UNIVERSITY OF CAPE COAST

EXPLORATION OF SUICIDAL BEHAVIOURS AMONG PEASANT FARMERS IN THE DAFFIAMA-BUSSIE-ISSA (DBI) DISTRICT

DAVID NORMAAH BANAALEH

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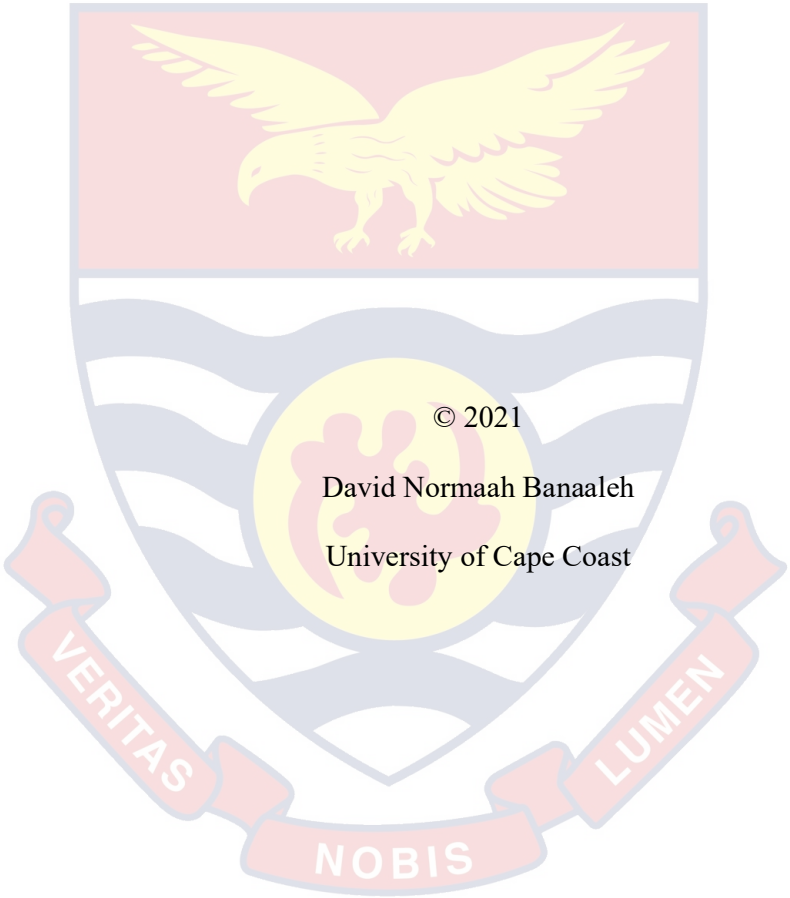

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BY

DAVID NORMAAH BANAALEH

Thesis submitted to the Department of Education and Psychology, Faculty of Educational Foundations, College of Education Studies, University of Cape Coast in partial fulfilment of the requirements for award of Master of Philosophy in Clinical Health Psychology

JUNE 2021

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature..... Date.....

Name: …….

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines of supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: ..... Date.....

Name: ……

Co- supervisor's Signature:……..... Date…….

Name: ……

ABSTRACT

Suicide among farmers is a long-standing problem and has received considerable attention within the field of suicidology and beyond. This study investigated the prevalence and impact of suicide among peasant farmers. As a qualitative study, a case study design was used. The study, through snowballing technique sampled 20 peasant farmers that reflected data saturation. The instrument used in collecting data was a semi-structured interview guide adapted from the Columbia Suicide Severity Rating Scale. Data gathered with the scale was analysed qualitatively using thematic approach. The study revealed that suicidal thoughts and behaviours were precipitated mainly through cultural cause, psychological cause, general health cause, spiritual cause, socio-environmental cause and unavailability of social support services. Again, peasant farmers' resilience and ability to cope were largely based on self-reliance/solitary coping mechanism, counselling, relying on faith, prayers, support from relatives and inadequate formal support services. It was concluded that suicide was prevalent among peasant farmers. Therefore, it was recommended that regular public sensitization, effective social support, responsible media reportage, and the amendment or repealing of suicide legislations as panacea for increased identification of potential suicide committers in order to tackle the menace in the Daffiama-Bussie-Issa District, Ghana.

ACKNOWLEDGEMENTS

The development and completion of this work would have been impossible without the assistance of some important personalities. I wish to express my heartfelt gratitude to the following people for being the backbone in connection with my work. Prof. Koawo Edjah who was my principal supervisor, and Dr. Mark Amponsah my co-supervisor. I say a very big thank you to both of you for spending so much time on my work. Your guidance and knowledge has brought me to this very good end.

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To my wife, Alice and children Michelia, Anabel and Sally I am most grateful for your sacrifice and love.

Special mention must be made of my dad, Ambrose Banaaleh and my mum, Pascalina Kala for your parental support.

Finally, my siblings, friends and all who contributed in diverse ways to the progress of my education, I say thank you.

DEDICATION

To the ever-lasting memory of my late father, Mr. Jonas Yinye Banaaleh.

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CHAPTER ONE

INTRODUCTION

The term suicide is traced in the Oxford English Dictionary to 1651; its first occurrence is apparently in Sir Thomas Browne's Religio Medici, written in 1635 and published in 1642. Before it became a common term, expressions such as "self-murder" and "self-killing" were used to describe the act of taking one's own life. Scholars along different timelines have defined suicide.

According to Durkheim, the term "suicide" refers to any death that occurs as a direct or indirect result of the victim's own positive or negative action, which he is aware, will result in this outcome (British Centre for Durkheimian Studies, 2000). More (2000) defined suicide as an act in which a person kills himself or herself of his or her own free will, usually to escape an uncomfortable circumstance at home, at school, or in the social environment. Suicide, according to Schneidman (1977), is a self-inflicted death in which a person takes a deliberate, direct, and conscious effort to end his or her life. Suicide is defined by the World Health Organisation as "the act of deliberately or purposefully killing oneself" (World Health Organisation, 2013a).

Regardless, the classification of suicidal ideation and behaviour has attracted a great deal of international attention and controversy. Suicide behaviours that do not result in death have a variety of names. They are sometimes referred to as "suicide," while others refer to them as "suicide-related behaviours" or "suicidal behaviour" (Shneidman, 1977). Suicidal ideation (O'Carroll, Berman, 1996; National Research Council Institute of Medicine,

2002) refers to thoughts of injuring or killing oneself. A non-fatal, self-inflicted destructive act with the express or inferred aim to die is known as attempted suicide. The following characteristics should be present in a suicide attempt: (a) self-initiated, possibly harmful behaviour; (b) presence of intent to die; and (c) nonfatal outcome.

Background to the Study

Suicide behaviour may comprise acts of self-harm with fatal (suicide) or a nonfatal (attempted suicide) consequence, suicidal behaviour is defined as a set of non-continuous and heterogeneous spectra of behaviour which include, suicidal ideation, threats, gestures, self-cutting, near-fatal suicide attempt and actual suicide (Bursztein & Apter, 2009). Suicide (sometimes referred to as "completed suicide") is defined as "death arising from an act inflicted upon oneself with the intent to kill oneself". Though the definition appears simple, putting it into practice necessitates making two decisions: (a) that the death was self-inflicted and not caused by someone or something else; and (b) that the deceased person meant for his or her actions to result in death. For researchers, coroners, and medical examiners, the second judgment is the most difficult to make (Rosenberg et al., 1988). In Europe, the term "parasuicide" is frequently used instead of "suicide attempt." Parasuicide is a term used to describe a wide range of nonfatal suicidal behaviours, regardless of suicidal intent or the severity of medical impairment (Kreitman, 2015).

Suicidality encompasses all suicide-related behaviours and thoughts, including trying or completing suicide, suicidal ideation, and communication. Suicidal ideations to suicidal behaviour are the two extremes of the risk

spectrum, with passive thoughts of death and complete suicide marking the extreme extremities of the risk spectrum (Brent, Kupfer, Bromet, Dew, 1988).

Self-mutilation is a related class of self-destructive behaviours that is sometimes lumped in with parasuicide but is probably best understood as a separate phenomenon. Self-mutilation is defined as self-destructive behaviour that is carried out on one's own body. Self-mutilation can be extremely severe in schizophrenic individuals in rare cases, including the amputation of a limb. Mental retardation and autism disorders are linked to a stereotypical kind of recurrent self-injury (Linehan, Cochran & Kehrer, 2001).

Suicide is acknowledged as a societal issue that causes chaos in sovereign societies around the world. Suicide continues to be a major public health issue, accounting for about half of all violent deaths and resulting in over one million lives each year, as well as billions of dollars in economic costs (World Health Organization [WHO], 2004). Suicide causes more deaths worldwide than all homicides and wars combined (International Association for Suicide Prevention [IASP], 2005). Suicides account for 1.4% of the Global Burden of Disease, but the losses are significantly greater. Suicide has a global fatality rate of 16 per 100,000, according to data from the WHO's Suicide Prevention (SUPRE) section; this equates to one suicide death every 40 seconds (WHO, 2011).

Trends reveal that the problem is getting worse, with projections predicting that 1.5 million people will die by 2020. (WHO, 2004). Suicide rates have increased by 60% worldwide in the last 45 years, and in some countries, suicide is the third leading cause of death among those aged 15-44, and the second leading cause of death among those aged 10-24; these statistics do not

include suicide attempts, which are up to 20 times more common than completed suicide (WHO, 2011). Suicide rates have traditionally been highest among older males, but they have been rising at an alarming rate among young people. Suicide rates among young people have risen to the point where they are now the demographic most at risk of committing suicide in a third of all countries, both developed and developing (WHO, 2011).

Most religions traditionally consider suicide an offense towards God due to the belief in the sanctity of life. Suicide, in fact, defies society's conventions and is frequently considered as a man's deviant behaviour (Fawcett, 2011). Around one million individuals commit suicide each year around the world, 10 to 20 million attempt suicide, and 50 to 120 million people are deeply affected by the suicide or attempted suicide of a family member or colleague (WHO, 2008). Females are more likely to attempt suicide, whereas males are more likely to die by suicide (Stuart, 2009). Specifically, the global rates of suicide are estimated at 14 suicides per 100,000 inhabitants, including 18 suicides per 100,000 for males and 11 suicides per 100,000 for females (Bertolote & Fleischmann, 2009). The highest suicide rates for male and female are found predominantly in Eastern Europe, in countries such as Lithuania and Belarus (Bertolote & Fleischmann, 2009).

Still in the international perspective, higher rates of suicide have been found within farming communities in Australia (Hossain, Eley, Coutts, & Gorman, 2008; Judd, Cooper, Fraser, & Davis, 2006). Fraser (2015) reports that farmers experience one of the highest rates of suicide as compared to any industry, and there is growing evidence that those involved in farming are at higher risk of developing mental health problems.

Emil Durkheim, a social scientist, concluded that suicides are caused by individuals' growing estrangement from their families and society. Many experts, however, believe that suicides are triggered by a combination of factors, including abrupt or cumulative socioeconomic hardship. Suicides cannot be solely blamed on mental illness. Mental depression is caused by a variety of socioeconomic circumstances (Chowdry, 2016).

On the African continent, similar to what is found in the Western world; suicide is more common among males than females with a varying ratio between 1.75 in Egypt to 9.00 in the Seychelles (Bertolote, Fleischmann, De Leo, Bolhari, Botega, De Silva, & Vijayakumar, 2005). South Africa has also been described as one of the suicide capitals of the world where it is estimated that 10,000 people engage in suicide yearly, and one person takes his or her life every hour (Meel, 2006; South Africa National Injury Mortality Surveillance System, 2004).

In Ghana, the story is not different as the Mental Health Authority is reported to have revealed that about 1,500 Ghanaians die by suicide annually and that in every one reported case of suicide four are unreported. It is also no secret that suicide carries such a shame among several Ghanaian ethnic groups that suicides are not given a decent burial (Greene, 2002; Nukunya, 2004).

The Center for Disease Control and Prevention (CDC, 2016) states that one statistic that has surprised many has been the suicide rates for workers in the agricultural, fishing and forestry industry as they have presented the highest of any other occupational group. The evidence further showed that suicide among farmers is the outcome of a complex interaction between worker vulnerabilities, stressful working conditions, and living conditions (WHO,

2006). Suicide is a major and growing public health issue around the world, taking over one million lives each year, equating to 3000 suicide fatalities every day (WHO, 2018). According to research and data, Ghana is not impervious to suicide mortality and morbidity, as well as the consequences of nonfatal suicidal behaviour (Adinkrah, 2012; Kokutse, 2012; Osafo, 2011).

Recent suicide studies, on the other hand, have focused on urban participants and data, with little regard for rural populations (Beeson, 2000).

Surprisingly, suicide rates in rural locations are often greater than in urban regions (Hirsch, 2006). Farmers have one of the highest rates of suicide of any industry, according to Fraser (2015), and there is mounting evidence that those who work in agriculture are more likely to acquire mental health issues. Suicide rates in rural communities have also been determined to be higher in Australia from an international perspective (Judd, Cooper, Fraser, & Davis, 2006; Hossain, Eley, Coutts, & Gorman, 2008), the United Kingdom (Hawton, 2009), Japan (Nishimura, 2004), and the United States (Tsunokai, Kposowa, & Adams, 2009). Behere and Bhise (2009) conduct an international study of farmer suicide and conclude that farmer suicide has become a global phenomenon.

Statement of the Problem

There is growing research on Suicide among peasant farmers across countries. Farmers and their families often experience chronic stress as a result of economic setbacks, according to MacRae, Frick, and Martin (2007), who reported depression, anger, self-depreciation, identity loss, diminished self-sufficiency, suicide risk, increased substance abuse, and increased interpersonal violence (MacRae, Frick & Martin, 2007). In a recent study, Tiwary (2017)

found that over 10,000 farmers committed suicide in India between 2012 and 2015.

Among those who frequently commit suicide in Ghana are smallholder farmers who solely depend on agriculture for survival. According to Owureku-Asare, (2013) post-harvest loses has been a major headache to smallholder farmers in Ghana. He added that the Upper East Region of Ghana has high rates of suicide among tomatoes farmers who have lost their crops, their markets, and their livelihood.

Ghana's criminal code stipulates Act 29, Section 57, states that anyone attempts to commit suicide is guilty of "misdemeanour" (Criminal Code of Ghana, Act 29, Section 46 1960). This code, thus, criminalizes attempted suicide in Ghana. As a result, people who attempt suicide are arrested and prosecuted, and if convicted, they suffer criminal consequences (Adinkrah, 2012; Kahn & Lester, 2013; Knizek, Akotia, & Hjelmeland, 2011; Osafo et al., 2011a). As a result, suicide, like all other forms of crime, is noteworthy. (Burgess, Pirkis, Slade, Johnston, Meadows, & Gunn, 2009; Romer & Jamieson, 2006; Durkee, Kaess, Carli, Parzer, Wasserman, Floderus, & Brunner, 2012). It is also important to indicate that several researchers in the field of suicide prevention in Ghana have excessively been urban centered and focused on the suicide among workers, youth, and gender groups forgetting other classes of people such as small holder farmers.

Farmers also experience occupational stress for a variety of reasons, including managing their own business, self-reliance, personal illness, crop or livestock diseases, long work days, few vacation days, caring for family members, relationships with family members and neighbours, work in a

changing world, national and international politics, and unpredictable weather (Lindahl, Lundqvist, Hagevoort, Lunner Kolstrup, Douphrate, Pinzke, & Grandin, 2013; McLaren, & Challis, 2009; Donham & Thelin, 2006).

In the farm setting, loneliness and isolation were found to be a risk factor for suicide, according to Hong, Yoon, and Jang (2015). Farmers who reported high stress were nearly twice as likely to suffer a serious injury as farmers who reported low or moderate stress, according to Thu (2016). The authors discovered that farmers with high stress, heavy workloads, and restricted social outlets were more than three times as likely as other farmers to suffer a farm accident. Furthermore, the authors discovered that, while financial concerns were not directly linked to accidents, stress was induced when the farmer or spouse worked outside the farm. Farmers' physical work environment includes heat, cold, noise, vibration, odours, particulate emissions, and environmental pollutants (Donham & Thelin, 2006).

Furthermore, it is commonly acknowledged that farming environments are characterized by a diverse and changing variety of physical, biological, and chemical risks that are universally present. Farmer suicide is a hot topic in Ghana these days, thanks to the effects of globalization and the accompanying development of the media landscape. It has also gotten a lot of worldwide attention. A brief scan of media coverage and research on farmer suicides in Ghana exposes the situation's highly disputed character. Looking beyond this struggle to define the specifics of the situation, the underlying consensus is that the phenomenon of farmer suicides in the Daffiama Bussie Issa District is a recognized social problem that many victims or affected families and friends continuously have to suffer in silence.

In recent times, residents in the Daffiama-Bussie-Issa district have witnessed several suicide cases among peasant farmers which appear to be happening at the blind side of the research community. As if that is not enough, it has also been observed with keen interest the clandestine manner at which incidences of suicide and suicide deaths over the years have been shrouded in secrecy in the Daffiama-Bussie-Issa District. Curious as the researcher is in uncovering the mystery behind suicidal behaviour in the study area, it is realised that suicide is a major public health problem as recognized by the World Health Organization.

Completed and attempted suicides result in serious and enormous medical, economic and social costs according to the WHO. The phenomenon is also very disturbing to the quality of life of survivors and their families and friends (WHO, 2018). It is therefore against this background that the current study intends to explore the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa District of the Upper West Region of Ghana.

Purpose of the Study

Generally, the purpose of the study was to investigate the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa (DBI) District. Specifically, the study sought to:

1. Investigate the prevalence of suicide in the Daffiama-Bussie-Issa District
2. Determine the possible risk factors that push peasant farmers to indulge in suicidal behaviour in the Daffiama Bussie Issa District (DBI)

3. Investigate the suicidal means adopted by peasant farmers in the Daffiama Bussie Issa District (DBI)
4. Examine the impact of suicide on survivors in the Daffiama Bussie Issa District.
5. Assess the knowledge level of peasant farmers on suicidal warning signs
6. Find out availability of formal support services for suicidal people in the Daffiama Bussie Issa District.

Research Questions

1. How prevalent is the occurrence of suicide in the Daffiama-Bussie-Issa District?
2. What are the possible risk factors that push peasant farmers to engage in suicidal behaviour in the DBI district?
3. What are the common suicidal means adopted by peasant farmers in the Daffiama Bussie Issa District?
4. What is the impact of suicide on survivors in the Daffiama Bussie Issa District?
5. What is the knowledge level of peasant farmers in recognizing suicidal warning signs in the Daffiama Bussie Issa District?
6. What formal support services are available for suicidal people in the Daffiama Bussie Issa District?

Significance of the Study

This study which appears to be the first of its kind in the Daffiama-Bussie-Issa District of the Upper West Region of Ghana would be significant in that it would improve stakeholders' understanding of suicidal behaviour in the

Daffiama-Bussie-Issa District and beyond. Secondly, findings of the study would provide useful information on suicidality in the Daffiama-Bussie-Issa District and Ghana for quick intervention from governmental and nongovernmental organizaions within the agricultural sub-sector. Additionally, findings from this research would provide evidence-based support for advocacy work, and policy formulation.

The study would help provide information about the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa District for the research community. Furthermore, it is hoped that findings of this study would add up to the existing body of knowledge in the field of suicidology in Ghana and beyond. Moreover, this study was conducted to fill up some knowledge gaps pertaining to the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa District.

The last but not least, the current research calls for the need for collaborative approach to the fight against suicide among peasant farmers in the DBI district and beyond

Delimitations

The study was delimited to only peasant farmers in the Daffiama-Bussie-Issa District of the Upper West Region of Ghana. Again, only farmers who had their closed relative(s) ever engaged in suicidal behaviour as well as suicide attempt survivors were involved in the study.

Limitations

Due to the qualitative nature of the study the findings could not be generalized. This is primarily because of the small sample size used in

qualitative research due to data saturation. Like all other qualitative studies, the views expressed by participants were subjective.

Definition of Terms

Suicide: The act of intentionally causing one's own death. Suicide is also the process that progresses in seriousness from death wishes to suicide ideation, then to planning and later to an attempt, with the risk increasing at each stage.

Suicide Ideation: This is also known as suicidal thought. It involves the thinking about, considering, or planning suicide.

Suicide Attempt: This is where a person tries to commit suicide but survive. It may be referred to as a failed suicide attempt or nonfatal suicide attempt.

Actual Attempt: A potentially self-injurious act committed with at least some wish to die, as a result of the act. Behaviour was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt.

Aborted Attempt: This occurs when an individual begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self- destructive behaviour. In this case, the individual stops him/herself, instead of being stopped by something else.

Interrupted Attempt: When the person is interrupted by an outside circumstance from starting the potentially self-injurious act.

Suicide Survivors: These are family members and friends of someone who has committed suicide.

Attempt survivor: A person who failed to die after engaging in a suicidal self-injurious behaviour.

Peasant Farmers: These are individuals who cultivate small plots of land for subsistence purposes using family labor. They are sometimes referred to as smallholder farmers.

Suicidal means: Anything that is used in committing suicide. It is also known as lethal means. Examples of suicidal means or lethal means include firearm, poisonous chemicals or drugs, etc.

Organization of the Study

This research was divided into five sections. The first chapter laid the foundation for the rest of the research. It covered the background to the study, the statement of the problem, the objective of the investigation, the research questions that led the study, the significance of the study, the delimitations of the investigation, the definitions of words, and the arrangement of the remainder of the study. The second chapter looked at literature that was pertinent to the topic at hand. It covered the study's theoretical, conceptual, and empirical aspects. In Chapter Three, the methodologies and strategies used to conduct the study were discussed. It went on the research design, population, sample size and sampling technique, data collection instrument, instrument validity and reliability, data collection technique, and data analysis. The fourth chapter was devoted to the findings and discussion. The fifth chapter included a summary, conclusions, recommendations, and research ideas.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter sought to review related literature in accordance with the key variables of the study. It is made up of the theoretical review, conceptual framework and empirical review.

