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ORIGINAL ARTICLE

Self-harm in secure settings: Exploring the lived experiences of people who self-harm in secure hospitals

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ABSTRACT: *Globally, an increasing number of people who Self-Harm (SH) are being treated in mental health hospitals. Incidences of SH are common in secure hospitals, with those using the behaviour being highly dependent on staff for care and support but impacting on often limited resources. While literature related to the lived experiences of people who SH exists, this is in its infancy in African countries. The aim of this study was to explore the lived experiences of people who SH in two secure mental health hospitals in Ghana. Interpretive Phenomenological Analysis (IPA) was used to explore the experiences of people who SH in two secure mental hospitals in Ghana. A convenience sample of nine participants were recruited and face-to-face in-depth semi structured interviews were used to collect data. With the permission of each participant, all interviews were audio recorded and notes were made by the researcher (first author). Each interview was transcribed and analysed using the IPA seven-step approach, with three superordinate and 11 subordinate themes being identified. The superordinate themes were: Being let down; Living with the negative self; Forces of the supernatural and religion. Findings demonstrate that there is a need to develop a collaborative health care package if appropriate care and support is to be offered to people in secure settings who use high-risk behaviours, such as SH. To ensure care is holistic, culturally, and temporally relevant research is needed, particularly in Sub-Saharan Africa.*

KEY WORDS: *culture, interpretative phenomenological analysis, narrative, self-harm, spirituality.*

INTRODUCTION

Self-harm is a contemporary global public health issue, with related high-risk behaviours including suicidal risk and self-harm (Castelpietra *et al*. 2022; Lim *et al*. 2019). Of those diagnosed with self-harm, a higher prevalence is found in marginalized groups, including those admitted to secure settings (Cawley *et al*. 2019; Sandy & Shaw 2012). In the United Kingdom (UK), the annual prevalence of self-harm in secure settings is said to be 5–6% in men and 20–24% in women (Hawton *et al*. 2014). Nonetheless, while there is extant literature of self-harm in secure settings in western nations such as the UK, United States (US), Canada and Australia, research into self-harm in secure settings in developing countries, such as those in Sub-Saharan Africa, Ghana being one of them, remains in its infancy. The aim of this study was to address this gap by exploring the lived experiences of people who SH and were inpatients in two secure mental health hospitals in Ghana.

Ghanaian context and mental illness

Ghana has six major ethnic groups which can be sub divided into approximately 60 subgroups. The six main

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groups comprise Akan (Ashanti and Fante (central region/county), the Ewe (Volta region/county), the Ga-Adangbe (Greater-Accra region/county), the Mole-Dagbani, the Guan and the Gruma (Upper East or Upper West region/County)). While Ghana has a rich cultural heritage, the main ethnic differences are expressed through unique languages and/or dialects, and various cultural practices, such as celebration of unique ethnic festivals, traditional religious practices, farming and industry.

In addition to the six major ethnic groups, Ghana has three main religious denominations, with 71.2% of Ghanaians being Christians; 17.6% Muslim; and 5.2% Traditional (Johnstone & Alexander 2015). The cultural background of Ghanaians has influenced their traditional observance regarding peoples' beliefs, religious values, stigmatization of mental illness and cultural affiliations (Ofori-Attah *et al*. 2010). Individuals often seek mental health care from orthodox systems, alongside other care providers such as faith healers and/or traditional medicine men (Asare 2003). Approximately 80% of Ghanaians rely on unorthodox medicine from the 46 000 traditional healers that are found in rural and urban centres (Ghana's Population and Housing Census 2010). Regarding mental illness, some of the traditional healers hold the notion that mental ill health is caused by demons, it is a bad omen for the family and the nation, and conventional medicine cannot cure it. Amidst the conventional health care system, such healers still use crude practices such as exorcizing supposed demons in the mentally ill, isolating them from the public and incarcerating them in spiritual healing camps. Those who attempt to escape maybe chained and lashed (Adu & Oudshoorn 2020; Osafo *et al*. 2015).

In 2003, the National Health Insurance Scheme was introduced aiming to encourage citizens to purchase some form of initial insurance that would enable access to health care when needed. For those experiencing mental illness, most therapeutic interventions and psychotropic medications were, and are still, not covered by the health insurance scheme and this appears to have negatively affected mental health care in the country.

