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The Role of Religious Leaders in Suicide Prevention in Ghana. A Qualitative Analysis

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Abstract
Religious leaders play a key role in providing support to persons in mental health crisis. The aim of this study is to examine how religious leaders in the Ga Municipal District of Ghana perceive their role in the prevention of suicide in their community and the kinds of help they provide to persons in suicidal crisis. A semi-structured interview guide was used to gather data from 28 religious leaders. Thematic analysis of the transcribed data showed that religious leaders perceive their role in suicide prevention as *frontliners* with a caring obligation to help suicidal persons because of the possible loss of a life. Further, when religious leaders interact with suicidal persons, they *create healing communities*, *provide lay counseling*, *provide referrals to mental health professionals*, *offer prayer and deliverance*, *provide social support*, and *induce hope* in such persons. Implications for interprofessional collaboration and gatekeeper training for religious leaders in Ghana are addressed.

Keywords Religious leaders · Suicide prevention · Ghana · Qualitative research

Common to Christianity, Islam, and African traditional religion is the certainty in the judgment of the soul by God in the afterlife (e.g. Mbiti, 2006). Suicide is therefore perceived as a religious contravention connected with the eternal damnation in the afterlife of the souls of persons who have killed themselves (e.g. Osafo et al., 2011). In line with this perception, many people agree that suicide prevention is an emergent concern, yet they fail to notice the role of religious leaders in the suicide prevention process (Hirono, 2010). For example,

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while several researches in the field of suicide prevention have focused on the role of medical facilities, schools, and other local or state organizations (e.g. Carmona-Navarro & Pichardo-Martinez, 2012; Norheim et al., 2013; Osafo et al., 2012), the role of religious leaders in the literature has received little attention.

Religious leaders play a critical role in mental health crises in general in Ghana (Asamoah et al., 2014; Osafo et al., 2015a, b), and some studies have indicated that religion helps persons in suicidal crisis cope better (Agilkaya, 2011; Osafo et al., 2015a, b; Sakinofsky, 2007). However, in some instances, religion provides further spiritual crisis for the person in suicidal crisis (Akotia et al., 2018). Although religious leaders can provide social support to enable persons in suicidal crisis to cope better, sometimes because the act is considered 'sinful' this religious support may damage the relationship between suicide survivors and their religious communities (Hirono, 2013). The role of religion and the religious community in suicide prevention is thus doubled-edged (Koenig et al., 2012). This may be a major reason for the dearth of literature on religious resources and particularly the role of the religious community in suicide prevention.

Religion can be a broad framework within which suicide attempt survivors experience a spiritual crisis (Akotia et al., 2014). It can be protective against suicidal crisis through ethical condemnation of suicide and religious coping (Huguelet et al., 2007; Osafo et al., 2013). This reality is clear to African suicidologists, who work in a context filled with paradoxes. On the one hand, they find themselves working primarily in religious contexts where there are strong proscriptions against suicidal behaviours and persons in suicidal crisis (Osafo, 2016; Osafo et al., 2013). On the other hand, they find salutary factors occurring in abundance within such diverse religious contexts which can be anti-suicidogenic (Osafo et al., 2013).

Religion is widespread in Africa. For instance, current statistics show that Africa has the highest numbers of Christians, ahead of Latin America, Europe, and Asia (Johnson et al., 2018; Oladipo, 2016). Ghana is one of the most religious nations on the continent; in 2012 it was identified as the most religious country in the world (Gallup, 2012). Ghana has three major religions: Christianity, Muslim, and traditional, and its public space is deeply suffused with religious activities (Gifford, 2004). For more than six (6) decades, Pentecostal and neo-Pentecostal churches have dynamically changed the Christian landscape with their triumphant teachings and claims of being able to solve almost all existential problems (Asamoah-Gyadu, 2015; Beck & Gundersen, 2016; Onyinah, 2012). Consequently, people suffering from all forms of distress seek help and support from various religious leaders, which places religious leaders in a frontline role in providing mental healthcare services (Assimeng, 2010; Osafo et al., 2015a, b). Evidence of this role has also been reported in both the United States and Japan; 27% of Christian clergy in the United States and 11% of Buddhist clergy in Japan have helped someone in suicidal crisis (Hirono, 2013), and 42% and 11%, respectively, have taken some training in suicide prevention (Hirono, 2013).