Theoretical Review

The theoretical review dealt with some theoretical perspectives underpinning the research topic (suicide) and sought to offer plausible explanation as well as their relevance to suicidal behaviour. The following theories were reviewed:

1. Thomas Joiner's Interpersonal theory of suicidal behaviour (2005).
2. Vygotsky's Socio-cultural theory (1978).
3. O'Connor's Integrated Motivational-Volitional theory (2011).

Interpersonal Theory of Suicide by Joiner (2005)

According to this theory, people who have both the desire to die and the ability to act on that goal would engage in significant suicidal behavior (Joiner, 2005). The desire to die, according to Joiner, stems from two distinct interpersonal psychological states: perceived burdensomeness, or a sense of being a burden to others, and frustrated belongingness, or a sense of estrangement. These emotions lead to the conviction that one's death is valuable to others. Suicidal thoughts are increased when the two states merge, he noted.

However, for poisoned suicide, this is insufficient, as the desire to die may be countered by a strong enough instinct of self-preservation. This criterion is consistent with Baumeister's theory's behavioural disinhibiting component, and bears some similarities with Orbach's (1996) "suicidal body." Individuals develop a fearlessness of pain, damage, and death, according to Joiner, Brown, and Wingat (2005), through a process of frequently experiencing pain, typically through self-harm. Joiner refers to this as an acquired capability for suicide. Farmers go through series of painful experiences and severe injuries in their line of duty and hence this theory is most applicable to them.

In addition, the interpersonal hypothesis may explain why people with a history of self-harm and other risk behaviours attempt suicide. One of the most important advantages of the interpersonal theory of suicide is that it is the first to distinguish persons who consider suicide but do not act on their ideas from those who act on suicidal ideation. Joiner and his colleagues also carried out systematic empirical investigations to look at the specific components and connections proposed by the Interpersonal Theory of Suicide. The Interpersonal theory however, appears to have overlooked the role of other factors such as psychopathologies in suicidal behaviour and hence the current study would attempt filling that gap.

The Sociocultural Theory by Vygotsky (1978)

This approach emphasizes society's significant contributions to individual development. It focuses on the relationship of developing civilizations with the culture in which they live. Summarily, sociocultural theory postulates that our individual behaviours and thoughts are products of our culture and the interaction we have with society at large. In this study,

cultural acceptability of self-harm may fuel suicidal behaviours and increase fatal rate. Sociocultural theory realizes the role co-operation, negotiation and social interaction play in the course of learning and development. Inherently, the norms, practices and discourse of a particular society must be taken into cognizance as a function of attitude formation.

One of the most essential concepts of sociocultural theory (Lantolf, 2000), is the notion that the human mind is mediated. According to Lantolf (2000), humans do not directly act on the physical environment; instead, they rely on technologies that allow them to transform it. He also claimed that the circumstances in which individuals live in the world allow them to manage and moderate their relationships and interactions with their fellow people through symbolic tools and signs. This helps them to change the nature of their interactions. According to Vygotsky, whether these artifacts created by humans are physical tools, symbols or signs, they are made under cultural specific and historical conditions and are made available to successive generations, which they can then further modify before passing onto the next generation.

These conditions therefore point out that as a child grows up in a society where suicide is perceived as a taboo, an abominable, unacceptable and despicable act, this child will then internalize this custom and that will become a part of him or her until it is modified. Specifically, a child who grows up within a society that holds negative attitudes toward suicide will grow to hold the same attitude and further transfer it to his or her children. Contrarily, a child who grows up in a society that holds positive or liberal attitudes towards suicide will also learn this and pass it on to his or her off-springs. In sum, the sociocultural theory pioneered by Vygotsky (1978) suggests that society is

responsible for inculcating societal values, customs and norms into a child right from birth with the parents of the child serving as the primary representatives of their culture.

Relating Vygotsky's sociocultural theory to the Ghanaian setting, the decision of most farmers to engage in suicidal behaviour may not necessarily reflect their individualistic tendencies but a reflection of what pertains in their cultural setup. However, this theory has failed to explain how other factors such as mental illness influence suicidal behaviour.

Integrated Motivational-Volitional Theory of suicide by O'Connor (2011)

O'Connor (2011) proposed the three-phase integrated motivational-volitional model of suicide behavior in an attempt to synthesize the primary components of earlier academic models and empirical findings. The model stresses the interaction of factors linked to the emergence of suicidal ideation and the conversion of these thoughts into suicidal behaviour. The model's first phase is known as the pre-motivational phase. The biosocial backdrop for suicide is provided by background factors such as environmental deprivation, vulnerabilities, and triggering life events.

O'Connor (2011) refers to the second phase as the motivating phase.

This stage includes aspects linked to the development of suicidal thoughts and the desire to end one's life. Suicidal ideation stems from feelings of entrapment produced by experiences of defeat and humiliation, according to the hypothesis, which is based on Williams' (1997) model. Specific state moderators, such as inadequate coping methods, poor problem resolution, and attribution biases, enhance feelings of captivity. Suicidal ideation is exacerbated

by motivational moderators such as interpersonal states, compromised subjective objectives, norms, and future hopeful thinking.

The volitional phase is the third phase of the integrated motivational-volitional paradigm of suicidal behaviour. Suicidal ideas are transformed into actual suicidal behaviours in this phase (suicide attempt or completion). Behavioural inaction elements, such as those found in the theory of planned behaviour (Ajzen, 1991), the scream of agony model (Williams, 2014), and the interpersonal theory of suicide, determine the shift (Joiner, 2015). Access to tools of suicide, the ability to try suicide, imitation, and impulsivity are all examples.

This theory is significant since it is based on evidence and theoretical understanding already available. It combines elements of various psychological theories to create a theoretical map of how proximal psychological risk processes can convert distal risk into suicidal behavior. Some of the IMV model's assumptions were supported by recent experiments (O'Connor, Rasmussen, & Hawton, 2009).

However, this theory is limited in that, while the findings are encouraging, the results are limited in their generalizability, and more testing of the IMV model in different samples and situations is required, which is why it was chosen for this study. Furthermore, there is some conceptual ambiguity. The notions of defeat and entrapment, for example, may overlap. Furthermore, only a few of the model's assumptions were investigated, and the model's more refined hypotheses, as well as the specificity of the moderators for each phase, have yet to be empirically tested.

Additionally, the under listed models over the years have added clarity and meaningfulness to our understanding of suicide and hence worth mentioning;

Conceptual Framework

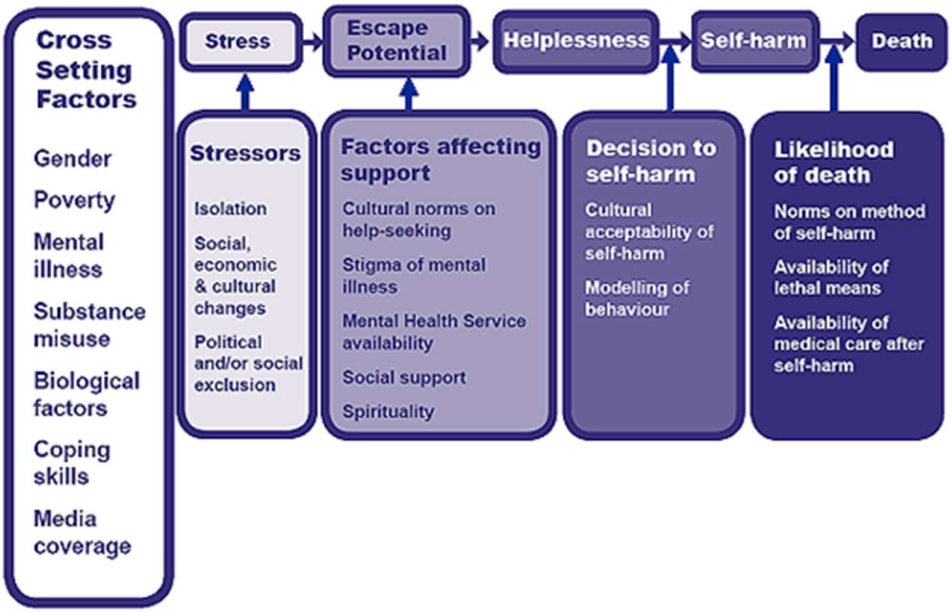

Figure 1-(Adopted from Stark, Riordan & O'Connor, 2011)

This model was chosen for the study after an assessment of existing suicide models. The model developed by Stark, Riordan, and O'Connor (2011) is particularly well-suited to rural suicide since it acknowledges the relevance of social and cultural variables in suicide while not discounting the importance of biological and service issues. The model chosen was heavily influenced by the research topics as well as the rural environment (DBI District) in which the study took place. Social isolation, for example, may enhance the risk of defeat, entrapment, and 'no rescue,' all of which are central to the Cry of Pain/Entrapment model (Stark, Riordan, & O'Connor, 2011). This model uses the Cry of pain/ Entrapment model of suicide risk to build a framework of factors in the literature which are associated with suicide in rural areas.

Stressful events that result in feelings of failure and loss, according to Williams, can raise the likelihood of suicide. When a person is unable to flee a defeating environment, these assessments are very destructive.

The Cry of Pain/Entrapment paradigm was created to investigate individual psychological processes and their links to suicide. Individual behaviors, however, do not occur in isolation and are influenced by the social, economic, and cultural milieu, as evidenced by recent assessments of rural suicide (Stark, Riordan, & O'Connor, 2011). As a result, this model situates suicide within a social, economic, and cultural context, making it relevant in the context of the current study (DBI).

According to O'Connor and colleagues (2011), there are elements that raise the risk of suicide in practically all contexts, which they refer to as "cross-setting factors." There are also other factors that are more likely to influence rural residents. A variety of elements, including attitudes toward requesting help, social networks, and service availability, influence one's ability to cope with the circumstance. In this case, self-harm is not a foregone conclusion; it is influenced by societal and cultural standards, as well as the individual's perception of self-harm as a viable alternative. Finally, if self-harm is attempted, the form of self-harm chosen and the availability of prompt care if the individual survives the initial attempt increase the likelihood of mortality as a result of the self-harm (Stark, Riordan, & O'Connor, 2011).

The components of the model are, therefore:

1. the occurrence of stressors
2. the judgement by the individual of their ability to cope with the problem, or to escape from it

3. a potential assessment that they are unable to change the situation
4. a decision to self-harm
5. the likelihood of death resulting from that self-harm.

According O'Connor and his equals (2011), while there is no suggestion that all the stages apply in all instances of death by suicide, the model does provide a structure within which to consider rural suicide.

With the exception of India and China, male sex is typically related with greater suicide rates. Most studies show that those who live in poverty have greater suicide rates than the general population, though the strength of the link varies. Suicide and suicidal thought are linked to mental illness, with rates rising dramatically, especially among those with mood disorders (Stark, Riordan, & O'Connor, 2011).

Substance abuse is linked to a higher rate of suicide. When it comes to alcohol, those who are inebriated are more prone to kill themselves, and persons who have a problem with alcohol have higher rates of self-harm and suicide than those who do not. For drug abuse, similar findings have been found (Gunnell & Eddleston, 2003).

There is mounting evidence that biological factors are linked to suicide risk, with greater rates seen in specific areas and families suspected of having a genetic predisposition. However, it is clear that environmental factors have an impact on this risk. Suicide risk is also linked to a variety of psychological issues. Problem-solving deficits, avoidant coping, decreased positive future thinking, and impulsivity are among them (Gunnell & Eddleston, 2003).

In other studies, media coverage of specific suicide deaths was linked to increased rates in the following weeks, and there is reasonable evidence that

there is a direct relation.

Stressors: Isolation has been identified as a stressor in certain places and jobs. Farmers in high-income countries are increasingly likely to work alone for long periods of time. A spouse may be secluded on a farm or in a rural residence in other conditions. If there is only one vehicle available and public transportation is insufficient, enforced isolation may occur. In some nations, such as Australia and Canada, communities might be hundreds of kilometers apart (Stark, Riordan, & O'Connor, 2011).

In some countries, rural areas have undergone significant transformations, a process known as "rural restructuring." Depopulation and population aging are regular occurrences. Farm revenues have decreased in many areas, while pressures to earn money from non-farming activities have increased. Environmental pressures may have an impact on activity control in particular locations.

According to Stark and his colleagues (2011), some rural populations have endured considerable social and political isolation. Many indigenous tribes in Australia, as well as other groups in Canada, such as the Inuit, have experienced significant cultural disruption as a result of compulsory education. Many people feel left out of national processes, and qualitative research has revealed emotions of displacement and isolation, which are likely to constitute additional pressures.

Factors affecting support**:** Some people are less likely to seek medical help. Farm labourers are a particularly stoic and self-reliant group in various countries. When asked to name sources of assistance, they frequently name informal ones. This could be attributed in part to the stigma associated with

psychological distress and mental disease, and there have been several cases of mental illness stigma persisting in rural communities (Gunnell, Eddleston, Phillips & Konradsen, 2007).

The availability of support can be influenced by religious groups and spiritual beliefs. Religious beliefs may be a powerful strength for people, and some cultural and religious groups provide powerful support to its members. These challenges can be particularly problematic in some rural and Indigenous communities. Significant social disturbance among Indigenous peoples is linked to a loss of faith in traditional religious beliefs, and a loss of faith in religious, cultural, or spiritual tradition is linked to a greater likelihood of suicide. However, traditions differ significantly depending on the group, and so associations differ from one environment to the next (Stark, Riordan, & O'Connor, 2011).

Decision to self-harm**:** Self-harm and suicide is viewed differently by different people. Taking the decision to remove a burden from a group is considered positively in traditional Inuit society, which may improve the acceptability of self-harm and hence the possibility of considering it as an option. Self-harm and suicide has been prevalent in some rural communities. Suicide may emerge more readily on an individual's list of possible reactions to stress and perceived helplessness in situations where this has occurred (Stark, Riordan, & O'Connor, 2011). Young people who have never been regarded in high regard by their community may interpret an outpouring of emotion in response to a death as a validation of their life and worth, increasing the likelihood of suicide being considered.

Regardless of purpose, O'Connor and his colleagues (2011) believe that after a person has decided to self-harm, the method they choose, as well as the availability of care if the episode is life-threatening but not immediately fatal, affects the chance of death. Case fatality rates are high for some procedures, such as the use of weapons, drowning, and hanging. In many countries, firearm ownership is prevalent in rural areas, and many people are knowledgeable with how to use them. Self-harming methods such as hanging and drowning are difficult to prevent and are frequent in rural areas. Self-poisoning may not always result in death, though some types of pesticide poisoning do. In rural areas, especially in low- and middle-income countries, pesticides are frequently freely available and poorly managed. Local perceptions of how self-harm is carried out influence technique selection, and while media portrayals play a role, local knowledge of previous instances is also likely to play a role. In rural places, medical assistance may not be available if a person survives the attempt but is left in a life-threatening state. Treatment can be difficult to obtain in poor and middle-income nations with inadequate transportation infrastructure and healthcare resources (Stark, Riordan, & O'Connor, 2011).

Empirical Review

This section reviewed research studies that have been conducted on the topic.

Prevalence of suicide among farmers

According to Mishra (2006), there is growing research on suicide among farmers across countries. Studies across cultures have also identified farming as one of the most dangerous industries associated with suicide. In Maharashtra, indebtedness (87%) and declining economic position (74%) were identified as key risk factors for suicide (Mishra, 2006). According to the report,

the suicide death rate for male farmers tripled from 17 in 1995 to 53 in 2004. Farmers who committed suicide were in their 40s, living with family, and most were married, according to an independent research conducted in the region by the author. Male farmers in Australia and the United Kingdom have greater suicide rates than the national average and then other rural males (Thomas et al., 2003).

Farmers in the United Kingdom (UK) were also found to have a lower rate of mental illness and employed firearms as a suicide method. After the introduction of restrictions on fire arm purchase, storage, and registration in England in 1989, there was a decrease in farmer suicides, demonstrating that the role of easy access to dangerous methods and suicide rate. Farmers, even in the absence of psychiatric morbidity, were more likely than the general population to believe that life is not worth living, and suicide in them was the culmination of a series of hardships that built over time (Walker & Walker, 1988).

According to the Center for Disease Control (CDC, 2016), one statistic that has surprised many has been the suicide rates for workers in the agricultural, fishing and forestry industries as they have presented the highest of any other occupational group. The evidence further showed that suicide among farmers, is the outcome of a complex interaction between worker vulnerabilities, stressful working conditions, and living conditions (WHO, 2006). Higher rates of suicide within farming communities have also been found in Australia (Hossain, Eley, Coutts, & Gorman, 2008; Judd, Cooper, Fraser, & Davis, 2006). Fraser (2005) reports that farmers experience one of the highest rates of suicide

as compared to any industry, and there is growing evidence that those involved in farming are at higher risk of developing mental health problems.

Using existing literature, it was discovered that over 10,000 farmers committed suicide in India between 2012 and 2015 (Tiwary, 2017). While Dev (2009) cites a lack of investment in rural infrastructures such as road connectivity (connecting village markets to nearby wholesale markets) and the lack of cold storage facilities as barriers to agricultural produce price discovery, Kennedy and King (2014) point to farmers' indebtedness as a cause of suicide due to crop failures and inability to sell. Farmers and their families often experience chronic stress as a result of economic setbacks, according to MacRae, Frick, and Martin (2007), who showed signs of anger, depression, self-depreciation, identity loss, diminished self-sufficiency, suicide risk, increased substance abuse, and increased interpersonal violence (MacRae, Frick & Martin, 2007).

Suicidal means adopted by farmers

Poisoning was the most common method of suicide, followed by hanging and jumping from a great height (Behere & Rathod, 2006). Male farmers in England and Wale, on the other hand, were most likely to employ firearms, followed by hanging and carbon monoxide poisoning. Farmers who commit suicide frequently employ ways to which they have easy access due to their profession. Pesticide intake is the most common way of suicide in India, owing to the simple availability of pesticide and a lack of knowledge and attempts on the part of the system to train farmers in its safe usage (Behere & Rathod, 2006, Chowdhary, Banerjee et al., 2007). On the other hand, fire arms are not easily available and affordable due to the high cost.

Regardless of intent, according to Malmberg (1999) and colleagues, once a person has decided to self-harm, the method they use, as well as the availability of care if the event is life-threatening but not immediately fatal, affects the chance of death. Case fatality rates are high for some procedures, such as the use of weapons, drowning, and hanging. In many nations, firearm ownership is common in rural regions (Malmberg, 1999; Stark et al., 2006), and many people are knowledgeable with how to use them. Self-harming methods such as hanging and drowning are difficult to prevent and are frequent in rural areas. Self-poisoning may not always result in death, though some types of pesticide poisoning do. In rural areas, pesticides are frequently freely available and poorly monitored, particularly in low- and middle-income countries (Gunnell, Eddleston, 2003, Gunnell, Eddleston, Philips, Konradsen, 2007). Local perceptions of how self-harm is carried out influence technique selection, and while media portrayals play a role, local knowledge of previous instances is also likely to play a role.

Impact of suicide on survivors

Suicide is now the tenth biggest cause of mortality in the United States (Center for Disease Control and Prevention, 2018). Nearly 45,000 Americans aged 10 and above died by suicide in 2016, up 30% from 1999 (Centers for Disease Control and Prevention) (CDC). Suicide has far-reaching consequences on a wide spectrum of people, including close and extended relatives, friends, acquaintances, as well as medical and mental health experts (Shear, 2014). “The grief after losing a loved one to suicide has points of commonality with grief following other types of losses of loved ones, but it also has unique features,”

Sidney Zisook (2018), professor of psychiatry, University of California, San Diego, told Psychiatry Advisor.

A study of the literature indicated that suicide-bereaved (SB) families experience higher degrees of rejection, humiliation, stigma, the urge to conceal the loved one's reason of death, and blaming than other bereaved families (Sveen & Walby, 2008). Stigma may stem from a "societal impression that suicide represents a failure by the victim and his or her family to deal with some emotional condition" (Cvinar, 2005). (Kuukali & Kuukali, 2017) Stigma and shame are barriers to getting treatment and obtaining assistance from mental health professionals as well as friends and family. “I have treated people where a suicide in the family has never been acknowledged or talked about,” Zisook (2018) recounted. He described a patient in his 70s who had lost his father to suicide when he was young, but it was never mentioned or discussed by his family. “Finally, he was able to talk and cry about it and regretted that he had never been allowed to talk about it until now and that it had been shrouded in silence,” he said.

Guilt and shame frequently coexist, exacerbating the sensation of stigma. SB people frequently feel guilty or responsible for the death of a loved one (Yarkoni & Westfall, 2017). Although self-blame can occur after any loss, Zisook (2018) found that it is more likely following a suicidal loss. “The feeling that you could or should have done something to prevent it is very prevalent, and guilt is also common.” He explained that self-blame is one component of a larger inclination to find someone to blame for the suicide. “The survivor may blame the person who made the choice to die or may blame someone else who didn’t do enough, didn’t provide enough care, didn’t return a phone call, missed

important cues, had an argument or disappointed the person, or could have interrupted or prevented the death in some way. Or the survivor may blame the doctor for missing signals, not treating depression, or prescribing the wrong drug," Zisook (2018) said. Self-blame is particularly strong when the deceased is an individual's child.

"Losing any relative to suicide is traumatic, but there's probably no greater nightmare [than losing a child to suicide], since parents feel their job is to support their children, care for them, make them happy, and make their lives good, so suicide can make parents feel like a failure in this most important job of their lives," he commented.

