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ORIGINAL PAPER

Influence of Religious Factors on Attitudes Towards Suicidal Behaviour in Ghana

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Abstract The objective of this qualitative study was to understand how religion influences lay persons' attitudes towards suicide in Ghana. Twenty-seven adults from both rural and urban settings were interviewed. Interpretative phenomenological analysis was used to analyse the data. Results showed that the participants are committed to core and normative religious beliefs and practices they perceived as life preserving. Such an understanding influenced their view of suicidal behaviour as unacceptable. Nevertheless, religion facilitated their willingness to help people during suicidal crisis. Religious commitment theory is used to explain some of the findings of this study. Implications for suicide prevention are discussed.

Keywords Religious factors · Attitudes · Suicidal behaviour · Ghana

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Introduction

Attitudes towards suicide are quite complex and intertwined with the values and religious perspectives of a person (Domino 2005). For instance, religion has been reported as influencing lay persons' views of suicidal behaviour (Walker et al. 2006). When Neeleman et al. (1998) analysed the relationship between suicide acceptability with religious beliefs among African and White Americans, they found that orthodox religious beliefs and devotion were associated with the rejection of suicide in both groups. Eskin (2004) has indicated that persons who are exposed to religious education do not accept suicidal behaviour as compared with those who are secular. Sawyer and Sobal (1987) also reported that the American adult public that held religious preferences and beliefs proscribed suicidal behaviour. Religion thus seems to be a major dimension of attitudes towards suicide (Domino et al. 1993).

Generally, suicidal behaviour is condemned by major religions such as Christianity, Islam, Judaism and Hinduism (Gearing and Lizardi 2009; Sisask et al. 2010). Whilst followers in some of these religions have thus been reported to have a negative attitude towards suicidal behaviour (e.g. Anglin et al. 2005; Dervic et al. 2004; Khan and Hyder 2006; Modifi et al. 2008; Sarfraz and Castle 2002), religious faith is, on the other hand, reported as facilitating positive feelings towards suicidal persons (Eskin 2004) and thus may be a motivating factor for helping people who are experiencing crisis situations such as suicidal ones.

Studies examining the relationship between religion and attitudes towards suicide in Africa are reported to be scarce (Schlebusch et al. 2009). Nevertheless, some studies have indicated that religion is a factor affecting attitudes towards suicide in some African countries (Alem et al. 1999; Lester and Akande 1997). For instance, religion influenced the negative attitudes of college students towards suicide in Nigeria (Lester and Akande 1994). In Ghana, previous studies among college students have reported religion influencing the negative attitude towards suicide (e.g. Eshun 2003; Hjelmeland et al. 2008). In a recent study among psychology students in Ghana, Osafo et al. (in press) found that the students' interpretation of suicide as constituting a breach of divine morality was influenced by their religious beliefs. To the best of our knowledge, previous studies on attitudes towards suicide in Ghana have concentrated on students, are largely quantitative, and have not specifically examined in depth the influence of religion on attitudes towards suicide among lay persons (e.g. Eshun 1999, 2003; Hjelmeland et al. 2008). The purpose of the present study was therefore to examine the influence of religion on lay persons' attitudes towards suicide and whether those attitudes influence their enthusiasm to help people during a suicidal crisis.

Ghana—The Study Setting

Ghana is a sovereign state in West Africa occupied by diverse groups of people distinguished mainly by language. The Akans constitute more than half of its population along with other major groups such as Mole-Dagbani, Ewes, and the Ga-Adangbe. The 1960 Criminal Code of Ghana criminalizes suicide (Adinkrah 2010), and there are no official public statistics on suicide in the country. Nevertheless, a previous study among psychology students in Ghana showed that almost half (47%) of the students knew someone who had attempted suicide and one in five knew someone who had killed themselves (Hjelmeland et al. 2008). Based on these findings, the authors indicated that suicidal behaviour could be a considerable public health problem in Ghana. There are three major

religious groupings in Ghana. Christianity pulls about 68%, Islam 15% and a significant portion of the rest are Traditionalists (Care International 2009).

Ghanaians live in a dynamic religious environment that influences their attitudes and value systems (Assimeng 1999; Buah 1998), with the Church viewed as the moral conscience of Ghanaian society (Yirenkyi 2000). Religious groups and leaders have become important stakeholders in mental health services in the country (MOH 2007). Many religious groups (especially churches) offer spiritual healing for mental health problems, and a large number of Ghanaians access such services (Roberts 2001; Read et al. 2009).

Method

Qualitative methodology was chosen in order to study in depth the influence of religion on the informants' attitudes towards suicide (e.g. Hjelmeland and Knizek 2010). Qualitative studies are interested in the sense people make of their world and how they experience events (Willig 2001). Our approach in this study is the interpretative phenomenological analysis (IPA; Smith et al. 2009). The aim of the IPA is to explore in detail the lived experience of participants and the meanings they make of that experience (Smith et al. 2009). The IPA has been found to be a suitable approach when one is trying to understand how individuals perceive particular situations they are facing, how they are making sense of their personal and social world, and especially, when one is concerned with a complex issue such as suicide (Silverman 2006; Smith and Osborn 2003). Such meaning making is in line with our objective and could provide us with a contextualized understanding of the influence of religion on suicide in this cultural setting. The study was carried out at the individual level. Our use of a semi-structured interview guide was in line with the IPA aim of acquiring a detailed account of the individual's experience (Smith et al. 2009). In the case of this study, we sought to understand the participants' attitudes towards suicidal behaviour in Ghana. Such an aim requires a flexible data collection instrument (as the semi-structured interview guide) which allows the researcher and participant to engage in a dialogue (Smith and Osborn 2003). This flexibility of the semi-structured interview allows both modification of initial responses based on the participants responses and also further probing of important areas arising during the interview (Smith and Osborn 2003).

Location

We were interested in comparing views of rural lay persons and their urban counterparts for possible differences in attitudes towards suicide. Therefore, we purposively selected the participants from two different settings. The rural site was in the Eastern Region and was about 40 km away from the capital (Accra). The urban cite was a suburb in the capital (the Greater Accra Region) of the country.