Ghana's mental health care system has been profoundly influenced by Western society, and particularly by the United Kingdom (UK) (Read *et al*. 2009). In 2012, Ghana's Mental Health Act (2012) was passed with the focus on improving mental health care, redefining the administrative line of care, as well as promoting and protecting the human rights of individuals with mental illness. This current Mental Health Act (2012) was influenced by the Mental Capacity Act (2005) and the Mental Health Act (1983) (Revised 2007) of England and Wales. Within the Ghanaian health system, mental health care functions at two main levels: institutional care and community mental health services. The institutional care is further divided into primary care and specialized care, with secure hospitals forming part of the latter.

Self-harm in Ghana

There are few studies about the concept of SH in Ghana and/or neighbouring countries such as Nigeria. For example, Avevor (2007) stated that throughout his medical education he did not come across incidents of SH among individuals residing in Ghana. However, many years earlier Roberts and Nkum (1989) undertook a 5-year case note review of deliberate SH (n = 53) in Ghana at one hospital, highlighting the male –female ratio being 2:1 (age range 15–30 years). According to the researchers, interpersonal relationship issues motivated the act of SH, with self-poisoning being the preferred method (Roberts & Nkum 1989). It has to be accepted that self-harm could have elements of suicidality and associated suicidal intent (Hawton *et al*. 2003), therefore, to broaden the understanding and allow for variance in categorizing self-harm, studies exploring suicide/suicidal ideation should also be explored.

Suicide/suicidal ideation among Ghanaians

Within Ghanian society there are prevailing religious and cultural norms, as well exclusions, that abate against reporting suicide. Suicidal behaviours and/or attempts are criminalized under Ghanian law, and any suicidal behaviours are portrayed as an abomination to the family and are most likely to have consequences for the family and the wider community. The Criminal Code 1960 (Act 29), Section 57, states: "whoever attempts to commit suicide in Ghana shall be guilty of a misdemeanour" (Akotia *et al*. 2016).

Studies by Adinkrah (2014) and Osafo *et al*. (2015) compared suicidal ideation among Ghanaian and Caucasian students in the United States of America (USA) demonstrating significantly lower rates of self-reported suicidal ideation among the Ghanaian sample. A larger survey compared 570 Ghanaian students with students from Uganda utilizing the Attitudes Towards Suicide Questionnaire (Akotia *et al*. 2016). This rating scale was developed by Renberg and Jacobsson (2003) and evaluated by Cwilk *et al*. (2017) for use in the African

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context. Of the Ghanaian sample, 30 (5.4%) reported having made a suicide attempt, but this was significantly lower than the sample from Uganda. In addition, nine of the Ghanaian respondents reported a completed suicide in their family, and 91 reported known suicides among non-family members, again these figures being markedly lower than those reported by the Ugandan respondents (Adinkrah 2014). Though these studies seem to suggest a low rate of suicidal ideation in Ghanaian students, generalization is cautioned, as all the studies were conducted with young, urbanized, highly educated participants.

There is no published data on completed suicides in Ghana. It is possible that the lower reported rates of suicidal ideation or suicide attempts above may in part reflect the likelihood that Ghanaian students would be less likely to report suicidal ideation due to negative societal attitudes towards suicide. Previously this has been supported by the research findings of Odejide *et al*. (1986) who reported 31% of their sample felt that suicide should not be talked about.

People who actively SH or are a danger to themselves or others are, in Ghana and in other countries, often cared for by mental health services and secure units. To date, there has been no studies carried out in Ghana exploring the lived experience of a people who SH in secure mental health hospitals. To explore people experiences, qualitative studies focusing on individual accounts are commonly used.

Aim of the study

To explore the lived experiences of people who Self-Harm (SH) in two secure mental health hospitals in Ghana'.