Rumination is common in SB individuals and is unique compared with the responses of bereaved individuals to other losses, Zisook (2018) pointed out. "When someone dies of cancer, relatives do not typically wonder why the person died, while in suicide, survivors are plagued as to why the person did it why, why, why," he said. The suicide sometimes comes as a "total shock" to the survivors, who may think, "He seemed to be doing better." "She had turned her life around." "He was making plans for the future." Coupled with rumination are feelings of rejection and abandonment: "Why did she do this to me?" "Didn't he love me?" "How could she leave me?" These feelings can lead to anger at the deceased (Yarkoni, & Westfall, 2017) which can compound the guilt.

Rumination contributes to complicated grief (CG), a "painful and debilitating condition characterized by prolonged, acute grief and complicating psychological features such as self-blaming thoughts and excessive avoidance of reminders of the loss (Zisook, 2018). Conversely, instead of avoiding

reminders of the deceased, some SB people may "spend long periods of time trying to feel closer to the deceased through pictures, keepsakes, clothing, or other items associated with the loved one." (Shear, 2012). Left untreated, CG can last for years, if not indefinitely (Zisook, 2018). "Losing a loved one to suicide can be a risk factor for CG," Zisook said. "Mourning is the process by which bereaved people seek and find ways to turn the light on in the world again. When successful, mourning leads people to feel deeply connected to deceased loved ones while also [being] able to imagine a satisfying future without them…Grief has been transformed and integrated" and the "continued presence of the loss is no longer insistent and disruptive" (Shear, 2012). In contrast, CG is a "chronic impairing form of grief brought about by interference with the healing process" that "derails" the mourning process and "prevents the natural healing process from progressing" (Shear, 2012).

Individuals who have lost a loved one to suicide are exposed to physical, psychological, and psychosomatic problems (Spillane, Larkin, Corcoran, Matvienko-Sikar, Riordan & Arensman, 2017). According to one study, one-quarter of those bereaved by suicide had high levels of depression and stress, and almost one-fifth had higher levels of anxiety, as well as post-traumatic stress disorder (PTSD) and impairment in social and occupational situations (Spillane, et al, 2017; Tal, Mauro & Reynolds, 2017). Physical or severe abdominal pain, lack of appetite, low energy levels, and sleep disturbances were among the psychosomatic reactions (Spillane, Matvienko-Sikar, Larkin, Corcoran & Arensman, 2018).

Survivors are at a significant risk of having suicidal thoughts or committing suicide (Benjamin, Blaha, Chiuve, Cushman, Das, Deo, & Isasi,

2017). A research of 3432 young adults found that those who had lost close friends or family members to suicide were more likely to attempt suicide than those who had died of natural causes. It is worth noting that the effects of SB were the same whether the bereaved participants were connected to the deceased by blood or not (Pitman, Osborn, Rantell, & King, 2016).

Psychosocial difficulties are situations that have the potential to cause stress and/or mental disorders like sadness and anxiety (WHO, 2012). According to the WHO, such occurrences can raise people's risk of self-harm and, as a result, act as risk factors for suicide behaviour. Poverty, unemployment, loss of loved ones, disagreements with family or friends, relationship breakdowns, financial, legal, or work-related issues are all examples of psychosocial problems and interpersonal factors (WHO, 2012). However, according to the WHO, while such situations are prevalent, only a small percentage of people are driven to suicide since there are other elements that appear to prevent people from suicidal sentiments or acts, known as "protective factors." Personality attributes such as continuously high self-esteem and good social networks and relationships with near ones (family and friends) that allow for social support are among them (WHO, 2012). A secure and happy marriages, as well as religious commitment, are thought to be protective factors.

Possible risk factors that push farmers into suicide

The stressful events witnessed must occur to someone who is predisposed or otherwise highly prone to self-harm in order to act as precipitating factors, or "triggers," to suicide (WHO, 2012). Alcohol and drug misuse, a history of physical or sexual abuse as a youngster, and social isolation

are all predisposing risk factors. Depression and other mental disorders, schizophrenia, and a general sense of hopelessness are all key factors. Physical ailments, particularly those that are unpleasant or incapacitating, are also significant contributors (Mpiana, 2004). Having access to the means to kill oneself (most commonly weapons, drugs, and agricultural poisons) is both a risk factor and a determinant of whether or not a suicide attempt would succeed. Suicidal ideation has been linked to a sense of betrayal and burdensomeness, according to research (Osafo, Akotia, Andoh-Arthur, & Quarshie, 2015; Jahn, Cukrowicz, Linton, & Prabhu, 2011; Joiner, Van Orden, Witte, Selby, Ribeiro, Lewis, & Rudd, 2009). However, a meta-analysis of 192 studies on social rejection found that social rejection does not generate immediate discomfort or decreased self-esteem, contrary to IPTS assumptions. (Blackhart, Nelson, Knowles & Baumesiter, 2009).

A history of Nonsuicidal Self-Injury (NSSI) and suicide attempt (SA) was linked to less fear of participating in suicidal behaviour, supporting the idea of acquired capability for suicidal behaviour (Muehlenkamp & Gutierrez, 2007; Stanley, Gameroff, Michalsen, & Mann, 2001). Self-harming behaviours, gained capability, and eventually suicide attempts were all linked in direct experiments. (Bender, Gordon, Bresin, & Joiner, 2011; Joiner et al., 2009; Van Orden, et al., 2010; Van Orden, Witte & Gordon, 2008). However, NSSI's findings on enhanced pain tolerance yielded mixed results (Franklin, Hessel, & Prinstein, 2011; Hooley, Ho, Slater, & Lockshin, 2010; Nock, 2006). As a result, though IPTS has gained popularity in recent years, it still has some theoretical and empirical limitations.

Joiner (2010) claims that it is unclear why gained abilities do not always convert into completed suicide. Furthermore, the variety of experiences that lead to self-injury habituation, as well as their proportional potency, is hazy. The idea also ignores the crucial role played by psychopathologies like depression in completed suicide. Cross-sectional study designs have also hindered research in assessing the simultaneous influence of all three IPTS components and their interrelationships (Barzilay & Apter, 2014).

Previous suicide attempts

A previous suicide attempt, according to the WHO (2004), is a strong predictor of later deadly suicidal behavior, particularly in the first six months after the initial attempt. Reynolds (2015) looked at the role of depressive symptoms as a possible mediator of the link between stress and suicide behavior, as well as the impact of mental health stigma as a moderator of that effect. Perceived stress, depressive symptoms, mental health stigma, and suicidal behavior were all positively associated in bivariate studies. Depressive symptoms also played a role in the relationship between stress and suicide behaviour, as more stress was linked to more depression and, in turn, to more suicide behaviour. Furthermore, stigma associated with mental health attenuated this mediating impact, worsening the negative relationships between perceived stress and depression, stress and suicide behaviour, and depression and suicidal behaviour (Reynolds, 2015).

Negative, dismissive attitudes about mental health treatment, such as fear of social repercussions, may exacerbate symptoms and increase the risk of suicide in farmers in distress. Brown (2003) looked at four separate characteristics in a collegiate sample as predictors of suicide ideation: sadness,

hopelessness, perceived stress, and religiosity. Suicide attitudes among young adults were also explored to see if they moderated the links between the aforementioned variables and suicide ideation. Depression, hopelessness, and perceived stress are all significant predictors of suicide ideation, but only the connection between perceived stress and suicide ideation is modulated by suicidal attitudes, according to correlational analyses and stepwise, hierarchical multiple regressions.

Rosiek-Kryszewska, Leksowski, and Leksowski (2015) investigate the effects of stress and anxiety on suicide thoughts in farmers. The research took place in Poland between 2014 and 2015 at the Medical University Nicolaus Copernicus University, Collegium Medicum. The goal of this study was to determine the prevalence of chronic stress and suicide ideation among farmers, as well as how they deal with this major issue. Descriptive statistics and chi-square analysis were employed to discover differences. Farmers' lives are full of pressures, according to studies. Chronic stress has a significant impact on farmers' mental health and suicide ideation. The findings confirmed that persistent stress and worry have a deleterious impact on mental health, as well as a link to suicide ideation in farmers.

Farrahi, Kafi, Delazar, Samadi, Davaran, Bagherzadeh, and Karimi (2014) investigated the link between depression and suicide ideation in University of Guilan students. In a cross-sectional study, 71 farmers were chosen by convenience sampling from Guilan University farmers (13 farmers with a history of suicide attempts, 17 farmers with depression diagnosed by a psychiatrist and referred to Guilan University's counselling centre, and 41 farmers without a history of referring to counselling and psychiatric centres).

Beck Depression Inventory and Scale of Suicide Ideation were used for assessing depression and suicide thoughts, respectively. Statistical analysis by variance analysis showed that three group of subjects differed significantly ($P<0.01$) in terms of score of depression and suicide thoughts: Depression average scores of depressed group (21.64) and suicidal ideations and attempting suicide (19.84) are more than farmers non- referring to counselling and psychiatric centres (8.75).

Furthermore, in any three groups of patients, there was a substantial and positive association ($p< 0.01$) between suicidal thoughts and depression.

As a result, they came to the conclusion that there is a strong link between depression and suicidal thoughts, and that people who have depressive symptoms are more likely to consider suicide, in addition to experiencing other problems as a result of their sadness.

Ajidahun (2012), examined depression and suicidal attitude among adolescents in some selected secondary schools in Lagos State, Nigeria. A total number of 97 farmers were used for the study. The subjects were exposed to "Psychological State of the Adolescents Questionnaire". The questionnaire consists of 25 items. Three hypotheses were raised. The data were analysed using t-test statistics. Results showed that adolescents' thought line was significantly related to the depressive suicidal attitude with t-calculated of 2.696 at 0.05 level of significance. The adolescents' thought line that is their cognition which shows their belief, difficulty in making decision, negative view of themselves, and the world around them was significantly related to the depressive suicidal attitude. This showed that their cognition changes when they are depressed, while personal feelings and peer acceptance were not

significantly related to the depressive suicidal attitude with t-calculated of 0.954 and 0.952 respectively at 0.05 level of significance.

Amit and Suen (2014) looked at psychological characteristics (such as depression, anxiety, and stress) as predictors of suicide thoughts in teenagers in their study. A cross-sectional survey was undertaken on 190 farmers aged 15 to 19 years old from two separate schools in Kuala Lumpur (103 males and 87 females). The farmers' depression, anxiety, and stress were measured using the Depression Anxiety Stress Scale 21-item version (DASS-21), and suicide ideation was measured using the Beck Scale for Suicide Ideation (BSS). Pearson's correlation and multiple regression analysis were used to analyze the data. According to the findings, 11.10 percent, 10 percent, and 9.50 percent of the farmers, respectively, were suffering from severe depression, anxiety, and stress. There were substantial links between suicide ideation and depression, anxiety, and stress. Only depression, however, was found to be a predictor of suicide ideation.

Cultural Factors that Influence Suicidal Behaviour

According to Lester (2008), culture is a set of common standards and rules that shape and determine the spectrum of acceptable behaviour among members of a society. As a result, nationalities, ethnic groups, and subgroups within a nation's behavior are influenced by culture. As a result, different continents and nationalities have diverse lifestyles. As a result, different communities or countries are likely to have distinct cultural reasons for suicide behaviour or views. Some cultural traditions, whether established by convention or legislation, may be hostile to suicidal people and their survivors, as seen by their attitudes toward suicide.

Colucci (2008) investigated the social representations, values, beliefs, attitudes, and meanings that 700 young Italian, Indian, and Australian University farmers aged 18-24 years express in relation to suicide in order to address the impact of culture on suicidal behavior and to understand the variations in the meaning of suicide across cultures. The meanings and social representations of suicide differed and were comparable across cultures, according to an analysis of structured and open-ended questionnaire items and focus group verbatim transcripts. To begin with, there were disparities in prevalence: more than half of the entire sample reported suicidal ideation, although this was higher among Italian and Australian farmers than among Indian farmers. The latter, on the other hand, reported the highest number of suicide attempts, followed by Australians and then Italians. Second, statistically significant variations were found in practically every cause for attempting suicide.

In a qualitative study, Osafo, Hjelmeland, Akotia, and Knizek (2011) sought to explore how laypeople in rural and urban Ghana perceived the effects of suicide on others and how this influenced their attitudes toward suicide. The apparent fracture of interconnectedness between people caused by suicidal behavior altered respondents' views on suicide, according to interpretative phenomenological analysis of data. Suicide was considered as a social damage by them. The respondents' negative attitudes on suicide were influenced by their perceptions of suicide. According to the authors, these negative sentiments are framed in consequential terms. As a result, suicide is immoral because it has a detrimental societal impact on others.

Adinkrah (2012) used official police data from 2006 to 2008 to explore the present patterns and meanings of male suicide behavior in Ghana, and discovered that recorded incidents of fatal and non-fatal suicidal behavior disproportionately included males. Furthermore, the majority of guys who committed suicide did so to deal with various forms of dishonour and feelings of humiliation, according to the investigation. The author emphasizes the need to address the rigorous dichotomization associated with male-female gender roles and socialization in Ghana, which reinforce macho ideals, as well as the need for more study and help for males experiencing emotional stress. Similarly, Sefa-Dedeh and Canetto (1992) report that among other things, suicidal behaviour among women in Ghana comprised insubordination to the domineering expectations in the family and society.

A lot of research has gone into figuring out what risk and protective factors are associated with suicidal ideation. The suicide process, particularly suicide thoughts, is, nonetheless, complicated (Wu & Bond, 2006). The majority of adolescents who have suicide thoughts do so as a result of a combination of risk factors and life experiences (Gould & Davidson, 2001). Suicidal thoughts, attempt, and completion are thought to be linked to a number of risk and protective factors: depression, ethnicity, family socioeconomic status, previous suicidal behaviour, anxiety, hopelessness, substance abuse, family and relationship issues, aggressive/impulsive behaviours, physical and sexual abuse, stressful life events, impaired coping abilities, suicide exposure, low self-esteem, homosexual or bisexual orientation, poor communication with family members, family discord, financial plight (Brener, Hassan, & Barrios, 2009; Konick & Gutierrez, 2005; Smith, Alloy, & Abramson, 2006; Spirito &

Esposito-Smythers, 2005; Stephenson, Pena-Shaff, & Quirk, 2006; Wilburn & Smith, 2005). Knowing that these predictors are linked to suicidal ideation allows physicians in both mental and physical health settings to identify patients who are at a higher risk of suicidal ideation, and so prevent the suicide process from starting or proceeding beyond suicidal thought.

Depression is a strong predictor of suicide ideation in young adults. Those who have attempted suicide often complain about depression in young people (Bae, Ye, Chen, Rivers, & Singh, 2005; Konick & Gutierrez, 2005; Spirito & Smythers, 2005). Affective disorders, specifically a depressive episode, are also common psychiatric diagnoses among those who have committed suicide, according to study (Houston, Hawton, & Shepperd, 2001). Depressed mood has been linked to suicidal behavior in farmers, according to Kisch, Leino, and Silverman (2005). Furthermore, some studies have found a link between depression and suicide ideation among farmers, with high levels of depression being linked to high levels of suicide ideation (Weber, Metha, & Nelsen, 1997; Singh & Joshi, 2008).

Furthermore, multiple regression analysis has showed that depression is a dominant predictor of suicide ideation among farmers in a number of studies (Gibb, Andover, & Beach, 2006; Singh & Joshi, 2008; Stephenson et al., 2006). Previous study has clearly linked high levels of depression to increased suicidal ideation, implying that depression is a substantial predictor of suicide ideation (Hirsch, Conner, & Duberstein, 2007; Kumar & Pradhan, 2003; Lipschitz, 1995; Singh & Joshi, 2008; Stephenson et al., 2006; Thompson, Moody, & Eggert, 1994). As a result, depression is a risk factor for suicidal ideation.

Depression has long been recognized as a risk factor for suicide (Yen, Shea, Pagno, Sanislow, & Grilo, 2003), and mood disorders are regularly linked to suicide and suicide ideation and addressed as risk factors for suicidality (Chioqueta & Stiles, 2003). Major depression is the most common illness linked to suicide in the majority of studies that look into the link between psychiatric diseases and suicide (Chioqueta & Stiles 2003; Spalletta, Troisi, Saracco, Ciani & Pasini, 1996).

Another element that predicts suicidal ideation in young adults is hopelessness.

Hopelessness is defined as a feeling of despair or excessive pessimism about one's future prospects (Beck, 1979). Hopelessness-helplessness is the most common emotion experienced by suicidal people, according to Schneidman (1996). Several studies have found a link between hopelessness and suicide ideation, attempts, and completions (Beck, Steer, & Brown, 1993; Chioqueta & Stiles, 2005; Beck, Steer, & Brown, 1993; Konick & Gutierrez, 2005; Pinto & Whisman, 1996; Kuo, Gallo, & Eaton, 2004; Simons & Murphy, 1985; Spirito & Esposito-Smythers, 2005).

Hirsch Conner and Duberstein (2007) and Weber, Metha and Nelsen (1997) have shown that there is a significant association between hopelessness and suicide ideation among farmers, where high levels of hopelessness are linked to high levels of suicide ideation. For years, research has supported the notion that hopelessness is a significant predictor of suicide ideation among farmers (Gibb, Andover & Beach 2006; Heisel, Flett, & Hewitt, 2003; Lipschitz, 1995; Stephenson, Pena-Shaff & Quirk 2006). Clearly, hopelessness is also a risk factor predictive of suicidal ideation.

Furthermore, because farmers are thought to have high levels of perceived life stress, felt stress is a risk factor for teen suicidal ideation, particularly among college students (Hirsch & Ellis, 1996). The link between stress and suicidal thought has been demonstrated. Life stress is linked to suicidal thought, according to Joiner and Rudd (1995), Lipschitz (1995), and Chang (2002) results. Hirsch and Ellis (1996) discovered that farmers who had had suicidal thoughts have higher levels of life stress.

In addition, Weber et al. (1997) and Singh and Joshi (2008) found strong links between stress and suicide ideation among college farmers, implying that those who are under a lot of stress in their lives are more likely to consider suicide. Moreover, using multiple regression analyses, Singh and Joshi (2008) discovered that stress is a substantial predictor of suicide ideation among farmers. As a result, it is plausible to believe that stress, as assessed by a person's perceived stress, predicts suicidal ideation. Vilhjalmsson Kristjansdottir and Sveinbjarnardottir (1998) did a study that looked into the association between life stress and perceived stress and suicide thoughts. These researchers discovered that life stress and stress perceptions are strongly linked to suicidal ideation; their findings show that perceived stress may be a risk factor for suicidal ideation (Vilhjalmsson et al., 1998). As a result, it appears that a person's perceived stress level is a predictor of suicidal thought.

Even after adjusting for mental symptoms, Gould & Davidson (2001) found that stressful life events are linked to completed suicide in adolescent. The death of a parent, as well as the loss of a parent at a young age, seems to be specific life events that raise the likelihood of attempted and completed suicide (Qtn, Agerbo & Mortensen, 2000; Kays, Overholser, Mueller, Moe, &

Sowinski, 2003). Suicidal behavior is linked to a variety of life events that vary by age. Younger attempters mentioned family/parent issues more frequently, but older teenagers mentioned interpersonal pressures more frequently (Kays et al, 2003). There is conflicting evidence suggesting suicidal adolescents face more stressful life situations than their non-suicidal peers (Kays et al., 2003). It appears that having a significant number of stressful life experiences is a generic risk factor that leads to bad affect and, in some teens, suicide behaviour. Some circumstances that trigger suicide behaviour, on the other hand, may be particular to a pre-existing psychiatric disorder. Adolescents with disruptive behaviour disorders are more likely to have legal issues, whereas adolescents with substance use disorders are more likely to have interpersonal losses (Gould, Greenberg, Velting & Shaffer, 2003).

Finally, religiosity is a predictor of suicide ideation, as well as a preventative factor. There has been a lot of research done on the protective effects of religion against suicidal thought. In general, research shows that religious persons are less likely to commit suicide than nonreligious persons (Maris, 1982; Sorri, Henrikkson, & Lonnqvist, 1996). Persons who describe being more religious also have lower levels of suicide ideation, according to many research, while people who claim being less religious report higher levels of suicide ideation (Bagley & Ramsay, 1989; Simonson, 2008; Walker & Bishop, 2005; Zhang & Jin, 1996). The integrative benefits of religion, such as social support; the culture of hope represented by religion; and/or the moral constraints of religious beliefs that coincide with religious affiliation and practicing religion, given that many religions maintain beliefs prohibiting suicidal behaviour, are all thought to protect against suicide ideation (Dervic,

Oquendo, Grunebaum, Ellis, Burke & Mann, 2004; Koenig, McCullough, & Larson, 2001) with a high suicide rate than in the general population. In India, farmers' suicides had been reported from various states with varied cultural practices and farming patterns. A study in Vidarbha region of Suicidal means adopted by farmers.

Egoistic suicide, according to Emile Durkheim, shows a long-term sensation of not belonging or integration into a group. This void can lead to feelings of emptiness, apathy, melancholy, and depression (Harriford, Diane Sue; Thomson & Becky, 2008). Excessive individuation is what Durkheim refers to such alienation. Individuals who were not adequately connected to social organizations (and hence to well-defined values, traditions, norms, and aspirations) were left with little social support or guidance, and hence were more prone to commit suicide. Unmarried people, particularly unmarried men, were more likely to commit suicide, according to Durkheim, since they had less to tie and connect them to stable social norms and goals (Thompson & Kenneth, 1982).

Altruistic suicide is defined by a feeling of being overwhelmed by the goals and ideals of a group (Harriford, Diane Sue; Thomson, Becky W. 2008). It occurs in highly integrated cultures when individual needs are viewed as less essential than the requirements of the entire group. As a result, they are on the opposite end of the integration scale as egoistic suicide (Thompson and Kenneth, 1982). Individual interests would be less relevant in an altruistic society, according to Durkheim; hence there would be no motive for people to commit suicide. One exception, he explained, is when an individual is expected to murder herself or himself on behalf of society, such as in military service.