Instrument and Procedure

Interviews were conducted using a semi-structured interview guide. This interview guide was not theory driven but rather contextually based. This is because it was developed from an earlier quantitative study on attitudes of psychology students towards suicide in Ghana (Hjelmeland et al. 2008). In order to be used among lay persons, we added other contextual (e.g. cultural) issues that emerged from the earlier studies. Therefore, there were seven major open-ended questions on this interview guide which had other sub-questions for the

purposes of probes. For instance, section one dealt with general questions about how Ghanaians view suicide and how the participant felt about it. Religious factors and how they influenced participants' attitudes towards suicidal behaviour were elicited in two ways: firstly, by questions that elicited their religious views about suicide and how that influences their attitudes towards the act and secondly, from their views on hypothetical short stories of crisis situations in which some people may become suicidal, such as HIV infection, business loss, mental illness or marital problems.

The interview guide was translated into Twi (the most widely spoken Ghanaian language belonging to the Akans). Since almost all participants were predominantly Akans, most of the interviews were conducted in Twi. However, those participants (especially urban dwellers) who felt comfortable communicating in English had their interviews in that medium. Interviews were conducted in the homes of participants. Sometimes the participants requested that the interviews be conducted in places free of distractions and where people may not eavesdrop what they were saying. Such places included sitting under trees. The interviews lasted between 30 and 45 min. The first author conducted the interviews. He is a native Ghanaian (from the Akan ethnic group). He is also a clinical psychologist with an experience in conducting qualitative research.

We considered that the topic of suicide could be a morally sensitive one, especially in the rural area since rural communities in Ghana tend to firmly hold onto traditional value systems (Adinkrah 2004). We, therefore, first approached community leaders and explained the purpose of the project to them. They in turn informed the rest of the members of the community. By this step, the ground was set for interviewing the lay persons.

With permission from the participants, the interviews were audio-recorded and later transcribed verbatim. Informed consent forms were filled, and contact details of those responsible for the project were provided in case some of the participants needed attention from a qualified counsellor following the interview. The study was approved by the Regional Research Ethics Committee in Central Norway and the Noguchi Memorial Institute for Medical Research Institutional Review Board (NMIMR-IRB) at the University of Ghana.

Participants

In all 27 adults who were interviewed (men = 12, women = 15), fifteen were from a rural centre and 12 from an urban centre. Gender distribution was such that five men and seven women were from the rural site and seven men and eight women from the urban site. The ages of rural participants ranged from 24 to 70 whilst urban participants ranged from 24 to 58 years. Rural participants were predominantly petty traders ($n = 12$), and the rest were farmers and drivers, whilst one was unemployed. Urban participants were also predominantly petty traders ($n = 6$) and the rest beauticians, drivers and photographers. The ages of the participants ranged between 23 and 70 years.

On the religious demographics across the sample, the majority of the participants were Christians ($n = 24$). Out of these, 13 were from the Pentecostal–Charismatic faith (this is a Christian movement that emphasizes the experience of a particular type of spirituality marked by speaking in tongues and possession of the gifts of the Spirit (Hunt 2008)), eight were Protestants and three Catholics. There were only three Muslims. The criteria for selecting lay persons for interviewing included interest in sharing views and experience about suicidal behaviour. Such adult persons should not have any professional knowledge about mental health issues and should be able to communicate fairly well in Twi or English.

As qualitative researchers, our sampling was guided by the understanding that case selection rigour involves explicit and thoughtful picking of cases that are in line with the purpose of the study (Patton 1999). Again, we were aware that some participants might have richer knowledge and could provide more insight into the issue of interest than others (Marshall 1996). Guided by these understandings, in certain occasions when participants have recommended other useful persons for the study, we have followed to seek their consent and interviewed them. The sampling procedure was therefore purposive in order to have in-depth views rather than a strictly representative sample. None of those identified as participants refused to be interviewed.

Analysis

Transcripts were generated semantically, but notable significant non-verbal utterances such as laughter and long pauses were also included. This is consistent with the IPA of interpreting the meaning of the content of the participants' account. (Smith et al. 2009). In analysing a large sample size with IPA, the emphasis is on assessing what the key emergent themes for the whole group is about (Smith et al. 2009). Guided by this, the first phase of analysis was reading to make a sense of the transcript. To get deep into the text, we were actively engaged with the text, noting anything of interest such as key words and phrases within the transcript (Smith et al. 2009). The objective of many qualitative methods is to identify themes from the data that reflect shared understanding of the phenomenon of interest (Flowers et al. 2006). We, therefore, identified recurrent themes in the transcripts, and typical quotes were selected to represent them as emergent themes. We made logical connections between these themes in a theoretical and analytical ordering, working up to more general categorizations (Smith and Osborn 2003).

Four major themes were identified as a result. They were: *Religiously Committed Persons; Endorsed Norms for Survival and Coping (with two sub-themes: Prayer as a Tool for Coping, and Hope as a Tool for Coping); Unacceptability of Suicide*; and *Motivation for helping people with suicidal behaviour*. We did not see any difference in these themes across locations, gender and religious affiliation. However, under the sub-theme *Prayer as a Tool for Coping*, we did find some gender differences. Generally, the views shared by the participants across locations, religions and gender were similar. For purposes of anonymity, we only report gender and location with the quotes.

Findings and Discussion

We start by indicating that generally the participants were religiously committed persons who highly endorsed religious beliefs and practices as survival and coping norms. Suicidal behaviour is thus perceived as a consequence of failure to utilize these survival and coping norms during crisis. With such a religious understanding and conformity to core religious beliefs, the participants find suicidal behaviour unacceptable. Nevertheless, religion provides them with the motivation to help persons during suicidal crisis.

Religiously Committed Persons

There were strong indications that the participants were religiously committed in that they considered themselves as religious persons and projected a religious identity during the interview. For instance, more than half ($n = 18$) of the participants clearly indicated that

they were speaking to the researcher as religious people: 'I am speaking to you as a Christian' (urban woman5). Others even claimed that they were sharing with the researcher: 'the mind of Christ' (urban man1) and 'what the Bible says' (rural man4) about suicidal behaviour. Almost all participants exhibited the tendency of citing scriptural quotations (especially the Christians) to explicate their opinions about suicide during interviews: 'one of the commandments in the Bible says don't kill' (rural man1). All the above descriptions perhaps demonstrate that as committed religious persons, the participants might find suicidal behaviour incongruent with the values of their worldview: *My training in the Lord was to the extent that I saw suicide as something that is not good* (urban man2). Such a religious worldview could be deeply ingrained as some participants viewed desisting from suicidal behaviour as probably an index of true religiosity: 'if you are a good Christian, you don't even think about committing suicide' (urban woman2).