METHODOLOGY

IPA (Smith 2009) was used to explore the lived experiences of people who SH in secure inpatient settings in Ghana. IPA differs from traditional phenomenological approaches, the latter using description when analysing data, the former introducing interpretation in its analysis (Crowther 2013). IPA advocates researchers acknowledge their basic understanding of a particular phenomenon but also recognize that an awareness of their pre-conceptions may not come to light until work has started in the interview or analysis stage of the research process (Smith 2009). IPA involves a process whereby the researcher attempts to interpret how participants make sense of their experiences (Crowther 2013). IPA aims to explore individuals' perceptions and experiences by taking an idiographic approach, focusing on the individuals' cognitive, linguistic, affective, and physical being. This approach values the importance of each individual narrative, while identifying the contribution each makes towards a larger explanation from a small group of people sharing their experiences of the study phenomena (Smith & Osborn 2004). It is this exploring of the lived experiences and interpreting such experiences that differentiates IPA from other phenomenological approaches (Crowther 2013). IPA focuses on understanding experience with the belief that there is no clear pathway into the lifeworld of others (Smith 2011).

Ethics

The University of Salford Post-Graduate Research Ethics Panel and two Ghanian hospitals (referred to as hospital A and hospital B) approved the study. Ethics approval was predicated on the acknowledgement that individuals who SH have often been traumatized by significant events that happened to them in their life, including abuse related trauma (Rayner & Warne 2015). Talking about such lived experiences during a research interview has the potential to bring those painful experiences to the fore. To minimize the possibility of re-traumatization, strategies were put in place during and after each interview. Participants were reassured that they could stop the interview at any time if feeling uncomfortable. Each participant was offered debriefing session at the end of the interview to say how they were feeling and if they required any further support. Arrangements were put in place for further support if needed. For example, support from their named nurse, psychology team or any member of staff they felt comfortable talking to.

Recruitment

When using IPA, it is suggested that between three and ten participants will provide sufficient data for an in-depth exploration of the chosen phenomenon (Smith 2009). While the intention was to use a convenience sample to recruit ten people who SH, (n = 5) from each of the two hospitals, the number of people who participated was nine, five from hospital A and four from hospital B. There were four inclusion criteria. (i) People who SH within the age range of 20–60 years old. This is the age range of people admitted to secure hospitals in Ghana. (ii) People with

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psychiatric disorder who use SH behaviour while in a secure mental hospital (iii) Those who have the mental capacity to consent and are fit to be interviewed. (iv) Those who have used SH within the last 12 months.

Recruitment to the study was voluntary. Initial contact with the two-hospital managements teams was made via email, with telephone discussions about the research and the proposed recruitment process. Both hospitals required the researcher to attend ward/Patient Council meetings to discuss the research and answer question related to it. Potential participants were also given information sheets about the research and study posters were displayed in ward communal areas.

When recruiting people who SH, the opinion of the potential participant's responsible clinician in collaboration with their interdisciplinary care team was sought. This enabled the researcher to establish if their participation in the study would adversely affect the individual's health, particularly their mental health, and/or whether they had capacity to consent and were fit to be interviewed (Human Rights Act 1998; Mental Capacity Act 2005).

Data collection

Face-to-face semi-structured interviews were used to explore participants' specific experiences of SH, with participants being encouraged to tell their own story in their own words (Smith 2009). This approach promoted in-depth exploration of the participants' lived experiences in relation to their mental ill-health, well-being, and treatment they received (Fusch & Ness 2015; Van Manen 1998).

Interviews were audio-recorded simultaneously with discrete note taking. Using audio-recordings in qualitative research is pivotal in ensuring truthfulness of research findings (Bazeley 2009; Boeije 2010). Note taking enabled the recording of non-verbal cues and gestures not captured by the audio-recordings (Silverman 2013). The interviews lasted no more than 2 hours, allowing time for participants to narrate their experiences without restriction (Bowling 2014; Smith 2009).

Data analysis

The transcribed recordings and notes produced a large amount of textual data. As there is no single way to analyse qualitative data, the researcher can adapt the method to their own way of working and in line with the topic that they are investigating (Van Manen 1998). The value of analysing qualitative data is dependent on the quality of the researcher's notes, the interview transcripts and his/her presence and focus on the in-depth lived experience narrated by the participants (Larkin *et al*. 2011). The focus for qualitative researchers is how to condense raw data into a meaningful conclusion through organizing, summarizing, and structuring the data (Bowling 2014). In this study data were analysed manually, with the researcher familiarizing himself with the data by repeatedly reading the notes and listening to the audio recordings. Interviews were analysed using the principles of the seven steps of IPA (Smith 2009). These are: (i) Transcribing the Interviews Verbatim (ii) Becoming Immersed in the Data (iii) Initial Noting (iv) Further Development of Themes (v) Identifying Connections Across Themes (vi) Analysing the Rest of the Interviews (vii) Identifying Patterns Across all Scripts (see Smith 2009). Smith (2009) proposed that the write-up of findings can be based on the researcher's preference and/or creativity. If adopting an idiographic approach, the researcher will present each individual participant's themes, whereas the thematic approach involves the presentation of themes across all participants' data. In this study the thematic approach was adopted.