There is evidence in Ghana of the role of religious leaders in providing social support and some form of health education (Ae-Ngibise et al., 2010; Appiah-Poku et al., 2004; Asamoah et al., 2014; Laugharne & Bums, 1999; Osafo et al., 2015a, b), and, according to a recent article, they may view themselves as part of a gatekeeping community providing support to persons in suicidal crisis (Osafo et al., 2019). The purpose of the present study was to examine the views of religious leaders towards suicide, and their perceived role and actual support in its prevention in Ghana. In line with these aims, the study sought to address the following research questions: (1) What are the views of Ghanaian religious leaders towards suicide? (2) How do Ghanaian religious leaders perceive their role in suicide prevention in Ghana? (3) What suicide prevention support do Ghanaian religious

leaders provide to persons in suicidal crisis? It is important to expand our knowledge of the gatekeeper role of religious leaders in suicide prevention in a country with scarce resources for mental health. Findings from this study might facilitate the development of evidence-based, community-wide suicide prevention programs in Ghana.

Methodology

Design

Suicide is a complex issue and a cultural artifact (Hjelmeland & Knizek, 2010; Silverman, 2006). Consequently, we identify with those who see the qualitative approach as an appropriate method for seeking an understanding of suicide generally and the meaning people make of it within their social and cultural contexts (Colucci & Martin, 2007, 2008; Hjelmeland & Knizek, 2010; Silverman, 2006; White et al., 2015). We thus chose a qualitative design for this study because it inquires about and interprets the meaning-making process (Patton, 1999).

Interview guide

A semi-structured interview guide was used to assess in detail participants' views about suicide, their perceived role in suicide prevention, and the actual support they provide (treatment regimen) for suicidal persons who come to them. Some of the questions in the guide were: 'What is your view about suicide and the person who is in suicidal crisis?' 'What role do you think you play in suicide prevention?' 'In your experience in working with someone who was suicidal, how did you "treat" or help them to get well again?' These and other questions in the interview guide necessitated the use of a flexible data collection tool, which also allowed an in-depth examination of the personal and social worlds of the participants (Smith & Osborn, 2003). This form of interviewing allows the researcher and participant to engage in a dialogue, and the interviewer is freer to probe interesting areas that arise (Smith & Osborn, 2003).

Participants and procedure

Participants in the study were ordained and certified Christian clergy, recognized Muslim clerics, and traditional priests. Purposive and snowball sampling techniques were employed to select participants for the study. The religious leaders were informed about the nature of the study through the heads of their denominations following the issuance of an introductory letter from the Department of Psychology, University of Ghana. Religious leaders who consented to participate in the study were asked to sign forms to formalize their participation. For each contact, a letter of introduction detailing the purpose of the study and its ethical clearance was presented to the participant. Interviews were conducted at the convenience of the participants, predominantly at their office and, for a few, at their home. A total of 28 adults, made up of 16 Christian (ordained reverends/ministers/pastors), 8 Muslim (imams), and 4 traditional (chief/elder/priest) religious leaders within the Greater Accra Region, participated in the study. We reached saturation with the 26th participant when we realized that the data was not throwing

Table 1 Demographic characteristics of participants

Variable	Frequency (*n*)	Percentage (%)
Age range		
20–30	1	3.6
31–40	5	17.8
41–50	11	39.3
51–60	11	39.3
Gender		
Female	14	50.0
Male	14	50.0
Marital status		
Single	2	9.1
Married	26	90.90
Religious leader category		
Christian	16	59.09
Muslim	8	31.82
Traditional religion	4	9.09
Ethnicity		
Ga-Dangme	12	42.9
Ewe	3	10.7
Akan	11	39.3
Dagomba	2	7.1

any further light on the issue under investigation (Mason, 2010). A sample of this size has the potential to provide more confidence in the findings of the study than a smaller sample (Yin, 2015). Interviews lasted between 30 and 45 min. Interviews were audio-recorded verbatim and transcribed. Fourteen of the participants were females, and 14 were males. Two participants were unmarried, and the rest were married. The ages of the participants ranged between 20 and 60 years, whereas their tenure in their role as religious leaders was 10 years or more. The majority of the participants (12) were Ga-Dangmes, 3 were Ewes, 11 were Akan, and the remaining 2 were from Northern Ghana ethnic groups. The participants' demographics are reported in Table 1.

