An Exploration of the Lived Experiences of People who Self-Harm in Two Secure/Locked Mental Health Hospitals in Ghana.

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Thesis

Submitted in Partial Fulfilment for the Requirement of the
Degree of Doctor of Philosophy

June 2021

Acknowledgements

Thesis work usually requires the involvement of a lot of people. Therefore, I take this means to express my acknowledgement of my supervisors, my family, colleagues and friends, without whom this thesis could not have been successfully completed. I wish to express my gratitude to Prof Susan McAndrew, my principal supervisor, for her outstanding expertise along with her patience, guidance, endless support and encouragement which made my thesis work complete. My thanks go to Dr Neil Murphy for his additional supervision, dedication, guidance, advice and support which made this thesis stronger.

My sincere thanks to Dr Gill Rayner and Dr Angela Cotton who were my initial supervisors for their involvement in my project work.

I wish also to extend my deepest gratitude to every participant in this project work who contributed their invaluable time for the benefit of others and without whom this project could not have ensued. These participants in my research will always hold a special place in my heart.

A special acknowledgement to the staff of the two study sites for supporting me in diverse ways when I was in Ghana for my fieldwork.

I express a definite thank you to my parents and most importantly, my father who did not live to see the completion of PhD programme who has played an immense role in the person who I have become.

I wish also to express my most sincere thanks to my wife Praise and sons Cyril, Benjamin, and Bernard, who instilled hope in me and assisted me in diverse ways during the duration of my studentship. This research would not have been possible without the patience, love, support and understanding from each of them.

Anyone who has done a PhD programme will recognise the cost and benefits of it. I therefore express my sincere thanks to the University of Salford for the support in my academic programme and anyone who has played a role in this project.

Finally, I will be thoughtless to declare that I have accomplished this thesis work without the presence of God Almighty in my life. He has been my inspiration, protector during this COVID-19 pandemic and has kept my heart full of resilience, joy and hope.

Dedication

I dedicate these words to the participants in the two secure/locked mental health hospitals in Ghana who graciously participated in the journey of this thesis work. Imagine it, sharing your experiences can make a difference. The nursing that we are *practising, there can be the risk of ‘knowing and understanding’ without listening to what is being said* ……………….

Let us provide *non-judgemental* listening ears and an inviting environment for our clients, so we can work smartly together and apply reflexivity in our problem solving and decision-making.

Remember, our best can still be improved upon.

Table of Contents

List of Tables and Figures

Abbreviations

AMH	Accra Mental Hospital
GHIS	Ghana Health Insurance Scheme
GHS	Ghana Health Service
KATH	Komfo Anokye Teaching Hospital
LAO	Lunatic Asylum Ordinance
IPA	Interpretive Phenomenological Analysis
MCA	Mental Capacity Act
MHA	Mental Health Act
MOJ	Ministry of Justice
MOH	Ministry of Health
NMC	Nursing and Midwifery Council
NRCD	National Redemption Council Decree
NICE	National Institute of Health and Clinical Excellence
PHC	Primary Health Care
IMF	International Monetary Fund
SH	Self-harm
SU	Service User
UN	United Nations
WHO	World Health Organisation

Abstract

Background

An increasing number of people who Self-Harm (SH) are being treated in mental health hospitals globally and it is now considered a major health problem. Incidence of SH are common in secure hospitals with those who use SH being highly dependent on staff for care and support, impacting on often limited resources

Whilst literature related to the lived experiences of people who SH and those caring for them in secure settings exists, this is in its infancy in African countries. The aim of this study was ‘to explore the lived experience and perceptions of people who Self-harm (SH) in two secure/locked mental health hospitals in Ghana.

Method

Interpretive Phenomenological Analysis informed a detailed exploration of experiences of people who self-harm in two separate secure mental hospitals in Ghana. A convenience sample of nine participants (two males and three females from one hospital and one male and three females from the other hospital) were recruited to the study. Face to face in-depth semi structured interviews were carried out with individual participants in in-patient settings. With the permission of each participant all interviews were audio recorded and each lasted approximately 60 – 90 minutes. Each interview was transcribed by the researcher and then analysed to identify subordinate and super-ordinate themes.

Findings

Four superordinate themes emerged from participants stories: Being let down; Living with the negative self; Forces of the supernatural and religion; and Living with the positive self. One of the interesting findings of this study is participants’ descriptions of their subjective assessment of spirituality, namely ’ghost of mental illness’, and how they attribute it to their self-harm and its possible treatment. This finding illuminates participants’ life world in the Ghanaian context, highlighting the implications for orthodox medicine and traditional/multifaith healers.

Conclusion

There is a need to develop 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 self-harm. To ensure care is holistic, culturally and temporally relevant more research is needed, particularly in Sub-Saharan Africa.

Chapter 1: Background and Context of the Study

1. Overview

The purpose of this introductory chapter is to present the background to the study and to offer a rationale for undertaking a study on the lived experiences of people who Self-harm (SH) in secure mental health hospitals in Ghana. This thesis is organised into six chapters. Chapter one offers an introduction and personal rationale for undertaking the study, as well as the research questions, aims and objectives of the study. It also provides a background to the study including definitions of Self-harm (SH) and its relationship to suicide, prevalence of SH and suicide, functions of SH and theoretical influences impacting the study are presented. Chapter two presents a review of pertinent literature some of which influenced data collection. The research methodology is presented in chapter three, whilst the findings of the study are presented in chapter four. A discussion of the findings in relation to existent literature is offered in chapter five. Chapter six presents a concluding summary of the work, the strengths and limitations of the research, recommendations emanating from the findings and the unique contribution this research makes to existing knowledge. The next section in this chapter provides a context for the study and elaborates on the health care systems in Ghana.

1.1 Justification of the Study

The central motive for conducting this study is to explore the perspectives of people who SH in secure mental health settings in Ghana. The location for the study was two secure settings in Ghana. From my experience and observation, as a Ghanaian man and mental health nurse initially working in Ghana, individuals living with various mental health problems are not effectively supported or involved in the planning of their care.

Whilst numerous studies in Western society have focused on the lived experiences of people who SH in secure settings, this is in its infancy in Sub-Saharan Africa/Ghana (Smith & Kaminski 2016; Alder & Alder 2013; Sandy & Shaw, 2012). So far, no qualitative study using Interpretive Phenomenological Approach (IPA) has been published on the lived experiences of people who SH in secure mental health settings in Ghana.

My desire in undertaking this study (see section 1.5 for more detail) exploring the lived experiences of people who SH and who are in-patients in secure settings is to influence the development of a service user lead mental health service and supporting policy formulation in Ghana.

1.2 Overview of Ghana as a Country

The present-day territory of Ghana dates to the 11th century when the land was ruled by various kingdoms and empires over the centuries, one such powerful empire being the Kingdom of Ashanti. By the 15th century, various European nations contested the area for differing political motives such as trading opportunities and by the late 19th century the British finally established authority over the land and named it the British Gold Coast (Adomakoh, 1972). In 1957, Ghana gained independence from

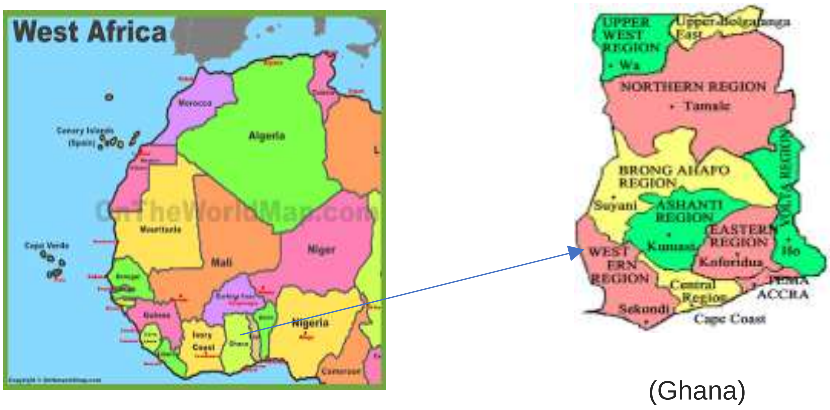
British rule and the name was changed from the British Gold Coast to Ghana, the name Ghana meaning '*Warrior King'* in the Soninke Language (Rodney, 1975).

In 1960, Ghana officially became the Republic of Ghana and a unitary presidential constitutional state in the sub-region of West Africa. The unitary state has been formed from a variety of diverse ethnic groups and/or tribes (Twumasi,1981). The country is surrounded by various countries and located along different bodies of waters, with the Gulf of Guinea and Atlantic Ocean being situated at the south of the country. Ghana also, shares its borders with different countries; and Togo is to be found to the East of the state; Cote D'Ivoire (Ivory Coast) to the West, and Burkina Faso to the North. The geographical land mass of Ghana covers an approximate area of 239,600 square kilometres (92,500 square miles) and is divided into 16 administrative regions/counties and further subdivided into 275 districts which comprise various ethnic groups. The regions/counties comprise Ashanti region/county with an area of 24, 869 km^2(9,601.9 square miles). Brong-Ahafo region/county has an area of 39,557 km^2(15,273 square miles). Central region/county area is 9,908km^2(3,825.5 square miles), Eastern region/county has an area of 19,323 km^2(7,460.6 square miles) Greater region/county area is 3,245 km^2(1,252.9 square miles), Northern region/countys area is 70,364 km^2(27,167.7 square miles), Upper East region/county area of 8,842 km^2(3,413.9 square miles), Upper West region area of 18,476 km^2(7,133.6 square miles), Volta region/county area of 20, 570 km^2(7,942.1 square miles), and Western region/county area is 23,941 kilometre's square(9,243.7 square miles). (See Figure 1 below).

The city of Accra is the capital of the country and the largest city within Ghana. Accra is in the Greater-Accra region/county. The second largest city in the country is Kumasi which is in the Ashanti region/county. The Republic of Ghana is made of various ethnic groups such as the Akans (45%), Dagbani/Mole (16.1%), Ewe (12.1%), Ga-Adangbe (7.3%), Guma(5.6%), Fulani (5.0%), Guan/Gonja (3.7%), Gurunsi(2.5%),Biassa/Mande(1.1%), and other ethnic groups (1.6%). As the country was colonised by the British for a period of time, the official language became English, although the country comprises of languages such as Asante Twi, Akuapem Twi, Bono, Dagaane, Dagbane, Ewe, Ga, Gonja, Kasem, Fante, Nzema, Wasa, Talensi, Frafra, Hausa, and Ghanaian Sign Language (Magesa,1997). According to the World Bank (2013), Ghana is a lower middle-income country, rich in natural resources, and has experienced a rapid economic growth between 2003 to 2007. The Gross National Product (GDP) in Ghana was expected to reach 50.00 USD Billion by the end of 2020, with a growth rate of 6.8%. Most of its sources of income are produced from agriculture, the rest being generated via gold, diamond bauxite, timber, and crude oil. Ghana's health expenditure is approximately 4.5 % of the GDP (Barker et al 2010; Read et al, 2009).

There are three main religious denominations in Ghana, with 71.2% of Ghanaians being Christians (Pentecostal/charismatic (28.3%); Protestant (18.4%); Catholic (13.2) & other 11.3%); Muslim (17.6); Traditional (5.2%); other (0.8%) and none (5.2%) (Johnstone et al., 2015; Magesa, 1997). The cultural background of Ghanaians has influenced their traditional (Christians, Muslims, and Animist) observance (Ofori-Atta et al, 2010). Considering peoples' beliefs, religious values, stigmatization of mental illness and cultural affiliations, individuals often seek mental health care from orthodox systems, alongside other care providers such as faith healers and/or traditional medicine men (Asare, 2003). For instance, about 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 held the notion that it is caused by demons, and it is a bad omen for the family and the nation, and even conventional medicine cannot find a cure for it. Therefore, amidst the conventional health care system, such healers still use crude practices such as exorcising supposed demons in the mentally ill. They also isolate the mentally ill from the public domain by keeping them in spiritual healing camps, and those who attempt to escape are chained and lashed (Adu, & Oudshoorn, 2020; Osafo et 2015).

The figure (1) below shows the location of Ghana in West Africa and its neighbouring countries



(Ghana)

Figure 1 Map of West Africa with Ghana

1.2.1 The Early Stages of Human Habitation in Ghana

During the early stages of human settlement in Ghana, the health system was dominated by the spiritual belief systems of the people, local medicine men or the priests who were consulted for care of the mentally ill, the latter using practices such as divination healing of sick people (Doku & Read 2012; Twumasi, 1981). In the past, mentally ill individuals tended to wander round in their localities where they could be found in bushes, streets of towns and villages and may even be confined to their homes or locked up or restrained by traditional medicine men or faith healers at spiritual camps. Medicines given to such individuals are in the form of herbal concoctions to drink, and at times the family and the mentally ill person are made to fast for a period as part of the healing process. Some individuals experiencing mental illness who are ‘treated’ by healers are exposed to the cane system to exorcise evil forces out of them. When this occurs the mentally ill person can be subjected to a lashing of their buttocks to drive out evil spirits (Read et al., 2009).

1.3 Background of Mental Health System in Ghana

The history of Ghana’s mental health care system has been profoundly influenced by international factors such as Christian missionaries, European colonists, the World Bank, and the International Monetary Fund (Read et al, 2009; Tooth, 1950).

1.3.1 Mental Health Care System in Ghana

The history of mental health care provided to the people of Ghana highlights the way in which stigmatization and discrimination has prevailed (Asare, 2003; Twumasi, 1981). People with mental illness were viewed as dangerous and a bad omen to the family and/or society. In the early days, the mentally ill were locked up in small cells at homes and/or restrained in camps by faith healers or traditional medicine men. However, with the arrival of Christian missionaries, European colonists, and world financial organizations, such as the World Bank, urban clinics were set up where relatives could send their family members who were mentally ill for orthodox treatments. In this direction, family members/next of kin, in collaboration with community elders, acted as the next of kin/ family representative in the referral process of the mentally ill person for orthodox treatment (Nukunya, 2016; Osafo et al, 2015; Asare, 2003).

Ghana was colonised by the British around the 18th Century, and by 1888 there was enactment of the Lunatic Asylum Ordinance (LAO) as a legal framework towards care of the mentally ill. Following the introduction of the LAO, mentally ill people were exposed to police power as they were portrayed as dangerous or at risk to self, others and/or both. Individuals with mental health problems were stigmatised as *'insane'*, arrested, and locked up in a special prison in Accra. By 1906, the first asylum institution was built to accommodate mentally ill people in their care process. 'The Lunatic Asylum', now known as Accra Psychiatric Hospital, was built to accommodate homeless people with mental illness. In the early days, home confinement was authorised, as part of the Lunatic Act (1888) of the Gold Coast (Adu & Oudshoorn, 2020). As a result, if an individual with mental illness was found wandering about in the streets, their family were made to take responsibility in dealing with them. This led to further stigmatisation and resulted in people keeping their family members with mental illness confined to their homes.

By 1957, when Ghana gained independence, the aims of the Government regarding health were focused on curative and/or public health to deal with epidemics and disease outbreaks. However, Ghana went through various regimes, such as a military coup, which influenced health care policy. The Hospital Order Fees Decree (1969), and the Hospital Fees Act (1970) focused on health care with its main aim being economic recovery. Prior to these Acts in the mental health sector, the Mental Health Decree, (National Redemption Council (NRC),1967) was passed, but was not fully implemented. The health Acts and policies evolved over time with various governments, leading to the development of policies such as the 'Cash and Carry System' which required Ghanaians and/or residents of Ghana to pay out of pocket fees at each point of Government health care delivery.

By 2003, the National Health Insurance Scheme was introduced. This led to the establishment of the National Health Insurance Authority which licenses, monitors, and regulates the functions of health insurance schemes. The aim was to encourage citizens and/or individuals residing in the country to make some form of initial insurance or upfront payments so they could have access to health care when needed. All expenditure from the individual's care during each hospital attendance was to be sponsored by the insurance scheme. However, 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 affected mental health care negatively in the country.

1.3.2 Present Structure of Mental Health Care within the Ghanaian Health Service

By 2012, Ghana's Mental Health Act (2012) was passed with the focus on improving mental health care, redefining the administrative line about 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 specialised care.