FINDINGS

Table 1 offers an overview of the participants' demographic information.

TABLE 1 *Demographic information*

Pseudonyms	Age	Gender	Ethnicity	Employment
AAN	33	Male	Bawku (UE/R) Kusasi	Farming
AVS	32	Male	Anum-Bosso (E/R) Guan	Unemployed
AJM	29	Female	Kade(E/R) Akan	Self-employed
AVN	34	Female	Nkwakwa (A/R) Akan	Petty trader*
AKM	42	Male	Somanya (E/R) Ga-Adagbe (Kobo)	Carpentry & Farming
BPA	35	Female	Kumasi (A/R) Akan	Petty Trader*
BPO	29	Female	Akan (A/R)	Unemployed
BNYO	48	Male	Akan (A/R)	Shoemaker and Farmer
BSED	26	Female	Ewe (V/R)	Midwife

*A Petty Trader is someone who engages in an economic venture involving selling and/or buying goods and services on a small scale.

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When conducting IPA studies, the analyst should initially seek subordinate themes and then finalize the analysis with superordinate themes (Smith 2009). Initially, 20 subordinate themes were identified, but after re-examining these and discussing them within doctoral supervision these were coalesced into 11 subordinate themes. Following this process, three superordinate themes across all participants' data were identified, with a subset of subordinate themes being intrinsic to each of them. Table 2 offers an overview of the three superordinate themes and their corresponding subordinate themes.

Theme 1: Being let down

The first superordinate theme, 'Being let down', illuminated the meanings the participants' attributed to the prompting of their SH behaviour, the latter often being described as an *'illness'* and/or *'condition'*.

The participants' experiences suggest they were not able to 'get what they needed' from significant others. This can be frustrating and discouraging, perhaps affecting their motivation towards achieving self-fulfilment and/or personal goals. It also appeared to prompt hopelessness, helplessness and disappointments for the participants. BPA talked of how her impending divorce impacted her mental health.

> The news of divorce from my husband was a shock and heartbroken as the divorce was unknown to me whilst I was still in our foreign marital home. Since I got to know of the unannounced divorce, I became unwell. As a result, I started seeing life as not worth living.

TABLE 2 *Superordinate and subordinate themes*

Superordinate themes	Subordinate themes
Being let down	Cannot get answers and inappropriate responses
	I am not getting what I need
	Hopelessness, helplessness and disappointments
	Abuse; being unsafe and feeling insecure.
Living with the negative self	The badness within me
	Being confined and suicidal ideation
	Who am I?
	Managing me through challenging times
Forces of the Supernatural & Religion	Ghost of mental illness
	Sharing the Stigma
	Shame & guilt

AJM expressed her thoughts and feelings of hopelessness, helplessness, and disappointment in response to the attitude of care providers. This led to her perception of the future being gloomy and lacking positive expectations. This resulted in her SH and suicidal ideation.

> I do feel hopeless, helpless, and frustrated and at times, it does occur to me to commit suicide.

Within the subordinate theme "hopelessness, helplessness and disappointment" participants' loss of trust in significant others was highlighted. Instead of being helpful, supportive and honest, participants were 'let down' and felt disappointed by those close to them. Due to their lack of control over these situations, the participants felt helpless in what they perceived to be hopeless situations. One way of dealing with their feelings of helplessness was to use SH behaviour and when hopelessness ensued suicide became an option for their disappointments.

Most of the participants gave account of how they were verbally, physically, emotionally or psychologically abused by staff, fellow patients and/or family members. For these participants, their ill-treatment caused them *'hurt'*. BSED was in tears as she described her experience of abuse:

> How disgusted I was, and I said to myself, is that what children are supposed to go through? I thought children are supposed to be joyful, happy, playful with their friends and family and have healthy relationship with their family, but I have been sexually abused by my own dad. So, any time that I experience flashbacks of the abuse, then I will resort to SH and I will think it was not worth living.