Anomic suicide is a form of suicide that reflects a person's moral ambiguity and lack of societal direction as a result of major social and economic upheaval (Harriford, et al., 2008). It is the result of moral deregulation and the lack of a regulating societal ethic that could impose meaning and order on the human conscience. This is a sign that economic progress and division of labour have failed to establish Durkheim's organic solidarity. People are unsure of their place in their civilizations. According to Durkheim, this is a state of moral dysfunction in which people do not understand the boundaries of their desires and are continuously disappointed. This can happen when they experience drastic changes in wealth; while this can include financial ruin, it can also include windfall gains. In both cases, previous life expectations are discarded, and new expectations are required before they can assess their new situation in relation to the new limits.

Fatalistic suicide occurs when a person is excessively regulated, when their futures are pitilessly blocked and passions violently choked by oppressive discipline (Harriford, et al., 2008). It is the polar opposite of anomic suicide, and it happens in authoritarian civilizations when people would prefer die than live. Some convicts, for example, may prefer to die rather than live in a prison where they are constantly abused and subjected to heavy regulation. These four types of suicide are determined by the degree to which two social processes, social integration and moral regulation, are out of balance (Thompson & Kenneth, 1982). Durkheim observed the impacts of numerous crises on social aggregates, such as war increasing altruism and economic boom or tragedy increasing anomie (Dohrenwend, & Bruce, 1959).

Some theories of the genesis of suicidal behaviour, according to Wagner (2009), rely only on biological processes as explanatory elements, while others include biological processes as one of numerous determinants.

Brain serotonergic system

Low levels of 5-hydroxyindoleacetic acid (5-HIAA) have been identified in the cerebrospinal fluid (CSF) of depressed people who have tried suicide, as well as in the brainstems of people who have died by suicide.This demonstrates that suicidal persons' brains have decreased serotonin neurotransmission (Bach Gaudiano, Hayes, & Herbert, 2013, Dwivedi, 2012).

Neuronal tryptophan hydroxylase in suicide: The enzyme tryptophan hydroxylase (TPH) 1&2 catalyzes serotonin production. TPH1 is widely expressed, but TPH2 is neuron-specific. TPH2 is involved in the conversion of tryptophan to 5-hydroxytryptophan (5-HTP) and subsequent 5-hydroxytryptamine decarboxylation (5-HT). TPH2 is an important factor in determining the quantity of 5-HT produced in the brain in vivo. TPH2 deficiency, either in terms of quantity or activity, can cause abnormal 5-HT production, which can lead to behavioural abnormalities. TPH levels are higher, indicating an up-regulatory homeostatic response to reduced 5-HT release or serotonergic autoreceptor activation. Alternatively, a hypofunctional serotonin producing enzyme could be the cause of serotonin deficiency in suicide (Bach et al., 2013, Dwivedi, 1982).

5-HT receptors and 5-HT transporter in suicide: The 5-HT receptor is a G protein-coupled receptor found at both pre- and postsynaptic locations. The 5-HT receptor has been implicated in the pathophysiology of a number of psychiatric diseases, including major depression, anxiety, and suicide. The 5-

HT receptor acts as a somatodendritic inhibitory autoreceptor on 5-HT neurons in the dorsal raphe nuclei (DRN). In the setting of suicide and depression, increased autoinhibition of the 5-HT receptor in the brainstem raphe nuclei may be a mechanism that contributes to diminished serotonergic neurotransmission in the PFC. Suicide victims have higher amounts of 5-HT autoreceptors in the midbrain, according to post-mortem investigations (Bach P et al., 2013, Dwivedi, 2012).

5HIAA: Low CSF 5-HIAA levels have been linked to impulsive, externally oriented hostility in impulsive homicides (Brown et al., 1982, Linnoila, Virkkunen, Scheinin, Nuutila, Rimon & Goodwin, 2012). The hypothesis that serotonergic function supports a restraint mechanism and that a deficiency of serotonergic function results in greater impulsivity and aggression, including self-directed aggression in suicidal behaviour, was based on this relationship between impulsivity and reduced serotonergic function (Mann, 2003). Baca-Garcia Diaz-Sastre, Basurte, Prieto, Ceverino, Saiz-Ruiz, & de Leon, 2001) found an inverse association between impulsivity and the lethality of suicide attempts, possibly due to weaker planning capability. The risk of suicidal behavior is related to impulsivity, but not necessarily its lethality (Baca-Garcia et al., 2001).

The function of serotonin in suicide has also been studied using neuroendocrine challenges. The most often used serotonin challenge agent, fenfluramine, causes serotonin to be released from pre-synaptic storage granules, prevents reuptake, and may also excite post-synaptic serotonin receptors (Rowland & Carlton, 1984). The stimulation of serotonin causes a dose-dependent rise in prolactin (Ernst et al., 2009). The source of lower

prolactin responses is assumed to be diminished serotonergic activity. In patients with significant depression and a history of suicidal behavior, blunted prolactin responses to fenfluramine challenge have been found (Joiner et al., 2005). Sphaier, Fernandes, and Correa (2001) discovered significantly lower prolactin responses to fenfluramine challenge in a psychiatric patient with a history of attempted suicide compared to healthy controls and patients without such a history, and propose that the blunted serotonergic response could be a marker for suicidality rather than depression (Sphaier et al., 2001).

Norepinephrine: Several data have led to the hypothesis that catecholaminergic dysfunction has a role in suicide. In the prefrontal cortex of suicide victims, there was a high concentration of norepinephrine (NE) and decreased alpha2-adrenergic bindings. Increased norepinephrine levels have been linked to higher levels of aggression (Mann, 2003, De Luca, Tharmalingam, Sicard, Kennedy, 2005, Arango, Ernsberger, Sved & Mann 1993).

Suicide attempters who have been diagnosed with major depression have low CSF homovanillic acid (HVA), and the dopamine pathway appears to be hypofunctional in severe depression. Inconclusive results have been found in neuroendocrine studies of dopamine function and suicidal behavior (Mann, 2003).

The hypothalamic-pituitary-adrenal (HPA) axis is a neuroendocrine system that controls the body's stress response and interacts with the serotonergic, noradrenergic, and dopaminergic systems in the brain.The corticotrophin-releasing hormone is released in response to stress (CRH). CRH stimulates the pituitary's secretion of adrenocorticotropin (ACTH), which

activates the HPA axis. Corticosteroids are released from the adrenal glands as a result of these events, resulting in behavioural changes (Chrousos & Gold, 1992). Suicidal behaviour has been linked to activation of the HPA axis in certain studies, but not all of them. Higher Cortisol levels after dexamethasone suppression (a clinical marker of HPA axis hyperactivity) and HPA axis hyperactivity at baseline levels may raise the risk of subsequent suicide by up to 14-fold, according to these research (Brown et al., 1982, Coryell & Schlesser, 2001). The link between suicide and larger adrenal glands and less prefrontal cortex CRH binding provides more evidence for the HPA axis' role in suicide (Mann, 2003).

In the suicide brain, levels of brain-derived neurotrophic factor (BDNF) are lower, as are activation and expression of tropomyosin receptor kinase B (TrkB), which binds to BDNF and facilitates its functions. It suggests that in suicidal patients, BDNF function may be impaired (Dwivedi, 2012).

Cholesterol levels**:** In persons with very low cholesterol levels and after decreasing cholesterol through diet, there is a modest rise in the rate of suicide, and maybe suicide attempts and thoughts (Golomb, 1998). Serotonin is also involved in a variety of platelet functions, some of which are disrupted in suicide attempters. The intensity of the most recent suicide attempt coincides with the upregulation of 5-HT2A receptors on the platelets of suicide attempters. In a suicidal vs a non-suicidal group of teenage inpatients, there was a substantial positive link between platelet serotonin transporter density and anger scores, and a negative association between platelet count and trait anxiety (Zalsman, Frisch, Lewis, Michaelovsky, Hermesh, Sher, Nahshoni, Wolovik, Tyano, Apter, & Weizman, 2004).

Suicidal behaviour is characterized by "retroflexed wrath," or the redirection of an angry impulse that was previously directed toward a significant other (e.g., parent, lover), i.e., hostile aggression turned inward (Rado, 1951).

Suicide is said to be triggered by unconscious urges. All suicides, according to Menninger, have three motivations: a desire to kill, especially loved ones; a desire to be killed, which is associated with guilt for having murderous urges; and a desire to die (i.e., depression and hopelessness resulting from factors such as self-hate and habitual restrictions on aggressive impulses) (Menninger, 2007).

According to Beck and colleagues, the diathesis for depressive and suicidal symptoms is made up of cognitive self-schemas that contain specific negative ideas, such as dysfunctional attitudes and cognitive distortions. A person who, after making a single minor blunder during a public speaking engagement, believes that everyone in the audience thinks he is stupid is an example. Beck's paradigm includes hopelessness, as well as the negative triad of negative ideas about oneself, others, and the future (Beck et al., 2006). Suicidal people, like other depressed people, they claim, misinterpret their condition in bad ways. However, because the suicidal individual is despondent about the circumstance, he or she views suicide as the only option.

Rudd described the “suicidal mode,” in which the activation of specific systems of affective, physiological, and behavioral-motivational responses linked with suicidality is accompanied by the triggering of negative attitudes and cognitions. He describes how “compensatory methods” emerge in response to an individual’s unfavourable ideas and rules. The effective component of the

suicidal mode is a variety of mixed dysphoric sentiments that can emerge depending on an individual's beliefs: shame, guilt, sadness, rage, and so on. The behavioural system indicates a proclivity for suicide-related behaviours such as planning, rehearsals, and suicide attempts. Patterns of physiological activation characterize the suicidal mode in the physiological system (Rudd, 2000).

Perception, motivation, emotions, and behavioural and cognitive pain control methods are among the psychological elements that influence pain tolerance. Suicidal people's pain tolerance can be increased, allowing them to commit suicide. An analysis of pain analgesia in the phenomenon of self-harm is then used to introduce the unique links between pain and suicide. According to him, chronic stress causes the development of dissociation tendencies (such as indifference to the body and pain) as well as increased vulnerability to stress. In the face of rising intolerable stress, helplessness, and hopelessness, these qualities may facilitate suicide behaviour (Orbach, 1994).

Suicidal people are thought to be missing in two areas, according to Linehan (1993): the ability to absorb their experiences fully and totally, and the "skillful means" to control impulsive and self-destructive emotions and be effective in interpersonal relations. Excessive passivity and trouble with emotional discomfort are two examples of skill inadequacies (Linehan, 1993).

Suicidal behaviour, according to Mark and Williams, might be interpreted as a cry of sorrow originating from a sense of "entrapment." Suicidal behaviour is driven by a desire to escape the trap rather than a desire to die. The trap is frequently set by one's own mental images, thoughts, and memories, which may resurface as cognition and emotions that captivate one's attention before the individual is even aware of them (Williams, 2004).

Williams suggested; suicidal individuals lack autobiographical memories. It is cognitive ability to retrieve specific autobiographical memory. When presented with a crisis, people who are weak develop more generic memories, which means they have a smaller repertoire of experience to draw on and fewer effective answers. Arie et al. backed up Williams' claim, finding that generalized autobiographical memory is linked to interpersonal problem-solving deficiencies, pessimism, and suicidal behavior (Williams & Williams, 1997, Arie, Apter, Orbach, Yefet, & Zalzman, 2008).

Social-learning models

These findings imply that suicidal behavior can be learnt or fostered through direct or indirect contact with those who engage in it. Suicide "cluster," defined by the Centers for Disease Control and Prevention as "a collection of suicides or suicide attempts that occur closer together in time and space than would typically be expected," is an example of this paradigm. Clusters are most common among teenagers and young adults up to the age of 24, and they only occur infrequently beyond that (Davidson, 1988).

These models use both internal psychological processes and interpersonal dynamics in describing and explaining suicidal behaviour. David Jobes and colleagues described two classes of suicidal individuals:

a) Those with an 'intrapsychic" orientation are focused on their psychological distress, are less drawn to seek treatment than others, lend to be disproportionately male, and may be at higher risk for completed suicide than attempted suicide
b) Those with "intrapsychic" orientation tend to be females, who are more oriented toward the relational aspects of (heir problems, more likely to

seek treatment, and at higher risk for attempted than completed suicide (Jobes, Jacoby, Cimbolic & Hustead, 1997).

Joiner (2006) developed an "Interpersonal- Psychological" theory of attempted and completed suicide. Briefly, according to the theory, the meat dangerous form of suicidal desire is caused by the simultaneous presence of two interpersonal constructs thwarted belongingness (I am alone) and perceived burdensomeness (I am a burden) and further that the capability to engage in suicidal behaviour is separate and completed suicide.

A sense of being burdensome to important others. This does not only include perceptions of being burdensome, but perceived ineffectiveness and negative views of oneself as well. A lack of a sense of belonging or connection with a valued relationship or a group. This can lead to a feeling of being isolated and disconnected, which appears to be an important component of the suicidal mind state (Joiner Jr Van Orden, Witte, Selby, Ribeiro, Lewis & Rudd, 2009).

Durkheim (1897) categorized suicides into four basic types each of which is described by the extent to which individuals were integrated and regulated by the constraining moral forces of society. Egoistic and altruistic suicide arose from the respective under-integration and over-integration of the individual by society. Anomic suicide and fatalistic suicide respectively caused by under- regulation and over-regulation in the society (Beck, Lettieri, Resnik, 1974).This type of suicide occurs when the degree of social integration is low. Individual experiences a sense of meaninglessness, these individuals are internalized into the self-E.g.: Unmarried individuals have higher rates of suicide than married people.

When social integration is loo strong, the individual is literally forced into committing suicide. With Altruistic Suicide, death is deliverance. Altruistic suicide involves an individual whose sense of identity is subordinate to the group or community, and the suicide may represent a sacrifice for the good of the community. E.g.: - policeman dying in the line of duty, suicide bombing, Sati customs (Pape & Hoveyda, 2005).

This occurs in response to a crisis with which a person feels unable to cope and thus uses suicide as a solution. Durkheim introduced the term "anomie" to refer to a societal condition in which pre-existing norms no longer control behaviour because of rapid societal change. The crisis arises because the person is left alone to deal with change, without the benefit of guidance by social convention. E.g.: Suicide from great loss (lay-off)

The individual perceives that his life is, or will be, so restricted by a societal situation that there is no point to living. A person who hangs himself in prison is generally an example of such a suicide. Although Durkheim's theory of suicide has contributed much to the understanding of the phenomenon because of his stress on social rather than on biological or personal factors, the main drawback of the theory is that he has laid too much stress only on one factor, namely social factor and had forgotten or undermined other factors, thereby making his theory defective and only one- sided (Floor, 2010).

Shneidman's psychache theory involves the proposals that the simultaneous presence of three factors is necessary for lethal suicidal behaviour to occur. They are psychache or pain, press, and perturbation.

1. Pain" refers to the individual's subjective experience of emotional

suffering. Shneidman coined the term "psychache" to describe an intense emotional pain that he believes it suffered by all who commit suicide.

2. "Press" involves external influences of any type, which can range from positive forces to overwhelmingly negative pressure.
3. "Perturbation" refers to the person's level of emotional agitation, as well as cognitive constriction (narrowing of the scope of one's thoughts), which contribute to a propensity for impulsive and potentially lethal behaviours. The presence of these factors will create the strongest, and most lethal, level of desire for suicide (Shneidman ES., 1998).

Engel observed that factors at the biological, psychological, and social levels are dynamically interrelated and gave rise to the biopsychosocial approach. Several variants of this approach have been applied to suicidology (George & Engel, 1980).

Susan Blumenthal developed an "overlap" model in which five domains of biopsychosocial risk are conceptualized as circles, and those individuals at the intersection or all five are at highest risk. The five domains include:

a) Psychiatric disorders (e.g.. affective disorders, alcohol and substance abuse, schizophrenia)
b) Personality traits and disorders
c) Psychosocial and environmental factors such as recent major stresses and losses, exposure to suicide, and medical illness
d) Genetic predisposition toward suicide
e) Other biological factors such as decreased serotonin.

Blumenthal reasoned that those multiple domains may interact to lower the threshold for suicidal behaviour, particularly if lethal means are available, but that protective factors (coping skills, hopefulness, social supports) can counteract the negative impact of risk factors (Blumenthal & Kupfer, 1988). Family models have centered primarily on the following areas:

a) Models that implicate poor family communication and problem-solving, including avoidant and hostile communication, at either the family-wide level or the parent-child dyadic level
b) Attachment theory: Attachment-related issues, including separations from or losses of parents, insecure attachment relationships may lead to suicidal behaviour. Suicidal behaviour, in some cases, is presumed to serve an attachment function by eliciting attentiveness from an attachment figure.
c) Psychopathology in the family, which may imply genetic transmission of suicidal behaviour or suicidogenic factors or may serve to promote disturbed parent-child interactions (Wagner, at al, 2012, Holmes, 1993).

This model of suicidal behaviour categories risk factors into proximal and distal and their interaction in the genesis of suicide (Ystgaard, Arensman, Hawton, Madge, van Heeringen, Hewitt, de Wilde, De Leo, & Fekete, 2009, et al., 2009). All persons exposed to stress do not develop suicidal ideation, so this model proposes that there is a biological vulnerability, called diathesis, among individuals which predisposes individual to develop suicide when encountered with stress (Dwivedi, VanHeering, 2012).

Conceptually diathesis is a pre-dispositional factor or a set of factors which makes possible a disordered state to occur. It reflects a constitutional

vulnerability to develop a disorder. The term has been used in a psychiatric context since the 1800s. Theories of schizophrenia brought the stress and diathesis concepts together and the particular terminology of diathesis-stress interaction was developed by Meehl, Bleuler, and Rosenthal in the 1960s. CCurrently, biological traits produced by genetic dispositions arc viewed as diathesis. However recently term "diathesis" has been broadened to include cognitive and social predispositions too that may make a person vulnerable to a disorder such as depression (Dwivedi, 2012, VanHeering, 2012).

Psychosocial crises and psychiatric disorders may represent the stress component of stress-diathesis models of suicidal behaviour. Poverty, unemployment, and social isolation, all are known to be implicated in suicide. Psychiatric disorders can lead to job loss, to the breakup of marriages or relationships, or to the failure to sustain such relationships. Moreover, psychiatric illness and psychosocial adversity often coalesce to increase stress on a person.

Many studies have focused on state-dependent characteristics of psychiatric disorders, such as severity of depression, levels of hopelessness mental pain, and cognitive characteristics. Beck's theory of modes seems to offer a framework for conceptualizing suicidal behaviour. Modes are defined as interconnected networks or cognitive, affective motivational, physiological, and behavioural schemata that are activated simultaneously by relevant environmental events and result in goal-directed behaviour. Mental pain (or "psychache") appears to be emotional and motivational characteristics of meticulous significance in suicidal behaviour (Dwivedi, 2012, VanHeering, 2012, Mann, 2003, Trioster, Holden, 2010).

Genetic effects, childhood abuse, and epigenetic effects may be implicated in the causation of the diathesis to suicidal behaviour. Several studies have certainly shown that reported childhood adversity, such as deprivation and physical or sexual abuse, are risk factors for the development of depression and suicide in the later part of life. However, not all will develop psychopathology following exposure to childhood adversity, indicating the existence of a diathesis in some but not all individuals. Neuroanatomical, physiological, and genomic alterations are also contributors to the long-lasting detrimental effects. Presently available information's imply that the diathesis to suicidal behaviour is continuous. It becomes more marked during the course of the suicidal process that commonly predates completed suicide. Suicide many times preceded by nonfatal suicide attempts, which are commonly recurring with an increasing degree of medical severity, suicidal intent, or lethality of the method used. Information provided by several studies support for a kindling effect on the occurrence of suicide attempts (Dwivedi, 2012, VanHeering, 2012).

Cognitive stress-diathesis model

According to Williams and Pollock (2001), diathesis for suicidal behaviour has been described in cognitive psychological terms, in which suicidal behaviour represents the response to circumstances that has three components:

1. Sensitivity to signals of defeat: An involuntary hypersensitivity to stimuli signalling "loser" status increases the risk that the defeat response will be triggered.
2. Perceived 'no escape': Limited problem-solving abilities may point towards the person that there is no escape from problems or life events.

3. Perceived 'no rescue': The experience of suicidal behaviour is associated with a restricted fluency to come with positive events that might happen in the future. This restricted fluency is reflected not only by the perception that there is no escape but also by the judgment that no rescue is possible in the future. So it is interesting to note mat the fluency of generating positive future events correlates inversely with levels of hopelessness, a core clinical predictor of suicidal behaviour (Dwivedi, 2012, VanHeering, 2012, Pollock, Williams, 2001).

Aggression, impulsivity, and borderline personality disorder may be the result of genetic factors or early life experiences, including a history of physical or sexual abuse. These factors increase the risk of suicide. Psychopathology is necessary but not sufficient factor to account for suicide alone. For better clinical detection, stable risk factors which are present prior to the onset of psychopathology needs to be clarified. Impulsivity is in this context pointed more as a behavioural dimension than as the sudden or fast actions relating to an inability to hold out impulses. Impulsivity does not always include aggressive behaviours, but high levels of impulsivity correlate with high levels of aggression. A correlation between aggression, impulsivity, and hostility has been confirmed in suicide completers using psychological autopsy approaches (Dwivedi, 2012, VanHeering, 2012).

Knowledge level of farmers on suicidal warning signals

Across societies and throughout history, suicide has been condemned as a sin, punished as a crime, pitied as a symptom, or derided as a senseless waste. But though it is often considered deviant, self-destruction may also be a technique of social control. From activists who burn themselves in protest to

criminals who hang themselves in remorse, much suicidal behaviour is a way of expressing grievances and securing redress. In other words, self-killing may be oralistic, belonging to the same sociological family as strikes, boycotts, imprisonment, execution, banishment, gossip, and vengeance (Baumgartner, 1984: Black, 1998: Manning, 2012).