Endorsed Norms for Survival and Coping

There was a generalized belief that a person should be resilient enough to face the crisis of life, and religion was identified as a mechanism in such a direction. All the participants strongly emphasized how religion has helped them to cope during crisis: 'My Christian faith helps me during crisis. Had it not been that life would have been terrible' (rural woman12). Though religion was not considered an insulator from crisis, it perhaps was viewed as an adaptive mechanism that helps in dealing with life's crisis: *if you commit your life to the Lord like me, even if life becomes so harsh, I cannot go and hang myself…living as a believer doesn't exclude you from life's difficulties but it helps you to deal with them* (urban man3). Conceivably, the religiously committed person will use his/her faith to cope when crisis strike. Suicidal behaviour was accordingly perceived as a consequence of having disregarded the utility of religious faith: 'So I will say whoever goes through crisis such as this and takes poison and dies in such situation failed to use his religious faith' (rural man5). It is possible that such an interpretation engendered the participants' attribution of suicidal behaviour to a deficit in the religious devotion of people in contemporary times in Ghana. An idea perhaps akin to low religious commitment: 'We have been raised to be religious as Christians and as Muslims. But because of how far we have wandered away from such training, that is what causes people to do these things' (urban woman3). Here, living as a religious person is considered as a life-preserving agent against suicide, and therefore, there were calls for the youth to consider religious lifestyle as a way to prevent suicidal behaviour: *So this also calls for the youth to consider becoming Christians in order to avoid this behaviour* (urban man3).

To emphasize the need for this norm of survival and coping, the participants provided counterexamples of how they would have used religion to cope during crisis. For instance, a participant sharing her opinion on a hypothetical story in which a man who lost his job became suicidal said: *he didn't do well. I would have prayed to God to give me another job* (urban woman10). We gleaned prayer and hope as two major norms for survival and coping which participants used in dealing with crisis. These are discussed as sub-themes below.

Prayer as a Tool for Coping

More than half of the participants mentioned prayer ($n = 15$) as a coping mechanism. A participant indicated that: 'if some problems happen, you have to first go to God in prayer to find out what is really happening' (urban man2). Prayer perhaps creates a certain level of

relationship between the person and the divine in which the person perceives help could come from God during crisis. The significance placed on prioritizing prayer in a crisis situation may help the participants to reappraise the situation with the understanding that the crisis is not a dead end because God will help them. In that sense, God perhaps becomes conceptualized as a significant form of social support and such a perception could relieve distress (Levine 2008). Some participants indicated that prayer helps them gain control over painful experiences:

> *So I only prayed to God, that God you know what had happened to me or what is going to happen, so show me a way. So through my prayers, I got strength. It was a very painful experience that if you did not hold your heart, you can go and hang yourself. Yes! Yes! I had suicide thoughts, I had them, but prayers kept me going* (urban woman8)

The first part of this quote shows the use of prayer as a means of surrendering the problem to God and seeking for direction as in 'So I only prayed to God, that God… show me a way'. Such a practice could be attention diverting as the person conceptualizes an active Deity taking control over seemingly uncontrollable situations. The person does not spend time and energy, making futile efforts of something beyond his or her capacity. As a result, self-focused attention, worry and rumination that could induce painful emotions might reduce, and this could bring relief (James and Wells 2003; Levine 2008). This finding that the participants are using prayer to cope is consistent with other studies (e.g. Ai et al. 2005; Baker 2008; Dein and Littlewood 2008). In contemporary Ghana, prayer groups are one of the prevalent forms of religious expressions for solving problems (Assimeng 2010), and perhaps, such a phenomenon emphasizes the value and the reality of the practical use of prayer in the lives of the participants.

Hope as a Tool for Coping

More than half of the participants ($n = 16$) made many references to hope from their religious orientation that they claim is useful for living. This kind of hope is different from what we find in the scientific literature. It is more institutionalized as it stems from a religious perspective: 'God says we must have hope in life for whatever happens' (rural woman11). The participants perceived a connection between living and hope and also between death and hopelessness: 'But I think once I am alive, all hope is not lost' (urban man4) and 'all hope is lost to the dead but not to the living' (rural man1). Living perhaps provides them the evidence that one can still expect a better future. Goal attainment thus becomes futuristic, and perhaps, crisis presents the opportunities in learning to deal with impediments towards the desired goal. A popular adage that is almost axiomatic in Ghana could accentuate this interpretation: 'until you are dead your chances of success are not exhausted'. We could logically argue that the participants perceive routes towards goal achievement attainable whilst living. Suicide, therefore, might not become an option during crisis but rather allowing the continuity of life: 'so you need to move ahead in life…that is the most important' (rural woman7). Such survival and coping thinking could emphasize the importance the participants attach to hope as crucial for adjustment and surviving during life's crisis. Religion fosters hope as it often promotes the belief that God cares about the problems of people (Stack 1983). Some studies have found a positive correlation between religion and optimism (Mattis et al. 2004) and a negative correlation between religion and hopelessness (Hammermeister et al. 2001). As semantically related, hope and optimism are future-oriented concepts (Levine 2008). The thought that God cares

could make enduring crisis worthwhile, because it might give meaning to the crisis as a possible part of a divine grand plan to get things better for the person: *I sat down and told myself, God has a plan for me in all these difficulties* (urban woman15). This way, the person views the brighter side of life; a future that has something pleasant one looks forward to. Such a perception could facilitate thoughts about oneself as capable of meeting desired goals in life in spite of an actual crisis. This could be associated with positive feelings which could reduce anxiety, avoid possible depression (Peterson and Seligman 2004) and eventual suicidal behaviour. Optimism, for instance, has been reported as one of the cognitive patterns that act as a buffer against suicidal crisis (e.g. Hirsch and Conner 2006; Hirsch et al. 2007).

In general, women ($n = 14$), especially all the urban women ($n = 8$), were using religion as a coping mechanism during crisis more than men. A potential explanation could be that religion has emerged in Africa as a potent social force and has been seen to be influencing women's health behaviours (Assimeng 2010; Takyi 2003; Gyimah et al. 2006). As urbanization in contemporary Africa weakens the role of the extended family (Nukunya 2003; Moore et al. 2006), many people living in urban centres (including those in Ghana) are exposed to extreme manifestations of alienation of people from their traditional practices, and others may not be around to provide emotional and other forms of social support to members experiencing stressful life events (Assimeng 1999; Nukunya 2003). In such environments, people might experience emotional difficulties which could evoke the need to look for someone who cares. This is where religion may satisfy such an emotional response as people turn to God as an archetype of a carer (van Praag 2009). A study has indicated that women in 49 countries viewed themselves more religious than men (Stack 2002). Therefore, one can reasonably say that the urban women in this present study might view religious activities as providing them the care, a sense of meaning and hope from the alienation and stressors of city life.

