

SUICIDE IDENTIFICATION, SIGNS, SYMPTOMS, AND PREVENTION

Oheneba-Dorny, S.

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Abstract

Suicide remains one of the most urgent yet misunderstood challenges in mental health and pastoral care. In Ghana and many African settings, suicidal distress is not expressed only in psychiatric language; it is often carried in the idioms of shame, family burden, spiritual heaviness, broken belonging, and exhausted hope. For that reason, prevention cannot rely on clinical screening alone. It requires a framework that is psychologically sound, culturally grounded, and pastorally discerning. This article expands the discussion on suicide identification, signs, symptoms, and prevention by placing classical suicidology in dialogue with Ghanaian realities and pastoral counselling practice. It argues that suicide is usually the end point of accumulated pain rather than a sudden isolated act, and that this pain is intensified when stigma, silence, humiliation, trauma, family pressure, and spiritual misinterpretation prevent timely help-seeking. The article examines major psychological, relational, social, cultural, and spiritual contributors to suicidal risk; outlines emotional, cognitive, verbal, behavioural, and spiritual warning signs; and proposes a culturally responsive pastoral-clinical model for prevention built on early identification, compassionate inquiry, collaborative safety planning, means safety, referral, and continuity of care. The central claim is that suicide prevention in Ghana becomes more effective when churches, families, schools, and mental health systems learn to respond neither with condemnation nor panic, but with informed presence, responsible action, and hope-bearing accompaniment.

Keywords: suicide prevention; suicidal ideation; pastoral counselling; Ghana; stigma; community mental health

1. Introduction

Suicide is one of the deepest ruptures in human experience because it confronts caregivers, families, faith leaders, and communities with a painful question: how can a person come to feel that continuing to live is harder than stopping? The question is never merely medical. It is emotional, relational, moral, social, and spiritual all at once. The latest global estimates from the World Health Organization indicate that 727,000 people died by suicide in 2021, with a substantial proportion of deaths occurring in low- and middle-income countries and among younger age groups (World Health Organization [WHO], 2025). These figures remind us that suicide is not a marginal issue. It is a major public health concern with profound human and communal consequences.

Yet global estimates do not explain how suicidal distress is actually lived within particular cultures. In Ghana, distress is rarely interpreted in purely psychiatric terms. People often speak of a tired heart, a heavy spirit, a disgraced life, or the feeling that one has become a burden to the family. In such contexts, the person at risk may remain outwardly composed, active in church, or faithful in public responsibilities while inwardly collapsing under despair. Ghanaian research repeatedly shows that suicide is surrounded by stigma, taboo, and moral judgment, all of which can discourage disclosure and delay help-seeking (Osafo et al., 2019; Osafo et al., 2018).

This means that suicide identification in Ghana and similar African settings demands more than technical assessment. It requires cultural hearing and spiritual discernment. If caregivers reduce suicidal distress to weak faith, moral failure, or spiritual attack, they may overlook depression, trauma, grief, social defeat, or hopelessness. If they reduce everything to diagnosis alone, they may fail to understand the force of shame, family honour, gender expectation, and communal identity in shaping suicidal thoughts. A whole-person response is therefore essential.

This article expands the original manuscript into a fuller journal-style piece suitable for publication. It preserves the pastoral-counselling distinctiveness of the article while strengthening the scholarly frame with authentic in-text citations and a clearer argument. The central thesis is that suicide prevention in Ghana is most effective when psychological science,

cultural insight, spiritual sensitivity, and community-based care are brought into deliberate conversation. Such integration allows earlier identification of risk, more humane intervention, and stronger pathways toward hope.

2. Conceptual and Theoretical Foundations

Modern suicidology has moved away from the simplistic belief that people die by suicide because they merely desire death. The more careful view is that suicide usually emerges from a complex interaction of unbearable psychological pain, cognitive constriction, relational disconnection, social defeat, and reduced access to protective support (Turecki & Brent, 2016; O'Connor & Nock, 2014). One of the most useful concepts in this regard is Shneidman's (1993) notion of psychache. He describes a form of inner torment so overwhelming that the mind begins to seek escape from pain itself. This insight remains important because it directs attention to suffering rather than sensationalism. Many suicidal persons are not straightforwardly pursuing death; they are trying to end anguish that feels impossible to carry.