Ethical considerations

Ethical clearance was attained from the Ethics Committee for the Humanities at the University of Ghana, Legon. Approval was sought from the head pastors, imams, and chiefs of the various religions from which the participants were chosen. Participants were notified that participation was completely voluntary and that they could opt out at any time during the interview sessions. Furthermore, they were also guaranteed confidentiality by way of withholding their names due to the highly sensitive nature of suicide. Arrangements were made for participants who might need attention from a clinical psychologist or competent counselor following the interview session.

Validity issues

In qualitative studies, the validity of the interpretation is a key issue (Whittemore et al., 2001). To ensure validity, the researchers in the current study used member checking, in which they summarized during the interview process whether the views of participants had been accurately recorded (Whittemore et al., 2001). Furthermore, during analysis each author read all transcripts and developed initial themes, which were further discussed by all authors until we reached consensus. Such cross-validation and group interpretation are useful in increasing intersubjective comprehension, analytic rigour, and validity of the interpretations of the findings (Creswell & Miller, 2000; Steinke, 2004).

Analysis of data

Analysis was conducted using the thematic analysis approach recommended by Braun and Clark (2006). This is a method for identifying, analysing, and reporting patterns within qualitative data. Clearly defined steps were followed. These included familiarizing ourselves with the data, after which we generated the initial codes. We further used the codes to search for initial themes and reviewed them. Finally, we defined the themes and produced the report (Braun & Clark, 2006). The analysis was at the group level (*nomothetic*) more than the *idiographic* level of providing in-depth analysis of a particular case (Smith et al., 2009). During the thematic analysis process, the researchers had several rigorous exchanges and intersubjective discussions to ensure that the analysis and interpretation of data gathered from participants were fair and objective. The findings are presented in line with the aims of this research.

Findings

The themes relate to the role religious leaders play when they interact with suicidal persons. Specifically, they address *how they perceive their role* and the helping *regimens* they employ in helping suicidal persons. Participants perceived two main roles they play when they come into contact with suicidal persons: gatekeeping services, whereby they detect warning signs early enough and consequently refer, and the provision of a form of religio-psychosocial services for the suicidal person. These are discussed under two main themes with subthemes: *frontliners* (subthemes: 'obligation to provide care', 'early detection of warning signs', and 'referral') and *religio-psychosocial services* (subthemes: 'counseling', 'healing communities', 'spiritual healing', 'social support', and 'hope induction').

Frontliners

Obligation to provide care Research shows that attitudes can influence willingness to help persons in suicidal crisis. Consequently, we analyzed the way participants conceptualised their role as religious leaders as a measure of their enthusiasm to help persons in suicidal crisis. Participants generally explained their frontline role as an obligation towards anyone in any form of crisis, but they prioritized suicidal crisis since it might lead to death. This appears to hinge on the notion that human life is sacrosanct and thus any circumstances that might compromise this state requires caring hands which can provide some support: For example:

> My obligation as a minister is to everybody, helping someone who is suicidal is one of the needs. There are other needs that are equally serious, yet suicide borders on taking life and so becomes a paramount issue. So, as a minister, I have an obligation towards the sanctity of life, to everybody, so whether you are going to get married or you are going to school or you are looking for a job or you want a house-help or you are becoming a potential suicide case, I have an obligation towards you. (CRL,[1] male, 55 years old)
>
> Definitely. It is my responsibility to help anybody in my congregation with such a problem. (MRL, male, 48 years old).
>
> Yes. We as leaders in this community have a responsibility toward suicidal persons. When they share their problem with any of us, we then direct them on what they can do to help them in solving the problem. (TRL, male, 48 years old).

Researchers such as Ratnarajah and Schofield (2000) and Joiner (2007) posit that the role of religious leaders in modifying suicidal behavior is very important, especially in helping to prevent intergenerational suicide among friends, relatives, or even within the same family. Hence, the above narratives suggest that religious leaders perceive that they are in a frontline role of providing caring services for people.