1.3.3 Primary Care

Primary mental health provides care for individuals with potential mental health problems who visit general hospitals but may be diagnosed with mental health problems and/or the doctor suspects mental health problems in such individuals. For example, an individual may present with persistent headache, high blood pressure, or feeling unwell or anxious for a period. The doctor will then deal with the physical health problem, but if the problem persists and no underlying cause is found, the person may be referred to the psychiatric unit/clinic which are within the hospital for further assessment and management.

The Mental Health Act (2012) authorised the creation of mental health units. These were set up as short stay and/or assessment units in each regional/county hospital to deal with individuals' mental health issues. Regional/county mental health units provide services such as initial assessment and referral services to the main psychiatric hospitals and outpatient services. At times, the units receive referrals from the main psychiatric hospitals as a step-down service for those who have recovered and may only require outpatient services. These psychiatric units/clinics found within each district and regional/county hospital have a work force of regional/county community mental health teams who are responsible for care of the mentally ill within their catchment are. At district level, the team comprises psychiatric nurse/ community psychiatric nurse and other support staff, and at regional/county level, the team includes a psychiatrist(s), psychiatric nurses, and other support staff.

1.3.4 Specialised Mental Health Care

At this level of care, individuals with severe and/or moderate mental health issues are attended to by a team of mental health staff, and they are usually a referred from the primary care system. The institutional care comprises three main national and/or public hospitals and some independent psychiatric hospitals. The three main state hospitals are the Accra Psychiatric hospital established in 1906 with a bed capacity of 800; Ankaful Psychiatric hospital; Cape Coast, built in 1965 and having a bed capacity of 500; and Pantang Hospital built in1975 with the aim of supporting bed capacity at the Accra psychiatric hospital. The hospitals offer assessment, treatment and rehabilitation, outpatient services, referral services, as well as follow-up for those who have been discharged and/or showing signs of relapse.

1.3.5 Out-Patient Service/Community Psychiatric Nursing

The mental health clinic/units do provide out-patient care to individual with mental illness. Community psychiatry started around 1975 and Community Psychiatric Nurses' (CPNs) are affiliated to various hospitals or psychiatric units to provide mental health services to individuals in their catchment areas (Asare, 2003). Funding for community psychiatric nursing falls under budget management centres, where they can plan their activities to be incorporated into the activities of their defined catchment areas (Doku et al, 2012).

The CPNs (RMNs with additional one-year specialist training towards care of people with mental health problems in the community) provide outreach day and night services to individuals in the locality. Their services include assessing individuals with potential mental health problems and referrals to various hospitals for observation and management. The CPNs make follow-up home visits to individuals who have been discharged from the hospitals into the community and they do liaise between the community and hospital in care and management of people with mental health issues (Asare, 2003). About 180 CPNs have been trained and assigned to the 16 regional/county capitals and 110 districts of the country. The districts without CPNs are supported by the nearest catchment area with CPNs.

1.3.6 In-Patient Care

In-patient care is provided by the specialised hospitals where there are locked wards. Admission to specialist hospitals is done under the auspices of psychiatrists and this could be for a long or short stay based on the individuals' health/risk issues. Common reasons for admission to the specialist hospitals are acute mental illness, elderly people with mental illness, people with dementia, child and adolescent mental health problems, personality disorder, suicidality and/or self-injury, alcohol and/or drug related conditions and long stay rehabilitation (Doku et al, 2012; Akondo, 2011; Asare, 2003).

1.3.7 Forensic Psychiatry in Ghana

Forensic psychiatry in Ghana dates back 320 years, when the land was colonised between the years of 1701-1800; and during the first half of 19th century and psychiatry has evolved over the years (Walker, & Osei 2017; Kaliski et al, 2014; Doku et al, 2012). The Lunatic Asylum Ordinance (1888) led to the establishment of prisons and asylum hospitals that provided custodial care to the mentally ill. In the past, people with mental illness were kept in custodial care and/or prison, but their custodial care was not covered by the Mental Health Act (Doku, et al, 2012). Their arrest and detention in custodial care were mainly considered on merits of diminished and/or lack of responsibility (Kaliski et al, 2014; Doku et al, 2012).

It is interesting to note that throughout the world, there are differences between countries in relation to the level of development regarding forensic mental health services (Doku et al, 2012; Akondo, 2011). As such there has been confusion in relation to the application of forensic psychiatry in Ghana. The Mental Health Act (2012) was implemented to deal with individuals with index offences/offending history of high-profile cases; individuals with mental disorder who commit crimes such as homicide, assault, robbery (Kaliski et al, 2014; Doku et al, 2012). Also, the law focuses on the extent of responsibility that the individual had at the time the crime was committed (Mental Health Act, 2012). If a person is brought before the high court of justice and found not guilty by reason of ‘loss of their mind’, they are likely to be referred to a prosecutor. The prosecutor then reports to another level of the court system requesting a decision as to whether the person needs medical treatment within the law. The decision is then made by both medical and legal experts using specific assessment criteria. If it is deemed by law that the individual requires treatment, a hospital order is authorised for their detention in specialist forensic services and if not mentally ill, the individual is re-referred to the court system for trial proceedings (Mental Health Law, 2012).

1.4 Decentralization of Mental Health Services

The origin of decentralising mental health services in all the regional/county capitals was designed to ease congestion in the three main psychiatric hospitals in Accra, Ankaful and Pantang and to make mental health services accessible to residents of Ghana living in remote places (Doku & Read 2012; Asare, 2003; Twumasi, 1981). As a result, policy was put in place to provide psychiatric care in general hospitals and other facilities in the community (Asare, 2003). This led to the creation of psychiatric units and/or department within each regional hospital of the country with various bed capacities for short stay admission purposes. That is, the policy enabled the creation of beds and/or in-patient services attached to each of the ten regional hospitals across the country. This included a psychiatric unit being established in Ho the Volta Regional/county capital; at the Komfo Anokye Teaching Hospital in Ashanti region/county; at Wa in Upper West Regional hospital in Sunyani General Hospital in Brong-Ahafo region/county; and in Koforidua general hospital in Eastern region/county.

Within the above organisation of mental health care there is an overall management structure to ensure smooth running of all the facilities. The mental health unit operates as a separate and/or autonomous entity within the Institutional Care Division of the Ghana Health Service. Within the Institutional Care Division of the Ghana Health Service there are five other divisions comprising: Public Health, Human Resource, Project Planning, Monitoring and Evaluation, Hospital Administration and Support Services and Stores and Supplies Divisions. The Mental Health Unit is represented at the Headquarters by the Chief Psychiatrist and the National Co-ordinator of Community Psychiatry. Although these structural arrangements are in place, the mental health sector is still underfunded (Walker, & Osei 2017; Kaliski et al, 2014; Akondo,2011).

1.4.1 Ghana Health Service and Ministry of Health

The Ministry of Health (MOH) is the government ministry responsible for the health of Ghana. It provides public health services, managing Ghana’s health care industry and building hospitals and health education systems. The MOH is responsible for policy formulation, monitoring and evaluation, resource mobilization and regulation of health service delivery in the country. With the enactment of Act 525 (2012) of parliament, the functions of preventative, curative and rehabilitative care have been delegated to the Ghana Health Service and Teaching hospitals (Kaliski et al, 2014; Akondo,2011). The Ghana Health Service (GHS) was established in 1996 as part of health sector reforms and it is regulated by, and accountable to the MOH. The mental health unit is a subset of the Ghana Health Service (Asare, 2003; Underhill et al, 2003).

1.5 Types of Admission Procedures in Ghana

The Mental Health Act (2012) established various types of admission; voluntary admission and/or involuntary admission of patients. Admission can be facilitated by the following: Compulsory admission/ Emergency admission must be authorised by a psychiatrist that a person (vagrant person) needs psychiatric care due to the individual being a risk to self, others and/or both. This form of admission does not require consent from the individual and the length of hospitalisation is determined by the point at which the person is no longer a risk to self, others and/or both.

Also, admission can be facilitated via a court order and/or emergency admission which is an order from the court authorising hospitalisation of an offender who presents with mental health problems and is a risk to self, others and/or both. The person is admitted into a psychiatric hospital/facility for observation, assessment, and management. In this case, a psychiatrist determines if such a person needs psychiatric care and custody due to risk of harm to self, others and/or both. Initial length of hospitalisation is six months and is reviewed at the end of that period for further detention, being sent back to court for trial, or being discharged. Another form of admission is voluntary admission, and this requires consent from the individual and/or their family, with the length of stay depending on the patient's progress of recovery. The next section discusses my rationale for choosing this topic for study.

1.6 Professional Rationale for Choosing this Topic

There are several indicators that are central to undertaking this study, these being:

- Mental illness and Ghanaians' perspective and attitude
- Self-harm in secure settings through a psychoanalytical lens

1.6.1 Mental illness and Ghanaians' Perspective and Attitude

The WHO (2020) estimates about 31 million people are living in Ghana, and 650,000 are suffering from a severe mental health problem and a further 2,166,000 are suffering from moderate to mild mental disorder. Also, according to the statistical department of Ghana the current population of Ghana is about 31 million based on projections of the United Nations (UN) data. The UN has compared Ghana's annual growth rate from 1985 to date and indicated that the current annual population growth is 2.15%. This appears to have slowly decreased from 2.95% in 1985 but remains high. The main cause of this growth is Ghana's high fertility rate of 3.89 births per female and the country's effort to minimize mortalities (WHO, 2019; UN Statistics, 2017). The life expectancy is 70 years, and the residents are prone to various health problems such as malnutrition, malaria, typhoid fever, diarrhoea, meningitis, poor reproductive and mental health care (WHO, 2019; UN Statistics, 2017; Paul et al, 2014; The Bureau of Ghana languages, 2006).

Cultural beliefs and family play a vital role in Ghanaian society and cultural values are considered a dominant factor in the life of individuals in Ghanaian society (Nukunya, 2004). Also, religious beliefs have influence on the Ghanaian cultural practices (Abotchie, 2006). The Ghanaian culture has been described by the interaction or ties those individuals have with their family lineage, relatives, friends and neighbours and this is linked to various ethnic groups who live in unity with diverse views and practices (Abotchie, 2006; Twumesi, 1987). Various ethnic groups and cultures have their traditional and/or religious beliefs acting as an important factor in the determination of their destiny, health, well-being predispositions, precedents, and laws of the communities (Nukunya, 2016). Any deviations from these cultural values, regulations and practices can have repercussions for the individual and/or the family. Also, repercussions and being cursed by the Gods/Deities (who are presumed to be the governors of the living and the dead) can be passed on from generation to generation in the form of dreadful disease conditions such as mental illness (Osafo et al, 2015; Twumesi, 1989). In Ghana, the cultural belief is that people with mental health problems are dangerous and a bad omen for the family and society (Opare-Henaku et al, 2017; Nukunya, 2016; Osafo et al, 2015; Awenva et al, 2010).

Various studies have reiterated the role of spirituality in the causation of mental illness, and reliance on the supernatural powers of God for divine intervention (Osafo et al, 2015, Nukunya, 2006). This is reflected in names given to Ghanaians and/or greetings in various vernacular/languages from various ethnic groups. Such names include, ‘Gye Nyame (He who knows and see everything), ‘Omniscient and Omnipotent’ (powerful God), and in the Ewe dialect the names ‘Mawuli’ meaning ‘God Exists (Adinkrah, 2014, Awenva et al, 2010). Therefore, it is believed that the Gods/deities have powers to avert any calamity or can impose a bad omen on individuals or families and they operate through various faith healers and traditional medicine men (Nukunya, 2016).

In Ghana, the cultural value system is based on extended family, where loyalty of a person to a group exceeds the rights of the individual and this is reflected in the role the family has in the health care of their people. The exception to this cultural rule is those who are mentally ill, and whose relative often find it unbearable and uncomfortable to live in the same environment as these people (Arias et al, 2016; Osafo et al, 2015; Dye et al, 2014; Doku, et al, 2012; Abdullah & Brown, 2011; Sodzi-Tetteh,2007). The way in which people with a mental illness are treated in various communities tends to impact negatively on their self-concept, confidence, self-esteem, and coping mechanisms. In addition, those experiencing mental illness may feel stigmatized when living in co-existence with others, and at times such perceptions of self-victimization on the part of the individual may result in use of high-risk behaviours such as SH and/or suicidal ideation (Osafo et al, 2015; Adinkrah, 2014; Favazza, 1998). The health care system in Ghana has evolved over the years with phenomenal growth in orthodox care alongside traditional care (Adinkrah, 2014, Awenva et al, 2010). That is, considering peoples’ beliefs, religious values, stigmatization of mental illness and cultural affiliations, individuals often seek mental health care from orthodox systems, alongside other care providers such as faith healers and/or traditional medicine men (Asare, 2003).

1.6.2 Self-harm in Secure Settings through a Psychoanalytical Lens

It is central to note that exploration of the lived experiences of people who SH and the impact of their behaviour in secure settings/locked hospitals are yet to be illuminated. From a Western perspective I found it is helpful to consider self-harming behaviour through a psychoanalytical lens, but this is yet to be explored in the Ghanaian context. Whilst literature is sparse compared to other areas of mental illness within a Ghanaian context (outlined earlier in this chapter) it none-the-less has relevant to this study.

According to Freudian theory, individuals develop their inner core of the 'self' or personality through their lived world (Freud, 1923). Freud's (1923) concept proposed that the body and the mind are inter-related and that is why individuals choose to SH. In Freud's typology of the 'id' 'ego' and 'super-ego' he proposed that the ego, the part of the personality responsible for dealing with reality, is influenced during the early developmental stages, when the child becomes orientated to the immediate environment, primarily made up of the immediate family such as parents' and siblings. During the latter part of the developmental stage, individuals become more orientated to the external world and their ego, sometimes referred to as 'self', develops through gradual identification with others. Similarly, a secure sense of self development is attained through interaction with significant others who are caring and loving, and this would yield to effective bonding and effective adult coping mechanisms. The 'self'/ego holds the individual together, safeguards coherence, whilst allowing interpretation of the individual's lived experiences to effectively adjust to their environment. Any shortfalls in this process can lead individuals to use maladaptive behaviours such as SH (Freud, 1923). That is, if there is a lack of attachment and sensitive mirroring between parent and infant, or when a child's early experiences are engulfed with traumatic events such as abusive significant figures, the child internalises pathological attachment relationships and an impaired ability to apply effective emotional regulation. In this instance, the healthy development of the sense of self will be impeded and is poorly differentiated from internal representation of significant others. As such, the individuals' ego becomes fragile and relies on maladaptive defence mechanisms such as projection, projective identification, and splitting, to avoid emotionally distressing situations. This can lead to situations whereby anxiety-provoking events cannot be facilitated in the mind but are instead enacted and communicated via the body through SH (Freud, 1923). Based on the psychoanalytical lens, Favazza (1988), suggested when the body is under siege and/or emotionally traumatised, the speaking body uses SH as a form of communicating painful emotional distress.

Favazza concluded that the individual human body mirrors the collective biopsychosocial state of the 'self', and each continually creates and sustains or impacts on the other. Therefore, exploration of feelings of guilt, negative self-images, and all other maladaptive behaviours associated with mental illness or SH defy understanding without reference to the psychological, social, cultural and physical integrity of the central body. The intersubjectivity present in the psychotherapeutic encounter may help deal with inherent distress experienced by those who SH (Favazza, 1998). However, within the context of Ghanaian culture the role of spirituality as a causation of mental illness also needs consideration alongside the psychodynamics theories presented in this section.

1.6.3 Government Policy

The current global changes and innovations in health care has resulted in changes in international health policy directives (WHO, 2014). However, Ghana is still applying some aspects of its 1972 Mental Health Decree which advocates for institutional care to the detriment of providing mental health in primary health care settings, which is contradictory to international policy directives. For instance, the procedure for involuntary admission in the Mental Health Act (1972) did not sufficiently protect people against unnecessary admission (Walker & Osei 2017; Doku et al, 2012; Akondo, 2011). Such situations led to undue detention of individuals, resulting in some people been involuntarily locked away in institutions for decades (Ghana’s Mental Health Decree,1972). In recent years, and in still applying the now outdated Mental Health Decree (1972), Ghana has developed much of its health care practices and policies based on a blend of those from Western Countries such as the UK, (WHO, 2016). This appears to have resulted in some level of confusion in terms of effective application of the Acts to protect the human rights of individuals regarding mental capacity and consent (Doku, et al, 2012; Akondo, 2011).