Cognitive theory adds another necessary layer. Beck and colleagues showed that hopelessness is one of the most powerful predictors of suicidal behaviour (Beck et al., 1990). When hopelessness deepens, the future appears closed, the self is interpreted through failure, and alternatives become difficult to imagine. The person begins to believe that nothing can improve, that one mistake defines the whole story, and that burdens cannot be reversed. In pastoral practice, this may be expressed through language such as, "Nothing can help me now," "I have ruined everything," or "There is no point continuing." The event that triggered the crisis may be recent, but the hopeless interpretation has often been forming for some time.

Relational theories are equally important in collectivist cultures. Joiner's (2005) work, later elaborated by Van Orden et al. (2010), proposes that suicidal desire becomes especially potent when a person feels two things at once: that they no longer belong and that their existence has become a burden to others. This theory is highly relevant in Ghana, where personal identity is deeply tied to family membership, communal participation, and social usefulness. To feel cut off

from one's family, disgraced before one's church, unable to meet expected roles, or regarded as an embarrassment can become psychologically devastating. In such contexts, belonging is not an abstract need; it is part of personal survival.

Contemporary models of suicide also emphasize entrapment. O'Connor and Nock (2014) note that suicidal behaviour is shaped by the felt experience of being trapped in a situation from which no acceptable escape seems available. This entrapment may be psychological, relational, financial, academic, spiritual, or social. It is especially dangerous when it is combined with humiliation, trauma, substance misuse, or reduced fear of harm. The transition from thought to action is therefore not explained by sadness alone. It is influenced by multiple factors that weaken self-protection while intensifying the appeal of escape.

These theories remain valuable for pastoral counselling because they provide language for experiences that are often misread. A person who is withdrawing may not simply be stubborn. A young man who becomes reckless may not merely be rebellious. A woman who says she is tired of everything may not be speaking casually. Theories of psychache, hopelessness, belonging, and entrapment help caregivers interpret suffering more accurately and respond more humanely.

3. Suicide in the Ghanaian and African Context

Context is indispensable in any serious discussion of suicide in Ghana. Here, suicide is not experienced solely as an individual psychiatric issue. It is shaped by family systems, communal values, gender expectations, economic pressure, moral discourse, and spiritual interpretation. Osafo et al. (2019) found that community leaders in Ghana often hold two views at the same time: suicide as a health crisis and suicide as a moral taboo. This tension is significant. It means that the same person who shows compassion may also carry beliefs that reinforce shame and silence. A suicidal person may therefore anticipate help and condemnation at once.

Stigma remains one of the strongest barriers to disclosure. Ghanaian studies indicate that suicidal behaviour is frequently interpreted through the lenses of shame, taboo, weakness,

disgrace, or spiritual failure (Osafo et al., 2011; Akotia et al., 2019). The result is that many people do not speak directly about suicidal thoughts even when distress is severe. Instead, they speak in indirect language: feeling useless, wanting rest, being tired of life, or believing they have become a disappointment. In many homes and congregations, explicit disclosure is avoided because of fear of gossip, moral labeling, or family embarrassment. This silence can be lethal.

Gender meanings also matter. Adinkrah (2012) and Andoh-Arthur et al. (2018) show that masculinity, honour, and role failure may heighten suicide risk among Ghanaian men. In a society where male worth is often measured by provision, authority, and resilience, unemployment, public humiliation, or relational failure may be experienced not only as disappointment but as collapse of identity. This may partly explain why some men show risk through withdrawal, irritability, alcohol misuse, or reckless behaviour rather than through open emotional disclosure. The pastoral implication is plain: emotional silence should never be mistaken for emotional safety.

Young people are also vulnerable. Oppong Asante et al. (2017), using school-based data from Ghana, found substantial levels of suicidal ideation, planning, and attempts among senior high school students, with anxiety, loneliness, abuse, hunger, and substance use among key correlates. More recent qualitative work with Ghanaian adolescents who had attempted suicide identified family rejection, financial hardship, broken trust, academic frustration, failed relationships, and community stigma as major contributors (Axame et al., 2024). These findings underline the relational nature of youth distress. Adolescents often struggle not only with their own emotions, but also with the feeling that they are unheard, invalidated, or cut off from those who matter most.