Early detection of warning signs All participants further stated that one way they provided frontline services was through early detection of warning signs. They reported that suicidal behaviour could be detected early and prevented. This is demonstrated in the narratives: 'I get close when I suspect there's a problem somewhere. Not all religious leaders are able to see through the signs and to know what to do' (TRL, male, 55 years old). Perhaps by saying 'I get close when I suspect...', the participant might be referring to a sort of combination of intuition and observation that allows him to pick up on important signs of distress in people. A Christian clergy described how she detected early warning signs of a suicidal crisis:

> I met a man who didn't say he was going to commit suicide but from conversation I noticed some tendencies and marks on the body, so I started asking questions, and I realized from what he told me that he was a Presbyterian, and he had gotten ill, and gone to see a mallam[2] who gave him those scars and was given some instructions. Even before having sex with the wife, he had to do some things. I realized this was somebody in bondage. So, we talked, we prayed . . . but I encouraged him to go to Grace Presbyterian Church at Akropong, Catechist Abboah-Offei's place, for continuous prayers because he stays on the ridge at Aburi which is close. (CRL, female, 55 years old)

From the above narrative, the participant noticed certain suicidal tendencies in the client and explored further through probing questions and prayer. The result of detecting early signs and the psychoemotional state of the person was referral to a senior minister for further support and spiritual assessment. She thus played both a guardian and mediator role by way of keenly observing clues to suicide and based on the outcomes of the observation she

[1] The religious traditions of the participants are abbreviated as follows: CRL = Christian religious leader, MRL = Muslim religious leader, and TRL = traditional religious leader.

[2] This generally refers to an Islamic scholar who also helps people mediate the spiritual realm in search for answers for existential issues.

helped link the person to a resource where he could get help. It is clear from the narrative that conceiving the person's suicidal tendencies as perhaps a diabolical manipulation influenced the direction of the referral, which was to another religious setting. Her approach was consistent with Osafo's (2012) observation in Ghana that how suicide is viewed influences how people react to the act and the type of help given to or sought for persons in suicidal crisis.

Referral Some respondents reported that in extreme cases they referred suicidal persons to professionals such as psychiatrists or psychologists for clinical care, as indicated in the following narratives:

> Now, whenever I have opportunity and depending on the level I think they [suicidal persons] are, for instance, if they are just at the beginning, affirmation and re-orientation will help them. If they are beyond that, then they need immediate attention and we refer or ask that they be immediately sent to see the psychologist. (CRL, male, 55 years old)
> On a few occasions. I quite remember, we had a worker who was exhibiting some suicidal tendencies, and at a point we had to rush him to go and see a specialist. (MRL, female, 55 years old)

As can be observed in the above narratives, the religious leaders engaged in informal forms of pre-screening. Those cases which could be addressed with minimal skills were handled, and those beyond their competencies were referred to the appropriate quarters for attention. Thus, both the seriousness of the person's case as well as the competence of the helper influenced referral decisions.

Religio-psychosocial supports

The analysis examined further the kinds of methods religious leaders employed in helping suicidal persons who were in their care. Themes that emerged were '*counseling*', '*creating healing communities*', '*spiritual healing*', '*social support*', and '*hope induction*'.

Counseling Analysis showed that Christian religious leaders, compared to Muslim and traditional religious leaders, used counseling more often as a diagnostic and therapeutic tool to offer hope, support and encouragement to persons who had suicidal tendencies. As a diagnostic tool, an attempt was made using counseling to explore the potential cause of the problem, and as a therapeutic tool, counseling was used to reduce distress. A respondent indicated this:

> Well, sometimes we use counseling as a diagnostic tool, but I believe also that counseling is a therapeutic tool, so through counseling, we actually bring therapy- treatment and healing to people. (CRL, male, 55 years old)

Other participants also indicated that they counseled suicidal persons by talking to them, sharing other people's experiences with them to make them realize that the problem they were encountering was universal and that they are not the first to face such a problem (Yalom, 2005), as indicated here:

> By talking to the person, maybe sharing other people's experiences to make the person feel that he or she is not the first to go through such a thing. And also, to make the person put his or her trust in God. (TRL, male, 50 years old)

The counseling is perhaps not only meant to help the person normalize their crisis but also to re-energize their faith in the divine. Perhaps, that suicidal behaviour reflected a failure on the part of the suicidal individual to utilize their religious faith during the crisis, and thus talking to the person might provide a means of deterring the person from future attempts.

In some cases, participants reported that the counseling they provided was aimed at alleviating the distress of the supplicant following a financial crisis or other existential challenges:

> As a leader, I try to assuage the problems that can lead to suicide by talking to the person and trying to identify any suicidal tendencies and then try to help. If it's a marital problem, there is a marriage committee, and if our attention is drawn to it, we give them advice. In effect, we take a proactive stance. (CRL, female, 55 years old)

Specifically, the above narrative suggests a more preventive counseling approach, indicated as 'a proactive stance', with an already set in place standing committee to address issues earlier rather than later. Thus, counseling is restorative and helpful in modifying the behavior of suicidal individuals and hence preventing them from attempting or completing suicide (e.g. Sandage, 2009; Stake, 2005).