Many participants discussed how they experienced stigmatization from family members, the public or by staff during their in-patient care. AVN stated:

> There are some staff when they are on duty, they will just shout at me, scold me and then caution me not to spoil their shift for them following an incident of SH. Nonetheless, some nurses are better and supportive to some extent.

Theme 2: Living with the negative self

In this super-ordinate theme, most respondents verbalized how their SH was associated with their negative self-perception. Within this superordinate theme four subordinate themes were identified, these include the badness within me', 'being confined with suicidal

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ideation', 'who am I'? and 'managing me through challenging times'.

Most participants talked of their perceptions of 'badness within' prompted by a negative self-belief and low self-worth. AKM said:

> I think my incidents of SH might have been linked to the use of marijuana ('weed') in the past and this might have affected my brain. I used to hear voices which were telling me derogatory comments and instructing me to hurt myself and use cutlass to cut myself to expel the badness in me.

BPO blamed the badness within for her relationship breakdown with her boyfriend.

> I started to question myself as to whether there was any fault from me and if there could be any remedial measures to take. So, at times, I do use sharp objects to cut my body to let blood from me as a way of releasing bad substances and cleansing myself.

The instances above could be construed as SH being a means of healing or gaining control over one's 'self' in certain contexts. However, the participants expressed how continued hospitalization had impacted upon their freedom of movement, self-esteem and self-worth; all of which led to self-blame and resulting in some participants resorting to suicidality. AAN and AJM had been detained in hospital based on directives from the court; they had no visits from their family, no supervised community access and no information on their care pathway. Both participants perceived this to be unfair. AJM recounted:

> In this hospital, there is not much activity to do. We mainly eat and sleep. I do feel hopeless and frustrated and at times, it does occur to me to commit suicide.

The subordinate theme of questioning 'who am I? is closely linked to their 'purpose in life', 'disappointments', 'abuse', 'being unsafe and feeling insecure', 'shame and guilt' and 'managing me [self] through difficult times'. AAN grew up without knowing his biological father which caused him to be confused about his paternal lineage, and subsequently led to him questioning his identity.

> I trusted my mother, but she lied to me by not telling the truth about the whereabouts of my dad. When my friends are talking about their parents, their dad, I have nothing to say and some of them do call me names such as a bastard, and I tend to ask myself "who am I?

This would be problematic for AAN, as in his tribe, paternal lineage is important and not knowing about such a figure head made him feel angry, distressed, and envious of others.

For BPA, the concept of 'who am I' is linked to being let down, disappointments, self-deprecation and low self-esteem, all of which made her question her sense of purpose in life and may have been a precursor to her suicidal ideation. BPA recalled:

> The news of divorce was a shock to me, I got so low in mood and depressed and attempted to end it all. I see myself as not a complete human being as I cannot fulfil my role as a woman to give birth for my husband and this seemed to be the root cause of everything.

In Ghanaian culture, large families perpetuating the family tree are valued, and the expectation is that a married couple will have children. Failure to do this can be overwhelming for the woman who will be blamed for not being able to produce children for the man.

Theme 3: Forces of the supernatural and religious beliefs

The final super-ordinate theme of "Forces of the Supernatural and Religion" and subordinate subthemes of 'Ghost of Mental Illness', 'Sharing the Stigma', and 'Shame and guilt' revealed participants' perspectives of life beyond their SH.

AJM believed her illness was *'spiritual'* and that the voices and spirits tell her to follow their instructions and if not, they will attack her. AJM believed her illness was a *'curse'* imposed on her. Therefore, she wanted staff to let her go to a prayer camp for cure and deliverance, but felt staff were not listening to her. She said:

> I told staff that my sickness is not psychiatric illness. It is spiritual and I do see the one that I killed which frightens me. So, I became unwell, and I was taken to a spiritual centre for treatment. When I see him holding the knife that I used in killing him, then, my heart will be beating very fast and the only way to overcome this nightmare is to put myself on the floor head banging until I will not see him again.

BPA's husband convinced her to believe in supernatural forces being the cause of her illness and she would only be healed through the power of a supernatural being (God):

> My husband arranged for me to seek treatment in Ghana with the notion that there might be some supernatural forces which were making me to become unwell.