The legal and public discourse around suicide has also been changing. For many years, attempted suicide in Ghana was treated under a criminal framework that reinforced stigma and fear. Research with judges and lawyers, however, reflected a growing shift toward viewing suicide survivors as persons needing help rather than punishment, captured in the memorable

phrase, "we now have a patient and not a criminal" (Osafo et al., 2018). Parliament later moved to decriminalise attempted suicide, explicitly reframing the issue as one requiring medical and psychological support rather than penal sanction (Ghana News Agency, 2023). This shift matters because law shapes public imagination. When the state signals care rather than punishment, it becomes easier to encourage help-seeking and reduce shame.

Finally, spirituality cannot be treated as peripheral in African settings. Many persons first seek help from pastors, prayer leaders, or traditional healers before presenting to formal mental health services. This pattern reflects both service limitations and the cultural reality that suffering is often interpreted spiritually. Spiritual care can strengthen resilience, but it can also delay intervention when all signs of depression, trauma, or suicidal risk are explained only as spiritual attack. Wise prevention therefore requires integration, not rivalry, between pastoral care and mental health care.

4. Signs and Symptoms of Suicidal Risk

Recognizing suicidal risk early is one of the most important responsibilities of counsellors, pastors, parents, teachers, and health workers. The difficulty is that warning signs are not always dramatic. Often they are subtle, cumulative, and easily dismissed. Emotional signs commonly include persistent hopelessness, deep sadness, shame, chronic guilt, panic, emotional numbness, or the repeated sense that one is trapped. These states matter because hopelessness and unbearable inner pain have repeatedly been linked to suicidal behaviour (Beck et al., 1990; Shneidman, 1993). In pastoral settings, they may be expressed through phrases such as, "My heart is tired," "I cannot carry this anymore," or "Nothing good remains ahead of me."

Cognitive signs are equally important. These include harsh self-condemnation, all-or-nothing thinking, overgeneralizing from one failure, magnifying humiliation, and imagining that one's life has become a burden to others. The person may begin to think in final terms. Problems seem permanent, identity becomes fused with failure, and the future feels sealed. These distorted

appraisals are not minor mood shifts; they represent a narrowing of mental space in which alternatives become increasingly hard to imagine.

Verbal indicators may be direct or indirect. Some persons speak openly about not wanting to live. Others speak more cautiously, saying they want rest, wish they could disappear, or feel others would be better off without them. In Ghanaian communication, such statements may come wrapped in modest or indirect language. This makes careful listening essential. Recurrent talk about weariness, worthlessness, disappearing, or ending the pain should not be dismissed as mere exaggeration.

Behavioural and relational changes often provide the clearest outward signs. These may include social withdrawal, unusual quietness, loss of interest in work or studies, neglect of personal care, giving away valued belongings, sudden disengagement from church life, risk-taking, increased alcohol or substance use, and a shift from visible agitation to unexplained calm. Adolescents may show risk through truancy, isolation, academic decline, conflict, or resignation rather than dramatic verbal disclosure (Oppong Asante et al., 2017; Axame et al., 2024). Some young people become irritable rather than tearful. Others become excessively compliant after a period of turmoil. Patterns matter more than isolated actions.

For pastoral counsellors, spiritual signs should also be taken seriously. A person who was once engaged in prayer, fellowship, or worship may suddenly withdraw. Others become preoccupied with themes of punishment, divine rejection, or spiritual unworthiness. Some stop praying altogether because they feel that heaven has gone silent. These experiences should not be over-spiritualized, but neither should they be ignored. In many African Christian contexts, spiritual despair and psychological collapse are intertwined. The task is to discern whether spiritual language is expressing guilt, depression, trauma, exhaustion, or hopelessness.