Unacceptability of Suicide

Against the backdrop that the participants are religiously committed and highly endorsed norms of survival and coping, suicidal behaviour did not resonate well with their religious values. All the participants respected and were committed to a religious moral conduct that excludes suicidal behaviour: 'the Bible does not permit you to go and pick a rope and hang yourself! And so we must respect that' (rural man2). The participants perceive it as a religious duty to conform to this code: 'religion always condemns suicide. Yes! So we don't encourage it' (urban man1). The religious conformity could be gleaned from the usage of the inclusive pronoun 'we', implying harmony with such a normative religious moral code. The belief that suicidal behaviour breaks the sanctity of life is an undercurrent making suicidal behaviour unacceptable to the participants. They reasoned that the source of life and its end all fully rest with God. As a source of life: 'it is God who created us and gave us that breath of life' (urban man4) and as a terminator of life: 'my religion says God holds life and if he hasn't taken it, no one has the right to take his life' (urban woman9). Implicit here could be a belief that supports the preservation of life. Perhaps, the idea that life is God's makes it sacred and invaluable, and thus saving it during crisis should be an ultimate goal: *life is much more precious than what one might be going through and thus no matter what, one must not destroy it* (urban woman6). One Christian tenet is that life is a precious gift from God, and thus, a deliberate destruction of it is considered morally wrong (Leach 2006; Gearing and Lizardi 2009). Additionally, the view that suicidal behaviour has far-reaching consequences also bolstered the participants' view that suicidal behaviour is

unacceptable. One of such consequences is divine retribution; the idea that there exists a negative outcome which is punishment for suicidal behaviour after death: 'God himself will punish you when you die and get there' (rural man3). Some studies have reported that religious people hold the belief that suicidal persons will be punished after death (Eskin 2004). The belief of eternal punishment for those who do not pattern their lives in accordance with the Bible; and a promise of eternal bliss for those who do so is a common Christian teaching. This belief of after-life punishment could motivate a commitment in the participants to attain the goal of a blissful after-life. The implication could be that if suicidal behaviour is perceived as blocking that goal, it certainly might not resonate well with them. Probably, the fear that divine punishment awaits suicidal persons could be life preserving as it might facilitate the drive to desist from certain behaviours that are perceived as a guarantee for a positive outcome of salvation: *my Bible tells me don't kill, don't steal, don't commit adultery…when you break away from these you will be saved. You become pure. You will be saved* (rural man4). Much as one cannot be sure whether such behaviours indeed guarantee salvation, the participants' belief in such religious actions as life preserving seems key to them. Consequently, the avoidance of any negative outcome after death and thinking of achieving the ultimate goal of salvation (Geyer and Baumeister 2005) could reinforce the participants' view of suicide as unacceptable behaviour. Religious beliefs and values affect people's identity, behaviour and attitudes towards suicide (Wielhouwer 2004; Eskin 2004). People's religious values and beliefs are based on authorities and rules, and religion provides clear standards of what is considered right and wrong (Wisneski et al. 2009; Geyer and Baumeister 2005). These authorities and rules such as God and the Bible could create a code of moral conduct that governs life to which people conform. In Ghana, religion has become one of the major value systems by which people are socialized (Awusabo-Asare et al. 2004). Christianity, for instance, has had great influence on Ghana's cultural scene to the extent that its impact has been described as incalculable, and the public sphere of the country seems Christianized (Gifford 2004; De Witte 2005; Meyer 2004). Religion has established a moral code of conduct that influences the attitudes of the participants in viewing suicidal behaviour as a religious transgression.

Motivation for Helping People with Suicidal Behaviour

Irrespective of the fact that the participants find suicidal behaviour unacceptable, they are motivated by religion to help during suicidal crisis 'you see as a Christian, when you see that someone is suicidal, you will be alarmed. So you quickly go to his aid' (urban man1). All the participants indicated their readiness for such prosocial behaviour, and religion was one of the major ways of providing such help: *mostly if I meet such people I use God's word and encouraging words to speak to the person* (urban man6). The implicit point here is the empathy expressed by the readiness to provide some sort of talk therapy to such distressed persons. Some participants, for instance, cited occasions in which people had sought help from them during crisis and they had used religion as means of providing help: 'a woman came and told me she has crisis in her marriage. I told her 'keep the words of your Bible and pray in the night'. She came to me and thanked me the next morning for my advice to her last night' (rural woman13). The person in crisis is encouraged through religious exhortation to be committed to certain religious rituals and practices such as prayer and perhaps meditating on scriptural texts. Essentially, there is an attempt of redirecting the attention of the person from the crisis to a religious practice considered useful in dealing with the crisis. Indicating that the person in crisis later expressed gratitude might be meant to highlight the efficacy and possibility of providing help through religion

for that specific person. One explanation for this enthusiasm to help suicidal persons could be that as religiously committed persons, the participants could perceive suicidal persons as committing a transgression that they need help to avoid: 'suicide is sinful, so it is important we help those persons' (urban woman3). From the Judeo-Christian point of view, a divine principle of love is supposed to govern all human social relationships captured as 'love your neighbour as thyself'. In situations where prosocial decisions are evoked, morally concerned figures such as God become cognitively salient (Norenzayen and Shariff 2008). The participants might perceive helping people in suicidal crisis as a sacred act within the broader realm of divine morality in order to satisfy their own conscience.

Closely linked to the above reason could be the social arrangement of interdependency in Ghana which highlights connectedness and the showing of care to other people during crisis as an index of morality (see Osafo et al. in press). The participants might be acting in consonance with such contextual core moral values. Morality is a construct related to prosociality (Belgrave 2009; Moore 2000) and religious/spiritual concerns such as the moral principle of agape love and fellow-feeling in church have been found to underlie lay persons' conceptions of moral behaviours such as showing care to others (Miller 2007). Another reason is that discussing prosocial decisions with the participants who generally perceived themselves as religious could evoke a social desirability response. As religious persons, they might perceive an expectation from society which behoves them to be prosocial. In that sense, expressing the readiness to help suicidal persons could be a normative way of publicly managing their prosocial reputation (Norenzayen and Shariff 2008). Therefore, such enthusiasm to help suicidal persons could also reflect a normative response rather than individually reflected decisions.