Being aware of the chaotic nature of policy and its lack of implementation, I became concerned about policy, treatment, the cultural impact on decisions, and Government funding for the mentally ill. For instance, Ghana’s Health Insurance scheme does not cover all expenses for the treatment of mental illness (Anokye et al, 2018). According to Awenva et al (2012), the current government financial budget allocated to the mental health sector is funded by government and supplemented by a minute amount of internally generated funds and donations. This has led to insufficiency in budgetary allocation for Ghana’s mental health services, resulting in poor mental health care (Awenva et al 2010). Also, some of the people experiencing mental illness have been locked away in psychiatric hospitals for decades without any defined review processes in their care pathway (Anokye et al, 2018; Walker & Osei 2017).

The mental health system in Ghana is currently experiencing pressure from within and without regarding its purpose, policies, and procedures in relation to practice and research (Walker & Osei, 2017). In response, the MOH and Ghana Health Services have passed a new Mental Health Act, (2012) to promote best practice in treatment and care, and to protect the human rights of people who experience mental illness (Walker & Osei, 2017; Doku, et al, 2012). While people who SH have their individual distinct lived experiences, learning about policy, treatment, the cultural impact on decisions, and restricted Government funding for the mentally ill, prompted me to think about what could be done to make a difference to people who SH in secure settings in Ghana, within the framework of the Mental Health Act (2012).

1.7 Policy & Legislation in Ghana in Relation to Mental Health

As Ghana’s mental health care policy has been influenced by the Mental Health Act of England and Wales (1983), the next section sheds light on health care and secure services in the UK, in order to draw links between the two mental health care systems in the UK and Ghana.

Global health reports suggest that mental disorders are becoming one of the leading causes of disability, but in Ghana, there are no available or functional mental health policies and procedures in place for focusing on clinical governance of the mentally ill (WHO, 2014; Omar et al, 2010). A nation's health policies are strategies and plans that guide health care delivery to their citizens and/or individuals residing in the country. Studies indicate that only half (50%) of countries in Africa have a mental health policy, in particular their mental health laws are either weak and/or formulated, but not in total use, with Ghana being no exception (Doku et al, 2012). Ghana is configurated and organised differently to the Western world (WHO, 2016), yet Ghana has derived its much of its health care practices and policies based on a blend of those implemented in Western Countries.

The World Psychiatric Association postulate that the shortcomings regarding the development of mental health institutions and programmes of treatment are in relation to various government budgets not being focused on mental illness, and in particular, inadequate provision of human and material resources for dealing with mental health problems (Doku & Read, 2012). Also, there is stigma associated with seeking psychiatric care (Asare, 2003). It is estimated that in Ghana, at least 2,816,000 people do suffer from some form of mental health problem, but only 1.4% of the total health budget is devoted to psychiatric hospitals (Doku & Read, 2012). Moreover, it is estimated that there is one psychiatrist per 1.5 million people in the country and as such, the three main state psychiatric hospitals, Accra Psychiatric Hospital, Pantang Hospital and Ankaful Hospital, are underfunded and understaffed (Blanchet et al., 2012).

Ghana's mental health policy is driven by the WHO global and regional strategy for mental health (WHO, 2012). Mental health is under the umbrella of the overall programmes of the Ghana Health Service. Reports indicate that Ghana's mental health policies and laws have been in existence since 1888 with emerging policy formulation and review over the years.

Ghana's mental health care focused on community-based services, the integration of mental health into general health care, promotion of mental health and rehabilitation and/or prevention of mental illnesses. While the new Mental Health Act (2012) stated values and principles required in coordinating mental health care, as well as protecting the human rights of individuals, little attention is paid to procedures involved in identifying human and material resources in terms of funding for implementation. Such resources would include, staff training, a recruitment, and retention strategy, as well as advocacy services and empowerment of the service users and their family/carers. Table 1 below is a chronological ordered series of policy and mental health care initiatives that aims to provide a brief synopsis of mental healthcare development/ changes in Ghana.

Table: 1 Policy and Mental Health Care in Ghana

1888 The first mental health legislation	The Lunatic Asylum Act of Gold Coast. It was more for providing custodial care, rather than for treatment purposes.
1906 The first Asylum was opened	The Accra Asylum hospital
1972 Mental Health Decree (NRCD, 30).	Replace the Lunatic Asylum Ordinance. It was however never implemented (Doku et al 2012). The 1972 Mental Health Decree gave the directives in treatment of the mentally ill as if they had no rights. Financing of mental health treatment at in-patient and/or outpatient levels was supposed to be free. This provision is termed ‘decree’ as it was put in place by a military regime but not through constitutional regime
1975 Community Psychiatric Nursing	Introduction of community psychiatric nursing in order to work in collaboration with the primary health care system.
1986 National Therapeutic Drug Policy/Essential List of Drugs	This was introduced as guidance for prescribers of various medical and psychiatric medications
1990 Substance Abuse Policy	This included three main laws such as the Narcotic Drug Control, Enforcement and Sanctions law (1990), PNDC Law 236 and Pharmacy and drug Act (1961)
1992 Mental Health legislation	The NRC, Decree 1972, Mental Health Law, was revised in 1992 and 1995 and has been in draft form for a long period of time. This was supposed to be an improvement on the Mental Health Act (1972), with the focus of responsibilities being on the head of institutions of psychiatric hospital, in particular Accra Psychiatric hospital, without taking due consideration of other psychiatric hospitals on the country.
1994 National Mental Health Policy & programmes	National Mental Health Policy & programmes was formulated in 1994 and revised in 2000. Some of the identified weaknesses of the law were that it was more focused on institutional care with little and/or no emphasis on the community and rehabilitation components of mental health care. The provision of facilities in general hospitals was not enshrined in the law and did not address specific Human Rights of the services users. Also, the law did not cover care of the mentally ill outside psychiatric hospital, in particular those who sought help from faith healers and/or traditional healers or medicine men and spiritual homes and camps.
2006 Mental Health Bill	This drafted bill in 2006 was presented to parliament (Walker & Osei 2017). This legislation promotes Community based mental health care and protects the rights of people with mental illnesses.
2012 The Mental Health Act	The Mental Health Act (2012) replaced the 1972 Mental Health Decree (NRCD, 30).

1.8 Self-Harm (SH) and its Relationship to Suicide

Various terminology is used to describe SH and suicidal behaviour including self-injury, self-inflicted violence, self-injurious behaviour, and non-suicidal self-injury (American Psychiatric Association (Curtis, 2018; APA), 2013; Klonsky, et al 2013; James et al., 2012; Lewiecki & Miller, 2012; Hawton et al., 2007). According to Hawton et al. (2012, *p13*), SH is "*self-poisoning or self-injury regardless of the intent.*" Recently, there has been a move to differentiate between non-suicidal self-injury (NSSI) and suicidal behaviour, the former being proposed as a new diagnostic category in the Diagnostic Statistical Manual of Mental Disorders V (APA, 2013). NSSI can be viewed as the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned. It includes behaviours such as cutting, burning, biting, and scratching skin (APA, 2013). The criteria for NSSI include five or more days of self-inflected harm over the course of one year without suicidal intent, and the individual must have been motivated by seeking relief from a negative state, resolving an interpersonal difficulty, or achieving a positive state (APA, 2013). NSSI has been listed as a proposed disorder in the DSM-5 under the category '' Condition for Further Study. This proposal of diagnostic criteria for a future diagnosis is not an officially approved diagnosis and may not be used for clinical situations, but is meant for research purposes only (APA, 2013). According to the Oxford English dictionary, a lay definition of SH suggests '' deliberate injury to oneself, typically as a manifestation of a psychological or psychiatric disorder'' (2010). The definition can be used to understand more clearly why someone might SH and how they might access help.

Research suggests the visual perception of SH is of a human behaviour and that the concept of SH is not a natural act, but an aggregation of unlikely acts which individuals make meaning from, and this may vary from person to person (WHO 2012; Adler & Adler, 2011; DoH, 2009; Hawton et al., 2008; NICE, 2004). When people SH they may be both suicidal and non-suicidal at the same time, or simply do not know as they are in distress (Marshall et al., 2016). Other people are very clear about the function of their behaviour being of non or suicidal intent (Rayner & Warne 2015; Butler & Malone 2013; Zetterqvist et al., 2013; Chandler et al., 2011; Klonsky 2009; Hawton et al., 2007). Tsirigotis et al. (2015) investigated participants who SH and/or attempted suicide (n=147; 114 females and 33 males). The aim of the study was to investigate the link between participants' indirect self-destruction and their suicide attempt. The researchers used valid and reliable assessment tools such as the adapted Polish version (Tririgotis, 2015; Schutte et al, 2009) of the 'Chronic Self-Destructiveness Scale' (CS-DS) (Kelley, 1985). The Polish scale comprises the following categories: Transgression and Risk (test for street drugs), Poor Health Maintenance (test for physical health), Personal and Social Neglect, Lack of Painfulness, and Helplessness and Passiveness in relation to problem issues. Results indicated that there was a significant relationship between indirect-destructiveness and methods of suicide. It was also noted that helplessness and passiveness were the main determinants of SH and/or suicide (Tsirigotis et al., 2015).

The use of terms NSSI and SH vary between health settings in Western society and those used in Ghana. SH is commonly used in mental health practice in the UK and Ghana, and for clarity, the term **SH** will be used throughout this thesis, except when explaining terms used by other authors. It is important to note that various guidelines and published literature offer no universally accepted definition of SH (WHO, 2012; Brausch & Guiterrez, 2010; DoH, 2009; Mental Health Foundation (MHF), 2008). The best way of defining SH is from the lived experience of those who SH (NICE, 2011). However, the NICE (2011) definition and guidance on SH adopts a neutral stance, and for this thesis this definition will be utilised:

''An expression of personal distress, usually made *in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion and should not be presumed to be the same.'' (p.8*).

Most of the literature on SH focuses on the motives behind the behaviour which are often interpreted as a coping mechanism, an emotional release from distress, body decoration or a deceptive effort to gain the attention of health professionals (Segal et al, 2016; Marshall et al, 2016; McAndrew & Warne, 2014). The meanings and parameters of SH are also reported in the literature. In a study by Nielsen et al. (2016) on people who SH (n=1,157), with an age range of 16-49 years, and who had received in-patient care, were surveyed. The study examined their ways of coping with distress in the previous three months. Results showed 40% of the respondents who had used SH within the last three months noted symptoms of anxiety, depression and poor emotional regulation were triggers to their SH (Nielsen et al., 2016). It was concluded that triggers to SH may differ from one situation to another. This finding is in keeping with the evidence recognised by NICE (2011).

Some authors (Marshall et al., 2016; Hawton et al., 2007; Klonsky & Muehlekamp, 2007) have proposed that the most common form of SH is skin cutting. However, SH can also be behaviours such as, but not limited to, banging, or hitting body parts, interfering with wound healing (dermatillomania), hair pulling (trichotillomania), tattooing the body, burning, scratching and the ingesting of toxic substances or objects. A study by Klonsky, (2007) noted that 8% of SH involves stabbing and/or cutting the skin with a sharp object. Various reports and studies, (DoH 2015; Hawton et al., 2014; WHO, 2015; NICE, 2004) suggest that it is challenging to get accurate data on those who SH, as many may hide their incidents and some may not require medical attention; therefore, compromising the accuracy of available statistical data (Long et al., 2013).

In the United State of America (USA) approximately 4% of the population are reported to use SH as a means of coping (Deborah, 2008), and it is the eighth-leading cause of death in the USA (Rockett & Caine, 2015).

Jackson (2010) conducted a case note survey to examine the prevalence and frequency of SH among male secure patients. In total 127 men aged between 17-65 years with mental and/or psychopathic disorder and detained in a high secure setting in the UK took part. The study revealed 24 (19%) of the participants had engaged in SH during the previous six-month period and there were 122 separate incidents of SH. Of the participants taking part, 13 (14%) with a mental disorder engaged in SH. It was also noted that those who engaged in SH were younger (mean age = 31.21years) than those who did not (mean age = 38.47 years) (Jackson, 2010). This study suggests that age plays a role in the act of

SH. However, it was not clear as to why this occurs (Jackson, 2010). One weakness of the study is data was collected from an incident logbook kept by nursing staff. As it is noted that SH is usually done in a hidden way, the available incident log might not give an accurate account of the prevalence and frequency of SH acts (Long et al, 2012).

There are some reports on the prevalence of SH behaviours among various ethnic groups. Studies in Britain have found that women of South-Asian ethnicity have a higher-than-average rate of SH compared with white men and women (Bhugra & Desai, 2002). Those under 35 years are at higher risk than older women, but there were inconsistent findings for SH rates among teenage girls. South Asian women who engage in SH have also been found to be less likely than their white counterparts to have a psychiatric disorder (Husain et al., 2006). Similarly, Dickinson et al. (2009) conducted a study on the incidence of SH in various ethnic groups during the period 2005- 2007 in the Manchester area of England. The results indicated black women had higher rates of SH than any other group. Rates for black women were 24% higher than for white women aged 16 years and over. South Asian women also had slightly higher SH rates than white women. These results differed from the rates for males, in which white men had the highest incidence of SH, followed by black men and South Asian men. Individuals from other ethnic groups (including Chinese and mixed race) had the lowest SH rates overall. Chinese men had very low rates of SH at 44 per 100,000 population. Rates in Chinese women, however, were over three times as high, at 154 per 100,000 (Dickinson et al., 2009). Tiatia-Seath et al. (2017) carried out a longitudinal study over the period of 1996 to 2013 with the aim of describing trends in suicide mortality for Pacific people in New-Zealand. In this study, death registration was used to examine the underlying cause of SH and/or suicide. Results showed that there were 380 Pacific suicides (4.1%) out of 9,307 suicides nationally (Tiatia-Seath et al 2017). Using a psychological autopsy study, Kodaka et al. (2017) explored the psychological and psychiatric characteristics of suicide completers in Japan using semi-structured interviews with bereaved family members and/or close friends of those who had died. The study aimed to explore gender differences in those who had died from suicide. Result revealed that (n=28) of the sample (those who had died by suicide) were females and (n=64) were males. Females had a significantly higher prevalence of a history of SH and/or suicide attempts ($p< 0.001$).

These studies suggest SH and suicide are different concepts but may be a conceptually interconnected episode (Rayner & Warne, 2015; Hawton et al., 2014). This speculation is evident in studies about service users' perceptions about the phenomenon of SH (McAndrew & Warne, 2014; Freeman, 2010; Cuellar & Curry, 2007). While SH may not be inherently suicidal in nature, people who frequently SH are commonly considered at high risk of suicide (Hawton, et al, 2013, Cuellar & Curry, 2007).

1.8.1 Self-harm and violence

According to a Ministry of Justice (MoJ) (2011) study in high secure hospitals in the UK, people with mental health problems are at greater risk of SH than those who have been through the criminal justice system and are also at increased risk of suicide. A case control study by Hawton, et al. (2013) carried out between 2004 and 2009 and focusing on people who SH in secure settings in England and Wales, suggested some links between SH and subsequent suicide. The aim of the study was to establish the prevalence of SH in relation to triggers and/or risk factors related to subsequent suicide attempt following SH. Results of the study identified 139,195 SH incidents in relation to 26, 510 people. Moreover, SH rates were more than ten times higher in females than males, and 5-6% of males and 20-24% of females SH on an annual basis (Hawton et al., 2013). This suggests that SH in secure settings is more common in women and is linked with successive suicide attempts in such settings. Even though regular SH may arguably increase further suicide risk, it cannot be assumed that all people who SH have suicidal intent. Moreover, some people who SH do not intend to kill themselves, but do so by accident (Rayner et al., 2014, Wilkinson, 2013; Allen, 2007).