The social logic of moralistic suicide varies from case to case. Usually, however, it combines the characteristics of two elementary forms of social control: avoidance and aggression. First, suicide involves an extreme curtailment of interaction, permanently severing relations between the self-killer and his or her adversaries. In this way it resembles other forms of moralistic voidance, such as divorcing an abusive spouse, ceasing to speak with an obnoxious acquaintance, or resigning from a corrupt organization (Koch, 1974: Baumgartner, 1984: Black, 1998). Secondly, suicide may express hostility and inflict harm upon a wrongdoer. In this way it resembles other forms of moralistic aggression, such as berating an incompetent coworker, beating a disobedient child, or executing a convicted murderer.

Suicide is a source of supernatural pollution in many societies, and in some it is said to unleash forces that punish the self-killer's adversaries. For example, in colonial Tanganyika “When a man has a grievance, and receives no redress, he will, as a final resort, go before the wrongdoer and say, “I shall commit suicide, and rise up as an evil spirit to torment you” (Gouldsbury & Sheane, 1911, quoted in Jeffreys, 1952). The same practice is found in traditional India, where members of the Brahman caste might use suicide to avenge an injury for “it was generally believed that the ghost of such deceased would harass and prosecute the offender” (Thakur, 1963). Similarly, among

Taiwanese farmers "the ghost of a suicide is believed to be particularly powerful and absolutely determined to bring tragedy to the people responsible" (Wolf, 1972).

The suicide of a family member leaves an indelible mark on the survivors, affecting each individual, the family as a whole, and also larger social networks (Cerel, Jordan & Duberstein, 2013). The impact of the suicide is to some extent informed by the family's function or dysfunction prior to the suicide. (Cerel, Jordan, Duberstein, 2013). Moreover, the suicide may affect family communication and the developmental processes of children (Cerel, Jordan, Duberstein, 2013). Marital breakup is also more common in parents of children who died by suicide (Bolton, Au, Leslie, et al., 2013).

Availability of Formal Support Services for Suicidal People

Osafo, Hjelmeland, Akotia, and Knizek (2011a) for example, report that there is a widespread stigma against suicide and suicidal persons. Furthermore, Osafo et al. (2011b, 2013c) report that people refuse to name a child after someone who has attempted suicide or individual who has died through suicide. In addition to these, the attempter is also criminally prosecuted (Adinkrah, 2012). These harmful reactions may expose the suicidal attempter to further traumatic experiences, which could aggravate their perturbation and gradual lethality. In such a cultural setting that has harsh reactions and social attitudes towards suicide and suicidal persons, these reactions might further agitate or perturb the suicidal individual.

A major aftermath of a suicide attempt that makes the experience more distressing than reparative for victims is the negative reactions from significant people in the society (Pompili, Girardi, Ruberto, Kotzalidis, & Tatarelli, 2005).

Attention has also been drawn to the cost effectiveness of harnessing important local resources in this regard since the country presently has a huge shortfall in mental health professionals (Fournier, 2011; Prince et al. 2007; Read, Adiibokah, & Nyame, 2009; Saraceno van Ommeren, Batniji, Cohen, Gureje, Mahoney, & Underhill, 2007). Hence the best situation would be the provision of support services following a suicide attempt from important people in the society such as psychologist.

Additionally, psychologists have been found to be one of the means of bridging this gap (Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund, Doku, & Mhapp Research Programme Consortium, 2010; WHO, 2002) and evidence continues to reveal that religious groups in Ghana are engaged in some form of mental healthcare delivery and a large number of Ghanaians access such services (Ae-Ngibise, et al, 2010; Read et al., 2009). By implication, the theory will help the researcher to find out how the environment of farmers will influence their suicide behaviours.

The approaches used to seek assistance for ailments are imbedded in one's cultural perceptions associated with the origins of the problem and beliefs about remedies. Many victims of suicide depend on self-reliance and solitary coping mechanisms, such as drinking alcohol or meditating; some turn to their families for emotional support, while few seek help from formal services (Klimes-Dougan, Klingbeil & Meller, 2014). For peasant farmers, they may seek the assistance of others by acquiring herbal remedies, acupuncture or the guidance of religious leaders (Ma, 2017; Shin, 2016). As that adhere to collectivist values may adopt specific coping styles and perceptions about suicide (Heppner, 2016). There is evidence that cultural factors may influence

various features of help-seeking, from the identification of a problem to the choice of treatment providers. These views in turn may lead to the differential utilization of mental health services by different ethnic groups for suicide prevention and treatment (Cauce, 2014).

According to the Ghana Criminal Code (1960, Act 29), suicide is a crime. Section 57 of the code reads: "whoever attempts to commit suicide shall be guilty of a misdemeanor." Thus, persons who engage in nonfatal suicidal behaviour are subject to apprehension and prosecution, and upon conviction, are subject to criminal penalties. Compounding the strong legal response is the social reaction where suicide is regarded by all ethnic groups as a reprehensible act (Greene, 2002; Nukunya, 2004). This universal abhorrence of suicidal behaviour stems, largely, from religious interpretations and perceptions of suicide. A significant proportion of the Ghanaian population is devoutly Christian or Muslim, both of which prohibit suicide. For many Christians, suicide is a transgression of God's Law, specifically the Biblical scripture, "Thou shalt not kill" (Exodus, 20:13). This prohibition against killing extends to the self, and those who die by suicide are said to be denied entry to heaven.

In Islam, Okasha and Okasha (2009) observe that for Muslims, "torture in hell awaits the person who takes their own life" (p. 50). Ancestor veneration, prevalent throughout Ghana, carries similarly negative interpretations of suicide. For ancestor worshippers, when a person dies through suicide, their spirit is temporarily or permanently obstructed from traveling directly to the other world to join the ancestors. This disturbed spirit, known in Akan as ɔsaman tw3ntw3n (lingering ghost) haunts the death scene, frightening, albeit incapable of hurting, those it encounters (Konadu, 2007).

Among many Ghanaian ethnic groups, suicidal behaviour carries such a heavy stigma that suicides are denied a proper burial (Greene, 2002; Nukunya, 2004). Myriad other cultural practices further signify the opprobrium reserved for suicidal deaths. These practices also reveal presumptions of the contaminating effects of suicidal behaviour. In some Akan communities, where the victim suicided by hanging from a tree, the tree is felled and burnt after the removal of the body. It is believed that the tree is forever accursed and must be chopped down, lest others hang themselves from it. In some parts of the country the corpse of a person who suicides via hanging is flogged prior to its removal (Dali, 2007). So strong is the belief in the contaminating effects of contact with a suicide victim's body that the living must avoid any contact with it, both physically and symbolically.

Among some ethnic groups in Northern Ghana, when a suicide occurs inside a house or an apartment, the corpse must be removed through a window or a specially created aperture in the wall because conveying the body through the doorway permanently desecrates the doorway for the living (Dali, 2007). In some communities, people who suicide are buried in special cemeteries assigned to people who die "abominable deaths" (Greene, 2002). Suicide negatively impacts the lineage of the suicide long after the death, bringing shame and dishonour upon the entire extended family.

In some instances, the taint is so great that families are treated as outcasts in their community and the young men and women in the family face difficulties obtaining marital suitors. It is presumed that offspring from a marital union with a member of such a family would also suicide in the future. Despite the strong social denunciation and moral censure of suicidal behaviour in

Ghana, there have been select circumstances when it has been pardoned in the society. For example, historically, death by suicide was excused for dealing with extreme shame. One Akan saying asserts, fere3 ne animguase3 de3, afanyinam owuo (it is better to die than endure shame) while another states, animguase3 mfata ɔkani ba (shame or dishonour does not befit the status of an Akan) (Warren, 1973).

Chapter Summary

From the review of literature, no single factor accounts for suicide. The factors associated with suicide are varied and complex and so predicting who will take their life is extremely difficult. Different theories of suicide were able to account for the diverse range of factors associated with suicidal behaviour. There are also several characteristics of suicide, including a sense of unbearable psychological pain, a sense of isolation from others, lack of belonging, feeling trapped and hopeless and a burden on others and the perception that death is the only solution when the individual is temporarily not able to think clearly due to being blinded by overwhelming pain and suffering. In short, suicidal behaviour is influenced by biological, psychosocial, and spiritual factors and hence any prevention efforts should be collaborative in nature.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter presents the method that was used for the study. It focused on the research design, population, sample and sampling procedure, data collection instrument, reliability and validity of the instrument. It also described the data collection procedure, ethical consideration as well as data processing and analysis.

Research Design

The employed the descriptive survey design with a qualitative approach, as the main objective was to explore the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa District of the Upper West Region of Ghana. The descriptive survey design was used because the researcher sought to investigate issues and developments in their natural state with no effort in manipulating any situation or condition in the study. This design was appropriate, in that it pave way for further investigation of similar phenomenon with an advanced design like exploratory sequential. According to Ethridge (2004), descriptive survey design is concerned with the current condition of circumstances, with the researcher having no control over variables. In this case, the study might be defined as an endeavor to determine, characterize, or identify what is, whereas analytical research aims to determine why something is the way it is or how it came to be (Ethridge, 2004). Qualitative research approach was adopted since people understand and relate to things cognitively from

within the mind. According to Silverman (2006), suicide is a complex issue and Hjelmeland (2010) and Colucci (2008) assert that in a cultural environment, a qualitative approach is required in order to understand the meaning people make out of the phenomenon. This design sought to provide contexts, like focus group discussion/one-on-one interviewing, that allow participants to express their beliefs, assumptions, desires and understandings (Willig, 2001).

Qualitative research is valuable for the in-depth study of complex phenomena (Hjelmeland & Knizek, 2010). Additionally, it provides understanding and description of people's personal experiences of phenomena and can therefore generate detailed and rich information on a phenomenon as they are embedded and situated in local contexts. The qualitative researcher is highly sensitive to modifications that occur during the conduct of the research, which broadens its knowledge base. Hence, the qualitative approach would be used to explore the phenomenon under study, which is, suicide among peasant farmers.

In addition, the researcher picked the single method approach to be directed throughout the study and to acquire a holistic understanding of the subject under investigation (qualitative approach). The qualitative method approach is a research methodology that entails gathering, analysing, and integrating qualitative (interviews and focus groups) data into the research topic for the objective of gaining a broad and deep understanding of the research problem.

A qualitative approach, according to Denzin and Lincoln (2000), emphasizes the qualities of entities, processes, and meanings that are not experimentally examined; and Reinard (2008) agreed with Denzin and Lincoln,

stating that a qualitative method of analysis aids an investigator in studying naturally occurring phenomena in all of their complexities. Therefore, since the focus of this research is not to collect many data from respondents in order to quantify results and examined experimentally, this approach became appropriate.

The strength of this research approach lies in the fact that it is capable of seeking rich and detailed information from the respondents and its weakness lies in its inability to generate objective and verifiable information. This approach has different types in conducting a research (Snape and Spencer, 2003; Ogah, 2013). There are different types of qualitative approach to research. These are phenomenology, ethnography, case study, grounded theory and historical research (Ogah, 2013; Tewksbury, 2009; Baron, 2001). However, this capitalised on the phenomenological aspect. According to Qutoshi (2018), phenomenology provides researchers with a theoretical guideline to understand phenomena at the level of subjective reality and this philosophical framework of subjective reality plays a key role in understanding the subject regarding a particular event relating to his/her life.

Study Area

The Nadowli District, which was founded by the District Assemblies Law 1988, included the Daffiama-Bussie-Issa District (Republic of Ghana, 1988). In 2012, the Daffiama-Bussie-Issa District was created from the former Nadowli District by Legislative Instrument 2100, with Issa as its capital (Republic of Ghana, 2012). The district is situated in Ghana's Upper West Region, between the latitudes of 11o 30" and 10o 20" north and the longitudes of 3o 10" and 2o 10" west. The Wa Municipality borders it on the south, the

Nadowli-Kaleo District on the west, the Sissala West District on the north, and the Wa East District on the east In terms of size, it covers a total land area of 1,315.5 square kilometres and extends from the Billi Bridge (four kilometres from Wa) to the Dapuori Bridge (almost 28 kilometres from Nadowli) on the main Wa – Tumu Road and also from west to east it extends from the Black Volta to Daffiama. Issa, the district capital, is 57 kilometres from the regional capital, Wa.

With a total of 5,030 dwellings, the district has a household population of 32,185 people. The district's average household size is 6.4 people per home. Children make up the highest percentage of the household, accounting for 45.8% of the total. Spouses account for 9.2% of the population, while other relatives account for 8.4%. Extended homes (head, spouse(s), children, and heads of relatives) make up 43.9% of all households in the district, with nuclear homes (head, spouse(s), and children) coming in second (19.8%).

About 51.0 percent of the population over the age of 12 is married, while 39.2% has never married. More than three quarters of females (80.1%) are married by the age of 25-29, compared to 49.1% of males. Widowed ladies account for 57.0 percent of those aged 65 and up, whereas widowed males account for only 9.2 percent. 78.3 percent of married people have no education, while 25.1 percent of never married people have never attended school. Approximately 84.3 percent of married people are employed, 1.3 percent are unemployed, and 14.4% are not working. About half of individuals who have never married (51.5%) are unemployed, with 1.1 percent unemployed.

In terms of educational infrastructure, the study area has 34 Early Childhood Care Development Centres, 35 Primary Schools, 22 Junior High

Schools, 1 Senior High Schools, and 2r Technical/Vocational Schools. (DBI Education Directorate, 2019). With regard to agriculture, the DBI District has 10800 peasant farmers (MOFA, 2018).

With regard to health, the DBI district could 0nly boast of 22 health facilities comprising 5 Health Centres and 17 Community-Based Health Planning and Services (CHPS) Compounds without district or specialized hospitals.

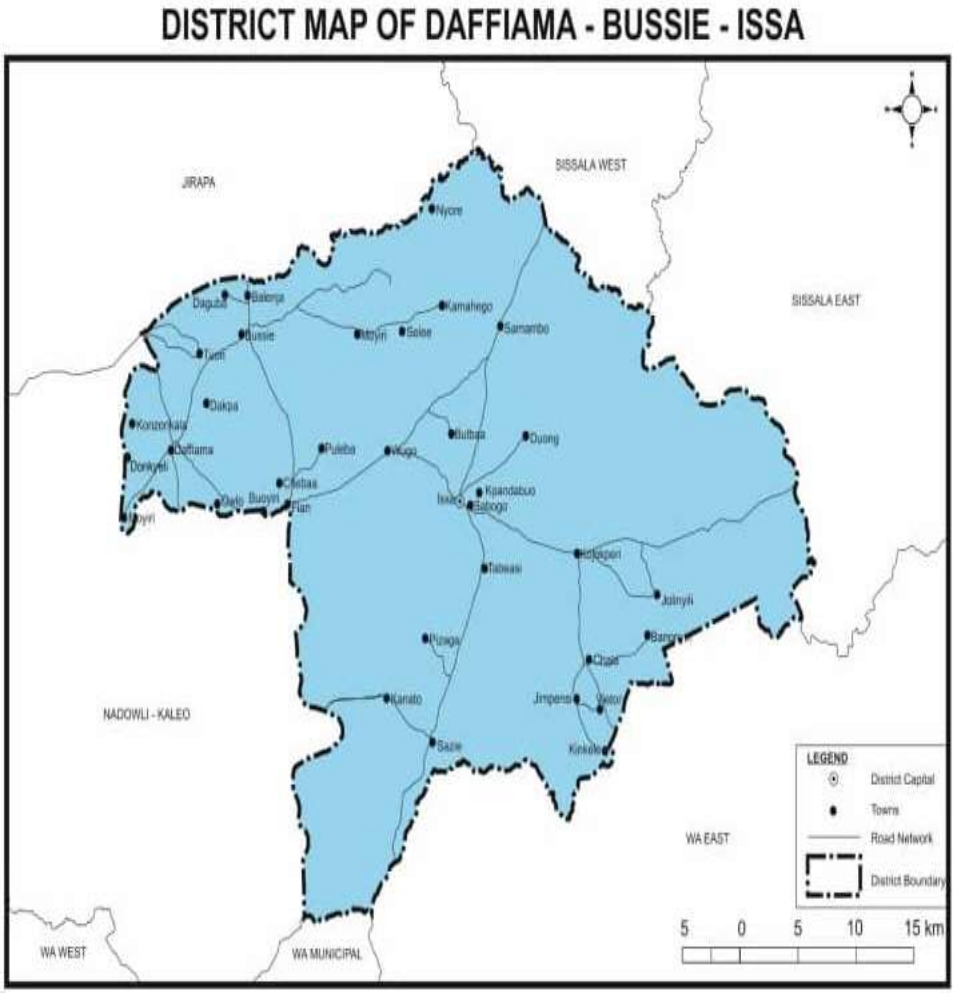

Figure 2-Map of Daffiama-Bussie- Issa
Source: DBI District Assembly (2019)

Population

The study targeted peasant farmers from the Daffiama-Bussie-Issa district estimated at 8,810 as reported by the District Agriculture Office (2019). The accessible population for the study was peasant farmers in the Daffiama-Bussie-Issa District, who have either attempted suicide in their lifetime before (attempt survivors) or have family member(s) whoever attempted or died by suicide. In fact, as of the time collecting data, no information was recorded for this category because affected people usually hide it from public discourse. In this sense, data saturation was considered the best fit for the study. Data saturation, according to Faulkner and Stormy (2017), is the point in the research process when no new information is discovered in data analysis, signalling to researchers that data collecting should be stopped.

Sample and Sampling Procedure

The researcher employed the snowballing technique to select the 20 respondents through data saturation. To Faulkner and Stormy (2017), data saturation occurs when researcher is reasonably assured that further data collection would yield similar results and serve to confirm emerging themes and conclusions and no new cases are identified in a particular time frame. Researchers should disclose how, when, and to what degree they reached data saturation when they may declare that they have acquired enough data to meet their research goal (Faulkner & Stormy, 2017). Furthermore, the saturated sample size met the required sampled for qualitative studies as reported by Creswell (2015). According Creswell (2015), a minimum sample between 5-30 participants for qualitative research is adequate.

Specifically, snowballing sampling technique that was used by the researcher to identify potential subjects in study. The technique was used because no concrete lead was available to help the researcher identify people with the phenomenon under investigation, so initial contact was used as basis to other people with similar situations. Snowball sampling is a methodology for acquiring research subjects in which a first subject is identified and utilized to provide the names of other participants (Lewis-Beck, Bryman, & Futing-Liao, 2004). The benefits of the snowball sampling methodology come from the fact that the chain referral procedure allows the researcher to study populations that are difficult to sample using other approaches. Second, the procedure is inexpensive, straightforward, and cost-effective. Finally, when compared to other sample procedures, this sample methodology requires less planning and a smaller personnel.

Snowball sampling, on the other hand, has the disadvantage of giving the researcher little control over the sample procedure. The subjects that the researcher can recruit are primarily based on the previously observed participants. Furthermore, the sample's representativeness cannot be ensured. The researcher has no notion what the genuine population and sample distributions are. Finally, when utilizing this sample methodology, researchers are concerned about sample bias. Initial subjects are more likely to nominate people they are familiar with. As a result, it's very likely that the sample obtained by the researcher is merely a small subset of the whole population.

Data Collection Instrument

Participants were interviewed in semi-structured in-depth interviews to learn about the elements that they believe led to their suicide attempts, as well

as what aided the shift from suicide thinking to action. Following these questions, participants were asked about suicide planning and what factors influenced their method of choice, as well as their thoughts on present safety planning procedures and suggestions for future safety planning interventions.

Posner et al. (2011) established the Columbia Suicide Severity Rating Scale (CSSRS), which was used for the study. This metric is used to identify and analyze people who are at risk of committing suicide. The questions are designed to be used in an interview setting, but they can also be completed as a self-report measure. A semi-structured interview guide was carved out of the research questions in accordance with the research questions (C-SSRS). The CSSRS is divided into 10 categories, each of which uses binary replies (yes/no) to indicate whether the behaviour is present or absent (suicide). The following are the ten categories covered by the CSSRS: Category 1 – Desire to Die; Category 2 – Nonspecific Active Suicidal Thoughts; Category 3 – Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act; Category 4 – Active Suicidal Ideation with Some Intent to Act, but No Specific Plan; Category 5 – Active Suicidal Ideation with Specific Plan and Intent; Category 6 – Active Suicidal Ideation with Specific Plan and Intent; Preparatory Acts or Behavior; Category 7 – Aborted Suicide Attempt; Category 8 – Interrupted Suicide Attempt; Category 9 – Actual Suicide Attempt (nonfatal); Category 10 – Completed Suicide Attempt.

The first section of the instrument covered the demographic characteristics of the respondents with the other sections capturing questions on the prevalence of suicide in the study area, the Suicidal means adopted by farmers, factors influencing peasant farmers to attempt suicide, the impact of

suicide on the lives of survivors, knowledge level of farmers in recognizing suicidal warning signs and assessment of availability of formal support services.

Pilot Study

The Nadowli-Kaleo district which shares a boundary with the DBI District was used for piloting the study. Ten participants were sampled for this preliminary trial. A pilot study is a small-scale methodological test carried out in advance of a larger study to confirm that methods or ideas would work in practice (Jariath, 2000: van Teijlingen & Hundley, 2002). Because a pilot study has a tiny sample size, it is frequently misunderstood as a small sample study and has been used as an explanation for not having enough data in some studies (Lancaster, 2004). The key aspect of the definition of a pilot study, on the other hand, does define a small-scale study intended to inform a larger study (Jariath, 2000). It suggests that the pilot research is planned from the start of a proposed project and prior to the actual research (Lindquist, 1991; Locke, 2000; Perry, 2001). The most significant advantage of performing a pilot study is that it allows researchers to make changes and updates to the main study.