This finding that the participants, although opposed to suicidal behaviour, nevertheless showed willingness to help suicidal persons corroborates, previous finding in Turkey, that though religious persons have less tolerant attitude towards suicide, they are, however, reported to be accepting of suicidal persons (Eskin 2004). In fact, religion has been reported as predicting prosocial behaviours and less aggression in Belgium and the USA (Saroglou et al. 2005; Leach et al. 2008).

General Discussion

This study set out to examine the influence of religious factors on the attitudes of the participants towards suicidal behaviour. The analysis has shown that the participants are religiously committed and viewed religion as a prime requisite norm for survival and coping with life's crisis. They also conformed to core religious beliefs and practices which they found mutually incompatible to suicidal behaviour and thus rejected it. This finding could be explained within the postulations of the religious commitment theory of Stack (1983). This theory proposes that commitment to a few core religious beliefs and rituals may be a sufficient counteragent to suicidal behaviour. Thus, commitment to an orthodoxy and devotion to religious beliefs and practices (i.e. religious factors) can lead to less acceptability of suicide (Eskin 2004; Greening and Stoppelbein 2002; Neeleman et al. 1997). In the present study, the participants' commitment to core religious beliefs and practices such as sanctity of life, salvation and the after-life, faith, prayer and hope was the basis for rejecting suicidal behaviour. These religious elements fostered a negative attitude of suicidal behaviour as antithetical to life preservation and therefore should not be accepted. Furthermore, participants in this study have clearly showed that religion is perceived as protective in crisis and specifically suicidal ones. The attribution of suicidal

behaviour to lack of religious commitment could be an indirect reference to the value the participants place on religious coping and thus lack of coping on the part of those who are not religious. Studies have reported that moral objections to suicide, perceiving oneself as religious and endorsing religious coping could be protective of suicidal behaviour (Anglin et al. 2005; Dervic et al. 2004; Sisask et al. 2010). Perhaps, this is the understanding of the participants of this study when they reasoned that religion is useful as a survival and coping norm. Two models have been offered regarding how people use religion to cope (Klaassen et al. 2007). One is the stress-deterrent model which hypothesizes that religious coping is effective irrespective of the level of stress. The other is the stress-buffering model that posits that religious coping functions best when people are under high stress situations (Klaassen et al. 2007). Although religious coping was not within the scope of this study, what we have gleaned from the participants' understanding of religion as a survival and coping norm may be interpreted as support for these models. For instance, the indications that some participants reported experiencing high stress situations and used religious rituals (e.g. prayer) to cope could lend some support for the stress-buffering model. The general idea that suicidal behaviour results from lack of religious commitment could also give some support to the stress-deterrent model that religion is essentially useful for coping with crisis.

A previous study conducted on psychology students reported that Ghanaian students compared with their Ugandan counterparts were more reluctant to provide help during suicidal crisis (Hjelmeland et al. 2008). In contrast to this, the present study found that these Ghanaian lay persons were indeed willing to help suicidal persons. We could explain this difference from a developmental perspective. For instance, more than half ($n = 17$) of the lay persons are in their middle ages as compared with the students whose mean age was 25. As relatively older adults (i.e. the lay in the present study), their experiences might present them with reflections on life, themselves and others. They perhaps find helping others as a venture to maximize strength and contribute towards the betterment of society, a developmental stage Erikson called generativity (McAdams 2001). In that sense, they are more likely to show care and concern for people who are experiencing suicidal crisis. Furthermore, we cannot, however, underrate their religious consciousness as these lay persons perceived themselves as religious, and religious people express greater belief than non-religious persons that suicide should be prevented (Bascue et al. 1982). Additionally, religious traditions support prosocial behaviour in both theory and practice (Oman and Thoresen 2005). Thus, perhaps, their religious understanding of the preservation of life in relation to their negative attitude towards suicidal behaviour might account for this enthusiasm to help others during crisis. In a study by Walker et al. (2006), the belief that God was responsible for life among African Americans positively correlated with suicide stigma. In this present study, although the participants' religious beliefs (e.g. belief that God is responsible for life and divine retribution for suicidal persons) could foster stigmatization of suicidal behaviour, we did not find that extended towards suicidal persons. They seemed to have separated their attitudes towards suicide as a phenomenon (an act contrary to their faith) and the suicidal person (someone who needs support and care). The participants were therefore ready to provide help. It has been indicated that religious persons and faith communities show support and compassion towards suicidal persons (Suicide Prevention Resource Centre 2009). This is perhaps what we find demonstrated by the participants in this study. Such care and support norms which are fostered by the participants' religious beliefs could reduce the potential effect of stigma on suicidal persons. This influence religion exerted on the participants' moral decision to provide help during suicidal crisis could lend further support to the relationship between religion and

prosociality in this cultural context. This is because such gesture could be conceived as a manifestation of true religiosity.

From an IPA perspective, the participant is the experiential expert (Reid et al. 2005; Smith and Osborn 2003; Smith et al. 2009) on the issue of interest and in our case, the religious influence on attitudes towards suicide. It was therefore our duty to take a phenomenological interest in the experiences and views of the participants and interpret these (Reid et al. 2005). Therefore, our understanding and the interpretations we have offered in this study are built around the experiences of the participants. The result is that we have showed specific religious factors and how the participants conceive their influence on attitudes towards suicide contextually.

In conclusion, this study found that the participants' religious orientation and commitment to observing fundamental religious beliefs affect their interpretation of suicidal behaviour as unacceptable behaviour. Their religious beliefs and practices provided alternative avenues of dealing with crises. Religion is thus seen as life preserving and counteracting the decision for self-destructive behaviours such as suicide. Religion was a source of coping and thus could be protective of suicidal behaviours. It also provided the motivation for the participants' willingness to provide help to suicidal persons. Religion in this cultural context thus influences attitudes towards suicide and becomes an important variable to be considered when planning future research and intervention programmes on suicide in Ghana.