A study by Selenius et al. (2016) regarding the incidence of SH among female service users in secure settings (n=130) indicated that 88% have SH at least once in their lifetime, and 57% presented with physical and/or verbal aggression towards staff and/or peers (Selenius et al., 2016). Also, Slade's (2018) UK study concluded that patients who engage in SH and violence are common in secure/ in-patient settings/institutions. Slade (2018) termed harm to self (either as SH or suicidal behaviour) and engaging in harm to others (violence towards others) as 'dual harm'. Slade noted that the prevalence of dual harm in secure settings is between 11 and 16% in men, but lower in women. Richmond-Rakerd et al.'s (2019) study used participants from the Environmental Risk Longitudinal Twin Study (n=2,232), a UK cohort born in 1994 and 1995. Results revealed within this cohort there was an association between SH and violent crime. Dual harmers, as referred to by Richmond-Rakerd et al, (2019), were noted as being victims of violence from childhood, exhibiting lower childhood self-control, and had a lower childhood IQ than those who only used SH. Also, 29-35% were likely to engage in violence within institutional settings (Richmond-Rakerd et al, 2019).

These studies have implications for clinical practice. For instance, staff must balance the risk posed to others alongside those posed to people who SH by making clinical judgements in relation to care practices. All the studies in this section indicate an association, directly or indirectly, between violence towards self and others. However, all these studies were quantitative in nature, leaving opportunity for an in-depth exploration of the lived experiences of those who use SH whilst in secure settings, to apply strategies that will help minimise violence against staff and other service users in the care setting. Additionally, as all the studies are from Western countries it would be useful to seek information from those living in Sub-Saharan Africa as a way of moving towards a global perspective of SH and violence.

1.8.2 Causation and Functions of Self-Harm

It is paramount to explore conceptual theories of SH to pave the way for raising awareness, research, theory development, management, effective interventions and evaluating the care of individuals who use SH (Tofthagen & Fagerstrom, 2010). Some researchers (Sutin et al, 2018; Rodham et al, 2007; Favazza 1998; Pembroke,1996) have a normalising view about the act of SH, believing all human beings use SH in one way or another during their lifetime. In some cultures, it is the perceptions of the people which determines whether the SH is acceptable or not. Pembroke (1996) proposed that SH can be used as a coping strategy for an unresolved problem and/or needs. This can have positive and/or negative consequences for the person who uses SH. Pembroke (1996) therefore classified SH into two main forms: SH with suicidal intent and SH without suicidal intent. Pembroke (1996) considers SH as a form of lifestyle and a way to socialise with peers within a group. Methods of SH that could be socially acceptable include excessive smoking, drinking, exercise, liposuction, bikini-line waxing, wearing high heels and body piercing (Pembroke, 2007). Also acceptable, to some extent, are behaviours such as displacement of anger on a substituted object such as kicking or punching a door in anger, whereby the individual is aware of the risks involved, but carries it out as way to curtail their anger, the behaviour serving as a form of emotional relief (Pembroke, 2007). Furthermore, socially unacceptable SH behaviours are cutting, burning, and smashing bones (Pembroke, 2007). In contrast, some authors are concerned with the detrimental effect of SH to the individual, as it can be maladaptive, illogical and poses health, safety, and a security risk to the individual (Allen, 2007; Arnold, 1995). Hawton (2012) noted that mental health staff who held negative beliefs about individuals' who SH tended to view them as being manipulative and attention seeking. As a result, they appeared to reject people who SH and/or approached them with anger, consequently worsening the situation by provoking further SH (Hawton, 2012). Also, members of staff who focus on the physical manifestations of SH were more likely to use medical intervention as their first line of action without any further support, and/or use of less supportive care (Mikhail & King, 2001).

It has been suggested that there is a multi-factorial basis for the causation of SH (Shoumitro, 1998). Such multiple causes could be classified into organic and environmental factors. Bronfenbrenner (1979) held the belief that psychodynamic causes might play a leading role in the development of SH. Basic causes such as compulsion and dependence (which are habitual in nature) and other inherent factors that are interdependent and interrelated could drive the individual to SH. For some individuals, childhood experiences such as loss, abandonment, abuse and/or childhood traumatic flashbacks might contribute to the development of SH (McAndrew & Warne, 2014).

Whilst the causation of SH is multi-factorial, there are also many different related functions of SH. Pembroke (1996) proposed that individuals' who SH may be influenced by the notion of self-punishment to deal with some unresolved personal issues and/or personal conflict. It has been suggested that individuals who have experienced traumatic life events such as childhood abuse and other forms of abusive relationships, may perceive themselves as 'bad' (Pembroke, 1996). Therefore, one way to cleanse themselves might be to SH in order to let out those 'bad' attributes within them, and/or they may have an internal morality that needs to punish the self in order to be 'purified' (Favazza, 1998). According to Garner (1997), SH is a defence to thinking about the past and a method of articulating a sensation of an earlier violation in another form. Hawton et al. (2014) argued that when individuals have experienced repeated abuse and/or criticism from others, they may use SH to denote self-distress, as they may perceive that the usual way of communicating has been ineffective and by means of SH, others may be able to acknowledge their distress and/or emotional turmoil (Hawton et al,2014). It has also been suggested that SH is used to communicate and/or authenticate the truthfulness of their story and its inherent distress (Rayner & Warne, 2015).

Self-harm can also be perceived as a source of relief from intense emotional and/or psychobiological pain (Ogden & Bennett, 2015; Deborah, 2008). Although there has been an absence of evidence of any hereditary factors to explain the onset of SH in individuals, it is proposed that the biological make-up of the individual might play a role in the causation of SH (Ogden & Bennett, 2015; Rayner & Warne, 2003; Ferenczi, 1956). For instance, hormonal imbalances in the individual, faulty neurotransmitters, in particular opioids which are alleged to regulate individuals' thoughts, feelings and actions and/or pain threshold, and other chromosomal factors, gender and age, can affect the homeostasis of the individual. This, in turn, can affect the level of stress-vulnerability and/or personality of the individual in adjusting and adapting to his/her environment (Ogden & Bennett, 2015; Rayner & Warne, 2003; Favazza, 1998).

Furthermore, some researchers (Florentine & Crane, 2010; Nock, 2010; Klonsky, 2007) suggest that physical pain may be used as a method to mask emotional pain and turmoil. For example, individuals may SH to induce some form of momentary relief from psychic pain. That is, some individuals tend to SH by inflicting pain on their body in order to make meaning of their experiences of problem/situations that they have suppressed and/or opposed or could not resolve in one way or another (Ogden & Bennett, 2015; Hawton, 2008). Deborah, (2008) noted that SH could be linked to faulty coping mechanism to distract oneself from; emotional pain, end feelings of numbness, offsetting feelings of low self-esteem, controlling helplessness or powerlessness, to calm overwhelming or unmanageable feelings, maintain control in a chaotic situation, self-punishment, self-shame or hate, to express negative thoughts or feelings that cannot be put into words, self-nurture, or self-care. Also, it is suggested that some individuals may be motivated to SH to attain a peak level of euphoria and/or sensual and enjoyable form of momentary pleasure, thereby, substituting their perceived anxiety-provoking situations for pleasure (Favazza, 1998; Babiker & Arnold, 1997).

Proponents of SH argue that it can be a medium for communication/ attention seeking/ providing sensory stimulation (WHO,2012; Rayner, 2011; Laye-Gindhu et al., 2005; Muehlenkamp, 2005). The body and/or the skin and the alimentary tract system could be viewed as serving as a medium of communication between ourselves and others (Favazza, 1998; Pembroke, 1996). Therefore, SH could be a means of venting individual's thoughts, feelings, emotions, and beliefs regarding an unresolved problem (Deborah, 2008). However, such a means of communication is usually unseen and may conceal meaning (Pembroke, 1996). This is common with people who have communication issues such as Learning Disability (Rayner & Warne 2003; Ingram, 1989). Deborah (2008) stated that people who SH have difficulties with emotional expression (clinically known as Alexithymia- inability to recognise emotions and their subtleties and to understand or describe thoughts and feelings) (Deborah, (2008).

Some proponents of the functions of SH speculate psycho-social functions can become compromised when individuals use SH in response to their overwhelming thoughts and emotions (Tantam & Whittaker, 1992). In this instance SH could be regarded as a faulty coping strategy, used for individuals to adjust and adapt to situations (Tantam & Whittaker, 1992). In contrast**,** some people may SH as a way of depicting an unconscious wish to end one's life (Tantam & Whittaker, 1992). Additionally, it has been noted that SH can depict 'Thanatoes/death wish' among individuals who may be redirecting murderous intents from the external environment to self (Rayner & Warne, 2003; Ferenczi, 1956).

Pembroke, (1996) and Favazza (1998) proposed that the concept of SH is based on religious motives by offering various forms of sacrifices to their maker. For example, it is argued that some individuals may harm one part of their body for the other parts of the body to survive (Favazza, 1998). In some religious practices, blood customs are used as sacrifices to seal the past and by letting out blood, it may initiate and enhance their reconciliation and/or loyalty among their group or social network. These differing views regarding the functions of SH need careful consideration within the context of the theoretical influences of SH that are pertinent to this study.

1.8.2.1 Epidemiology/Prevalence of Self-harm and Suicide

Epidemiological data indicate that globally every year one million people die from suicide and the rate is 16 per 100,000 or one death every 40 seconds, (DoH, 2015; WHO,2015). In England one person dies every two hours as a result of suicide, and this is likely to have a devastating effect on bereaved family and friends. Moreover, many others involved in providing support and care will feel the impact of suicide (DoH, 2012). Additionally, the global estimation of attempted suicide is that approximately 5% of persons attempt it at least once during their life, and the lifetime prevalence of suicidal ideation within the general population is between 10% and 14% (DoH, 2012; WHO, 2012). The Office of National Statistics (ONS) (2019) Suicide Report states there were 5,691 suicides registered in England and Wales. Around three-quarters of the suicides in 2019 were among men (4,303 deaths), which follows a consistent trend dating back to the mid-1990s. The male suicide rate of 16.9 deaths per 100,000 is the highest since 2000. The rate for females was 5.3 deaths per 100,000 in 2018. Males aged 45 to 49 years had the highest age-specific suicide rate (25.5 deaths per 100,000 males); for females, the age group with the highest rate was 50 to 54 years at 7.4 deaths per 100,000. The Suicide Prevention in England report (DOH, 2016) sets out strategies that services, communities, individuals and society can use to help prevent suicides and/or reduce the risk of suicide in key high-risk groups.

In a study by Hawton & Harris (2008), results showed the rate-ratio of SH to suicide was 36 (95% CI 34.9- 37.1) based on annual person-based rates of SH episodes and was nearly five times higher in females (87.9; 95% Cl 84.4 91.6) than in males (18.7; 95% CI 17.9-19.6). The ratios tended to decrease with age (Hawton & Harris, 2008). Epidemiological data from the MoJ for England and Wales (2019) indicated a rise in the incidents of SH, reaching a new record in secure settings. That is, SH incidents reached a record high of 57,968 incidents in the last 12 months to March 2019, an increase of 24% from the previous 12 months. In the most recent quarter, self-harm incidents increased by 1% to 14,415 incidents.

In a 28-year longitudinal study in a high secure setting in England and Wales, Jones et al. (2011) examined the suicide rate among patients (n=5,955) as compared to the general population. The results showed there were 218 deaths, and the overall suicide rate was significantly higher among women than men. That is, women were more than twice as likely to complete suicide in secure settings than men. Also, both men and women had significantly higher rates of suicide than the general population. That is, suicide was nearly seven times higher among males and over 40 times higher in females in high secure settings than in the general population. One of the advantages of Jones et al.’s study was that it was a mixed methods study by using a variety of approaches that one method cannot address, bearing in mind that the concept of SH is complex to comprehend. However, a mixed method approach can be a complex design for novice researchers. Moreover, it was a longitudinal study with a large sample that can be used to generalise to other populations (Jones, et al., 2011).

1.8.2.2 Self-Harm and Suicide in Ghana & Neighbouring Countries (West Africa)

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, 18 years earlier Roberts & Nkum (1989) undertook a five-year case note review by examining incident reports of deliberate SH (n=53) in Ghana at the Komfo Anokye Teaching Hospital. Results indicated there had been an increase in cases of SH between 1984 and 1987. The male –female ratio was 2:1 and the main age group where SH occurred was 15- 30 years, with some females being 34 years and above. Also, common antecedents to SH were a reaction to stress-related situations, personality disorder, mental illness, depressive conditions, family problems, and marital and financial problems. Of the 53 cases reviewed within the study, six were diagnosed with psychosis and 28 with acute reactions to social stresses such as marital and financial problems. An important feature of this study was the use of case review in relation to statistical difference of prevalence of SH in terms of gender, primary diagnosis, age, and antecedents to SH (comparison among groups of cases), as well as to guide clinicians when assessing people who SH. However, Hutchison et al. (2015) advised that where the outcome of a process is known before a review begins, there is strong evidence to suggest that bias may be introduced to the review as the result of that knowledge. Another example of case study review of SH in neighbouring country Nigeria relates to the demographic variables of gender and age. Odejide et al.'s (1986) study involved a review of mental health patients (n= 23, 859) attending a hospital over a given period (1986). They found that 76.9% of the participants who used SH were under 30 years of age, and more females engage in SH than males. Both case reviews (Roberts & Nkum, 1989; Odejide et al.1986) demonstrated interpersonal relationship issues motivated the act of SH, with self-poisoning as being the preferred method.

More recent studies carried out in neighbouring countries of Africa focus on SH among student populations or community samples. For example, Van der Walt (2016) carried out a survey of university students (n=201, females-55%, & males 45%) in South Africa. The aim of the study was to find out about various forms of SH behaviour, frequency, and context of the occurrence. The result was that 19.4% of the participants reported SH behaviour, with pain being the most common category associated with SH. Also, more females engaged in SH behaviours than men. It was noted that triggers to such behaviours were linked to substance misuse and risk-taking behaviours in general.

Lippi (2014) used multiple inventory tools to examine the possible relationship between SH & symptoms of depression and anxiety among South African university students (n=603). The study involved the use of Becks Depression Inventory (BDI-11), State-Trait Anxiety Inventory (STAI) and Deliberate Self-Harm Inventory (DSHI). Results indicate high rates of SH among participants, but there were no significant rates of difference in gender. Participants aged 20-21 years were significantly more likely to SH, as were those who experienced severe depression. The findings have implication for further research regarding the identification of other variables in relation to African context.

Studies by Adinkrah (2014) and Osafo et al. (2015) compared suicidal ideation among Ghanaian and Caucasian students in the USA. Both studies showed significantly lower rates of self-reported suicidal ideation among the Ghanaian sample, as well as more negative attitudes towards suicide (Osafo et al, 2015; Adinkrah, 2014). A larger survey compared 570 Ghanaian students with students from Uganda utilising the Attitudes Toward Suicide Questionnaire (Akortia et al,2016). This rating scale was developed by Renberg & Jacobsson (2003) and evaluated by Cwilk et al., (2017) for use in the African 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 suicides among non-family members, again these figures being markedly lower than those reported by the Ugandan respondents (Adinkrah, 2014; Doku et al, 2012). Though these studies seem to suggest a low rate of suicidal ideation in Ghanaian students, generalisation is cautioned, as all the studies were conducted with young, urbanised, highly educated participants.

Another recent study by Osafo et al. (2014) carried out in Northeast Ghana, examined SH behaviour among female secondary school students, and a condition which has been considered rare in non-Western cultures, namely anorexia nervosa. Western research suggests anorexia nervosa is a mental illness with a high mortality rate (WHO, 2014, DoH, 2011; NICE,2011). The researchers completed a clinical examination of physical and mental health, using two standard measures of eating behaviour and attitudes, and a screening tool for depression. Of the 666 students participating, 29 were pathologically underweight, of which ten were diagnosed with morbid self-starvation based on clinically significant indicators such as denial of hunger, self-punishment, and perfectionist traits. Most of the participants, both Christian and Muslim, reported regularly engaging in religious fasting. For the ten engaged in morbid self-starvation, this fasting was particularly frequent, at least once a week, and associated with feelings of self-control and self-punishment. Since self-starvation was not associated with a desire to be thin or a morbid fear of fatness, a diagnosis of anorexia nervosa according to DSM-5 (APA, 2013) or ICD-10 (WHO, 2015) criteria could not be made.

There is no published research 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.