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Participants described how counselling from church elders, reading the bible and prayer enhanced their healing process and well-being. Being pre-occupied with reading the bible and engaging in trying to help others enabled BNYO to feel better during his recovery process:

> I do read the bible and that comforts me and takes my mind away from any form of hurting myself. I also do sing gospels songs which are ways for me to narrate my troubles to God for his merciful intervention.

The ghost of mental illness is culture bound. In Ghanaian culture spirits or ghosts are perceived to be directly and/or indirectly attributed to a person's ill health. These belief systems about them being the cause of one's illness are at times shared among family members or communities which can impact the recovery process, as they can be linked to rejection, discrimination and stigmatization.

In Ghanaian culture it is believed that spiritual forces influence an individual's personality (Roxburgh 2018). Spiritual forces are often referred to as ghosts, demons, devils and/or negative energies (Nanewortor 2011). Generally, the spiritual forces or a component of the personality is in the form of a ghost or subtle bodies (spirits) of departed ancestors, who determine the individual's personality and destiny. Ghanaians often believe deeds and past events influence personality.

DISCUSSION

The definitions of SH from existing literature suggests that there is no unified and generally acknowledged definition, due to it being a complex phenomenon and one where there is diverse terminology resulting from the various ways of understanding it (World Health Organization 2015). Some of the explanations and/or definitions offered in the literature are in line with the findings of this study (James & Stewarts 2018; Mumme *et al*. 2017). SH was perceived by participants as a way of coping with, and/or communicating, emotional distress such as abuse. Existing literature from western countries suggest SH is usually carried out without suicidal intent (Brown & Kimball 2013; World Health Organization 2014). However, in this study some participants acknowledged having suicidal ideation associated with their SH. One participant stated that their primary motive for SH was to die by suicide. An earlier 5-year longitudinal study of Ghanaian patients who used SH (Roberts & Nkum 1989) reported that most used ingestion of a poisonous substance as the most common method of SH (81%) with simultaneous suicidal ideation. While common methods of SH by participants in this study were superficial cuts to the body with sharp objects, head banging or slapping of the face or body with a hand or an object, two participants had considered drinking poison. No matter how a person defines their SH behaviour, or whether there is suicide intent, the findings from this study suggests that participants were using SH as a medium of communication. It is paramount to note that while this might be the main motive for SH; some individuals may find it challenging to talk about it and particularly the reasons underlying the behaviour. It is essential for mental health nurses to explore the issues underlying the individual's SH behaviours to collaboratively find other means for coping with distressing situations.

The first superordinate theme of 'being let down' reflects participants' perceptions and experience that led to, or maintained their SH behaviour (Larkin *et al*. 2011). Some of the participants used SH prior to their hospitalization, and it was evident they were 'let down' in other settings such as home and/or community. The findings of this study revealed participants had gone through challenging situations in their personal life and often had backgrounds which generated a sense of hopelessness and helplessness. This can lead to negative perceptions of self-and/or others, which can be distressing and difficult to cope with (Wang *et al*. 2020). In Ghanaian culture, sexual abuse of children is sometimes normalized, creating further distress for those who experience it. Acceptance of child sexual abuse within Ghanaian society has been found to exacerbate hopelessness, helplessness and disappointment in individuals who are victims of abuse (Markwei & Osei-Hwedie 2019). These findings together with those of this study clearly demonstrate the need for a well-structured child abuse preventive programme, and the implementation of safeguarding measures to protect and support children who are victims of sexually abusive relationships (World Health Organization 2014).

In terms of mental health services, Ghanaian research suggests the essence of an effective support system and helpfulness enhances an individual's self-esteem, hope and self-worth (Akotia *et al*. 2016). However, a lack of help and loss of hope can trigger maladaptive coping such as SH and suicide. In the current study, some participants expressed thoughts and feelings of hopelessness, helplessness and disappointment triggered by the attitude of care providers. Likewise, Lindgren *et al*. (2011) found participants hoped for

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help and support from staff, but their experiences in care prompted feelings of hopelessness. As a result, they compensated for having their expectations thwarted by using SH to cope with their situation and maintain hope in themselves. It is therefore paramount for health professionals to have a good understanding of the impact of hopelessness, helplessness and disappointment on people who SH. Understanding the impact of these phenomena will illuminate the importance of promoting the positive aspects of self and engendering helpfulness, hopefulness and fulfilment/happiness in their care approaches.