At the same time, assessment should include protective factors. Trustworthy relationships, responsibility toward children or dependants, meaningful faith, future goals, willingness to accept help, and the ability to name distress rather than hide it can all create openings for

intervention. Protective factors do not cancel risk, but they often provide the first anchors for safety planning. It is therefore wise to ask not only what is making life feel unbearable, but also what has helped the person remain alive thus far. That question can uncover fragile but real reasons for living and can become an important part of the therapeutic and pastoral response.

5. Pastoral Counselling Assessment and Early Response

A pastoral-counselling response to suicidality should begin with calm presence rather than alarm. Many suicidal persons already feel they are too much for others. If the first response they receive is panic, scolding, hurried preaching, or dismissal, their sense of being a burden may deepen. A helpful initial posture communicates three simple truths: I am taking you seriously, I am staying with you in this moment, and we will seek help together. This stance is both clinically sound and pastorally faithful.

Assessment needs to be direct, respectful, and clear. Research shows that asking about suicidal thoughts does not plant the idea; rather, it opens the possibility of relief and truthful disclosure (O'Connor & Nock, 2014). Pastoral counsellors do not need complicated jargon to ask wisely. They can ask whether the person has felt that life is no longer worth living, whether they have wished not to wake up, whether they have thought of harming themselves, and whether they feel safe right now. What matters is the tone in which these questions are asked. Questions framed with compassion and steadiness are more likely to invite honesty than questions framed with fear or accusation.

In listening to the response, the counsellor should attend to intensity, frequency, immediacy, access to danger, available support, and the factors that intensify or reduce risk. A person who feels isolated, intoxicated, humiliated, recently bereaved, or severely depressed may require urgent intervention. Adolescents facing family rejection, school crises, relationship pain, abuse, or academic collapse also require careful attention (Oppong Asante et al., 2017; Axame et al., 2024). The counsellor must not assume that a calm voice means low risk. Sometimes the most concerning statements are given quietly.

One of the major errors in faith settings is over-spiritualization. Some people are told merely to pray more, fast more, or rebuke the enemy more aggressively. Prayer and spiritual support can be deeply sustaining, but they are not substitutes for risk assessment, safety planning, and appropriate referral. A person may indeed describe the experience through spiritual language, yet still be suffering from depression, trauma, exhaustion, or social defeat. Mature pastoral care refuses the false choice between spiritual care and mental health care. It honours both.

Early response must also be collaborative. A suicidal person should not be left to carry the crisis alone after disclosure. Where risk is acute, accompaniment to emergency or specialist care is necessary. Where risk is significant but not immediate, a same-day plan should be created. This may include contacting trusted relatives, reducing isolation, securing dangerous means, arranging urgent follow-up, and connecting the person to professional care. Confidentiality remains important, but when life is at stake, safety must take precedence over silence.

Pastoral counsellors must also be honest about limits. Presence is powerful, but it is not enough in every case. Some individuals require psychiatric review, trauma-focused therapy, medication support, structured psychotherapy, or hospital care. Good pastoral care does not end when referral begins. It continues through accompaniment, stigma reduction, prayerful support, and coordinated follow-up. That continuity often makes the difference between a one-time crisis intervention and a genuine pathway toward recovery.

6. Prevention: Clinical, Communal, and Pastoral Pathways

Suicide prevention works best when it is layered. No single intervention is enough. Strong prevention combines public education, early identification, family involvement, evidence-based treatment, means safety, and follow-up care. In resource-constrained settings such as Ghana, gatekeepers are especially important. Community leaders, pastors, teachers, lay counsellors, parents, and youth workers often encounter distress long before a mental health specialist does. Osafo et al. (2019) showed that community leaders in Ghana can play meaningful gatekeeping roles when they are trained to recognise suicidal crises and respond without condemnation. This

suggests that prevention is not the task of clinicians alone. It is a shared communal responsibility.

For adolescents and young adults, school-based and family-based strategies are vital. Ghanaian school data link suicidality with anxiety, loneliness, abuse, substance use, and deprivation (Oppong Asante et al., 2017). Qualitative research has further highlighted family rejection, educational frustration, and broken trust as major contributors to adolescent attempts (Axame et al., 2024). Prevention must therefore include teacher training, anti-bullying efforts, stronger school counselling systems, safe reporting structures, parental education, and emotionally responsive family communication. Young people are more likely to seek help when adults respond without ridicule or moral shaming.