In Ghana and Africa, suicide remains a taboo topic, with cultural and religious beliefs challenging its acceptance (Beiden et al., 2019; Asante et al., 2017; Hjelmeland et al., 2014). Cultural and religious beliefs of the people condemn the act of suicide and blame it on the individual; hence the law criminalises attempted suicide in Ghana (Hjelmeland, 2014). Similar perspectives appear to be evident in other African countries, with survivors of suicide attempt being sent to prison (Liu et al., 2018; James, et al., 2017; Hjelmeland et al., 2014; Osafo et al., 2012). For instance, Hjelmeland et al. (2014) explored the views of health professionals and police officers in Ghana about their attitudes towards suicide being an offence. Some participants did not agree with the law based of their reflections on the act of suicide, and those in favour of the law believed no one has the right to take life and that the law as a deterrent helps to reduce the suicide rate.

However, these studies also point to possible factors in Ghanaian society which could be employed in suicide prevention, including family support, religious beliefs, and emphasis on the value of the belongingness to a group. Qualitative studies related to beliefs and attitudes towards suicide, as well as risk factors from personal experiences, will enhance the quantitative data identified above and enable a deeper exploration of some of the correlations observed (Adinkrah, 2014; Osafo et al 2014).

1.9 Personal Motivation for this study

I grew up in a community where there were people with mental health issues. For instance, during my adolescent period, there was a vagrant of similar age with a mental health problem living in the neighbourhood. From my experience and observation, I can recall an incident when the vagrant used a big knife to slash off his big toe. It appeared that the person was dealing with some form of delusional ideation and responding to unseen stimuli, as he stated, *“he did not want the big toe because it was creating problem for him.*” After this incident of SH, he did not show any sign of pain and there was no one to intervene, as he was a ‘tramp’ and apparently on-lookers were scared about what would happen next. The man just continued to wander about with blood following his footsteps in the town centre, and he was observed talking to himself. It was quite challenging for those of us around to comprehend his behaviour. This incident made me think about individuals with mental health problems, including SH, and how in Ghana they are ineffectively supported. It also made me aware about how little information of such conditions is available, perhaps creating a barrier for those around to assist such people, due to lack of insight into his health problems. When reflecting on this experience I believe it gave me insight into the needs of individuals living with mental health problems, including SH, and it started me thinking about how mental health services could be more sensitive in attending to the needs of those who have mental health problems.

In later life, I developed a passion to become a health professional so I could support people with mental health problems. Eventually, I graduated as a nurse, became a nurse practitioner in secure mental health settings in Ghana where I worked for approximately 15 years, before moving to England to continue my career as a nurse. I migrated to the UK to continue with my nursing career and encountered differing service users with their unique problems and needs. My experience over the years has meant that I have provided care for people who SH in different clinical settings. As a senior nurse I have also been involved in therapeutic sessions and/or debriefing sessions with people who have been involved in incidents of SH. Caring and supporting people who SH can be challenging in terms of knowledge, empathy, ethical, technical, and philosophical issues (Hawton et al, 2014; Benner, 1988). In my clinical experience of supporting people who SH, some of them tend to progress well over time in their recovery process, and this invokes in me some sense of inner satisfaction, but later they may relapse, at times resulting in fatal incidents of SH (Thompson et al., 2008). Such situations of remission and relapse tend to be cyclical for some of service users, and this made me question how these individuals can be better supported within the clinical setting.

Over my years of experience as a senior mental health nurse practitioner, my interest in SH in secure settings has developed, particularly in relation to how people who SH experience and could influence practice. It has been proposed that health professionals need to work smartly with service users through developing a therapeutic alliance, to explore and gain an understanding of their needs and problems. In doing this effective and high-quality mental health care will be delivered (Warne & McAndrew, 2014; Benner, 1988). In the UK service user-lead perspectives play an important role in providing insight into the experience of mental health care (Warne & Rayner, 2015). Therefore, the central motivation for conducting this study was to explore the perspectives of people who SH in secure mental health settings in Ghana. Whilst Western studies have focused on the lived experiences of people who SH in secure settings, this is in its infancy in Sub-Saharan Africa, and specifically Ghana (Smith & Kaminski 2016; Alder & Alder 2013; Sandy & Shaw, 2012). To date, no qualitative studies have been published on the lived experiences of people who SH in secure mental health settings in Ghana. In summary, an in-depth exploration of the experiences of people who SH is essential if understanding and care is to be improved.

Also, my interest in undertaking this study emerged from my desire, not only to gain insight into the lived experience of people who SH or individuals living with mental health problems, but also to use the findings to influence the development of a service user led mental health services and policy formulation in Ghana. It is evident that mental institutions and the mental health care system in Ghana are configurated and organised differently to those in the Western world (WHO, 2016), regardless of Ghana deriving much of its health care practices and policies from Western Countries. For instance, Ghana has derived some of its initial Mental Health Laws from the UK, one of them being the Lunatic Act in England. Due to advancement in science, technology and introduction of newer medicines, the Lunacy Act (UK) was repealed and replaced with Mental Health Act of 1959 in the UK. Over time this evolved into current mental health legislation, the Mental Health Act 1983 (Revised 2007) (UK). These changes in the UK have led to improved mental health services, but this initiative is still at its infant stage in Ghana. For instance, the three main psychiatric hospitals in Ghana are overcrowded (Doku et al., 2012; Asare, 2003). Accra psychiatric hospital has the capacity to accommodate 600 patients at any given time. However, this has not been the case as the hospital is overcrowded with an increasing population with limited facilities, with patients being admitted at approximately more than the hospital bed capacity which will have impact on patient care and safety (Asare, 2003).

1.9.1 Goffman's (1966) Total Institutions

Over the years of my professional career in Ghana, I read about Goffman's (1969) 'total institutions' and I identified that some aspects of mental health care practice in Ghana were similar to how Goffman (1969) described as 'total institutions' with its inherent impact on service delivery. Having migrated to the UK to continue my professional career, I identified that although Ghana has derived most of its health services framework and policies from the UK, unlike the UK, care practices in Ghana have not moved away from the concept of 'total institutions'. This made me reflect on mental health care in Ghana and develop a questioning approach as to why things happen. This eventually influenced my affiliation and inclusion of Goffman's concept of total institutions to help offer readers part of the backdrop to this thesis.

Goffman (1969) studied inmates in institutions; prison, army, police, sporting clubs, and then referred to such environments as ''Total institutions. According to Goffman, a total institution is a place of residence and work where several individuals with similar situations are kept away from the wider society and they lead an enclosed, formally administered life. Individuals who live within these institutions have their needs met under bureaucratic control (Goffman, 1996). In a total institution, members of staff tend to focus on surveillance and expect the inmates to conform. There appears to be conflict between the two groups which in turn impact therapeutic relationships. In addition, there is misunderstanding and mistrust between the two groups. Inmates do not have a direct line of communication between them and senior management, as they must pass through the intermediate staff and permission must be granted from senior management. Inmates are not involved in their decision-making process and such restrictions tend to split inmates from staff, and inmates tend to function without motivation. It could be suggested inmates are humiliated, programmed to suit management, restricted in terms of their human rights, and can be reproached. Being in this predicament can lead to boredom and demoralization among the inmates which can impact the *'self'* (Goffman, 1969 p. 39).

Goffman (1969) noted environmental situations, such as being in institutions and subjected to controlled measures used by staff on the individuals' human rights, can have a negative or positive impact on people. As such, people can adjust and adapt to their lives in three main ways:

- They may accept the values and rules of the institution which is termed the ''colonization line''.
- They may challenge or rebel against the institution this is termed the ''intransigent line''.
- They may drastically control their interaction with others, and this is termed the ''situational withdrawal or regression line'' (p.33).

The behaviours identified above can have impact on the mental health and well-being of individuals thereby making them ''dull'' or distressed and frustrated, and in response they may use maladaptive means such as SH to cope with the environment (Austin, 2016; Konrad et al 2007; Goffman, 1969). As argued by Foucault (2002, *p.69*), *"asylum, or total institutions should offer protection, therapy, and socialization for the mentally ill."* However, practices in total institutions appear to be encouraging repression, where draconian bureaucratic rules have replaced conventional health practices. Goffman's (1969) ethnographic study on patients' social life focused on participants' gestures such as facial expressions, comments, and attitudes during interactions with inmates and then noted that those meanings convey cues or messages to others during an interactional process that influenced their behaviour. Results indicated social interactions tend to predict human behaviour, as well as influencing and/or impacting each other's behaviour. Blumer, (1969), argued that Individuals react towards the environment and/or things, based on the meaning they hold for them, and such meanings are based on social interaction and modified through interpretive processes used by the individual in dealing with situations he/she encounters (Blumer, 1969).

The use of Goffman's (1969) concept of social institution in SH studies in forensic units has been used prior to the emerging NICE (2004) guidelines. Existent literature indicates there are studies of SH based on Goffman's (1969) concept, used to explore participants' narratives of SH and implications of their choice of behaviour and the effects of SH (Sandy, 2012; Weitz, 2011; Hawton et al., 2010; Beasley, 2000). A study by Alder & Alder (2013) in a non-clinical setting used Goffman's (1969) concept of symbolic interaction to explore a subculture of loner self-injurers/cyber colleagues who used the internet in their everyday interactions to engage in SH. This study highlighted the powerful influences of other people's SH via social media (O'Connor et al, 2018; Hilton, 2017; Kwok & Yip, 2017; McDermott, 2014; O'Connor & Nock, 2014, Daine et al, 2013). Frost et al. (2013) used a mixed methods study to explore the experiences of people who SH and use the internet to learn how to SH. Findings from the study found the majority of participants preferred increased awareness, the creation of internet use for support, anonymity in seeking help, means of access for help from professionals and relationship issues (Frost et al 2013). A survey was used, indicating that within the sample (n=457), 168 participants reported seeking online support, while 289 did not seek support online. In all, there was no significant difference in those who seek support via social media and those who did not seek this type of support (Frost et al., 2013). One of the merits of involving professionals to support people who seek help during their SH encounters, is that it may help reduce any inherent risk issues rather than seeking guidance and support from their peers (Smithson, et al. 2011). Hilton, (2017) used qualitative research, collecting data via twitter to explore the experiences of people who SH. It was reported there had been 362 twitter responses, with a common theme being SH is still misunderstood by society and such people are either ridiculed and/or stigmatised which makes individuals carry out their behaviours in secrecy. The response rate would suggest social media tends to provide safe and valuable support to such people, where they can network with peers with no humiliation, the latter possibly perpetuating the incidence of SH among such groups (Hilton 2017). In the next section I explore the rationale for building Goffman's work in relation to mental health care in Ghana.

1.9.1.1 The Work of Goffman's (1969) Concept of Total Institutions

Goffman (1969) used his concept of frame-analysis to explore lived experiences of a phenomenon. Goffman argued that 'frames' organize individual experiences and guide action for the individual and this can structure the individual's perception of phenomenon, in this instance SH. The frame represents 'schemata of interpretation' of what people who SH are experiencing in their life and/or use as guidance in their problem solving or decision process (Goffman, 1974). This can be an experience of an individual that would originally be meaningless and make it meaningful. As such, the way people who SH is considered an aspect of how they frame their lived experience (Goffman, 1974, p.34). As noted by Gitlin, (2003) framing is how media information is organised or collected, presented, and interpreted, and/or it facilitates ways to compose implicit theories about what exists, what happens and what is substantial. Sieff (2003) conceptualised a frame to be media frames of mental illnesses. For instance, the media frame of mental illness illuminates how negative frames used by the media to portray mental illness. These can have impact on the public's negative perspectives of the mentally ill, negative/positive attitude towards individuals with mental illness, and mental health care (Murphy et al., 2013; Sieff, 2003). For example, a study by Brandt (2021) in Sri- Lanka showed how SH or suicidal behaviour are portrayed in newspaper articles. Results indicated that certain aspects of the issue were overemphasised (inappropriate behaviour) and other aspects underemphasized (complexities of SH). Another media frame was related to political issues and SH in relation to a presidential election. The article depicted a man who seemingly SH owing to his's political engagement (SH as a result of distress over election results). The salient themes were that these articles showed recurring themes related to individual behaviour and relationship breakdown. The first article expressed judgment towards the individual's inappropriate behaviour, and the latter communicated shock when the individual had stayed within certain boundaries of acceptable behaviour, questioning how someone who was committed to their social role would SH. This study has implications in terms of highlighting situations where people who SH can involve reporting bias. However, Karp (1996) advised that an attempt to explore any links between media messages and decision making of third parties can be challenging and confusing, as one of the main problems with the media *''is that it represents us with multiple and contradictory points of view on nearly everything''* (Karp 1996, p186).

Goffman related his concept of total institution to 'moral conversion', where patients behave according to staff views. According to Goffman, inmates in Asylums do experience a 'moral career' where they judge self as compared to others, and they may perceive themselves as losing their *'mind'*. It is interesting to note that Goffman (1974) used an ethnographic approach to investigate the social life of inmates in total institutions, such as patients in a secure hospital with perhaps restriction on their capacity and basic rights in decision making and problems solving situations. It has been argued that the concept of frame does give emphasis to explore some phenomena such as the concept of SH (Staniland & Smith 2013). Although, Goffman was concerned with adoption of frame and experiences in human actions, he focused on issues of pretence in exploring human lived experiences. Furthermore, Goffman's work presented personal experience of institutionalization which mainly explored the negative impact on patients' psyche (Ogden & Bennett, 2015; Sandy, 2013; Goffman 1969). This research will build on Goffman's work by adopting IPA to explore in-depth experiences of what it means to SH in secure settings in Ghana, by focusing on inherent negative and/or positive lived experiences of participants in such settings.

Goffman's (1974) concept of 'social institution' has provided me with distinctive insight into the perspectives of individuals who SH and their unique motives of engaging in such behaviours to cope with various stressors, and this may be construed as maladaptive by others (Wojciechowski, 2017; Austin, 2016; Smithson 2010; Favazza 1998). Researchers have noted that people who SH do encounter 'social risk issues' such as stigma and this is compounded by being detained in a secure setting (Favazza, 1998; Goffman, 1969). It is presumed that in such settings, there is an imbalance between a powerful minority who are staff and a disempowered majority who are service users (White et al, 2003; Goffman, 1969). It is speculated that due to the power imbalance between staff and service users who are detained under the MHA (1983) [Revised 2007], some of their fundamental human rights may be affected negatively and/or positively, probably due to security risks and/or health and safety issues in such secure settings. Seemingly, the fragile nature of therapeutic relationship between staff and service users may make the latter prone to maladaptive behaviours such as SH (Wu Chang, Haung, Liu & Stewart, 2013). In part, this study has been built on the work of Goffman by exploring whether the notion of service users' lived experiences in 'social institutions' may be similarly reflected among people who SH in secure mental health settings in Ghana (Wojciechowski, 2017, Austin, 2016; Sandy & Shaw 2012; Favazza, 1998; Goffman, 1969). In my opinion, the preceding discussions draws together salient points to consider when undertaking an in-depth exploration of the lived experiences of people who SH in secure settings (Waever, 1996).

1.9.2 Research Aim, Research questions and Objectives

The aim of this study was to explore the lived experiences of people who Self-harm (SH) in two secure/locked mental health hospitals in Ghana.

1.9.2.1 Research Questions

The aim of this study prompted three research questions, these being:

- How do people who self-harm make sense of their experiences in a secure hospital environment, at home and in the community?
- What negative perceptions and experiences do people who self-harm have of care in a secure hospital environment, at home and the community?
- What positive perceptions and experiences do people who self-harm have of care in a secure hospital environment, at home and the community?

1.9.2.2 Research Objectives

To achieve the aim of the study and answer the research questions the following research objectives were addressed:

- To explore the knowledge and understanding of SH from the perspective of those who use this behaviour and are being cared for in secure setting/locked mental health hospitals in Ghana.
- To discuss the experiences leading to SH of people in secure setting/locked mental health hospitals in Ghana.
- To ascertain which aspects of care people who SH in secure setting/locked mental health hospitals in Ghana consider to be negative.
- To elicit which aspects of care people who SH in secure setting/locked mental health hospitals in Ghana describe as positive.
- To recommend ways in which experiences of people who SH in secure setting/locked mental health hospitals in Ghana might be improved.