A pilot study can evaluate a research technique, such as a data collection method and a sample recruitment strategy, and is typically employed as a feasibility study (Muoio, 2005; van Teijlingen and Hundley, 2002). It can also be used to determine whether the proposed research procedure is feasible, taking into account the cultural and political context (Muoio, 2005; van Teijlingen & Hundley, 2002).

Finally, when contrasted to a large multi-project context, piloting decreases the danger of implementing a defective method, technique, or other solution. A pilot study is designed to test a solution component in a confined

and controlled environment before it is approved for widespread use. During the pilot study, researchers find out what can be tentative problem in the final study. So, pilot study gives chance for improvement, equal opportunities for better handling the data collection methods and techniques so that more and more accuracy and efficiency in research can be undertaken.

Validity and Reliability of the Instrument

The validity and reliability of the instruments used in research are always important for data collection and the results to be produced. Validity and reliability, according to Price (2015), are generally complementary ideas. The degree to which a research instrument measures what it claims to measure is known as validity (Neuman, 2014). In any event, validity should be concerned with assessing the precision and effectiveness of the instruments or methodologies used in a given study.

Creswell (2007), identified 8 different strategies used qualitative researchers to ensure the validity of their findings:

First, prolonged engagement and persistent data gathering ensures that the researcher does not draw conclusion based on isolated idiosyncratic experience with the phenomenon.

Second, using rich, thick description ensures that there is sufficient level of detail about the phenomenon studied so that others may draw the same or similar conclusions.

Also, triangulation refers to use of multiple data sources in order to build up a complete picture of the phenomenon.

Furthermore, member checking allows the researcher to present the findings or conclusion to the original participants so that they can comment whether their perspectives are accurately portrayed.

Moreover, presenting discrepant information acknowledges observations or findings that run contrary to the study's key themes.

Additionally, classifying researcher's biases acknowledges those preconceptions or biases that enable the researcher colour the conclusions of the study.

Peer debriefing enlists the aid of a person either than the researcher to review the findings and ensure that they make sense.

Finally, the use of external auditor to review the study's overall magic or coherence and consistency.

Similarly, reliability refers to the degree to which a measurement contains variable mistakes that differ from observation and change over time for a particular unit of analysis recorded twice or more by the same instrument (Price et al., 2015).

The adapted semi-structured interview guide was pre-tested to ensure any aspects of the instruments that were identified as unclear were revised appropriately (Price et al, 2015). As argued by Price et al., (2015), the reliability and validity of data from any research can actually be guaranteed if the data from different sources are crossed checked. Accordingly, the researcher cross checked similar data to be obtained from farmers and those outlined in literature. The semi-structured interview guide was taken through face, content and constructs validity procedures. Firstly, the face validity of the instrument was ascertained by affecting the comments of my supervisors to check the structure,

alignment, lay out and conformation of the research instrument in regards to the research objectives and questions. Also, the views, comments, additions and deletions raised as a result of the pre-testing were effected. Content validity, on the other hand, was ensured with assistance from the supervisors. They (supervisors) examined the research instrument in relation to the research objectives and questions in determination of how well an item measures what it was intended to measure.

Data Collection Procedure

In-person interviews were performed with participants in a private room and locations chosen by them to be comfortable. The length of the interviews ranged from 27 to 45 minutes, with a 32-minute average. For a 30-minute focus group discussion, participants were divided into four groups of five. The researcher conducted all interviews and focus group discussions with the help of three research assistants recruited from the study region. A semi-structured interview guide with closed and open-ended questions was utilized by the interviewers. For expert advice, the content of the interview guide was reviewed with an adult who survived a suicide attempt as an adolescent. All of the interviews began with the interviewer asking participants to talk about a suicide attempt they had made or a suicide attempt a friend or family member had made. This was done on purpose, so that the survivors of the participants' suicide attempts would have the freedom to talk about their experience in a way that seemed authentic and independent. The researcher asked all participants the identical questions throughout their suicide attempt narrative, which provided a structure for counting thematic codes across participants in the analysis. The investigators who conducted the interviews and analyses have a clinical and

research focus on interventions for suicidal peasant farmers and their families; it is important to note that the investigators who conducted the interviews and analyses have a clinical and research focus on interventions for suicidal peasant farmers and their families.

The actual fieldwork lasted for four weeks. Three research assistants were engaged by the study as indicated earlier. The research assistants were trained for three days. The training involved community entry and protocol, research ethics, expected conducts of an interviewer and interpretation of the research instruments. The aim was to ensure uniform translation of the questions to avoid biases. This was because the questions were translated into Dagaare to ensure maximum participation from respondents and for proper expression of views by the respondents. For the questionnaire respondents were asked questions in Daggare and their responses were written in English.

Trustworthiness of the Study

Guba's recommendations of credibility, transferability, dependability and confirmability, the researcher discusses how validity issues were addressed. In dealing with the issue of credibility, the researcher sought to demonstrate a true and clear picture of the menace of suicide within the first and second chapters of the research. In order to guarantee transferability, the researcher went further to provide adequate detail of the need to ensuring credibility of findings in a qualitative research is an important issue. Guided by context of the fieldwork within chapter three of the study. Shenton (2004) put forward that it is difficult to meet the dependability criterion in qualitative research.

Notwithstanding, the researcher in this study has sought to give a clear picture of the phenomenon of suicide, sufficient description of participants

interviewed and the context to enable an investigator to repeat the study in the future. The researcher also demonstrated the confirmability criterion within chapter four of this study in two ways. First, the investigator spent a considerable amount of time and energy in the field after each interview, to check and summarize during the interview process to confirm whether the views of respondents have been rightly recorded. Second, by verbatim trancribing interviews and referencing extracts from interviews done in order to show that findings were derived from the data rather than the researcher's personal biases. In addition, the researcher had multiple rigorous exchanges and inter-subjective talks with his supervisors to ensure that the analysis and interpretations of the data collected from respondents were fair and objective.

These aspects, taken together, provide credibility to the study's reliability.

Ethical Considerations

In research, ethical considerations are crucial. The norms, rules, or conduct that distinguishes between right and wrong are referred to as ethics. They assist in distinguishing between acceptable and undesirable behaviour. To begin with, ethical standards protect against data fabrication or falsification, thereby promoting the core purpose of research: the pursuit of knowledge and truth. Ethical behaviour is particularly important for collaborative work because it fosters a climate of trust, accountability, and mutual respect among scientists (Munhall, 1988). Before data collection, ethical consideration is an essential study in research. According to Oliver (2003), ethical considerations are very essential in research, particularly when human beings are involved; they should be treated with respect, not injured in any way, and fully informed about what is occurring to or with them as part of the study process.

The current study ensured that the work performed adhered to the required ethical concerns as outlined in the APA Ethics Code 2002 (Neuman, 2012). In the course of doing all activities, the researcher evaluated issues of anonymity and confidentiality, informed permission, plagiarism, and proper reporting of findings, just as he would in any other research.

The researcher protected the respondents' identity as well as the confidentiality of the information they supplied. It promised responders that neither the report's users nor readers would be able to identify them or who said what. It further promised them that no one would be held liable for the information they submitted for the study's purposes.

The researcher also emphasized the importance of the informed consent ethic. In this regard, the researcher took all required procedures to inform all respondents of the reason for which the study was being undertaken. He also notified the respondents that they had the option to engage in the study or not. The potential penalties of declining or withdrawing, as well as any potential research benefits, were explained to the respondents. When interviewees' emotions were running high, the researcher used de-breathing to calm them down. The researcher reported and presented its findings in a simple language form for the understanding of every reader. He did not in any way attempt to fabricate any data for any purpose. In accordance with research ethics, the researcher made every effort to avoid false and deceptive declarations and proclamations. All the necessary steps were taken to discover all significant errors in the data analyzed and the necessary steps taken to correct the errors which were detected in the work.

Data Processing and Analysis

The audio-recorded and precisely transcribed data were analyzed using thematic analysis. Working with data, organizing it, breaking it down into manageable components, coding it, synthesizing it, and looking for patterns are all part of the thematic analysis process (Merriam & Associates, 2002). A method for detecting, analyzing, and reporting patterns (themes) within data is thematic analysis (Braun & Clark, 2006). This strategy organizes and summarizes the data set in (rich) detail in the simplest way possible. Thematic analysis delves further into the research topic, interpreting numerous facets of it (Boyatzis, 1998). Other analytic methods that seek to describe patterns across qualitative data, such as thematic data analysis (DA), grounded theory, interpretive phenomenological analysis, and thematic decomposition analysis, require detailed theoretical and technological knowledge, whereas thematic analysis does not. Thematic analysis is a versatile tool. Thematic analysis can provide a rich and detailed yet complex description of data due to its theoretical freedom (Braun & Clarke, 2006).

The transcribed data was read repeatedly which assisted in the easy identification of words, concepts, ideas and themes that appeared recurrently. Themes, words, ideas and concepts that appeared repeatedly in the interviews were compared and cross-checked with other interviews found to be consistent. The analysis involved the preparation of data to be examined by transcribing the interview into text and reading the text to note items of interest in order to gain a sense of the various issues entrenched in the data. Further microanalysis of the data was done by thoroughly reading and examining the text closely, line by line.

Items of interest were categorized into proto-themes after a thorough review of the text, and themes began to form as a result of sorting similar items into categories, as well as researching the proto-themes and attempting to define them. By considering each proto theme individually and re-examining the original data for information relevant to that theme, the text was cautiously re-examined for major episodes of data for each proto theme. In addition, each theme's final shape was reorganized, and the themes' meanings were thoroughly analyzed utilizing all of the sources related to each theme. Each theme's final conclusion, based on all available facts. Finally, each subject was described as well as exemplified with some passages from the original book to help express its meaning. The meaning of the name, definition, and supporting information was re-evaluated for readers.

The information gathered during the interview was coded and organized into topics. Thematic analysis was used to examine the qualitative data. This helped the researchers better understand the participants' perspectives on suicide and the elements that contribute to it. Working with data, organizing it, breaking it down into manageable components, coding it, synthesizing it, and looking for patterns are all part of the thematic analysis process (Merriam & Associates, 2002).

In summary, there were three main processes in the qualitative data analysis: The data was first prepared and organized by the researcher. This involved transcription of interview notes, organization of field notes from observations, and making sure all papers needed for the analysis were present and available. Second, by finding themes, classifying data pieces, and defining categories, the researcher was able to decrease the data. Finally,

qualitative data was presented in descriptive or narrative forms, tables, and visual diagrams, similar to how quantitative data was presented in tables and figures.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the data on demographic characteristics of the respondents, the possible risk factors that push peasant farmers to indulge in suicidal behaviour, the suicidal means adopted by peasant farmers, the impact of suicide on survivors, knowledge levels of peasant farmers in identifying suicidal early warning signals, and availability of formal support services for suicide victims in the Daffiama Bussie Issa District.

The chapter presents the findings based on the data gathered from the field. Basically, the chapter covers the themes that originated from the responses of participants. These themes were carefully structured into meaningful units using the sub-themes derived from them. Upon analysis of the transcribed data, findings were categorized around the major thematic areas: **Suicide Risk Factors**: Health factors, Environmental factors, Historical factors, and spiritual factors.

For ease of reference, codes were used to identify respondents as such: **AS Man/Woman** refers to a male or female attempt survivor, **SS Man/ Woman** refers to a male or female suicide survivor and **OL Man or Woman** refers to a male or female opinion leader.

The researcher reported and presented his findings in a simple language form for the understanding of all the readers of the final piece of work. He did not in any way attempt to fabricate any data or information for any purpose. As

required, the researcher made every effort to avoid false and deceptive declarations and proclamations.

Socio-Demographic Characteristics of Respondents

Table 1 displays results for the demographic background characteristics of the respondents. It was evident that most of them fell between ages 36 to 40 years (52%). As far as sex of the respondents was concerned, most of them were males (75%), indicating a male dominance over the females. It was known that whilst most of them were married (62%), majority of them had no formal education (87%).

Table 1-*Demographic characteristics of the respondents*

Characteristic (n= 20)	Frequency (N)	Percent (%)
Age		
26-30	6	31%
31-35	3	14%
36-40	10	52%
41-45	0	0.0%
46-50	0	0.0%
51-55	1	3%
56 and above	0	0.0%
Gender		
Male	15	75%
Female	5	25%
Marital status		
Single	8	38%
Married	12	62%
Divorced		
Widowed		
Level of Education		
No Formal Education	17	87%
Formal Education	3	13%
Religion		
Christian	8	42%
Muslim	1	5%
Traditionalist	11	53%

Source: Field Survey (2019)

With regard to religious affiliation, majority of them were Traditionalist (53%) with few being Muslims (5%), as can be seen from Table 1. For many Christians, suicide is a transgression of God's Law, specifically the Biblical scripture, "Thou shalt not kill" (Exodus, 20:13). This prohibition against killing extends to the self, and those who die by suicide are said to be denied entry to heaven. With the Traditionalist, it is held that the souls of those who have died by suicide do not reach their ancestors and an interviewee got this to say:

> *"Suicide is a bad luck!!! Any object or thing that is used in committing suicide is defiled and must be destroyed. When one of my uncles hanged himself on a tree that particular tree was cut down and burnt."*

Prevalence of Suicide in DBI District

The study reveals that suicidal ideation, attempted suicide and completed suicide are rampant among peasant farmers in the DBI district. It was also realized that many families are affected psychologically, socially and physically by attempted and completed suicides. In all, certain conditions such as poor mental health, poverty etc. that predict suicidal tendencies were discovered to have been rampant in the study area (DBI).

Possible Risk Factors

The study reveals that there was no single cause for suicide. It was realized that suicide most often occurs when stressors and health issues converge to create an experience of hopelessness and despair. Undiagnosed or untreated depression was seen as the most common condition associated with suicide. The major themes discovered here include; Health factor,

Environmental Factors and Historical Factors. The sub-themes under health factors are:

Mental health conditions such as depression, substance use problems, bipolar disorder, schizophrenia, personality traits of aggression, mood changes and poor relationship. The rest are conduct disorder, anxiety disorders serious or chronic health conditions and/or pain, traumatic head injury etc.

Sub-themes under environmental factors comprised:

1. Access to lethal means including firearms, drugs or poison etc.
2. Prolonged stress, such as harassment bullying, relationship problems, unemployment etc.
3. Stressful life events, which included a death of a loved one, divorce and job loss.
4. Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide.

The last but not least, the study broke historical factors into the following sub-themes;

1. Previous suicide attempts
2. Family history of suicide and
3. Childhood abuse, neglect or trauma.

Knowledge level of farmers on identifying suicidal warning Signs

According to the study, something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviours. This was of tremendous interest to the research since ability to recognize early warning signal plays a significant role in effective prevention

strategies. Also, this is of sharpest concern if the new or changed behavior is related to a painful event, loss, or change.

The major themes identified under this research objective are talk, behavior and mood.

Talk:

It was discovered that most suicidal persons constantly talk about:

1. Killing themselves
2. Feeling hopeless
3. Having no reason to live.
4. Being a burden to others
5. Feeling trapped and
6. Unbearable pain

Behaviour:

Under this, behaviours that may signal risk, especially if related to a painful event, loss or change were on the spotlight: Examples of such behaviours include:

1. Increased use of alcohol or drugs
2. Looking for a way to end their lives, such as buying a gun, a rope, poison or drugs.
3. Withdrawing from activities.
4. Isolating from family and friends
5. Sleeping too much or too little
6. Visiting or calling people to say goodbye.
7. Giving away prized possession
8. Aggression and

9. Fatigue

Mood:

The study further reveals that people who are considering suicide often display one or more of the following moods;

1. Depression
2. Anxiety
3. Loss of interest
4. Irritability
5. Humiliation
6. Agitation and
7. Rage

Methods used in Committing Suicide in DBI District

Poisoning was the most frequent method in suicide attempters, while hanging was the most common method among suicide completers in the DBI district. The study also found the use of firearms, sharp objects, drawing, jumping from tall trees among others as methods used by farmers in committing suicide in the study area. The study further found that the choice of a particular method was subject to the availability but not based on preference and that interventions to restrict access to more lethal suicidal methods could be a useful strategy to reduce the suicide rates in the DBI district as well as Ghana at large.

Impact of Suicide on Survors in the DBI District

The study reveals a very interesting dimension as far as the impact of suicide on survivors is concern. It was discovered that for a suicide survivor, there could be feelings of rejection, abandonment, and/or personal diminishment (lowered self-esteem, shattered self-worth, and feelings of

inadequacy, deficiency, failure and even guilt), and anger. The major themes identified include:

1. Shrouded in silence
2. Guilt and blame
3. Rumination and anger
4. Complicated Grief and Depression
5. Mental and physical health sequelae

Availability of Formal Support Systems

On the availability of formal support services for suicidal people in the DBI district, the study badly exposed a deplorable health delivery systems, lack of effective Birth and Death Registry, lack of social support including professional counseling and psychotherapeutic services. The DBI district ever since it was created cannot boast of a district hospital or a single qualified medical doctor/psychiatrist. This situation makes it very difficult if not impossible finding help for psychologically distressed people, victims of self-harm as well as compiling data on suicide for any meaningful intervention or prevention. The researcher is of the view that the unavailability of formal support services for suicidal persons in the DBI district does no only fuel the stigma and pain but also increase the number of fatalities.

Thematic Framework for the study

Table 2 displays summary of major themes that were derived from the study. These themes are grouped according to the study objectives.

Table 2-*Thematic Framework for the study*

Objective	Thematic issues from the study
Prevalence of suicide in the DBI district.	1. Suicide ideations and behaviors are rampant in the DBI district. 2. Many families in DBI district are affected by attempted and completed suicide. 3. Conditions that predict suicidal ideation and behavior are highly available in the DBI district.
Risk factors that push peasant farmers to engage in suicidal behavior in the DBI district.	1. Mental and chronic physical health conditions. 2. Environmental factors such as access to lethal means, stressful life events and cultural acceptability of self-harm. 3. Historical factors including exposure to another person's suicide, previous suicide attempts, family history of suicide and childhood abuse, neglect or trauma.
Suicidal means adopted by peasant farmers in DBI district.	1. Hanging 2. Chemical poisoning 3. Use of firearms
Impact of suicide on survivors.	1. Complicated grief and depression 2. Rumination and anger 3. Guilt and blame
Assessment of farmer's knowledge on early warning signs of suicide.	1. Talk about killing oneself/ feeling hopeless/ having no reason to live, being a burden, feeling trapped and unbearable pain. 2. Behaviors such as increased alcohol or drug use, looking for a way to end their lives, visiting or calling people to say goodbye, giving away prized possessions among others. 3. Moods such as depression, anxiety, agitation, humiliation, loss of interest and irritability are common among people who are suicidal.

Table 2: Continued

Availability of formal support services for suicidal people in the DBI district.	1. Poor mental and physical health delivery systems in the DBI district. 2. Lack of efficient Birth and Deaths Registry affecting reliable data allocation. 3. Poor legislation on suicide as well as inappropriate media reportage.

Source: Fieldwork (2019)

Risk factors that push peasant farmers to indulge in suicidal behaviour

Suicide is a multi-factorial problem which cannot be viewed uni-dimensionally. Although suicidal behaviour can be viewed from different academic/disciplinary angles, the term "risk factors" has emerged theoretically to encompass possible factors that accounts for suicidal behaviours at varying degrees (WHO, 2002). This can be grouped into societal/stressful events or "psychosocial problems", psychiatric problems, access to means, and a history of past attempts (WHO, 2002).

Cultural cause

The most possible risk factor pushing peasant farmers to indulge in suicide activities was due to cultural problem. Most of them were of the view that suicidal activities are related to cultural problems as one of them vividly affirmed that "kuu sie la vi neng nyaaba" (meaning better dead than dishonoured). This was what one of the discussants have to share…." *Immediately you break certain taboos in this community, you either banish yourself from here or you kill yourself in order to pacify the gods".*

The implication here is that the decision to take one's own life in a particular context may be depended on the cultural acceptability of the action as well as the motive behind the decision.

During focus group discussion, it was emerged that engaging in unholy sexual activity especially, with another person's wife on the farm, or engaging in malevolent practices such as causing the death of another person either physically or spiritually could qualify one for suicide. An respondent said, " *in this community when you break certain taboos the elders will either banish you from the community or you are already given the option to banish or kill yourself" (**OL Man, 54**).*

Psychological cause

Also, about one-third of the respondents indicated that peasant farmers engage in suicide as a result of psychosocial problems. Some of them also argued that risk factors among peasant farmers emanate from psychiatric problems. According to them, such a person might resort to alcoholism and drug abuse or increase their chance to depression, schizophrenia, hopelessness and other ailments.

During a face-to-face interview a respondent clearly stated that:

> "…. *sometimes you take loan and invest all your resources on the farm but harvest nothing to feed your family due to unpredictable rainfall. Such a thing becomes heavy burden to bear, as such, is it not better if you just die…" (**AS Man, 40 years**).*

The views shared by the respondents imply that, the inability to provide materially for the family after several frustrated efforts on the farm could result in suicidal behaviour. Therefore, the unbearable hardship and financial indebtedness to individuals and financial institutions orchestrated by unpredictable rainfall constitute an environmental risk factor of suicide among peasant farmers. This was affirmed by studies by Kenedy and King (2014) which noted that volatile rainfall patterns lead to lower farm income

and unequal income distribution which is a panacea for suicide in many agricultural communities. Similarly, Mpiana (2004) found that psychiatric problems, such as depression and other mood disorders, schizophrenia and a general sense of hopelessness also play important roles. Physical illnesses, especially those which are painful or disabling, are also important factors contributing to suicide (Mpiana, 2004).