Methodological Limitations and Future Research

Qualitative study is an interpretative enterprise (Whittemore et al. 2001), and therefore, we try to minimize errors that might compromise the trustworthiness of the interpretations. To ensure quality and rigour of interpretations, the research group thoroughly discussed any emergent theme, scrutinized the quotes that could typically represent the theme, and discussed until we reached consensus. Furthermore, the research group involves two non-indigenous persons and two indigenous persons as far as the context of the study is concerned. During analysis, the non-indigenous members and the other indigenous member have queried the assumptions, beliefs, biases and challenged the first author's (an indigenous member) interpretations of the data (Creswell and Miller 2000). We believe that such cross-validation and group-interpretation could reduce bias, enhance inter-subjective comprehension, and increase the analytic rigour and trustworthiness of the findings in this study (Steinke 2004; Whittemore et al. 2001). Nevertheless, this study has a limitation as the participants were predominantly Christians with a few Muslims. Ghana's religious sphere has been described as a zoo (Assimeng 1999), implying several other religious sects coexisting. Therefore, the religious attitudes towards suicidal behaviour and the meaning uncovered cannot be generalized as representing the entire views of all the religious groups in Ghana. Future studies could therefore consider the opinions of people of other religious affiliations and their unique conceptualizations of suicide in order to further our understanding of the relationship between religious factors and attitudes towards suicidal behaviour in Ghana.

Implications for Suicide Prevention

The findings of this study could have some implications for suicide prevention in Ghana. Religion has become a dynamic force underlying tremendous social changes in West Africa, including Ghana (Assimeng 2010). Religious groups in Ghana (faith healers) have

become part of health care delivery, and a large number of people access their services during health crisis more than conventional ones (Roberts 2001; Tabi et al. 2006; MOH 2005). As a result, Government is strategizing to improve such alternative forms of health care and incorporate them into formal health care system (WHO 2007). The relevance of religion in this study as shown in the analysis leads us to argue that religion could be used as a resource tool for suicide prevention in several ways.

Firstly, religious leaders should be trained and educated about protective and risk factors in suicidal behaviour as well as how to reduce stigma towards suicidal persons. Religious leaders are trusted and respected members in Ghana (Buah 1998), and people therefore listen to them. A message or act of compassion from them towards suicidal persons could be instrumental in reducing stigma about suicide. For instance, when Ghana began to effectively deal with the prevention of HIV/AIDS, religious leaders were targeted to reduce stigma and to encourage compassion and support for people affected with HIV/AIDS. Today, this programme has been deemed a success story in the country (USAID 2003).

Secondly, the regular schedule programmes, built-in audience, the intergenerational nature of membership, and altruistic values are inherent features of religious groups that can make them ideal sites for community health education (Hale and Bennett 2000; Koenig 2008). Education and training on reducing judgmental attitudes and increasing sensitivity, sense of care and compassion could be organized for members in their churches, mosques and temples. The participants in this study have reported their willingness to provide help to suicidal persons. This is a positive indication that religious persons could be trained as peer counsellors who can help in identifying warning signs of suicidal behaviour and how to provide first aid before referring the person to a professional mental health provider. Giving the fact that Ghana has a serious shortfall in the number of professional mental health workers/facilities, the need to rely on the general public to help each other could be seriously emphasized through public education by religious bodies.

Thirdly, closely related to the above is that churches can initiate programmes such as social counselling and other support services for people (including their own members) who find it difficult to handle life's crisis such as marital distress, loss of job, disappointments and other crisis that could be risk factors for suicidal behaviour. Some religious persons in this study have indicated how they are already providing some help to people who are in distress. Such persons could be potential counsellors who could be trained and supported by religious groups and other stake holders to work in their communities as counsellors. Although religious groups have been involved in providing mental health services to people in the country, there have been reports of abuse such as chaining and long fasting, for instance, in certain religious prayer camps (Roberts 2001). This is where a strategic engagement with organized religious groups through training programmes is needed to improve their services of handling mental health issues. Engaging religious groups in suicide prevention in Ghana would be a culturally relevant step in contributing meaningfully to improving attitudes towards suicidal persons. It will tailor the intervention efforts to be compatible with the cultural context (Joe et al. 2008; Colucci and Martin 2007) of Ghanaians' worldview, values and norms.

References

Adinkrah, M. (2004). Witchcraft accusations and female homicide victimization in contemporary Ghana. *Violence Against Women, 10*(4), 325–356.