1.9.3 Chapter Summary

In this chapter **(Chapter one**), the background of the study and justification for conducting this research, both personal and evidential, has been presented. A brief history of Ghana and its health delivery system has been provided to give context to the study. The introductory chapter has provided an overview of Ghana as a Sub-Saharan country situated within West Africa and its history in relation to how its health care system emerged. The chapter offers insight into the present structure of mental health care within the Ghanaian Health Service, with attention being paid to policy and legislations in relation to mental illness and forensic psychiatry. Within the chapter, Ghanaian perspectives of mental illness were presented, accounting for the prevailing attitudes influenced by cultural and societal practices. The phenomenon of SH, prevalence rates, its relationship to suicide and violence was also discussed, and my personal motivation for undertaking the study was also presented. As well as highlighting contextual issues about self-harm and suicide, this chapter has also offered theoretical influences of SH, followed by discussion in relation to building on Goffman's (1969) concept of total institutions. Finally, and based on the information presented, an outline of my research; aim, research questions, objectives, have been identified, as has the reasons why this study is valuable for in-patient mental health care in Ghana.

Chapter 2: Literature Review

2 Introduction

This chapter presents the process used to find published research relevant to this study, how the quality of the identified literature was assessed and the way in which it informed the researcher's thinking prior to starting the field work. Additionally, the focus of this literature review is to situate the current study and pertinent research questions in the framework of extant literature related to lived experience of people who SH.

Various approaches such as systematic literature reviews, traditional or narrative reviews and meta-synthesis were considered to determine how to approach the literature review process for this study (Daine et al., 2013; Arksey & O'Malley; 2007). Global knowledge has broadened the approaches used in reviewing literature, and collecting, evaluating and presenting available research evidence (Arksey & O'Malley, 2007, Pawson, 2002). Arksey and O'Malley (2007) argued that there is no one way of reviewing literature whereby there will be no bias in relation to collecting, evaluating and presenting available research evidence. Therefore, in this review of the literature, as the researcher, I adopted a fluid approach, believing this would create an opportunity to utilise any other approaches that were appropriate at different stages of the research journey (Diane et al., 2013; Arksey & O'Malley 2007; Newhouse et al, 2007).

As part of the initial phase of the literature review, a researcher needs to carry out an in-depth search of extant literature in relation to the phenomenon being studied (Webster & Watson, 2020; Winchester & Salji, 2016; Diane et al.,2013; Pawson, 2002). The essence of conducting a literature review is for developing a research idea, to solidify what is already known about the phenomena under study, and to allow the researcher to scrutinise any knowledge gaps and consider how the proposed study can contribute to additional understanding (Winchester & Salji, 2016). Once the gap is identified, the study carried out and findings established, the literature review can be further interrogated throughout the discussion phase of the current research to ascertain new facts or theories and how they could illuminate future areas of research and add to the extant body of knowledge (Silverman,2013; Newhouse et al, 2007). A literature review is also vital in evaluating the current research data and shaping their significance and clinical value or usefulness (Webster & Watson, 2020; Bryman, 2012).

Invariably, researchers should engage in critical appraisal of the current collective knowledge on the phenomenon to avoid undue duplication, or to provide a full list of research studies that have already been conducted or published (Diane et al., 2013). By so doing, the literature review enables the researcher to identify other research that supports, substantiates, or differs from their findings, to establish the position of their study within the specific field of research (Webster & Watson, 2020; Bryman, 2012). The literature review establishes the researcher's depth of understanding of data within the auspices of the study topic (Anastasiadis et al., 2015). The aims of this literature review were to synthesise research knowledge regarding the phenomenon of SH, to explore the strengths and weaknesses of the studies reviewed and to identify gaps for further research.

This chapter is organised into numerous sections. The first section presents the search strategy utilised to retrieve research pertinent to the proposed study. Critical review of research articles related to the lived experiences of people who SH in secure settings in both Western countries and Sub-Saharan Africa is presented in section two. These sections are followed by development of the research questions and chapter summary/conclusion.

2.1 Search Strategy for Research Articles

As the researcher I identified primary studies and reviews suitable for answering the central research questions (see Chapter 1, section 1.9.3 for details). Strategies that were adopted involved searching for research evidence via The Salford University Library (SOLAR), the internet and search registers and hand-searching of key journals. The Boolean operators ''AND'' ''OR'' were used to ensure differing terminology would be captured, whilst keeping the search focused. The following English key terms were used: deliberate self-harm* OR self-harm# OR parasuicide*, self-mutilation# OR non suicidal self-injury# OR self-injurious behaviour# AND care# OR Nurse# AND secure# OR forensic# OR mental health* OR psychiatry# OR unit # OR ward# were used to search the databases, as these are common terminologies being used in the literature to denote SH, and therefore serve as a blueprint for various search engines (see section 2.2 for details).

Furthermore, the literature search included journal articles from January 2000 to December 2020, as it was assumed that a wide search would enable the researcher to attain primary sources of information, perhaps still applicable to everyday situations of SH and relevant to the current study. Focusing the search strategy from January 2000 was in relation to the start of the service user movement in the early/mid 1990s; the movement focusing on people's experiences of health and social care services (DoH, 2000). The inception of the National Service Framework for Mental Health (1999) set out priroties for those experiencing mental illness, including SH, setting quality standards for services in England, which included the active involvement of service users in their care. As Ghana has often adopted a similar stance to that of the UK when establishing mental health policies and given the proposed research topic, it seemed appropriate to use this timeframe for my literature review. In addition, the review focused on studies that were related to people who SH in secure hospitals. Papers written in any language other than English were excluded because of the cost and time involved in translating such materials. It is worth noting that only including papers that were written in English for practical reasons might have led to missing out potentially relevant papers related to the study. The focus for the search was very much on all studies exploring the lived experiences of people who SH in secure hospitals. Due to the study being time limited, the search was then narrowed down to the last 20 years and included only peer-reviewed articles, conference reports and dissertations/theses. It is expected that year range period will provide adequate and recent and up to date extant literature to appropriately inform the current study. Full details of inclusion/exclusion criteria are presented in Table 2.

Table 2 Inclusion and Exclusion Criteria

Inclusion	Exclusion
Adults (18 years and above) people in secure hospitals who self-harm	Children and youths (up to and including 17 years) Patients with Primary diagnosis of psychotic disorder, bipolar disorder, depression disorder, eating disorder. Studies related people who SH in prison population.
English language papers only	Research articles not available in English
Research studies related to people who SH in secure mental health settings.	Research studies that are not related to people who SH in secure mental health settings, community interventions
Peer reviewed journals/paper which, prior to publication have been examined by experts related to the phenomenon of study.	Papers that are not research based or have not been peer-reviewed
Systematic reviews that have a meta-analysis and/or a meta-synthesis as these are considered as research.	Systematic reviews that do not have a meta-analysis or meta-synthesis
Research articles published within the past 20 years 2000 to 2020: The outset of this thesis in 2014 (but regularly updated until December 2020	
Primary research-based papers	

2.1.1 Selection of Studies

The initial results from the databases searched are shown in Prisma figure 1 below.

The main search identified 347 studies. However, of the 347 studies, 78 were found to be duplicate studies and therefore eliminated. Data from each of the 269 studies (i.e., name, author, country of origin, year of publication, as well as study characteristics such as population type, sample size, average age, sex distribution), were then extracted and the inclusion and exclusion criteria applied. Following this process, a further 223 studies were eliminated, and 46 were selected for a full-text review. Based on the full-text review, 34 studies were excluded. Finally, 14 studies were included for the literature review (see Prisma figure 1).

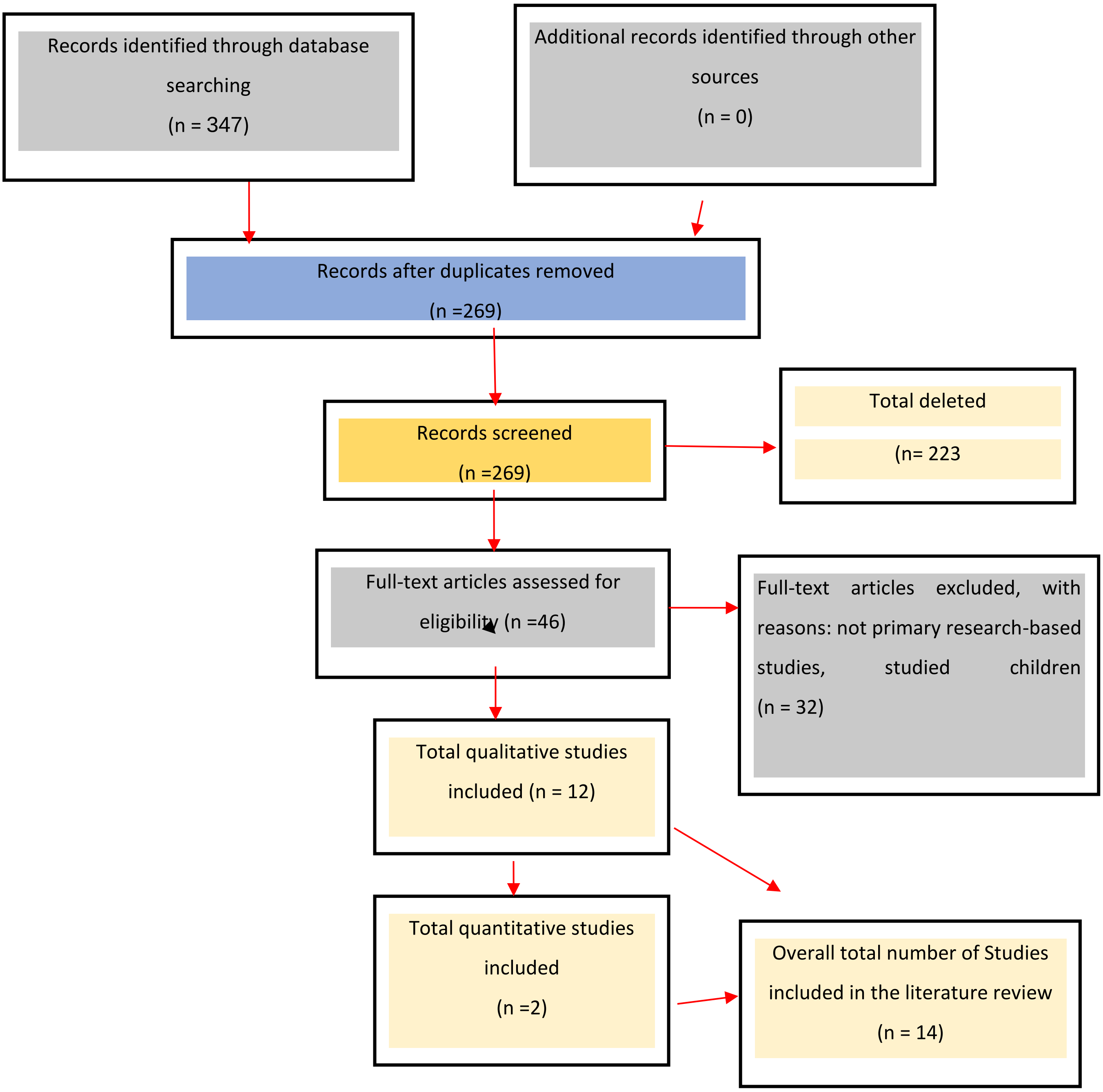


Figure 2. Description of Literature Review Search and Selection Process

Regarding sources of literature, much of the understanding of people who SH in secure settings is based on literature from Western countries such as the UK, Canada, United States of America, Europe, Australia and New Zealand and therefore this body of literature was included in the review. Twelve studies used qualitative research to explore the experiences of people who SH. The remaining two papers used quantitative research.

2.2 Main Review of the Identified Literature

In this review, pertinent research articles were printed and read through as part of the review process. As the researcher, I have summarised the critical issues of the research article in relation to the aim of my study, including methodology, participant recruitment, data collection, process of analysis and findings (see section 3.9).

The review has been organised using themes which were generated through a close reading of the papers relating to people's experiences of SH. The first section of the review process explored the notion of perceptions of SH, the emergence of lived experience relating to SH in an in-patient population, and more specifically, in secure settings Western Countries. Also, central to the review were studies on SH in Ghana, as well as perspectives of SH and mental illness in Sub-Saharan Africa. The final section within this chapter provides a discussion of the reviewed studies and the gaps in knowledge identified within this literature review. This is followed by the chapter summary and my personal reflections on the review process. Matrix of pertinent research articles reviewed are also presented in table 3 below (see section 2.2.1 for details).

2.2.1 SH Matrix of Literature Review (Table overview)

Background: The review of literature on people who SH was performed using the SOLAR search engine at the outset of this thesis in 2014 (but regularly updated until December 2020). The aim of this search was to give an overview of the available research and determine the main findings. A chronological timeline of published studies is shown in the table below (for a rationale for inclusion and exclusion, (see section 2.1 for details of the main thesis).

Table 3: Main Studies of SH in Western Countries and Sub-Saharan Africa and Ghana

Studies in Western Countries (excluding UK)

Author(s) and Title, Location and Type/Design of Study	Findings
Eckerstrom et al. (2020) Brief Admission for Patients with Emotional Instability and Self-harm: A Qualitative Analysis of Patients Experiences During Crisis Sweden Descriptive, using thematic analysis	This article was a research summary with the purpose of providing for Brief Admission (BA) with time out, in situations of increased stress and threat to participants who SH due to history of emotional instability, history of SH. *Eckerstrom et al*. found that participants appreciated having to take responsibility during crisis by contacting health professionals for support and it was helpful. The authors advised that more research is needed to find out short-term effect of admission during crisis. Future research could be aimed at exploring health cost aspect of the intervention(cost-effectiveness) to aid in evaluating admission.
Wand et al. (2019) Why Do the Very Old Self-harm? A Qualitative Study. USA Qualitative descriptive study using thematic analysis including N-VIVO.	*Wand et al* explored the perspectives of people who SH regarding their reasons for SH, consequences, and their perspectives of care. Two approaches were used in data collection in this study: The use of structured psychiatric assessment including cognitive testing (DSM-5 (APA 2013) diagnosis), and in-depth interviews. Participants reported antecedents (themes from SH) to SH as; 'enough is enough', 'feeling isolated', 'disintegration of self', 'being burdened', 'hopelessness and endless suffering', helplessness with rejection, untenable situations, and cumulative adversity. Further, the results of SH were: 'being engaged with or distanced from family', 'problem was solved', 'gaining control', 'I'm worse off now'', 'rejection by staff', and tension in the role of the in-patient clinical environment.

	Wand et al. (2019) concluded that SH may communicate a need that cannot otherwise be expressed. Given the nature of the age range of participants that were included in the study, future research into exploring in depth experience of SH, that may involve younger participants.
Selenuis & Strand (2017) Experience of Self Injury and Aggression Among women Admitted to Forensic Psychiatric Care. Sweden Data were collected retrospectively and prospectively by Interview approach.	The findings were linked with how participants dealt with emotional distress and negatives thoughts by use of SH and/or aggression towards others to gain relief. Selenuis & Strand recommended that subjective views of participants' lived experience is central to care staff gaining insight into how patients' needs can be addressed.
Lindgren et al. (2011) 'They Don't Understand… You Cut Yourself in order to Live'. Interpretive Repertoires Jointly Constructing Interactions Between Adult Women Who Self-harm and Professional Caregivers. Sweden Ethnographic and informal interviews(descriptive). Longitudinal	The aim of this six month's study was to explore participants' experience of care they received and their desired care in a secure environment. Finding was that participants felt victimised and belittled by being restricted from being behind locked doors to not having access to needed support from staff. Additionally, participants described they had to follow the rules and routines without questioning them. They therefore turn to blame themselves if anything went wrong. Another finding was that participants verbalised staff did not understand them as it was felt that SH was a means to die but this was not their motive as SH was only a means to live. Furthermore, Participants noted to be defiant when staff were not trying to reason with them. The researcher was an observer- as participant. To ensure credibility, the authors used investigator triangulation where more than one researcher analysed the data. Thus, data analysis involved two authors for consistency in the data. In this process, the first author's thoughts and reflections concerning observed interactions were written down in a diary. Reflective field diary was used by the first author. The demerit of this study is that participants who took part in the study suffers from suffers from mental health problems and do use SH to cope and can be perceived as vulnerable individuals. This may raise ethical concerns based on the approach used in data collections (participant observation and interview technique). There is the risk that participants may disclose more than they really wanted to, and that observation and interview approach together can be viewed as violation of integrity and privacy of the participants.

