on the other hand in the present study, reported more *moralistic view* towards suicidality. This moralistic view is parallel to the attitude reported by casualty nurses in a previous study in Ghana (Osafo et al., 2012) and Japan. In Japan, the nurses who worked in intensive care units were less likely to understand the suicidal patient and also unsympathetic to interact with them (Kishi et al., 2011). From our experience in gatekeeper training in Ghana, it is plausible, the physicians compared to the nurses have had training in mental health issues and this might have accounted for the improved attitudes among them compared to the nurses. Similar improved attitudes have been reported among psychiatric nurses than non-psychiatric nurses (Kishi et al., 2011).

In addition to the reported attitudes towards suicide in Ghana such as silencing, trivialization and condemnation (Osafo et al., 2011a), three other attitudes in relation to the act of suicide, the suicidal patient and the law that criminalizes the act have been found in this study. These are: stable, dissonant and transitioned attitudes. These attitudes were shaped by religious beliefs, professional ethics and personal experiences with suicidal patients. Health professionals’ attitudes are very important in any suicide research and prevention programs. This is because, they can hinder or improve their caring relationships with the suicidal patient (Carlén & Bengtsson, 2007; Cutcliffe et al., 2006). Addressing these attitudes therefore is an important prevention target.

 The doubled-edged stable attitudes in the present study were reported in an earlier study by both nurses and psychologists with the former expressing negative stable attitudes and the latter the opposite (Osafo et al., 2012). These negative attitudes of the nurses towards the suicidal patient could reflect the demands of nursing care for patients. As confirmed by some studies, nurses expressed anger and frustration towards suicidal patients as a result of the perceived fruitless time invested in caring for the person (Bohan, & Doyle, 2008). From our experience and work in communities on suicide prevention in Ghana, the negative stable attitudes are widespread and they promote the stigma which is often expressed towards suicide persons. When the attitudes are positively stable, the health professional is more likely to report the ability to be empathetic and provide care for the suicidal patient than when the attitude is negatively stable.

 Dissonant attitudes were influenced by trivialisation of reasons for the act and moral conceptions. They were elicited through working relationship with suicidal patient or stories about such acts. Generally, the dissonant attitude appears to reflect a contention between professional ethics (as health professionals) and the generalized moralized socio-cultural context in which they work. Arguably, it further illustrates the general clash between pathologizing suicidality and thus therapeutizing actions and reactions as remedy; in contrast to proscribing suicide on moral grounds and thus endorsing sanctions (including criminalization) as a preventive measure. Such dissonant attitudes towards suicide is consistent with similar findings among Uganda health professionals who were torn between their religious beliefs and professional ethics in making judgments about suicidal patients and the law that condemned them (Knizek et al., 2013).

In previous study of the attitudes of psychologists and nurses, a key finding was that their attitudes toward suicide was in transition from a condemnatory moral position toward a mental health position. Such transition could reflect a transformation from a condemnatory position to a non-condemning attitude toward suicidal patients (Osafo et al., 2012). We opined that the transitioned attitude as described in the present study is akin to such transformation. In one study the learning experiences of newly educated physicians regarding how they related and treated suicidal patients were found to be transitioning from simple knowledge such as recognizing similarities and differences in patients they have treated, to accumulating pattern knowledge, which then contributed to their personal feelings of competence, confidence and awareness of own attitudes and experience gained from treating patients (Høifødt et al., 2007). Though such transitioned attitudes might not exactly parallel ours, we find some semblance of that in the present study as far as the newly acquired attitude is pro-patient and improves health workers’ composure in relating and working with such patients.

 In the present study, the transitioned attitudes were influenced by various factors including educational development, religious beliefs, continuous professional training and experiences from working with suicidal patients. Consistent with other studies, those who have had some form of training have improved attitudes (e.g., McCann et al., 2006). Attitudes are not cast in brick and stone. They are malleable, and thus changeable (Gawronski, & Bodenhausen, 2006). As argued elsewhere, indeed, attitudes toward suicide in Ghana are in transition from condemnation to understanding (Osafo et al., 2017c).

***4.1. Limitations of the Study***

One limitation of the study is that time and logistics did not allow further investigation of the views of mental health nurses. This group could have been compared to the nurses in this study in order to clearly see where their differences in attitudes lie in order to guide training needs. Also, the study could have further explored how many of them are engaged with inter-professional collaboration on suicidal patients. That could have shed more light on their clinical practice behaviours on suicidality and how to target training needs. Future studies should look into addressing this. This study was not designed to generalize but to seek understanding that can guide training needs. The findings should be accordingly applied.

***4.2. Implications for training***

The findings of the present study have important implications for training of health professionals in suicide prevention in Ghana. Overall, the results show the gatekeeping resource available in this population that can be tapped to improve suicide prevention programs in the country, as observed in community leaders, psychology students, judges and lawyers, police personnel etc (Osafo et al., in press; Osafo et al, 2011a, Osafo et al., 2017a; Osafo et al., 2017b). Gatekeeping however, requires strategic education. One of such strategies is to train health professionals to be aware of their own attitudes and how they inhibit or facilitate clinical skills and composure in suicidal patient care. The content of the training should address religious and personal values and how they creep into the professional space of these health workers. Religion exerted major influence on the attitudes of the health workers and this is parallel with the religion-induced negative attitudes toward suicide as reported in most studies around the world (e.g., Colucci & Martin, 2008; Eskin, 2004; Ineichen, 1998; Mugisha et al., 2013; Osafo et al., 2011c). The moral plane on which suicide rests, within the sociocultural landscape of Ghana, needs to be carefully interrogated and challenged in order to increase these health professionals’ awareness of their own attitudes and how they hamper the provision of help to suicidal patients. There are indications of the readiness of the medical fraternity such as Ghana College of Physicians and Surgeons, (Osafo, 2017d) and Heads of Health Training Institutions (Osafo, 2017e) to improve their knowledge on suicide and their role in suicide prevention in Ghana. Several studies have reported some improvements in attitudes of health professionals towards suicide after training (Berlim et al 2007; Chan at al. 2009; Gask et al., 2006; Kishi et al., 2011; Samuelsson & Åsberg, 2002) and thus continuous professional education and training is very much needed in this population in Ghana.

Another strategy is to find innovative ways of increasing contact between suicidal patients and health professionals. The experiences and contacts health professionals reported in this study seemed to have accounted for the transitioned attitudes (a positive one) toward suicidal patients. Contact hypothesis simply proposes that interaction between members of different groups reduces prejudice (Dixon et al., 2005). Some studies further suggest that repeated exposure affects attitude formation (Hansen & Wänke, 2009). Increased public education that will target encouraging suicide reportage in the various hospitals in Ghana could be useful in getting health professionals to work with suicidal patients and perhaps improve their attitudes towards these patients.

***4.3. Conclusion***

In conclusion, health professional’s attitudes toward suicide in Ghana continue to be influenced by moral and personal values more than professional ethics. As gatekeepers in suicide prevention in the country, their attitudes might improve if targeted training addresses these negative vestiges of the socio-cultural contexts in health care services for suicidal patient in the country.

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