Adinkrah, M. (2010). Beter dead than dishonored. Masculinity and male suicidal behavior in contemporary Ghana. *Social Science and Medicine*. doi:10.1016/j.socscimed.2010.10.011.
Ai, A., Tice, T., Peterson, C., & Huang, B. (2005). Prayers, spiritual support and positive attitudes in coping with September 11 national crisis. *Journal of Personality, 73*(3), 764–792.
Alem, A., Jacobsson, L., Kebede, D., et al. (1999). Awareness and attitudes of a rural Ethiopian community toward suicidal behavior. *Acta Psychiatrica Scandinavica, 100*, 65–69.
Anglin, D. M., Gabriel, K. O. S., & Kaslow, N. J. (2005). Suicide acceptability and religious well-being: A comparative analysis in African American suicide attempters and non-attempters. *Journal of Psychology and Theology, 33*(2), 140–150.
Assimeng, M. (1999). *Social structure of Ghana: A study in persistence and change* (2nd ed.). Tema: Ghana Publ. Corp.
Assimeng, M. (2010). *Religion and social change in West Africa* (2nd ed.). Accra: Woeli Publ. Services.
Awusabo-Asare, K., Abane, A. M., & Kumi-Kyereme, A. (2004). *Adolescent sexual and reproductive health in Ghana: A synthesis of research evidence* (Occasional Report No. 13). Retrieved 3 Dec 2009, from http://www.guttmacher.org/pubs/or_no13.pdf.
Baker, J. O. (2008). An investigation of the sociological patterns of prayer frequency and content. *Sociology of Religion, 62*(2), 169–185.
Bascue, L. O., Inman, D. J., & Kahn, W. J. (1982). Recognition of suicide lethality factors by psychiatry nursing assistants. *Psychological Reports, 51*(1), 197–198.
Belgrave, F. Z. (2009). *African American girls, advancing responsible adolescent development*. New York: Springer.
Buah, F. K. (1998). *A history of Ghana (Rev. ed.)*. Malaysia: Macmillan Publ. Ltd.
Care International. (2009). *Ghana statistics*. Retrieved on 8 Nov 2009 from: http://www.careinternational.org.uk/2753/ghana/ghana-statistics.html.
Colucci, E., & Martin, G. (2007). Ethnocultural aspects of suicide in young people: A systematic literature review. Part 1: Rates and methods of youth suicide. *Suicide and Life-Threatening Behaviour, 37*(2), 197–221.
Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*(3), 124–130.
De Witte, M. (2005). The holy spirit on air in Ghana. Retrieved 8 Nov 2009, from http://www.waccglobal.org/en/20052-christian-fundamentalism.
Dein, S., & Littlewood, R. (2008). The psychology of prayer and the development of prayer experience questionnaire. *Mental Health Religion and Culture, 11*(1), 39–52.
Dervic, K., Oquendo, M., Grunebaum, M. F., Ellis, S., Bruke, A. K., & Mann, J. J. (2004). Religious affiliation and suicide attempt. *Am Journal Psychiatry, 161*, 2303–2308.
Domino, G. (2005). Cross-cultural attitudes towards suicide: The SOQ and A personal odyssey. *Archives of Suicide Research, 9*(2), 107–122.
Domino, G., Niles, F., & Raj, S. D. (1993). Attitudes toward suicide: A cross-cultural comparison of Singaporean an Australian university students. *Omega: Journal of Death and Dying, 28*, 125–137.
Eshun, S. (1999). Cultural variations in hopelessness, optimism, and suicidal ideation: A study of Ghana and US college samples. *Cross Cultural Research, 33*, 227–238.
Eshun, S. (2003). Sociocultural determinants of suicide ideation: A comparison between American and Ghanaian college samples. *Suicide and Life-Threatening Behaviour, 33*(2), 165–171.
Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. *Social Psychiatry Psychiatr Epiemiology, 39*, 536–542.
Flowers, P., Davis, M., Hart, G., Rosengarten, M., Frankis, J., & Imrie, J. (2006). Diagnosis and stigma and identity amongst HIV positive Balck Africans living in the UK. *Psychology and Health, 21*(1), 109–122.
Gearing, R. E., & Lizardi, D. (2009). Religion and suicide. *Journal of Religion and Health, 48*, 332–341.
Geyer, A. L., & Baumeister, R. F. (2005). Religion, morality, and self control. In R. F. Paloutzian & C. L. Park (Eds.), *A handbook of the psychology of religion and spirituality* (pp. 413–432). New York: The Guilford Press.
Gifford, P. (2004). *Ghana's new Christianity. Pentecostalism in a globalizing African economy*. Indiana: Blooming and Indianapolis.
Greening, L., & Stoppelbein, L. (2002). Religiosity, attributional style, and social support as psychosocial buffers for African American and white adolescent's perceive risk for suicide. *Suicide and Life-Threatening Behavior, 32*(4), 404–417.
Gyimah, S. O., Takyi, B. K., & Addai, I. (2006). Challenges to the reproductive-health needs of African and Maternal health utilization in Ghana. *Social Science and Medicine, 62*, 2930–2944.

Hale, W. D., & Bennett, R. G. (2000). *Building healthy communities through medical- religious partnerships*. Baltimore, MD: Johns Hopkins University Press.
Hammermeister, J., Flint, M., Havens, J., & Peterson, M. (2001). Psychosocial and health-related characteristics of religious well-being. *Psychological Reports, 89*, 589–594.
Hirsch, J. K., & Conner, K. (2006). Dispositional and explanatory style optimism as potential moderators of the relationship between hopelesness and suicidal ideation. *Suicide and Life Threatening Behavior, 36*(6), 661–669.
Hirsch, J. K., Wolford, K., Lalonde, S. M., Brunk, L., & Parker-Morris, A. (2007). Dispositional optimism as a moderator of the relationship between negative life events and suicide ideation. *Crisis, 31*, 533–546.
Hjelmeland, H., Akotia, C. S., Owens, V., Knizek, B. L., Nordvik, H., Schroeder, R., et al. (2008). Self reported suicidal behaviour and attitudes toward suicide and suicide prevention among psychology students in Ghana, Uganda, and Norway. *Crisis, 29*(1), 20–31.
Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior, 40*(1), 17–80.
Hunt, S. J. (2008). Were the Jesus people pentecostals? a review of the evidence. *PentecoStudies, 7*(1), 1–33.
James, A., & Well, A. (2003). Religion and mental health: Towards a cognitive-behavioural framework. *British Journal of Health Psychology, 8*, 359–376.
Joe, S., Canetto, S. S., & Romer, D. (2008). Advancing prevention research on the role of culture in suicide prevention. *Suicide and Life-Threatening Behaviour, 38*(3), 354–362.
Khan, M. M., & Hyder, A. L. (2006). Suicides in the developing world: Case study from Pakistan. *Suicie and Life-Threatening Behavior, 36*(1), 76–81.
Klaassen, D. W., McDonal, M. J., & James, S. (2007). Advance in the study of religious and spiritual coping. In P. T. P. Wong & L. C. J. Wong (Eds.), *Handbookof multicultural perspectives on stress and coping* (pp. 105–132). USA: Springer.
Koenig, H. G. (2008). Religon, spirituality and public health: Research, applications, and recommendations. A report submitted to Subcommittee on Research and Science Education of the U.S. House of Representatives on September, 18, 2008. Retrieved 28 Oct 2009, from http://www.democrats.science.house.gov.
Leach, M. M. (2006). *Cultural diversity and suicide. Ethnic, religious, gender, and sexual orientation perspectives*. New York: The Haworth Press.
Leach, M. M., Berman, M. E., & Eubanks, L. (2008). Religious activities, religious orientation and aggressive behaviour. *Journal of the Scientific Study of Religion, 47*(2), 311–319.
Lester, D., & Akande, A. (1994). Attitudes about suicide among the Yoruba of Nigeria. *The Journal of Social Psychology, 134*, 851–853.
Lester, D., & Akande, A. (1997). Attitudes about Suicide in Zambian and Nigerian students. *Perceptual and Motor Skills, 87*, 690.
Levine, M. (2008). Prayer as coping: A psychological analysis. *Journal of Health Care Chaplaincy, 15*, 80–98.
Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice- An International Journal, 13*(6), 522–525.
Mattis, J. S., Fontenot, D. L., Hatcher-Kay, C. A., Grayman, N. A., & Beale, R. L. (2004). Religiousity, optimism, and pessimism among African Americans. *Journal of Black Psychology, 30*, 187–207.
McAdams, D. P. (2001). Generativity in midlife. In M. E. Lackman (Ed.), *Handbook of midlife development* (pp. 395–443). New York: Wiley.
Meyer, B. (2004). "Praise the Lord": Popular cinema and pentecostalite style in Ghana's new public sphere. *American Ethnologist, 31*(1), 92–110.
Miller, J. G. (2007). Cultural psychology of moral development. In S. Kitayama & D. Cohen (Eds.), *Handbook of cultural psychology* (pp. 477–499). New York: Guilford Press.
Modifi, N., Ghazinour, M., Salander-Renberg, E., & Richter, J. (2008). Attitudes towards suicide among Kurdish people in Iran. *Social Psychiatry and Psychiatric Epidemiology, 43*, 291–298.
MOH. (2005). The Ghana health sector 2005 programme of work. Retrieved on 14 May 2010, from: http://www.moh-ghana.org/UploadFiles/Policies_Programs/AnnualProgrammeofWork.
MOH. (2007). A very progressive mental health law. Retrieved on 14 June 2009, from http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.pdf.
Moore, J. (2000). Morality and the elephant. Prosocial behaviour, normativity and fluctuating allegainces. *Journal of Consciousness Studies, 7*(1–2), 52–55.
Moore, A. R., Vosvick, M., & Amey, F. K. (2006). Stress, social support and depression in informal caregivers to people living with HIV/AIS in Lome, Togo. *The International Jounal of Sociology and Social Policy, 26*(1/2), 63–73.