Brown & Kimball (2013) Cutting to Live: A Phenomenology of Self-harm. USA Phenomenology	The study explored lived experiences of people who SH insecure settings. There were three superordinate themes of the study. Firstly, SH was misunderstood by others. Secondly, SH as not suicidal. Thirdly, SH as an addiction or a means of coping which makes them feel different and compared themselves to those who use substance to same reasons. The nature of the research question posed was used to advocate for future research into exploring in depth experience of SH, that may capture all aspect of their experiences.

Studies in the UK

Author(s) and Title, Location and Type/Design of Study	**Findings**
Owen-Smith et al. (2014) 'When You're in Hospital, you're in a Sort of Bubble'': Understanding the High Risk of Self-harm and Suicide Following Psychiatric Discharge: A Qualitative Study UK Descriptive using qualitative analysis	The authors explored the lived experiences of people who SH during the discharge process. The findings were linked to participants' attitude to discharge and the immediate post discharge period. Six participants were happy with their discharge, but the remaining four participants had been disappointed to be discharged without their involvement in the discharge process
Barker et al., (2013) *Baker, A., Wright, K. and Hansen, E.* (*2013*), A qualitative study exploring female patients' experiences of SH in a medium secure unit. UK Qualitative using IPA	The study was to share participants' understanding and experience with care staff to see if it would be helpful in their therapeutic encounters and improve patient outcomes. The main themes identified in the study were: traumatised individual; hidden experience; interrupted maturation process; crossing the line; nascent potential protection; and individual and systemic repercussions. It was noted that there were varied perceptions of SH, but there were also commonalities across participants' narratives of SH.

Parkes & Freshwater (2012) Parkes, J.H., & Freshwater, D.S. (2012) *The journey from despair to hope: an exploration of the phenomenological distress in women residing in secure mental health services*. UK Qualitative study using IPA	IPA study with females (n=11) with a history of SH and/or violent behaviour in a secure hospital in the UK. The study utilised IPA to analyse the data with the aim of acquiring an enhanced understanding of the women's lived experiences of psychological distress. The findings showed that all participants admitted to carrying out SH and had been violent to others when they were emotionally distressed. Secondly, findings demonstrated how SH enabled them to cope with intense emotional pain, often rooted in traumatic childhood experiences, and negative thoughts or despair. Thirdly, the theme 'losing it' was described by participants. For instance, when dealing with their emotions, they reported getting to a point where they could not cope and may feel vulnerable. Some participants reported to have benefited from crying for help and pressing for staff support, medication, and other therapies (Parkes & Freshwater, 2012). One of the perceived limitations of Parkes and Freshwater's (2012) study appears to be the use of a single trigger question, when asking participants to describe their lived experiences. Although the use of a single trigger question can be used to encourage participants to narrate their pre-reflexive lived experiences relevant to the phenomenon with minimal interruption from the interview, for some this will be difficult to do (Parkes and Freshwater's, 2012).
Adamson & Braham (2011) Pathways to Episodes of Deliberate Self-harm Experienced by Men in High Secure Hospital Over the Course of their Lives: Exploratory Study. UK Qualitative using grounded theory	Using grounded theory approach, the study explored pathways to episode of SH experienced by mentally ill men (seven participants) in a secure hospital in the UK. The researchers used theoretical sampling approach and semi-structured interviews to collect data. The findings revealed two pathways to episode of SH: Firstly, SH was linked to relief pathway of intrusive thoughts. Additionally, episode of SH appeared to function as a means of gaining relief which is similar to affect-regulation as described by Klonsky (2007).
Brown and Beail (2009) Self-Harm Among People with Intellectual Disability Living in Secure service Provision UK Qualitative study using IPA	The researchers explored experiences and understanding of SH among nine participants in secure provision. The results yielded three overarching themes: Firstly, there was the interpersonal context of SH relating to past experiences (relationship issues that were unresolved events), abuse and loss and issues of control and protection. Secondly, the emotional experience of SH was characterised by anger, frustration, hopelessness, relief, guilt and regret. Thirdly, the management of SH appeared to promote the disclosure of mixed experiences such as helpfulness, control and power within the environment, unhelpful interactions, or ridiculing.

	Perhaps, the limitation of the study is that due to the compromised cognitive abilities, including the interpretation of interview statements that can be challenging for people with intellectual disabilities. Other findings of the study were related to impulsive nature of SH irrespective of the pathway. They found that in contrast to hospital experience of SH, none of them described episode of SH within their hospitalisation within secure setting. The authors advised that more research is needed in relation to lived experience during hospitalization.
Fish & Duperouzel (2008) Why couldn't I stop her? Self-injury: the views of staff and clients in a medium secure unit UK Phenomenology	The focus of the study explored how personal experience of SH influences participants' interactions and relationships with staff. The study identified main themes such as staff-client relationships are pivotal to SH behaviour. Being or not being supported tended to have an impact on participant's coping skills. In contrast to negative findings, favourable aspects of staff-client relationships were also identified. For instance, staff attitudes from gestures/body language/tone of voice suggests a caring attitude and the perception of positive future through having a good relationship with staff can help clients to try to stop SH in the future.
James & Warner (2005) Coping with their Lives-Women, Learning Disability, Self-Harm and Secure Units: A Q-Methodology UK A Q-methodological approach. (it is designed to explore subjective understanding about a particular phenomenon such as SH).	The aim of Q-method approach is to search for patterns in the data (how participants have ranked statements) that reflect contrasting understanding of the issues under investigation. Q-factor analysis identified 6 themes: *1) Coping with here and now', 2) Coping with powerlessness and abuse*'. 3) *Controlling emotional distress'*: Patients are understood to be internalizing their distress and using SH as coping means to control it. 4) *Coping with blame: 5) Coping as an unknowable experience. 6) understanding of what is going on now.* the study is limited in terms of the following. Firstly, Q-methodology was used which may to collect data set and the potential impact was the biases effect where the approach may not be able to capture all aspects of lived experiences of individuals who SH. Additionally, concerns have been raised about using Q-methodology with people with intellectual disabilities, in relation to the 'richness' of the data. Perhaps, the assumption is that due to the limited vocabulary and expressive language skills, including interpretation or sorting out interview statements according to whether they agree with them may be challenging for people with learning disability. The potential influence of the context of the methodological approach justifies for further research into the area.

Studies in Sub-Saharan African Studies and Ghana

Author(s) and Title, Location and Type/Design of Study	Findings
Mfon & Osinowo (2015), Development and Validation of Prison Inmates Self-harm Urges Scale (IS-HUS): A Psychometric Study. Nigeria Cross-sectional survey by ex-post facto design	Initially utilising multi-stage method such as focus group, the study used cross-sectional survey by ex-post facto design (and the variable of interest was SH urges). Depression sub-scale of Hospital Anxiety and Depression Scale by (Zigmond & Snaith, 1983) were used. Additionally, a 19-item Inmates' Self-Harm Urges Scale (IS-HUS) developed by Ineme & Osinowo(2015) was used to measure participants' urges to SH. It was also reported that participants who used psychoactive substances before being sent to secure setting reported significantly higher levels of urges to SH than those who were non-users of any psychoactive substances. It was also reported that high level of depression had higher level of urges to SH than those who reported none or low level of depression
Kinyanda, et al. (2004) Deliberate Self-harm as Seen in Kampala, Uganda. *Journal of Social Psychiatry and Psychiatric Epidemiology,* Uganda Case control study	Utilising case-control study in Uganda the researchers examined SH in an African context. The researchers used the European Parasuicide Study Interview Schedule 1 (Lineham et al, 2006) to collect data. The selection of participants for the control was that they had been admitted to the surgical or medical wards of the participating hospital for nonrecurrent conditions with the aim of excluding somatic and mental illness that are likely to lead to suicidal ideations. It was suggested that common mental health problems, such as personality disorder, stress reaction and depression were identified as precipitating conditions for SH. Additionally, it was suggested that the reason for the high suicide intent in this study was linked to depression and hopelessness. The researchers advised that more research was needed in relation to other variables including issues related to cultural background of the people.
Akotia et al. (2016) I have Sinned: Understanding the Role of Religion in the Experiences of Suicide Attempters in Ghana. *Mental Health, Religion and Culture* Ghana Qualitative using IPA	The research examined the role of religion on in-patients (n=30: 12 men & 18 women) who SH or attempted suicide. The findings related to perception that God as the creator of humans and he is the only one to take life and so attempting take their own life was immoral and they therefore asked for forgiveness from God. However, a few expressed anger and disappointment in God for not protecting them or allowing them to be in such predicament.

2.3 Studies of Lived Experiences of SH Patients in In-patient Care in Western Society

This section is sub-divided into 2 sections, where the initial stage of the review focuses on (1) studies from Europe, Canada, USA, and Australia, (2) studies undertaken in the UK. The reason for doing it this way is that Ghana has tended to adopt mental health policies and procedures from the UK and integrated them into their health care system. While research into people who SH in in-patient care settings has mostly been undertaken in Western countries, qualitative research on lived experience among people who SH in secure locked settings in Sub-Saharan Africa has been mostly neglected. Available studies relating to the lived experience of people who SH in secure settings in Ghana and Sub-Saharan Africa, will be presented in section (2.5).

2.3.1 Studies Undertaken in Western Society

The purpose of this section is to present a comprehensive review of the literature on people who SH in secure mental hospitals, with a particular focus on Western societies such as the Europe, Canada, USA, and Australia. The challenge of supporting increasing numbers of people who present with the lived experience of SH in secure settings is central to this review (WHO, 2016; Royal College of Psychiatrists (RCP), 2014; NICE, 2011). One way to achieve this is to explore service user perspectives of health care services within western countries. In recent years, studies on the epidemiology and functions of SH in Western countries have shown some similarities (WHO, 2016; Hawton et al, 2014, NICE, 2011, DoH, 201). Studies have shown that more females than males have presented with SH in secure hospitals, and the age range where this appears to be a frequent occurrence is within the 17 years to 34-year-olds (DoH, 2018, WHO, 2016). Such commonalities may act as a benchmark when considering findings from Sub-Saharan African studies and my own study.

Employing exploratory phenomenological methodology, Brown & Kimball (2013). researched the lived experiences of people (11 eleven participants: ten females and one male) who SH in a USA study. Participants were in the age range of 18 years or older and semi-structured interviews were conducted with all participants. Findings described five superordinate themes reflecting participants' experiences. Firstly, participants report that SH was misunderstood as other people around them such as family, friends and health professionals did not understand what they were going through. A lack of understanding led to feelings of loneliness and a sense of rejection. Secondly, all participants described SH as not having suicidal intent. They described SH and suicide as separate entities and felt people attached stigma to SH behaviour by associating it with suicide. Thirdly, participants described SH as an addiction, or a means of coping, which made them feel different and akin to those who use substances. For example, participants used SH as a way of isolating themselves from others, or it served as barrier between them and others. For the participants it became a cycle of guilt, and this again led to their SH, the behaviour becoming an addiction (Brown & Kimball, 2013). A fourth theme related to participants describing people who SH as traumatised individuals. For instance, past traumatic live experiences such as sexual abuse, living in a chaotic house where parents fought (physically and verbally) all the time and no one to turn to, were cited as reasons for initiating SH behaviour. They also had difficulty in expressing their emotions or knowing how to cope, and thus resorted to SH. Another revelation was that participants experienced help that was not helpful. Participants suggested some professionals who were allegedly there to provide help and support, made them feel ashamed and misunderstood. For instance, staff attitudes and verbal messages such as *'' you are crazy, you need to grow up or you are stupid/just attention seeking'' s*uggests that staff did not understand them (*p.203*). The fifth theme suggested participants believed SH has a role or a means to cope with situations. In essence, SH was perceived as a control measure, where it provided a momentary release or euphoria in dealing with physical pain versus emotional pain (paying attention to physical pain such as cutting was easier than working through the emotions they were experiencing). SH also satisfied a need to be punished (Brown & Kimball, 2013). In conclusion the study made several recommendations for health professionals in terms of how they can better support and care for people who SH. Some of the recommendations included acknowledgement that SH may not be associated with suicide intent, those who use SH want to be understood, not judged and health professionals need more education regarding how best to help those who use SH (Brown & Kimball, 2013).

This study has it merits for clinical practice, but the participants were drawn from a convenience sample. Recruitment of the participants led to the sample being predominantly female, and the participants' ethinic backgrounds were all white which could limit the utility of these findings, and perhaps suggests a need for additional studies that access a variable and diverse sample.

A study by Wand et al. (2019) investigated people who SH across two in-patient hospital settings and associated community services in the USA. The study involved a mixed methods approach to data collection; use of structured psychiatric assessment including cognitive testing, DSM-5 diagnosis (APA, 2013; Regier et al., 2013) and in-depth interviews, the aim of the latter being to interview participants about their perspectives or triggers to SH, consequences of such behaviour and their perceptions of staff support. The qualitative aspect of the study used a narrative approach, aiming to explore the interactions between the researcher and research participants, in the co-construction of the stories. By asking story-eliciting questions the focus was on the meanings embedded in the narratives (Patterson, 2008). The findings identified participants related their antecedents to SH as; 'feeling isolated with disintegration of self', 'being burdened', 'hopelessness and endless suffering', 'helplessness and rejection', 'untenable situations', and 'cumulative adversity'. The consequences of SH noted were 'being worse off', 'rejection from staff', 'gaining control', 'tension in the role of the care setting', and 'becoming engaged with, or distanced from, the family' (Wand et al., 2019). This study has implications for holistic care to older people who use SH behaviour. For instance, the essence of risk assessment through in-depth exploration in identifying what individuals are communicating can be beneficial.

A study by Lindgren et al. (2011) used participant observation and informal interviews to explore how Swedish women, between the ages of 19 and 35 years, experienced the care they received and their desired care in a secure environment. The study involved six women who SH and who had a co-existent diagnosis of anxiety (1), depression (1) and borderline personality disorder (5). Lindgren et al. (2011) applied content analysis to their data and reported that participants verbalised how connecting with staff and the environment enhanced their connection with 'self'. However, when such a connection was not experienced by participants, they felt worse and had a desire to be in their own home, but instead they were in an acute secure unit feeling abandoned and being in a situation in which there is *'trauma'* (Lindgren et al., 2011).

Selenuis & Strand (2017) conducted a qualitative study to explore the perceptions and experiences of thirteen female patients who SH in a secure setting in Sweden. The purpose of the study was to share participants' understanding and experience of aggression in relation to SH. The interviews were audio-recorded, and IPA was used to analyse the data. The findings indicate participants do use maladaptive coping mechanisms, such as SH and/or aggression towards others, to gain relief from their negative thoughts and emotions. Additionally, participants identified the importance of a collaborative treatment approach or working with staff to develop less harmful strategies for coping with negative thoughts and emotions rather than engaging in SH. The authors concluded that salient subjective views of participants' lived experience are central to care staff gaining insight into how patients' needs can be addressed.

Eckerstrom et al. (2020) conducted a qualitative study in two separate wards in in-patient settings in Sweden with 15 participants (13 females and two males) who SH due to history of emotional instability. The aim of the study was to explore patients' experiences of Brief Admission (BA). Brief Admission includes time out in situations of increased stress and threat during times of crisis when everyday coping strategies do not work, to foster self-management interventions in a safe environment. The findings demonstrated participants appreciated having to take responsibility during a crisis by contacting health professionals for support. Participants found this was helpful, and better than previous admissions when their autonomy was taken away from them through constant supervision and coercive measures. Participants also reported that it was helpful to see the problem from a different perspective. For example, it was seen as a learning experience regarding different stages of their own symptoms. Hospitalisation helped them to increase their awareness about how their emotions and destructive thoughts vary over time. This knowledge improved their ability to assess what coping strategy to use, and participants stated it was comforting to know that help exists. Participants were pleased there was clear treatment plan, for instance writing a contract or formulating a collaborative management plan, and they talked about what it means in terms of being justified and respected as an individual. Furthermore, a friendly and welcoming approach from staff was appreciated by the participants. In their previous admissions, they believed they were not taken seriously, but this was not case at this time. Another finding was that participants identified opportunity to have a daily conversation with staff and saw this as a constructive experience. Such conversations reassured them that it was not shameful to talk about suicide and their emotional turmoil. Participants were satisfied with the approach from staff which manifested in differences in staff's competence.