Creating healing communities Some participants reported that one of the key means by which they provide help for suicidal persons is revving up support in the form of creating a healing community around them. Specifically, they befriend the person and also ask other key persons, such as friends and family of the individual. to help support them during their suicidal crisis. The following quote illustrates this: 'As a religious leader, I advise the close people around them like friends and family to support them out of the situation' (MRL, male, 42 years old). A traditional religious leader said something similar: 'But above all, we try to be very close to the person. If you try to be very close to the person, monitor the person's movement, you would help the person' (TRL, male, 42 years old). This approach was confirmed by a Christian clergy:

> You keep befriending them, you keep following up on them until you have come to the point of healing for them. Immediately, you also ask people to keep an eye on the person and form a healing community around the person. (CRL, male, 52 years old)

The above narratives indicate that religious leaders in this study, contrary to the many reports of stigma towards suicidal persons in Ghana, act contrary to these negative attitudes. Many people might avoid the company of a suicidal person and condemn them. However, by calling people to rather be empathic to such persons, religious leaders are redefining the negative reactions and attitudes towards suicidal persons.

Spiritual healing In other instances, such as when there is a suspicion of hereditability of suicidal behaviours in the family or there is a suspicion of diabolical interference, participants reported that they resorted to spiritual healing, such as prayer, in helping the suicidal person:

> I feel [the] majority of suicidal cases can be handled by religious folks, by pastors as well. Because you deal with the physical aspect through counseling and if there is any spiritual connotation to it, you pray and deal with it too. Because there are some people who can receive counseling from psychologists, they will be okay for a period of time. But if the thing is from a lineage where there have been suicidal tendencies, then of course that thing can resurface again . . . then you need to handle it spiritually. (CRL, female, 40 years old)
>
> I teach the women, so some of them often bring such problems—suicide and others concerning their marriages and children to me for counseling. I then bring together such people among them and pray for them. (MRL, female, 55 years old)
>
> If the suicidal person opens up to share his or her problems with top leaders in the community, he or she is helped with prayers, but if he or she doesn't, then it becomes their individual problem. (TRL, male, 60 years old)

It appears from the above quotes that the spiritual healing regimen largely depends on the subjective spiritual potency of the religious leader. Specifically, there seems to be a celebration of this regimen over the perceived limitations of the professional care from clinicians or psychologists. Noteworthy in the narratives of the traditional religious leaders is the notion that the efficacy of the spiritual support is predicated on the individual's readiness to share with the spiritual helper. Furthermore, religious leaders relied heavily on their *spiritual abilities* to either discern or diagnose the cause of the suicidal problem. According to Omenyo (2011), this is similar to *akwankyere* or *abisa* (Akan words used to refer to counseling and direction), where a diviner gives direction in life or instruction to avert a possible future mishap.

Social support According to some participants, the lack of social support from close friends and family seemed to be the major factor that made certain individuals suicidal. Therefore, in dealing with suicidal persons, they encouraged friends and family to provide support to such persons during their crisis. For example, a Muslim participant draws on his religious belief to justify his argument for social support:

> In such cases, if there is enough support—let us say from their friends—they can get back on their feet, this wouldn't happen. But when they feel there is nobody to help them out of the situation, they resort to committing suicide. A respected person, who is humiliated, could do anything to himself. So, Prophet Mohammed admonished us to help them so that they would still feel well, and that's what I do. (MRL, male, 50 years old).

According to participants, family and social support from friends can protect suicidal persons from further suicide attempts. These sources of support are curative and highly beneficial and can mitigate suicidal crisis because they originate from the inner social circles of the suicidal individual (Quinn, 2007). For example, a participant indicated: 'Well, as religious persons, we can help suicidal persons through counseling, but we advise the close people around them like family and friends to support them out of the situation' (TRL, female, 60 years old). Inferred from the above quote is the recognition on the part of the religious leader of the need to enhance existing social networks or to also create a network for emotional, informational, material, and spiritual support for persons in suicidal crisis.

Hope induction Religious leaders also reported inducing religious hope in suicidal persons who sought their help: 'As a religious leader, I do encourage such people. I give them hope' (MRL, female, 50 years old). Others induced hope in such persons through encouraging them to be conscious of their divine purpose in life: 'Yes, definitely. Our task is to give people hope and encouragement and to let them know that God has left them on this earth for a purpose' (CRL, Man 56 years old). A similar deeply fused religious view of hope is corroborated by the traditional leader: 'I also encourage the person to put his or her trust in God' (TRL, male, 48 years old).