Structured psychological treatments also have an important place. Cognitive and behavioural approaches are useful where hopelessness, self-condemnation, and distorted appraisal of problems are prominent. Dialectical behaviour therapy has shown strong value in reducing repeated self-harm and suicide attempts by strengthening distress tolerance, emotional regulation, and crisis coping (Linehan et al., 2006; McCauley et al., 2018). The Collaborative Assessment and Management of Suicidality provides another evidence-based framework centred on the therapeutic alliance and the identification of the person's specific suicidal drivers (Jobes, 2012). These approaches remind us that suicidality is not simply to be feared; it is also to be treated.

Collaborative safety planning is one of the most practical and adaptable interventions. Stanley et al. (2018) found that a safety planning intervention combined with follow-up reduced suicidal behaviour and increased treatment engagement. In Ghanaian settings, a good safety plan should be culturally adapted. It may identify warning signs, internal coping practices, trusted supporters, emergency contacts, safe places, and actions that reduce access to danger during periods of acute distress. Where appropriate, spiritually meaningful resources such as selected

Psalms, worship, or trusted prayer partners may be included, not as replacements for treatment, but as part of a broader stabilizing network.

Means safety remains essential. Restricting access to lethal means is one of the most consistently supported suicide prevention strategies in global public health (WHO, 2014; Zalsman et al., 2016). In practical terms, this means that families and caregivers should take seriously the safe storage or temporary removal of dangerous substances, medications, sharp objects, and other means during high-risk periods. This should be framed not as punishment, but as protection. The goal is to create time and distance between suicidal impulse and action.

Follow-up and continuity of care are equally important. Suicidal crises do not disappear simply because one conversation or one hospital visit has taken place. Recovery is often uneven. Continued contact after crisis has been associated with reduced suicidal behaviour and stronger treatment engagement (Stanley et al., 2018; WHO, 2025). In pastoral practice, follow-up may include scheduled check-ins, collaboration with clinicians, home visits where appropriate, family support, and church-based companionship. What preserves life is not only the strength of the initial response, but also the faithfulness of what follows.

Public language also matters. Research on Ghanaian online reporting of suicidal behaviour has shown important departures from recommended best practice, including sensational language that can worsen stigma and contagion risk (Quarshie et al., 2021). Prevention therefore requires responsible communication in churches, schools, homes, and media spaces. The suicidal person must not be reduced to scandal, shame, or spectacle. Language can either drive suffering underground or create pathways for help-seeking.

A survivor-centred ethic is equally necessary. Persons who disclose suicidal thoughts should be met with dignity, not interrogation. Families should resist turning the crisis into a courtroom; churches should resist public exposure disguised as testimony; helpers should resist language that brands the person as attention-seeking, weak, or spiritually defective. A humane response protects privacy, avoids sensational retelling, and keeps the focus on safety, support, and

recovery. In many communities, the fear of being talked about is itself a barrier to disclosure. Prevention therefore includes building confidential, trustworthy environments in which a distressed person can speak honestly without fearing humiliation. This ethical atmosphere is not an optional extra. It is part of the structure of life-saving care.

7. Toward a Culturally Grounded Pastoral-Clinical Model

If suicide prevention in Ghana is to be credible and effective, it must be built on an integrated model that respects the full ecology of distress. Suicidality rarely arises from one cause alone. It develops where psychological pain, social strain, shame, family conflict, economic pressure, trauma, stigma, and spiritual confusion converge. Any response that addresses only one dimension risks missing the person. The clinic cannot say the issue is only biological; the church cannot say it is only spiritual; the family cannot say it is merely attitude or disobedience. Such reductions leave the sufferer unseen.

A culturally grounded pastoral-clinical model for Ghana should include at least five commitments. First, it should normalize early help-seeking by reducing shame around emotional suffering. Congregations and families need to learn that suicidal thoughts are a crisis signal requiring compassionate care, not ridicule. Second, it should equip gatekeepers - pastors, lay counsellors, teachers, parents, youth leaders, and family elders - with practical skills for recognising warning signs, asking direct questions, and activating referral pathways safely. Compassion without skill may miss danger, while skill without compassion may drive distressed people deeper into hiding.