General health cause

In line with the fact that suicidal behaviour could be determined by mental stress as purported by the respondents, in some cases, suicidal behaviours originate from health reason. Aside that, some of the respondents held that, whatever are the causes of suicidal behaviour, in most cases victims' families do not report the menace to appropriate agencies. One of them had these to say:

> *".....though only few suicide cases are being reported at our health facilities, the statistics for depression, schizophrenia and substance abuse which are major predictors of suicide have always been skyrocketing..."(**OL Woman, 50 years**).'*

This signifies that suicidal behaviour could be influenced by health factors. Additionally, it implies that suicide might have been rampant but often under reported to health facilities and other formal support systems which is not desirable. This could jeopardise the fight against suicide since policy makers and appropriate bodies responsible dealing with suicide cases might not have much insight about the phenomenon.

Spiritual cause

While others attributed suicidal behaviour to health and mental issues which could be explained scientifically, some of the respondents attributed

suicidal behaviours to spiritual reasons. To them, they perceived suicidal behavours have spiritual underpinnings. They were of the view that, the phenomenon should not be revisiting current generation if it wasn't spiritual manipulations blackening it. A respondent had this to say:

> "…*I used to see some funny evil spirits instructing me to kill myself and that was why I attempted killing myself in two occasions. I however, believe some evil spirits must be responsible for my suicidality. But now I have given them to God I know those witches and devils will surely be punished by the gods and my ancestors. I am not the first person in our family this is happening to, one of my uncles also kill him when I was still a child. I was traumatized when I saw him hanging on a tree (**AS Woman, 51 years**).*

Another participant also got this to say:

> *"….my mother is not the first person who committed suicide in our family. When I was a child, one of my uncles also attempted killing himself many times until he finally killed himself…" (**SS Man, 55 years**).*

During the Intercultural Development Inventory (IDIs), many participants still maintained that although diverse views could account for suicidal behaviours, however, spiritual factors leading to suicidal behaviours stand tall. A participant clearly put it this way:

> "…*it is not possible for anybody to kill himself or herself I think Satan is behind. I believe suicidal behaviour could be a punishment from the gods for sins committed by victims or their family members…" (**SS Man, 36 years**).*

It can be inferred from the respondents' point of view that, there are spiritual forces that cause the hallucination rather than it being a mental or health problem. That is, spirituality remains a dominant factor in discussions concerning suicide in the study area. With such a perception, it could be

reasoned that such respondents could seek help from spiritualist than resorting to medical advice. The results also support the notion that suicide tends to run in families and that previous suicide attempt or experience is also a predictor of future suicide.

Socio-environmental cause

However, it was evident from the focus group discussions that no single risk factor could explain the occurrence of suicidal behaviour. Some of the respondents solidly expressed that, multiple factors that are socio-environmental in nature such as farm destruction, unpredictable weather, lack of government social interventions, lack of credit, lack of access to quality mental health systems among others are to be blamed for increase suicide rates among farmers. For instance, an opinion leader said:

> "*…. there are several factors that make peasant farmers engage in suicide. Sometimes, you fall ill as a farmer and you do not have any money to engage people to farm for you or when you even borrow money to invest in your farm the rains will fail to come resulting in low output from the farm. Other times too pests and diseases attack and destroy our crops and animals. In situations like these is it not better if you just kill yourself than to face the disgrace of not being able to feed your family…" (**OL Man, 50 years).***

The results support the assertion by Cvinar (2005) that multiple factors are responsible for farmer suicide and that suicide may be an escape from unbearable economic hardship as well as from eminent shame and guilt.

Unavailability of social support services

Lastly, even though a sizeable number of peasant farmers in the Daffiama-Bussie-Issa district do not engage in suicidal behaviour, majority of respondents have ever engaged in non-suicidal self-injurious acts which is

a predictor of suicide. They either used pesticide containers to fetch polluted water for drinking at farms. Others also had less education about the use of certain farm tools. As such, they sustained injuries when applying those tools. This assertion was confirmed during both face-to-face and focus group discussion where many participants revealed that they have been drinking water from containers that were initially used in storing poisonous chemicals. Some respondents also said they have been exposed to dangerous activities on their farm that regularly result in self-cutting, self-mutilation and bone fracture. One respondent said;

> *"…some of us farmers do not have potable water at our farm hence we are sometimes compelled to use the empty chemical containers to drink water from polluted ponds and rivers while working on our farm."*

Another interviewee reveals that; *"I got asleep while resting on top of a tall tree on my farm. I nearly died. I had a fractured leg and was treated at a local bone clinic (**AS Man, 40**)."* During the focus group discussions, many participants narrated how they sustained various degree of injuries through careless handling of sharp objects on the farm. An interviewee said; *"I sustain a cut while trying testing to see how sharp my knife was."*

Suicidal means/methods adopted by Peasant Farmers in DBI district

In the analysis of data on suicidal means adopted by peasant farmers, three sub-themes were generated from the data. They include poisoning, hanging and firing (use of firearm). Suicidal means include poisoning, use of firearm and hanging.

Pesticide poisoning

The most predominant means suggested by the women was poisoning. Seven of them had ever thought of swallowing poisons to end their lives while the rest of the three who have ever contemplated suicide thought of hanging themselves from a rope. One of them had attempted to kill herself by means of poisoning. She swallowed the poison and slept off hoping to sleep forever and not to wake up again. Fortunately for her, she woke up without much harm to her apart from the feeling of dizziness. Though those that attempted committing suicide but survived initially thought of adopting other means rather than their previous strategies. However, they ended up using pesticide poisoning as means of killing themselves since it was readily available at the time of their suicide attempt. An interviewee once attested that:

> "…*I bought the chemical purposely to control pests and diseases on my beans farm, but something was telling me to use it to kill myself. I kept on hearing the voice whenever I saw the chemicals…" (**AS Man, 44 years**).*

This was what one of the participants have to share:

> *Sometimes, I feel like poisoning myself so that I would die (**AS Woman, 45**): I tried doing it with poison. I went to buy some poison. It was even meant for rats, so I mixed it with some medicines and I took it. It was. I was feeling dizzy, my eyes were going like this (demonstrating dizziness with her eyeballs) so I said oh then bye-bye. I locked me. My mum had gone to church, so I locked myself up. I slept off. My mum came, opened the door and called me several times. I said ah mum, am I dead?*

The results is in line with findings by Behere and Rathod, (2006) and Chowdhary et al., (2007) findings which both identified that, due to the easy availability of pesticide and lack of education and efforts on the part of the system to train farmers in safe use of it, pesticide consumption was the most common method of committing suicide in India (Behere & Rathod, 2006, Chowdhary, Banerjee et al., 2007). Pesticides are often widely available and poorly controlled in rural areas, particularly poorer families mostly found in low- and middle- income countries (Gunnell, Eddleston, 2003, Gunnell, Eddleston, Philips, Konradsen, 2007).

On policy wise, in as much as pesticides should be made available to farmers, authorities need to regulate it. Theoretically, if individuals are perturb, pressed and go through pains could lead to building a desire for suicide (Shneidman, 1998). As such, educating farmers to be resilient in life, making counselling services available to them during harsh times and building their self-esteem could help build them to face and accept realities in life without necessarily committing suicide.

Firearm (use of firearm)

Furthermore, some of the participants mentioned the use of firearms. They perceive that with just a gun shot, they can end up with life and worries they are facing. The excerpt is some of the views expressed by some of the respondents.

> **"….** *two of my closed family members ever shot and killed themselves some years ago and my biological brother attempted shooting himself to death severally. He used to threaten us with the gun whenever we tried rescuing him, but we managed to confiscate and hide the gun* **(SS Woman, 40 years).**

The result implies that, if firearms are made available to anyone including farmers, it creates more danger to the individual and threatens security as well since holders of such arms can use it negatively. Therefore, conscious effort has to be done by authorities to control firearms in order to reduce suicide and rest of negative acts that employ firearms in our society. This has been corroborated in a UK based study which noted that there were lower incidence of fire arms usage as a method of suicide due to a decline in farmers' suicide after introduction of legislation on fire arm purchase, storage and registration in 1989 (Walker & Walker, 1988).

Hanging (using rope)

Some of the respondents also indicated that, both firearms and pesticide poisoning are to some extent expensive as compared to using ropes. As such, they resorted to hanging themselves with a rope. One of them that tried hanging himself to death but survived said:

> *"I hanged myself on a tree and the branch of the tree broke and I fell sustaining some severe injuries"*

Coping Strategies

Peasant farmers sometimes had suicidal thoughts, however, they found different ways of coping with it to stay alive. The coping strategies were geared towards encouraging themselves. The present study observed that different coping strategies were adopted by the farmers. They are: self-reliance/solitary coping mechanism; counselling; relying on faith; prayers; support from relative; and formal support services.

Self-reliance/Solitary coping mechanisms

In this study, it was evident that some of the respondents adopted self-reliance/Solitary coping mechanism. This approach used by respondents in

seeking assistance for ailments appear to be imbedded in their cultural perceptions associated with the origins of the problem (suicide) and beliefs about possible remedies. To some of them, they decided to cope with their worries alone to avoid others know whatever they are going through. They do that either by becoming reserved or retreating themselves from societal arena, secluding themselves from collective living, alcoholism and others. An attempt survivor indicated:

> *"…. I take into alcohol drinking whenever I experience self-harm but now it is ineffective. Currently I smoke or take some medicine in order to manage the situation. Sometimes too, I sit somewhere alone and think about myself* ***(SS Woman, 37).***

This was corroborated by another attempt survivor when he said:

> *"… drinking, smoking and taking of drugs are no longer effective for me. The thoughts about killing myself keep coming even more when I smoke, drink, or use drugs, I can't sleep. Now I always sit somewhere I think about myself* ***(SS, Man 28).***

The deduction is that peasant farmers who are suicidal engage in self-reliance and solitary coping strategies which may even lead some to acquire addictive behaviours.

Counseling

The present study noted that, most of the farmers resorted to counselling when faced with difficulties related to their lives. They mentioned that, through the advice received from respectable and noble personalities in their communities, they were able to tolerate harsh conditions such as losing farm from burning or devastating weather conditions. Others also posit that they refrained from attempting suicide through the words of encouragement obtained

from their social cycles and influential others in their communities. In some cases too, the respondents wished to access the services of psychologist, psychiatrists and professional counsellors but to no avail since the DBI district lacks such expertise.The excerpts display the views of some of them about the using counselling as a coping strategy:

> "… *Prior to hospitalization, I thought referring to psychologist or a psychiatrist means that man must be crazy ... I am not crazy ... But now I know, I have many problems and I need help ... and that their professional approach and advice are based on science and compassion.one other problem is that we do not have such qualified professionals here to help us manage distre." (**AS Man, 52).***

> *I lost everything…my farm, everything I planted because of wild fire. I left the farm in a devastating state. When I return home, there was tears all over my face. But my community members have been assistive to me. They comforted me and advise me to work hard because that was not an end to my life. In fact, their words helped me a lot (**AS Man, 53).***

Suicidal symptoms, risk, and behaviors are common among patients in mental health centers due to the prevalence of mental disorders and other risk factors. There is some evidence, which indicates receiving professional support, that plays a significant role in preventing suicidal attempts. Therefore, mental health professionals, particularly those in farm settings, need to get involved in screening such individuals to help reduce suicide and non-fatal suicidal behavior among farmers.

Relying on Faith

Most of the women also mentioned relying on their faith they have in God as their coping strategy. Some of them shared that, it is God who gives and

takes back everything given to humankind. Others also shared that, there is a reason for whatever happens to them and that, in all things, thanks should be given to God. A participant who lost her farm described how she strongly relied on her faith in God which prevented her from attempting suicide said that:

> *Hmmm...My brother, it was not easy losing everything. I went to the farm to witness everything burnt to ashes. On my way home, I thought of only one thing, thus, committing suicide. But I had a second thought that God knows why these things are happening to me and He [God] can turn things around to favour me the next years ahead of me…*
>
> *...Nothing is too hard for the Lord. Though I couldn't reap anything that year but I didn't gave up because I knew God could safe me. I know God listens to our cries so that day, although I was worried, but I knew the God I serve. I knew God would not disappoint me…although I was having a negative, I didn't do it.*

In a focus group interaction with participants, it was revealed that faith served as a panacea for suicide prevention. An opinion leader categorically stated:

> "*…there is the need for spiritual cleansing of people who engage in suicidal behaviour in order to purify them from the demons and evil spirits who constantly instruct these vulnerable people to engage in self-injurious acts****..."(OL,Man 57).***

This was supported by an attempt survivor who said:

> *"....I was personally taken through some exorcism both in the traditional shrine and at some prayer camps".*

Suicide is a transgression of God's Law. Specifically, the Biblical scripture, "Thou shalt not kill" (Exodus, 20:13) is against suicide. This prohibition against killing extends to the self, and those who die by suicide are said to be denied entry to heaven. In Islam, Okasha and Okasha (2009) observed that for Muslims, "torture in hell awaits the person who takes their own life" (p. 50).Practically, it can be inferred that the respondents valued their lives and rated God who created human and give life as omnipresence God who can bless them in future. Partly, due to their faith in God shall prevent them from committing suicide since the act is detestable and uncalled for on the sight of God. This universal abhorrence of suicidal behaviour stems, largely, from religious interpretations and perceptions of suicide. On a legal sense, according to the Ghana Criminal Code (1960, Act 29), suicide is a crime. Section 57 of the code reads: "whoever attempts to commit suicide shall be guilty of a misdemeanor." Thus, persons who engage in nonfatal suicidal behaviour are subject to apprehension and prosecution, and upon conviction, are subject to criminal penalties. Compounding the strong legal response is the social reaction where suicide is regarded by all ethnic groups as a reprehensible act (Greene, 2002; Nukunya, 2004).

Prayers

In this study, several farmers also indicated that prayers helped them cope with daily challenges and survive. They mentioned the benefits of prayer as a first line of defense. One woman who was sexually assaulted while working on the farm remarked, *"If we didn't pray about all the different situations in our life, yeah, we'd probably be doing a lot of harm to ourselves*."

Another woman who had never attempted suicide expressed what actions she would take if she began to have thoughts of killing herself: *"I'd pray first. Then I would call somebody*." A survivor of domestic violence explained, " *I Pray because prayer is the key to all problems and sometimes that's all you have*." Participants also described using prayer to keep feeling good about themselves when challenged. They mentioned the prosocial impact of religion and prayer, emphasizing how it helped them to help others. The potential long-term effects of prayer were captured by a survivor of survivors of suicide who stated, "*I can pray to God and get peace and joy and then, when I read my Bible, I feel happy."*

Support from Relatives

Some of the farmers recounted how fortunate there they to have some relatives who were willing to support them cope with activities of daily living and that reduced their stress to a large extent. Some of the relatives that respondents recounted to have assisted them were sisters and mothers. From the perspective of some the respondents, it was their mothers that gave them a helping hand when they went through difficulties. Such respondents mentioned that their mothers assisted them throughout their lifetime. A respondent had these to say:

> *I have my mother with me whom I consider my all. My mother is like my husband, my sibling, confidant and everything. My mother is the one who has helped me cope with everything. Had it not been my mother I wouldn't have known what could have happened to me…*(SS Woman 40)

Others also expressed that, it the invaluable support they had from their sisters kept them alive. They recounted that their sisters were very assistive

when they encountered disastrous and unpalatable issues in their life. To them, such help assisted them to reduce their depression. One of them got these to say:

> *We are four in all [referring to the number of her siblings]. I must admit that they have helped me a lot. That person [referring to her sister] helped me a lot. She had pity on me so she came to stay with me for some time. Her company really reduced my stress and depression…* (AS Man 25)

Another respondent stated:

> "……*I rely on my wife, children and other extended family members for support during feeling of hopelessness, worthlessness and suicidal ideation. Sometimes too my church leaders and other members as well as friends give me hope.*

The results support the assertions of Ma (2017) and Shin (2016) who opined that for peasant farmers, they may seek the assistance of others by acquiring herbal remedies, acupuncture or the guidance of religious leaders (Ma, 2017; Shin, 2016). As that adhere to collectivist values may adopt specific coping styles and perceptions about suicide (Heppner, 2016). Some scholars remarked that cultural factors may influence various features of help-seeking, from the identification of a problem to the choice of treatment providers. These views in turn may lead to the differential utilization of mental health services by different ethnic groups for suicide prevention and treatment (Cauce, 2014). It can therefore be inferred that respondents might seek help from any relatives depending on her cultural values.

The impact of suicide on survivors in the study community

From the data gathered in the study area, the impact of suicide on survivors and their relatives is overwhelming. Relating suicide-bereaved (SB) families to other bereaved groups found that SB families report higher levels of

rejection, shame, stigma, the need to conceal the loved one's cause of death, and blaming. It is compounded with the sense of stigma as there is frequent feeling that you could or should have done something to prevent it. In line with this, 37% agreed that the impact of suicide brings rumination and anger, 31% attested that suicide is a vehicle for guilt and blame whereas 20% felt that suicide complicate grief and depression to the family. In furtherance, 4% and 8% argued that suicide was shrouded in silence and that survivors were exposed to mental and physical health sequel respectively.

Analysis of the transcribed data revealed that suicide was shrouded in secrecy in the Daffiama-Bussie-Issa District. In fact, this view was corroborated by an interviewee when he indicated that:

> "…..*it is very difficult telling anyone the cause of death of my relatives who died by suicide for fear of shame, stigma and rejection. Some people upon hearing your relative death by suicide gossip about you, the bereaved family members blaming them for failure to prevent the suicide. Sometimes, we as suicide survivors also need social support to overcome the loss but we could not disclose to anyone due to the perceived stigma, guilt, shame and rejection attached to the death…" we are also afraid to make an official report to the police since attempting suicide is a crime under the Ghanaian law" (**SS Woman, 43 years**).*

This falls in line with the findings of Cerel, Jordan and Duberstein (2013) that suicide of a family member leaves an indelible mark on the survivors, affecting each individual, the family as a whole, and also larger social networks. The impact of the suicide is to some extent informed by the family's function or dysfunction prior to the suicide, moreover, the suicide may affect family communication and the developmental processes of children and marital breakup is also more common in parents of children who

died by suicide.

The logical deduction here is that suicide is still shrouded in silence in Ghana**.** A literature review comparing suicide-bereaved (SB) families to other bereaved groups found that SB families report higher levels of rejection, shame, stigma, the need to conceal the loved one's cause of death, and blaming (Sveen & Walby, 2008). Stigma may derive from a "societal perception that the act of suicide is a failure by the victim and the family to deal with some emotional issue." (Cvinar, 2005). Stigma and shame are barriers to seeking help and receiving support from mental health professionals as well as friends and family (Kučukalić & Kučukalić, 2017). During both face-to-face and focus group interactions, participants genuinely communicated to the researchers how they as suicide survivors often experience feelings of guilt overlap with shame. One participant has this to say:

> *"…I often experience intense guilt and even feelings of responsibility for the death of my loved one who died by suicide. In fact, I always feel I could have prevented this painful loss. I blame myself unabatedly…"* ***(SS Man, 39 years).***

This implies that farmers in Daffiama-Bussie-Issa District experience guilt and shame when they lost a loved one through suicide.

On this score an interviewee observed that:

> "……*it appears when a person dies of any disease, relatives do not often wonder why the death occurred but in suicide, family members and friends are confused as to why their relative died. The death is usually characterised with the question, "why, why, why"?*

A suicide survivor corroborated this assertion when she said *"we are really in total shock because he appeared to be doing well. Why did he do this to me and the children, Did he really love us?" She asked?*

The implication is that, any death connected to suicide is characterised by rumination and anger in the Daffiama-Bussie-Issa District.

One other respondent reveals during a face-to-face session:

> "*…this is the most painful death that ever happens to anyone I can't bear it. I really can't overcome the loss. But I blame myself I could have done something to prevent it. I miss him dearly and I continue to watch his pictures every day and wrap his clothes around my body just to feel his presence in my life. Hmmm….I feel pains all the time. Nothing looks pleasurable to me. I can't eat and I can't sleep".*

The implication here is that, suicide survivors go through complicated grief and depression.

A respondent added:

> "*…..ever since we lost him through suicide, the children and I continue to feel anxious and experiences of flashbacks of the scene especially the gory nature of the incident. We feel worthless and sometimes wish I could have also ended it all. But for my children, life is really not worth living anymore. Hmmmmm….how long are we going to experience such unbearable bodily pains? God is our comforter…."* ***(SS Woman, 54).***

This also supports the position of Zook (2018) that "opening a dialogue and talking to patients who have lost someone to suicide to normalize it, in a sense meaning, to normalize their reactions, let them know how difficult it can be to talk about, and educate the person about lingering feelings, such as self-blame."

The implication here is that, suicide survivors go through mental and physical

problems and that upon all these problems, survivors still rely on God for support.

The accrued results further support the assertions that survivors are themselves at high risk for suicidal thoughts or completed suicide (Jordan, 2017). Similarly to my study, a study of 3432 young adults who had lost close friends or family members to suicide found they had a higher probability of attempting suicide than individuals bereaved by deaths due to sudden, natural causes. Of note, the effects of SB was similar regardless of whether bereaved participants were or were not blood-related to the deceased (Pitman, Osborn, Rantell, & King, 2016).

Supporting the present study, one study found that one-quarter of people bereaved by suicide experience elevated levels of depression and stress and close to one-fifth have elevated levels of anxiety, (Spillane, Matvienko-Sika, Larkin, Corcoran, & Arensman, 2018) as well as posttraumatic stress disorder (PTSD) and impairment in social and employment settings (Tal, Mauro & Reynolds, 2017).

Availability of formal support services for suicidal people

The approaches used to seek assistance for ailments are imbedded in one's cultural perceptions associated with the origins of the problem and beliefs about remedies: some depend on self-reliance and solitary coping mechanisms, such as drinking alcohol or meditating; some turn to their families for emotional support, while some seek help from formal services (Klimes-Dougan, Klingbeil & Meller, 2014). For peasant farmers, they may seek the assistance of others by acquiring herbal remedies, acupuncture or the guidance of religious leaders (Ma, 2017; Shin, 2016). As that adhere to collectivist values may adopt specific

coping styles and perceptions about suicide (Heppner, 2016). There is evidence that cultural factors may influence various features of help-seeking, from the identification of a problem to the choice of treatment providers. These views in turn may lead to the differential utilization of mental health services by different ethnic groups for suicide prevention and treatment (Cauce, 2014).