Discussion

This study examined how religious leaders in Ghana perceive their role in suicide prevention as well as the specific help they provide when they engage with suicidal persons. In line with these purposes, participants in this study perceived that they provided frontline services to persons in suicidal crisis. This finding has been emphasized in several studies which examined the role of religious leaders in various facets of community mental health services, such as providing mental health care for the aged (Pickard & Guo, 2008), helping people with mental health problems (Osafo et al., 2015a, b; Wood et al., 2011), or helping victims of domestic violence (Wolff et al., 2001). This finding can be explained by role theory. Role theory posits that most of everyday activity tends to be an acting out of socially defined categories such as father, teacher, priest, or manager and that these specific social roles are accompanied by sets of rights, duties, expectations, norms, and behaviors that a person has to fulfill and face (Biddle, 1986; Katz & Kahn, 1978). This theory also implies that the roles that people occupy in society provide a good context for understanding what they do and why they do what they do. Thus, participants in the current study felt enjoined as religious leaders to act as frontline workers; they had a caring obligation or duty to help people in distress such as people in a suicidal crisis. Acting otherwise would likely raise questions about their capacity to remain in that role. Implicit is the supposition that the social position religious leaders occupy comes with social responsibilities that impel helping distressed individuals within the communities they lead.

Given that the Ghanaian cultural setting abhors or perceives suicide as unacceptable (Gyekye, 1995; Osafo et al., 2011), the participants' posture seemed to reflect a certain commitment that required them to use various reparative methods to address suicidal crisis. That is, they ensured that what is abhorred—killing oneself—would not occur as that could also imply failure on their part to preserve and enhance the lives of community members. Accordingly, the findings revealed five main ways in which participants helped suicidal persons. These were counseling, creating healing communities, spiritual healing, social support, and hope induction.

The participants indicated that healing communities were helpful for suicidal persons. The Suicide Prevention Resource Center (2009), funded by the U.S. Department of Health and Human Services, for example, discovered that faith communities and religious persons show compassion towards and support suicidal persons. This may be what the participants in this study demonstrated. Such support and care norms that are fostered by these religious leaders' beliefs and values could lessen the potential impact of stigma on suicidal individuals. Moreover, this kind of impact religion exerted on the participant's moral resolution to offer assistance during suicidal crisis could lend further support to the association between prosociality and religion in this specific cultural context. This is because such an

act could be conceived as a manifestation of true religiosity. In the present study, although the interviewees' religious beliefs (e.g. belief that God is responsible for life and enacts divine retribution on suicidal individuals) could promote stigmatization of suicidal behavior, the researchers did not find that attitude extended towards suicidal persons. The religious leaders appeared to have disconnected their attitudes towards the suicidal person (as a person who needed care and support) from suicide as a phenomenon (as an act divergent from their faith).

Additionally, the participants engaged in hope induction. Rasmussen and Wingate (2011) posit that hope induction lessens the probability of suicidal ideation and accelerates clients' recovery (e.g. Larsen et al., 2007), hence it is a critical component in mental or psychiatric nursing. Therefore, to widen the outlook of suicidal persons whose handling of their crisis is limited by feelings of hopelessness, participants in this study encouraged, talked to, and listened to suicidal persons. This finding corroborates that of Ae-Ngibise et al. (2010), who specified that a key reason why people seek the services of traditional and faith healers in Ghana is the psychosocial support offered to patients through talking to them as psychologists do in order to allay their fears and infuse in them positive thoughts. There are indications of the use of hope induction as a method of treating people in mental health crisis in Ghana among neo-prophetic ministers (Osafo et al., 2015a, b).