The findings of this study revealed that 'forces of the supernatural & religion' have been identified as central factors in the conceptualization of mental illness and SH. This finding is in keeping with previous studies, especially those conducted in Non-Western countries. In the current study, AJM linked her illness to the supernatural, describing how the voices and spirits tell her to follow their instructions and if not, they will attack her. She believed her illness was a 'curse' imposed on her. This is consistent with other studies regarding the relationship between the conceptualization of supernatural forces, religion and SH (Akotia *et al*. 2016; Osafo *et al*. 2015); While the socio-cultural and spiritual context of a person's life should not be overlooked, it should be understood in terms of the presentation of their mental illness. In the current study participants' spirituality and/or belief in God appeared to instil hope during their healing process, appraising their health status on the supreme spirituality of God. The implication from this study is that religion and/or supernatural forces should be actively included in health care delivery, and that policy needs to focus on redefining and incorporating these approaches into collaborative and holistic health care for individuals (Osafo *et al*. 2015).

In Ghana, SH and its association with suicide is highly stigmatized, and perhaps more important criminalized. In some religious groups it is a taboo subject and a sin to indulge in SH behaviours. Stigma can be initiated from; health professionals (Gibson *et al*. 2019), within the self, and from family members/society (Staniland *et al*. 2021). This study evidenced that individuals who SH can be adversely affected by stigmatizing attitudes on the part of people who would be expected to provide support. Similar findings were indicated in previous studies, whereby participants reported how they experienced stigma from health care staff, patients, and others (Staniland *et al*. 2021). The participants in this study attributed guilt and shame to their SH behaviours. Issues of mental illness, forces of the supernatural, 'stigmatization' and 'shame and guilt' are closely linked, the former three appearing to lead to the latter on the part of the participants. Where an individual deals with such internal stressors in a negative way, this can result in behaviours such as SH. The criminalization of suicide and suicide ideation under Ghanaian Law further complicates the lives of those who use self harm and those who provide care for them. This has implications for mental health professionals and service providers in terms of raising awareness regarding the varied nature and origins of stigma, and how it can have a devastating effect on the lived experience of people who SH.

Limitations of the study

Studies using IPA have the potential for researcher bias to impact participants' meaning making of their experiences during the interpretation of data. The personal and sensitive narratives obtained from the interviews were at times overwhelming and challenged my ability to detach myself and remain objective. Nonetheless, during supervision sessions, I was able to discuss and check out my interpretations, and ensure the findings presented were trustworthy. While the outcomes of qualitative studies cannot be generalized, in this instance to all secure mental health settings in Ghana, the findings provide a basis for future studies to reiterate, add to, or dispute these findings. In doing this a body of knowledge of SH in the Ghanaian context will continue the grow and eventually provide strong evidence that can change practice.

CONCLUSION

There has not been a great deal of research exploring SH in Ghana or in sub-Saharan Africa. The studies who were found all generally identify that the SH rates are probably influenced by the impact of potential negative social attitude, stigma and cost for mental health care. The use of IPA enabled the collection of rich data that illuminated three important super-ordinate themes, highlighting the significance of 'being let down' by others; 'living with a negative self-image' and for Ghanaians, the cultural implications of 'forces of the supernatural and religious beliefs'. While the first two super-ordinate themes maybe considered akin to SH in western society, the final super-ordinate theme is may be considered specific to Ghana and perhaps other non-western countries.

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RELEVANCE FOR MENTAL HEALTH NURSING

There is clearly room for further research in this area and implications for the education and training of mental health practitioners. For staff understanding and acknowledging the complexities and nuances of SH within the context of a person's life, will promote better care and more appropriate treatment. The participants' stories presented in this paper can only accentuate the role of the mental health nurse in taking a detailed history to contextualize the person's mental health problems. This would ensure those experiencing mental illness receive appropriate therapeutic interventions through co-constructed sensitive nursing care. Regarding religious/supernatural forces in relation to SH behaviour, the current research indicates this is a variance from western interpretations. However, with Ghanaian trends in migration rising, those providing care in western society perhaps also need to learn more about these cultural phenomena to ensure the delivery of sensitive care.

ETHICAL APPROVAL

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in University of Salford Repository at URL: https://www.usir.salford.ac.uk/id/eprint/62305.

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