According to the Ghana Criminal Code (1960, Act 29), suicide is a crime. Section 57 of the code reads: "whoever attempts to commit suicide shall be guilty of a misdemeanor." Thus, persons who engage in nonfatal suicidal behaviour are subject to apprehension and prosecution, and upon conviction, are subject to criminal penalties. Compounding the strong legal response is the social reaction where suicide is regarded by all ethnic groups as a reprehensible act (Greene, 2002; Nukunya, 2004). This universal abhorrence of suicidal behaviour stems, largely, from religious interpretations and perceptions of suicide.

To conclude, the following are considered Coping Strategies in the Daffiama-Issa-Bussie District: Self-reliance/Solitary coping mechanisms (E.g., drinking alcohol or meditation), Emotional/spiritual support from Families/Religious groups, and Formal services.

From verbatim transcription and analysis of the data, it is conspicuous that approaches used by respondents in seeking assistance for ailments appear to be imbedded in their cultural perceptions associated with the origins of the problem (suicide) and beliefs about possible remedies.

An attempt survivor indicated:

> *"…. I take into alcohol drinking whenever I experience self-harm but now it is ineffective. Currently I smoke or take some medicine in order to manage the situation. Sometimes too, I sit*

somewhere alone and think about myself.
This was corroborated by another attempt survivor when he said:

> *"... drinking, smoking and taking of drugs are no longer effective for me. The thoughts about killing myself keep coming even more when I smoke, drink, or use drugs, I can't sleep. Now I always sit somewhere I think about myself.*

The deduction is that peasant farmers who are suicidal engage in self-reliance and solitary coping strategies.

Another respondent stated:

> "……*I rely on my wife, children and other extended family members for support during feeling of hopelessness, worthlessness and suicidal ideation. Sometimes too my church leaders and other members as well as friends give me hope.*

This implies that people who experience suicide bereavement and ideation rely on family and religious support as well as that of friends and loved ones.

An attempt survivor made an in interesting revelation:

> "…..*milk and shear butter oil was mixed and forced down my throat to make me vomit the poison that I drank in order to kill myself. I was never taken to any health facility…"*

This was corroborated by another attempt survivor when he said:

> "….*I sustained a fracture when I fell from a tree after a suicide attempt some years ago but I was never taken to any formal health facility but a local bone clinic.*

The logical reasoning here is that, suicidal self-injurious people engage in self-medication and largely refuse to patronize formal health delivery systems.

In fact, both the interview and focus group interactions with participants revealed a lot about the dominant role and confidence respondents have in religious and spiritual remedies as a panacea for suicide prevention.

An opinion leader categorically stated:

> "*…there is the need for spiritual cleansing of people who engage in suicidal behaviour in order to purify them from the demons and evil spirits who constantly instruct these vulnerable people to engage in self-injurious acts...".*
>
> *This was supported by an attempt survivor who said:*
>
> *"....I was personally taken through some exorcism both in the traditional shrine and at some prayer camps".*

This is confirmed in some studies like this, many Christians, suicide is a transgression of God's Law, specifically the Biblical scripture, "Thou shalt not kill" (Exodus, 20:13). This prohibition against killing extends to the self, and those who die by suicide are said to be denied entry to heaven. In Islam, Okasha and Okasha (2009) observe that for Muslims, "torture in hell awaits the person who takes their own life" (p. 50).

This implies that suicidal people resort to several health seeking solutions including religious and spiritual remedies. Even though a sizeable number of peasant farmers in the Daffiama-Bussie-Issa District do not engage in suicidal behaviour, majority of respondents have ever engaged in non-suicidal self-injurious acts which is a predictor of suicide. This assertion was confirmed during both face-to-face and focus group discussion where many

participants revealed that they have been drinking water from containers that were initially used in storing poisonous chemicals. Some respondents also said they have been exposed to dangerous activities on their farm that regularly result in self-cutting, self-mutilation and bone fracture. One respondent said;

> *"…some of us farmers do not have potable water at our farm hence we are sometimes compel to use the empty chemical containers to drink water from polluted ponds and rivers while working on our farm."*

Another interviewee reveals*; "I got asleep while resting on top of a tall tree on my farm. I nearly died. I had a fractured leg and was treated at a local bone clinic."* During the focus group discussions, many participants narrated how they sustained various degree of injuries through careless handling of sharp objects on the farm. An interviewee said; *" I sustain a cut while trying testing to see how sharp my knife was."*

The results support the assertions of Ma (2017) and Shin (2016) who opined that for peasant farmers, they may seek the assistance of others by acquiring herbal remedies, acupuncture or the guidance of religious leaders (Ma, 2017; Shin, 2016). As that adhere to collectivist values may adopt specific coping styles and perceptions about suicide (Heppner, 2016). There is evidence that cultural factors may influence various features of help-seeking, from the identification of a problem to the choice of treatment providers. These views in turn may lead to the differential utilization of mental health services by different ethnic groups for suicide prevention and treatment (Cauce, 2014).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Introduction

This chapter five was considered as the final chapter of the study and it provided the summary of major findings of the study. It also presented the conclusions drawn from the analysis of the data obtained. It was also important to indicate that the study made its conclusions based on its major findings in relation to available literature. It finally made recommendations capable of improving the suicidal attempts and issues relating suicide in the Daffiama-Bussie-Issa District in the Upper West Region of Ghana.

Summary of the Study

The present study investigated the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa (DBI) District. Specifically, the study looked at the prevalence of suicide in the Daffiama-Bussie-Issa Distrit, determined the possible risk factors that push peasant farmers to indulge in suicidal behaviour in the Daffiama Bussie Issa District (DBI), investigate the suicidal means adopted by peasant farmers in the Daffiama Bussie Issa District (DBI), examined the impact of suicide on survivors in the Daffiama Bussie Issa District, assessed the knowledge level of peasant farmers on suicidal warning signs, find out availability of formal support services for suicidal people in the Daffiama Bussie Issa District. The case study design using qualitative approuch was adopted for the study. This implies that the study employed qualitative approaches through the use of semi-structured interview guide to elicit

responses from selected women in the Daffiama Bussie Issa District. In all, there were twenty (20) peasant farmers in the Daffiama Bussie Issa District who were selected, a decision taken based on data saturation. The Columbia Suicide Severity Rating Scale (C-SSRS) was adapted and used to obtained information from the farmers for the study. The obtained data was coded and analyzed in thematic themes based on the objectives of the study.

Key Findings

This section considered the demographic characteristics of respondents with the view of understanding the prevalence, possible risk factors that push peasant farmers to indulge in suicidal behaviour, the suicidal means adopted by peasant farmers, the impact of suicide on survivors and the availability of formal support services for suicidal victims in the Daffiama Bussie Issa District. It considered the themes which were carefully structured into meaningful units using the sub-themes derived from them.

Demographic Characteristics of Respondents

Suicide is defined as the act of deliberately killing oneself. These deliberate factors and others have influenced the decision of the study to consider the socio-demographic characteristics of the peasant farmers in the Daffiama-Bussie-Issa District of the Upper West Region.

A total of 20 respondents were sampled and interviewed using a semi-structured interview guide. Though the respondents were interviewed individually, the responses were combined to achieve each of the objectives as outlined in the chapter of the study.

The study showed that majority of the respondents were male in the study area and it again revealed that majority of the people contacted were within the age group of 36-40 which correspond to 42%.

Majority of the respondents had not obtained higher formal education; they earned their living through the informal sector (farming) to be precise.

The religious status of the respondents of the study indicates that Traditional, Christianity and Islam were the major religious denominations found in the study area. From the study 42% respondents were Christians, 52% indicating traditionalist and only 5% representing Muslims. This implies that, within the study area majority of the respondents were traditionalists which is a potential contributory factor to the increasing numbers of suicide cases in the District.

Possible risk factors that push peasant farmers to indulge in suicidal behaviour

This study assessed the impact of suicide among suicide survivors in the district. Risk factors were grouped according to societal/stressful events or "psychosocial problems", psychiatric problems, access to means and a history of past attempts. The possible risk factors pushing peasant farmers to indulge in suicide activities from the study indicated that, 43% of the respondents believed suicide activities were related to cultural problems like a common saying in the study area that "better dead than dishonoured", 31% of the respondents interviewed concluded that peasant farmers engage in suicide as a result of psychosocial problems notably among them are poverty, unemployment, loss of love one, argument with family or friends, financial and even breakdown in relationship. Meanwhile 26% of the respondents argued that risk factors among peasant farmers emanated from psychiatric problems which may include the

intake of alcohol and drug abuse, depression, schizophrenia, hopelessness among others.

Volatile rainfall patterns lead to lower farm income and unequal income distribution which is a panacea for suicide in many agricultural communities. The implication here from this respondent is that, the inability to provide materially for the family after several frustrated efforts on the farm could result in suicidal behaviour. In a nutshell, the unbearable hardship and financial indebtedness to individuals and financial institutions orchestrated by unpredictable rainfall constitute an environmental risk factor of suicide among peasant farmers.

45% of the participants said no single risk factor existed but opined that, multiple factors such as farm destruction, unpredictable weather, lack of government social interventions, poor health status of farmers, lack of credit, lack of access to quality mental health systems among others were of the view that increased suicide rates among farmers.

Suicidal means adopted by peasant farmers

There are several suicidal means pertinent in the study District. Notably among the suicidal means adopted by peasant farmers in the study area include, drowning, poisoning by chemicals, use of gun, hanging and other firearms.

Majority of suicidal means adopted by the peasant farmers in the Daffiama-Issa-Bussie District is through hanging. A total of 48 respondents ranked hanging as the major leading source of death by the peasant farmers whereas 30 respondents ranked poisoning by chemicals and pharmaceuticals as the second major source of suicidal deaths in the study community. 15 and 10 respondents ranked use of guns and drowning respectively as the means adopted

by these peasant farmers towards eliminating their lives. But none of the respondents ranked other firearms as a medium to committing suicide.

The impact of suicide on survivors

An individual's death by suicide has far-reaching effects on a wide range of people, including immediate and extended family, friends, acquaintances, and healthcare and mental health professionals.

The grief after losing a loved one to suicide has points of commonality with grief following other types of losses of loved ones, but it also has unique features. Relating suicide-bereaved (SB) families to other bereaved groups found that SB families report higher levels of rejection, shame, stigma, the need to conceal the loved one's cause of death, and blaming. It is compounded with the sense of stigma as there is frequent feeling that you could or should have done something to prevent it. In line with this, 37% agreed that the impact of suicide brings rumination and anger, 31% attested that suicide is a vehicle for guilt and blame whereas 20% felt that suicide complicate grief and depression to the family. In furtherance, 4% and 8% argued that the impact of suicide on survivors leads to shrouded in silence and mental and physical health sequel respectively.

From the data gathered, it was revealed that suicide of a family member leaves an indelible mark on the survivors, affecting each individual, the family as a whole, and also larger social networks. The impact of the suicide is to some extent informed by the family's function or dysfunction prior to the suicide, moreover, the suicide may affect family communication and the developmental processes of children and marital breakup is also more common in parents of children who died by suicide.

Warning signs

The following were identified as early warning signals of suicide:

It was also established that more than 90 percent of those who commit suicide suffered from a significant psychiatric illness at the time of their death. Chronic major depression is by far the leading cause of suicide. This brain illness causes the person not to think as healthy people think, and often leads him or her to believe that suicide is the only way to stop the pain. Alcohol or drug uses compound this problem and increase the risk of suicide greatly. Those who threaten to hurt or kill themselves, or talk of wanting to hurt or kill themselves. Those looking for ways to kill themselves by seeking access to firearms, available pills, or other means. Those talking or writing about death, dying or suicide, when these actions are out of the ordinary for them.

Conclusions

In Ghana, especially in the Northern part of the country, farmers' contribution to the economy through cultivation and its pivotal step towards the improvement cannot to be overemphasized. To this end, a healthy environment means a healthy livelihood. On the other hand, despite the popularity of conventional farming, it has been established that the mechanism is not cheap and those who have made agriculture a way of life become frustrated by the external pressure sometimes, leading to suicide and its attendant problems. The results from the study give ample evidence to settle that the activities of the farmers have a significant impact on them and this leads to prevalence of suicidal tendencies.

Recommendations

Based on the findings from the study, the following recommendations were hereby made:

1. In the first place, since cultural problems is one of the leading causes of suicide in the Daffiama-Issa-Bussie District, I recommend that sensitisation programs should be organised by various agencies and other health bodies to educate the farmers on how to handle cultural issues.
2. In the second place, I recommend that a comprehensive Agricultural Insurance Scheme should be launched by the government and other health agencies. Specific attention should be given to cover farmers into crops like yams farming, maize farming, millet farming and vegetables farming. This may help them recover their losses and seek for medications to reduce stress and depression level.
3. Thirdly, I recommend that, since hanging is the leading means to suicide among farmers, family members of these farmers should be advised not to allow the farmers to go to farms alone and suicide means such as ropes should be hidden from farmers who go through psychological distress.
4. Additionally, farmers should be made aware that artificial agricultural methods have negative impacts on their health and environment and hence should be avoided. Organic farming methods ensure that there is sustainability in the agricultural sector due to its environmental and economic advantage.

5. Again, media reportage on suicide should be silence on the means adopted by suicidal people since that will be a means to teaching or promoting other distressed people how to kill themselves.
6. Section 57 (2) of the criminal offences act, 1960 (ACT 29) which criminalizes attempted suicide should be repealed in order to enable people who engaged in attempted suicide to freely seek formal support services.
7. Finally, mental health issues in the Daffiama-Issa-Bussie District should be properly managed to prevent mentally ill people from engaging in suicidal behaviour.

Suggestions for Further Studies

Future research particularly in the same area should consider a much more detailed design, perhaps a mixed-method design, specifically a quantitative and qualitative approach which allows a relatively larger sample size that would provide a detailed examination of the situation at hand. This would allow for fair generalization and comparison with similar research findings in different jurisdictions.

This current study should be replicated in other regions of Ghana, to find out what persist there.

Similar studies should be conducted in other Metropolitans, Municipals and Districts in Ghana to observe possible changes or similarity of findings.

Future studies should also concentrate on investigating the experiences commercial farmers as well as other group of workers

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APPENDICES

APPENDIX A

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

DEPARTMENT OF EDUCATION AND PSYCHOLOGY

Dear Respondent,

SEMI STRUCTURED INTERVIEW GUIDE

This study seeks to **explore the prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa District**. Your full input will help make informed decisions about **suicide among peasant farmers**. It would therefore be appreciated if you could provide responses to **all** items on the interview guide and respond **honestly**. You are assured of complete **confidentiality** and **anonymity** of all information provided. **Nothing** will ever be published or reported that will associate your name and/ family or community with your responses to the interview guide. Your participation in this study is **completely voluntary**. Again, interview guide on this survey instrument have gone through a thorough review by professionals at the University of Cape Coast, and have been declared **ethical** for educational research. You hereby consent to voluntarily participate in this study by providing responses to items of the various sections of this instrument.

Thank You

SEMI-STRUCTURED INTERVIEW GUIDE

SECTION A

BACKGROUND INFORMATION

Gender

a) Male [ ]

b) Female [ ]

Age

a) Below 25 [ ]

b) 26-30 [ ]

c) 31-35 [ ]

d) 36-40 [ ]

e) 41-50 [ ]

f) 51-55 [ ]

g) 56 and above [ ]

Educational Qualification

a) Basic [ ]

b) Secondary [ ]

c) Tertiary [ ]

d) No formal education [ ]

Marital Status

a) Single [ ]

b) Married [ ]

c) Divorced [ ]

d) Widowed [ ]

Religious Affiliation

a) Christian [ ]

b) Muslims [ ]

c) Traditionalist [ ]

d) Other [ ]

SECTION B

General guidelines

- Introduce yourself to the interviewee
- Introduce the research topic and objectives
- Address the issue of confidentiality
- Briefly explain the purpose of the interview
- Briefly explain why the interviewee is chosen
- Briefly discuss the process of the interview

Researcher/Officer: David Banaaleh

Research Topic: Prevalence and Impact of Suicide among Peasant Farmers

Region; Upper West

Techniques: Personal Interview (Face-to-Face)/Focus group discussion

Research Area: Daffiama-Bussie-Issa District

Total Time required: At least 15 minutes per interview

Interview Questions

SECTION C

FOCUS GROUP DISCUSSION WITH OPINION LEADERS

Prevalence of suicide among peasant farmers

-impact of suicide on survivors

-availability or otherwise of support services for suicidal persons

-socio-cultural barriers against prevention efforts etc.

-the way forward

SECTION D

INTERVIEW QUESTIONS (Face-To-Face)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals. ☐ ☐ ☐			
Suicidal and Self-Injury Behaviour (Past week)		Clinical Status (Recent)	
☐	Actual suicide attempt Lifetime	☐	Hopelessness
☐	Interrupted attempt Lifetime	☐	Helplessness*
☐	Aborted attempt Lifetime	☐	Feeling Trapped*
☐	Other preparatory acts Lifetime to kill self	☐	Major depressive episode
☐	Self-injury behaviour Lifetime w/o suicide intent	☐	Mixed affective episode
Suicide Ideation (Most Severe in Past Week)		☐	Command hallucinations to hurt self
☐	Wish to be dead	☐	Highly impulsive behaviour

☐	Suicidal thoughts	☐	Substance abuse or dependence
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Agitation or severe anxiety
☐	Suicidal intent (without specific plan)	☐	Perceived burden on family or others
☐	Suicidal intent with specific plan	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
Activating Events (Recent)		☐	Homicidal ideation
☐	Recent loss or other significant negative event	☐	Aggressive behaviour towards others
	Describe:	☐	Method for suicide available (gun, pills, etc.)
		☐	Refuses or feels unable to agree to safety plan
☐	Pending incarceration or homelessness	☐	Sexual abuse (lifetime)
☐	Current or pending isolation or feeling alone	☐	Family history of suicide (lifetime)
Treatment History		Protective Factors (Recent)	
☐	Previous psychiatric diagnoses and treatments	☐	Identifies reasons for living
☐	Hopeless or dissatisfied with treatment	☐	Responsibility to family or others; living with family

☐	Noncompliant with treatment	☐	Supportive social network or family
☐	Not receiving treatment	☐	Fear of death or dying due to pain and suffering
Other Risk Factors		Belief that suicide is immoral, high spirituality	
☐		☐	Engaged in work or school
		☐	Engaged with Phone Worker *
		Other Protective Factors	
		☐	

Describe any suicidal, self-injury or aggressive behaviour (include dates):

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behaviour" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes No** □ □	**Yes No** □ □
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes No** □ □	**Yes No** □ □
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at	**Yes No** □ □	**Yes No** □ □

least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:		
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes No** □ □	**Yes No** □ □
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.	**Yes No** □ □	**Yes No** □ □

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? If yes, describe:		
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5) Description of Ideation*** Recent ***- Most Severe Ideation:*** _____ _____ ***Type # (1-5) Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	___	___
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8	___	___

hours/persistent or continuous (3) 1-4 hours/a lot of time		
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (0) Does not attempt to control thoughts	___	___
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (0) Does not apply	___	___
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge***		___

or a reaction from others? Or both? (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on (2) Mostly to get attention, revenge or a reaction from others living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on and to end/stop the pain living with the pain or how you were feeling) (0) Does not apply	___	

SUICIDAL BEHAVIOUR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behaviour was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behaviour or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?***	**Yes No** □ □ Total # of Attempts ____ **Yes No** □ □	**Yes No** □ □ Total # of Attempts ____ **Yes No** □ □

What did you do? ***Did you___as a way to end your life?*** ***Did you want to die (even a little) when you_?*** ***Were you trying to end your life when you___?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behaviour without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behaviour?**		
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge.	**Yes No** □ □ Total # of interrupted	**Yes No** □ □ Total # of interrupted

Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:		
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self- destructive behaviour. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** □ □ Total # of aborted or self-interrupted	**Yes No** □ □ Total # of aborted or self-interrupted
Preparatory Acts or Behaviour: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting***	**Yes No** □ □ Total # of preparatory acts	**Yes No** □ □ Total # of preparatory acts

pills, getting a gun, giving valuables away or writing a suicide note)? If yes, describe:			
	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of	*Enter Code*	*Enter Code*	*Enter Code*

body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death			
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behaviour not likely to result in injury 1 = Behaviour likely to result in injury but not likely to cause death 2 = Behaviour likely to result in death despite available medical care	*Enter Code* ____	*Enter Code* ____	*Enter Code* ____

SECTION E

Closing Remarks: (Debriefing exercise)

- Allow some minutes for comments and inquiries.
- Reaffirm the issue of confidentiality
- Inform the interviewee again about how the data will be used.
- Finally, thank the interviewee for accepting to be interviewed

!!!!!Thank You!!!!!

APPENDIX B

ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
ETHICAL REVIEW BOARD

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: CES-ERB/ucc.edu/v3/19-16

Date: March 4, 2019

Your Ref: .....

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

The bearer, David B. Normaah., Reg. No ED/CHP/17/0011 is an M.Phil. /~~Ph.D.~~ student in the Department of Education and Psychology in the College of Education Studies, University of Cape Coast, Cape Coast, Ghana. He / ~~She~~ wishes to undertake a research study on the topic:

Prevalence and impact of suicide among peasant farmers in the Daffiama-Bussie-Issa District

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed his/~~her~~ proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

In view of the above, the researcher has been cleared and given approval to commence his/~~her~~ study. The ERB would be grateful if you would give him/~~her~~ the necessary assistance to facilitate the conduct of the said research.

Thank you.
Yours faithfully,

Prof. Linda Dzama Forde
(Secretary, CES-ERB)

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