Stack (2013) has summarized the main models that explain why religion tends to be a protective factor in suicide. These include religious commitment theory, which states that religious individuals are influenced by the teachings of their traditions. The teachings provide a sense of meaning and/or a direct proscription against suicide, which in effect reduces the risk of depression and suicide. According to the religious network theory, the protective role of belonging to social groups, as suggested by several studies with community and psychiatric samples, lowers suicide rates among frequent church attenders (Nisbet et al., 2000; Rasic et al., 2011). The religious integration theory indicates that consistent adherence to religious ideas and practices as well as integration into a faith community offer a higher sense of hope and life meaning, as showed in several studies with community samples and psychiatric populations (Koenig et al., 2012). Finally, the moral communities theory states that social support found in faith communities and the size of the community reinforce acceptable behaviour. For instance, countries with a homogeneous religious affiliation reinforce the preservation of life and thus the unacceptability of suicide. For instance, Ghana has been rated as the most religious country on earth (Gallup, 2012). The strong and pervasive religious social environment within which life is organized and expressed in the country could create a strong moral community that inhibits suicidality. In the present study, Stark's explanatory models are all relevant in shedding some light on the various ways in which religious leaders help attenuate the suicidal crisis of people in Ghana.

Limitations of the study

To the best of our knowledge, this is the first study that has sought to carefully delineate the treatment regimens that religious leaders in a community in Ghana employ in suicide prevention. However, this research was not without limitations. The participants were Christian, Muslim, and traditional religious leaders. Assimeng (1999) describes Ghana's religious sphere as a zoo, implying that several religious sects co-exist. However, the present study did not consider other religious denominations. Future research should therefore consider the opinions of religious leaders in other religious faiths and their distinctive

perceptions of their role in suicide prevention to broaden our understanding of the connection between religion and attitudes towards suicidal behavior in Ghana.

Implications of findings

The findings of the current study have some implications for public mental health education as well as for gatekeeper training for religious leaders.

Public mental health education The findings on the treatment regimens employed by the religious leaders in this study indicate that they provide various forms of help to people who are at risk of suicide, and this can have implications for the prevention of suicide in Ghana. Specifically, the study discovered that the treatment regimens identified were more intervention-based than prevention-focused. These regimens were therefore employed as interventions only after a suicidal individual had been identified. Particularly, when participants noticed through counseling that a suicidal individual was exhibiting a sense of hopelessness, psychological distress, or frustration, they then induced religious hope in them to allay their fears through the use of religious or doctrinal teachings. However, the lack of training in suicide prevention skills and competencies may make it difficult for religious leaders to identify suicidal individuals with more innate or not easily identifiable suicidal tendencies. Also, the creation of healing communities and a social support regimen, though helpful, puts the people involved (the religious leader and others attempting to help the suicidal person) at potential risk of social stigma. This calls for adequate training in the selection of persons who will form the healing community around the suicidal person by providing social support. The celebration of spiritual healing (which is largely dependent on the perceived spiritual potency of the religious leader) as a single treatment regimen over conventional or orthodox approaches gives cause for concern due to its limitations. This calls for more reflection and research since the causes and pathways for suicide are multifactorial, and multi-component intervention strategies aimed at prevention are more effective than single strategies. Summarily, the pervasive stigmatization of suicide and mental health care in Ghana, coupled with the huge workforce deficit in the mental health sector, requires intense public mental health education to improve attitudes and task shifting in addressing the problem.

Gatekeeper training for religious leaders Worthy of note is the potential need to leverage the social position of religious leaders in Ghana for gatekeeping functions. As mentioned earlier, Ghana is a religious country, and religion is a major cultural manifestation in thought and action and also a meaning system which shapes attitudes towards suicide (Osafo, 2012). It is important to note some of the reasons for the attraction of religious and traditional leaders to persons in mental health crisis in Ghana, including accessibility and the less stigmatizing nature of their care regimen. Given this situation, the importance of religious leaders in suicide prevention cannot be overemphasized. Integrating their role formally into mental health care and suicide prevention by equipping them with suicide literacy such as identification of suicide warning signs and the provision of basic first aid will be complementary to the work of the few mental health professionals available in Ghana. This potential task-shifting role for religious leaders in a setting that has few mental health resources, such as Ghana, is a major contemporary discourse (Arias et al., 2016; Ofori-Atta et al., 2018; Osafo, 2016; Read, 2019), and the present study contributes to this discourse.

Conclusion

The aim of this study was to explore the suicide treatment and prevention regimens of Christian, Muslim, and traditional religious leaders in the Ga East Municipal East District of Ghana. This study has demonstrated that religious leaders are key persons who can help persons during suicidal crisis, thereby counteracting self-destructive behaviours. Additionally, the study has established that religious leaders are already engaged in some forms of mental health care, and their treatment regimens can be complementary to conventional support and therapies if improved through professional education and training. Religious groups should therefore be strategically enrolled in the vibrant discourse concerning effective ways to improve mental healthcare services in Ghana.

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