Third, the model should strengthen referral bridges between churches, schools, counsellors, psychologists, psychiatrists, and emergency services. Many people in crisis move first through informal support systems. If those systems do not know where to refer, precious time is lost. Fourth, the model must hold together spirituality and mental health without confusing them. Prayer, lament, Scripture, worship, and confession may offer profound strength, but severe

depression, trauma, and active suicidal ideation require clinical assessment and evidence-based intervention. Mature pastoral care therefore integrates rather than competes.

Fifth, the model should prioritize the rebuilding of belonging. Since many suicidal persons experience themselves as unwanted, burdensome, disgraced, or alone, prevention must restore relationship. This may involve family mediation, support groups, mentoring, youth discipleship, peer support, and church practices that communicate, in both word and action, that the suffering person still has a place among the living. Community itself can be both risk and remedy. The same structures that intensify shame can become channels of protection when reshaped by confidentiality, compassion, and accountability.

This model should also include post-crisis and postvention work. When a suicidal crisis has occurred, families, churches, and schools often do not know how to continue caring well. Some become over-controlling; others retreat into silence; still others respond with theological language that increases guilt. A stronger pastoral-clinical framework would therefore include guidance for families on how to remain supportive without becoming punitive, how to talk about emotional pain without shame, and how to recognise recurring warning signs. In cases where a suicide death has already occurred, communities also need careful bereavement support so that grief, blame, fear, and stigma do not create further trauma for survivors. Postvention is part of prevention because the way a community responds after crisis shapes whether others feel able to seek help in the future.

Policy and institutional leadership also deserve attention. Churches, counselling institutions, schools, and district health systems need written protocols for suicide risk identification, referral, documentation, and follow-up. Too often, helpers respond only from intuition, goodwill, or personal spirituality. While goodwill matters, high-risk situations require structured practice. Institutions should know who to call, how to document concern, when to involve family, how to preserve confidentiality while protecting life, and how to coordinate care after crisis. Counselling training programmes in Ghana would benefit from stronger modules on suicide

literacy, risk formulation, safety planning, trauma-informed communication, and culturally responsive pastoral referral. Such preparation would not weaken spiritual care; it would strengthen it by helping faith-based helpers act with clarity and competence in moments of danger.

This is where pastoral counselling brings unique value. It can help a person reconnect pain with language, language with relationship, and relationship with hope. It does not sentimentalize suffering, and it does not dissolve into detached technique. Rather, it offers truthful presence, responsible guidance, and structured accompaniment. In a subject as weighty as suicide, such integration is not optional. It is wisdom.

8. Conclusion

Suicide identification, signs, symptoms, and prevention cannot be handled adequately through a narrow lens. The evidence shows that suicidal behaviour is usually rooted in layered pain: hopelessness, shame, humiliation, rejection, trappedness, and the erosion of belonging. In Ghana, these realities are intensified by stigma, communal expectations, gendered pressures, economic strain, and spiritual interpretations that may both comfort and confuse. The early signs are often subtle. They may appear in tired speech, unusual silence, spiritual withdrawal, academic decline, agitation, resignation, or a repeated sense of being a burden.

For that reason, prevention in Ghana requires an integrated response. Psychological science helps us recognise hopelessness, psychache, relational disconnection, and entrapment. Ghana-based studies help us understand the weight of taboo, masculinity, family invalidation, adolescent vulnerability, and community gatekeeping. Pastoral counselling contributes a ministry of presence that listens without condemnation, asks hard questions with compassion, and accompanies the suffering person toward care and renewed meaning.

A publication-ready framework for suicide prevention in Ghana must therefore be clinically grounded, culturally alert, spiritually discerning, and practically communal. It must train

churches, schools, families, and health systems to identify risk early, ask directly, respond calmly, reduce access to danger, collaborate on safety, and remain connected after crisis. When this happens, suicide prevention becomes more than a public slogan. It becomes a disciplined practice of preserving life, restoring dignity, and keeping hope within reach.

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