Neeleman, J., Halpern, D., Leon, D., & Lewis, G. (1997). Tolerance of suicide, religion and suicide rates: An ecological and individual study in 19 Western countries. *Psychological Medicine, 27*, 1165–1171.

Neeleman, J., Wessely, S., & Lewis, G. (1998). Suicide acceptability in African–and White Americans: The role of religion. *The Journal of Nervous and Mental Disease, 186*(1), 12–16.

Norenzayen, A., & Shariff, A. F. (2008). The origin and evolution of religious prosociality. *Science, 322*, 58–62.

Nukunya, G. K. (2003). *Tradition and change in Ghana. An introduction to sociology* (2nd ed.). Accra: Ghana Universities Press.

Oman, D., & Thoresen, C. (2005). Religion and health. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 435–459). New York: Guilford.

Osafo, Hjelmeland, Akotia, & Knizek. (in press). The meaning(s) of suicidal behaviour to psychology students: A qualitative approach to understanding suicidal behaviour in Ghana. *Transcultural Psychiatry.*

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 35*(5), 1189–1208.

Peterson, C., & Seligman, M. E. P. (2004). *Character, strengths and virtues. A handbook and classification.* New York: Oxford University Press.

Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health an human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health, 5*(13). Retrieved on 12 Nov 2009, from http://www.globalizationandhealth.com/contents/5/1/13.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(2), 20–23.

Roberts, H. (2001). A way forward for mental health care in Ghana? *The Lancet, 357*, 1859.

Sarfraz, A., & Castle, D. (2002). A Muslim suicide. *Australian Psychiatry, 10*(1), 48–50.

Saroglou, V., Pichon, I., Trompette, L., Verschueren, M., & Dernelle, R. (2005). Prosocial behaviour and religion: New evidence based on projective measures and peer ratings. *Journal for the Scientific Study of Religion, 44*(3), 323–348.

Sawyer, D., & Sobal, J. (1987). Public attitudes towards suicide. Demographic and ideological correlates. *Public Opinion Quarterly, 51*, 92–101.

Schlebusch, L., Burrows, S., & Vawda, N. (2009). Suicide prevention and religious traditions on the African continent. In D. Wasserman & C. Wasserman (Eds.), *Oxford textbook of suicidology and suicide prevention. A global perspective* (pp. 63–69). USA: Oxford University Press.

Silverman, M. M. (2006). The language of suicidology. *Suicide and Life-Threatening Behavior, 36*(5), 519–532.

Sisask, M., Värnik, A., Kõlves, K., Bertolote, J. M., et al. (2010). Is religiosity a protective factor against attempted suicide: A cross-cultural case-control study. *Archives of Suicide Research, 14*, 44–55.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research*. London: SAGE publications.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology. A practical guide to research methods* (pp. 51–80). London: SAGE.

Stack, S. (1983). The effects of religious commitment on suicide: A cross- national analysis. *Journal of Health and Social Behaviour, 24*(4), 362–374.

Stack, S. (2002). Physiology and faith: Addressing the "Universal" gender difference in religious commitment. *Journal for the Scientific Study of Religion, 41*(3), 495–507.

Steinke, I. (2004). Quality criteria in qualitative research. In U. Flick, E. von Kardoff, & I. Steinke (Eds.), *A companion to qualitative research* (pp. 184–190). Loss Angeles: SAGE.

Suicide Prevention Resource Centre (SPRC). (2009). A report on an interfaith suicide prevention dialogue. Retrieved on 4 Aug 2010, from http://www.sprc.org/news/pressroom/index.asp.

Tabi, M. M., Powell, M., & Hodnicki, D. (2006). Use of traditional healers and modern medicine in Ghana. *International Nursing Review, 53*, 52–58.

Takyi, B. (2003). Religion and women's health in Ghana: Insights into HIV/AIDS preventive and protective behaviour. *Social Science and Medicine, 56*, 1221–1234.

USAID. (2003). Success stories, HIV/AIDS. Retrieved on 5 Dec 2009, from http://www.usaid.gov.

van Praag, H. M. (2009). The role of religion in suicide prevention. In D. Wasserman & C. Wasserman (Eds.), *Oxford textbook of suicidology and suicide prevention. A global perspective* (pp. 7–12). USA: Oxford University Press.

Walker, R. L., Lester, D., & Joe, S. (2006). Lay theories of suicide: An examination of culturally relevant suicide beliefs and attributions among African Americans and European Americans. *Journal of Black Psychology, 32*(3), 320–334.

Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research, 11*(4), 5222–5537.

WHO. (2007). Ghana: A very progressive mental health law. Retrieved on 12 Nov 2009 from http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.

Wielhouwer, P. W. (2004). The impact of church activities and socialization on African–American religious commitment. *Social Science Quarterly, 85*(3), 769–792.

Willig, C. (2001). *Introducing qualitative research in psychology. Adventures in theory and method*. Philadelphia: Open University Press.

Wisneski, D. S., Lytle, B. L., & Skitka, L. J. (2009). Gut reactions. Moral conviction, religiousity and trust in authority. *Psychological Science, 20*(9), 1059–1063.

Yirenkyi, K. (2000). The role of Christian churches in national politics: Reflections from laity and clergy in Ghana. *Sociology of Religion, 61*(3), 325–338.