2.4 Studies of Lived Experiences of SH Patients in In-patient Care in the UK

The perceptions and functions of SH impact on the way services are designed. In this direction, the current UK government mental health policy for England and Wales advocates for engagement with patient /service users as equal partners in the process of treatment and care (Mental Health Foundation (MHF), 2008; NICE, 2004). The aim is to ensure that care is planned around user-defined goals and quality of life outcomes (DoH, 2009). It is noted that until recently, the care and support of people who SH has not been a focus for research in the UK (Kapur, 2015; DoH, 2009). In England, the government agenda for guidelines in managing suicide and SH, and research into SH, was championed by the National Suicide Prevention Strategy (2002) and other organisations, as part of the move towards evidence based and value-based practice (NICE, 2004; DoH, 2002). Nonetheless, research is still needed into all facets of SH, particularly service user perspectives in secure settings (Royal College of Psychiatrists (RCP), 2014, Royal College of Nursing (RCN), 2012, Leitner et al, 2008; Kapur, 2005).

The following section reviews the literature specific to the perspectives of people who SH in secure/ in-patient settings in the UK. In recent years, there has been the emergence of researchers exploring lived experiences of people who SH as a central focus, underpinning collaborative care and support towards individuals in such as hospital settings (Fish & Duperouzel, 2008). However, incorporating the perspectives of people who SH regarding service provision in secure settings remains in relative infancy (RCP, 2014, RCN, 2012, Leitner et al,2008; Kapur, 2005).

Fish & Duperouzel (2008) used IPA to explore the views of nine participants (five women and four men), in a medium secure unit and one participant living in a satellite community house, about their personal experience of SH and how it influences their interactions and relationships with staff. Findings suggest staff-client relationships are pivotal to SH behaviour. Being or not being supported tended to have an impact on participants' coping skills. With support, strong emotions, or daily stresses, resulted in their ability to cope with urges to SH. However, another experience reported by participants was being '*put off'* by staff when they needed to talk to them about their problems. Participants believed staff could be slow to listen to their problems because of their other commitments. This led to participants perceiving staff as being uncaring and dismissive of patients' personal problems. Also, staff were perceived to have taken control of their involvement in the care process and participants found this frustrating, as they were not allowed to input into their care process. It was also identified that when certain staff were on duty the incidence of SH increased (Fish & Duperouzel, 2008).

In contrast to the negative findings of Fish & Duperouzel's (2008) study, favourable aspects of staff-client relationships were also identified. The more positive aspects of the relationship include individualised care from staff who are helpful, one to one session time with staff and staff being aware of the client's mood and making themselves available to talk. Staff attitudes from gestures/body language/tone of voice can suggests a caring attitude and the perception of a positive future through having a good relationship with staff can help clients to try to stop SH in the future. Similar findings were noted by Huband & Tantam (2004), who found that having an effective lasting therapeutic relationship enables clients to express their thoughts and feelings, ultimately finding effective ways of coping and reducing SH behaviours. Fish & Duperouzel (2008) recommend building an effective therapeutic alliance when providing patient care, developing good listening skills, and the involvement of clients in staff training and policy formulation.

A UK study by Owen-Smith et al. (2014) explored the lived experiences of people who SH during the discharge process. Ten participants who SH were recruited from five acute wards in two hospitals. The findings were linked to participants' attitude to discharge and the immediate post discharge period. Most participants (9) felt their period of hospitalisation was helpful to them, but one participant noted not to have experienced any benefit from in-patient care. Six participants were happy with their discharge, but the remaining four participants had been disappointed to be discharged without their involvement in the discharge process. This led to feelings of despair and the urge to SH with suicidal ideation during this period of time. Reasons for these feelings and urges related to there being constant availability of support and reassurance during their hospitalisation, when discharge plans were eminent, they experienced a feeling of vulnerability. Additionally, participants were of the view that in-patient care can disrupt existing family relationships and social networks and so making adjustment to home life can be more problematic.

Brown and Beail (2009) conducted a phenomenological study in a secure setting in the UK, exploring the experiences and understanding of SH among nine (five men and four women) participants (who have dual diagnosis including learning disabilities). Participants accounts of their experiences were analysed using IPA, with the researchers hoping to identify reasons associated with this behaviour to plan interventions that might better support them. The findings yielded three overarching themes: Firstly, there was the interpersonal context of SH relating to past experiences (relationship issues that were unresolved events), abuse and loss, and issues of control and protection. These findings supported previous research in the area, suggesting that the role of distressing experiences in childhood, including child sexual abuse, loss, family stress, illness, bullying, rejection, domestic violence, emotional and psychological abuse, with a secondary trauma of being restricted in secure setting, can result in ineffective coping strategies, such as SH (Owen-Smith et al. 2014; Dear et al., 2001). Secondly, the emotional experience of SH was characterised by anger, frustration, hopelessness, relief, guilt and regret. Thirdly, the management of SH appeared to promote the disclosure of mixed experiences such as helpfulness, control and power within the environment, unhelpful interactions, or ridiculing. Regarding these emotional experiences, participants gave accounts of difficulty with being around other people who are unhappy and stressed. The third theme was in relation to management of SH, and this was two-fold. For instance, participants adopted various strategies to deal with their SH behaviours of which some were formulated in collaboration with others. Some of the methods used to control SH involved; self-talk (e.g., saying no to self not to do it again) engagement in diversional therapy, finding a non-stimulus place, talking to staff and others. However, participants perceived a second aspect of the management process as something that was imposed on them externally. For instance, removal of belongings and/or use of physical restraint techniques which they perceived as punitive or putting patients on an enhanced level of observation which participants found frustrating and upsetting. This finding supported previous research in the area (Babiker & Arnold, 1997), whereby individuals cope by exerting some form of control over their personal situation. For example, using SH as an alternative in dealing with fear of intense feelings manifesting as aggression. Rather than harming others, such as staff who may be controlling in their interventions (external control such as removal of items), people who SH tend to direct frustrations to their body (Babiker & Arnold, 1997). Other findings from Brown and Beail's (2009) study highlighted the negative emotional experience of guilt, shame, anger and hopelessness associated with SH. In all, Brown and Beail (2009) suggest the study has implications for clinical practice in terms of staff training, supervision and exploring all inclusive and least restrictive measures and collaborative approaches to provide effective help for people who SH.

It is interesting to note that in Brown and Beail's (2009) study there were some commonalities in the experiences across participants in terms of gender (both males and females). However, the study is limited in terms of the following. Firstly, during data collection, three interviews were conducted in the presence of a member of staff. The potential influence of staff within the context of these interviews as a vehicle for data collection must be acknowledged and justifies the need for further research into the area. Concerns have been raised about how data was analysed using IPA with people with intellectual disabilities, in relation to the 'richness' of the data (Smith, 2009). Perhaps, the assumption is that due to the limited vocabulary and expressive language skills, people with intellectual disabilities will not be able to provide the richness of data relevant to the research method (Smith & Osborn, 2003). There is therefore the justification for future research with a purposive sample that did not have dual diagnosis including learning disabilities. Additionally, the idea of suicide was not included in the interview schedule, but some participants talked about it. Some participants talked about a wish to die at the time of their SH, whilst for others, ambivalence was manifested. Therefore, the range of perspective in this case may in part reflect the inclusion criteria which did not different between intent.

Barker et al., (2013) conducted a qualitative study to explore the perceptions and experiences of eight female patients who SH in a secure setting in the UK. The purpose of the study was to share participants' understanding and experience of SH with care staff to see if it would be helpful in their therapeutic encounters and improve patient outcomes. The interviews were audio-recorded, and IPA was used to identify six themes: 'the traumatised individual'; 'hidden experience'; 'interrupted maturation process' 'crossing the line'; 'nascent potential protection' and 'individual and systemic repercussions. It was noted that there were varied perceptions of SH, but there were also commonalities across participants' narratives of SH. One interesting finding of the study reported by all participants was their experience of mental health problems being a vital issue in terms of their SH. Barker et al. (2013) noted that the difficulty in trusting others and problems with being able to discuss SH, would appear to be linked to traumatic experiences. Additionally, participants had experienced significant events in their adolescent years that had interrupted the development of adult coping mechanisms. Their traumatic experiences and not trusting others, was linked to a secondary experience of feeling alienated from others which made participants carry out SH in secrecy. A lack of trust appears to prevail in in-patient secure settings and may be in part due to a lack of understanding of SH on the part of staff (Barker et al.,2013). This perceived mistrust can be a critical barrier to seeking out and accepting care from staff. Even though Barker et al.'s (2013) sample is small, there appear to be some similarities across several studies (Brown & Beail, 2009, James & Warner, 2005). Additionally, the use of diversional therapy was found to be beneficial, talking to staff was considered a better means of coping and promoted the avoidance of SH. Barker et al. (2013) suggest their study has clinical implications for assisting both staff and patients in the formulation of coping mechanisms that can help in reducing SH behaviours among individuals.

Similar findings were noted by Parkes and Freshwater (2012) in an IPA study with females (n=11) with a history of SH and/or violent behaviour in a secure hospital in the UK. The study utilised IPA to analyse the data with the aim of acquiring an enhanced understanding of the women's lived experiences of psychological distress. The findings showed that all participants admitted to carrying out SH and had been violent to others when they were emotionally distressed. Findings also demonstrated how SH enabled them to cope with intense emotional pain, often rooted in traumatic childhood experiences and negative thoughts or despair. Anger and frustration or sadness appeared to emerge out of the individuals' desire for the trauma to stop. Thirdly, the theme 'losing it' was described by participants. For instance, when dealing with their emotions, they reported getting to a point where they could not cope and may feel vulnerable. During such moments, they can display their anger and frustrations towards anyone by assaulting them, as they perceived them to be the cause of their heightened vulnerability. Following such occurrences, participants reported a sense of emotional relief/release, but this is often followed by self-blame, self-hatred and low self-esteem with associated suicidal ideation. Some participants reported to have benefited from crying for help and pressing for staff support, medication and other therapies (Parkes & Freshwater, 2012).

One of the perceived limitations of Parkes and Freshwater's (2012) study appears to be the use of a single trigger question, when asking participants to describe their lived experiences. Although the use of a single trigger question can be used to encourage participants to narrate their pre-reflexive lived experiences relevant to the phenomenon with minimal interruption from the interview, for some this will be difficult to do (Parkes and Freshwater's, 2012). There was no information regarding the nature and context in which minimal interruption was used during data collection which would have been useful for researchers undertaking the same or a similar method of data collection.

James and Warner (2005) explored the perspectives of members of staff who provide care to people who SH and the perceptions of female patients who have a LD and SH in a medium secure setting in the UK. The study adopted a Q-methodological approach. The Q-methodology (James & Warner, 2005) is designed to explore subjective understanding about a particular phenomenon such as SH. The approach involves constructing a Q –sort that is made up of statements about the issue in question. Participants are asked to sort these statements according to whether they agree with them. Statements are derived from sampling a range of sources that reflect the diversity of understanding that exist in the target population. In this study, statements were from interviews conducted with staff and patients within the secure unit. The aim of the Q-method approach is to search for patterns in the data (how participants have ranked statements) that reflect contrasting understanding of the issues under investigation. The initial sample group involved five staff from various units of a health care facility who completed semi-structured interviews regarding their opinions about why women with LD within a secure units SH. An additional 40 participants drawn from across the organization, including patients and staff, completed the Q-method study.

Q-factor analysis identified six distinct accounts. (1) '*Coping with here and now',* focusing upon the impact the current situation has on the women, in this instance coping with the stress of living in a secure setting. (2) '*Coping with powerlessness and abuse*', portrayed as being caught up in a conflict between their experience, such as abuse, and an inability to voice how they are feeling. Within this context the SH, as an alternative for coping with distress, is not necessarily directly associated with their experience of abuse, but rather a means of self-preservation or a way of regaining some power and control when more profound psychological change cannot be achieved. (3) '*Controlling emotional distress'*: Patients are understood to be internalising their distress and using SH as a means of coping to control it. SH enables them to exert control over their distress, acting as a safety valve and releasing tension. (4) *Coping with blame:* e.g., SH as a response to past experiences of abuse and rejection from others that in turn can lead to women experiencing low-self-esteem, which may be the result of them feeling in some way blamed by themselves or others, for the experiences underlying their SH. (5) *Coping as an unknowable experience:* SH is a unique individual experience that is nevertheless associated with some common issues such as low self-esteem and distressing emotions. It is about coping with build-up and rejects the notions that SH is a learned behaviour. SH is understood to be unique to each individual and her internal world and, as such, remains largely unknowable to those outside the experience.

Lastly, within the theme: *'understanding of what is going on now';* participants described the way health professionals can better approach those who SH. Participants also advised the way in which health professionals need to consider how treatment is delivered, so clients will not feel judged, and staff will be more empathic and sensitive to their plight during their therapeutic encounter. As the participants are leading restricted lives in secure settings, their ability to manage their lives is also restricted which can impact on them in accessing help and support. Staff need to be non-judgemental and listen more to the client group (James & Warner, 2005).

This study has its implications for clinical practice in relation to the establishment of effective therapeutic relationships with people who are distressed and vulnerable, and without staff being judgemental in their clinical decisions making and problem-solving encounters. However, the study is limited in terms of the following. Firstly, Q-methodology uses a pre-determined set of statements that have the potential to introduce bias and may have a restricted ability to be able to capture all aspects of lived experiences of individuals who SH. Additionally, concerns have been raised about using Q-methodology with people with intellectual disabilities, in relation to the challenge of sorting out interview statements according to whether they agree with them.

Secure settings have been in use to care for people who SH since the implementation of the MHA 1983 (revised, 2007). To date, data are inconclusive as to whether SH is more common in females than males. Some studies indicate that SH is more common in females than males (Muehlekamp & Guitierrez, 2007), whereas others have found no difference in the rate of SH between males and females (Briere & Gil, 2008). While studies in the main do not separate the genders, other studies focus on women (Parkes and Freshwater, 2012; James & Warner, 2005), with few studies focusing solely on men who SH. As secure mental health units often have a higher ratio of men to women (Briere & Gil, 2008), the following were of interest to me.

Adamson & Braham (2011) conducted a grounded theory study to explore pathways to episode of SH experienced by seven mentally ill men in a secure hospital in the UK. The researchers employed theoretical sampling and semi-structured interviews were used to collect data. The findings revealed two pathways to episodes of SH. Firstly, SH was linked to a relief pathway from intrusive thoughts. It was suggested that cognitive factors play a crucial role in precipitating episode of SH. It was therefore recommended that treatment may need to target the antecedent component of this pathway, such as rumination rather the aiming to change the functions of SH. Additionally, within the relief pathway, episode of SH appeared to function to gain relief which is similar to affect-regulation as described by (Klonsky, 2007). An associated function to this is self-hatred which seemed to be a secondary function within the relief pathway. It was concluded that self-punishment may be a secondary function of the relief pathway and may be associated with gaining relief from the act of SH. Secondly, episodes of SH were considered a response pathway to mental health problems. For instance, the presence of positive symptoms of schizophrenia might have directly influenced episodes of SH. It was therefore recommended that those who may experience this pathway may need to have their positive symptoms of schizophrenia addressed. Other findings of the study were related to the impulsive nature of SH irrespective of the pathway and the availability of means to engage in SH behaviour was sufficient to lead to the episode.

2.5 Self-Harm, Mental illness, and Sub-Saharan African Studies

Kinyanda et al.’s (2004) case-control study in Uganda examined SH in an African context. The researchers examined the cases of SH (n=100), with a control case of n=300. All cases had a similar age range and gender split and were from three in-patient care facilities in Kampala. Researchers used the European Parasuicide Study Interview Schedule 1 (Linehan et al, 2006) to collect data. The findings suggest that higher educational attainment, higher socio-economic class, and poor housing were significantly associated with SH. Pesticides and medication, mainly antimalarial and diazepam, were the dominant methods used for SH, and common mental health problems, such as personality disorder, stress reaction and depression were identified as precipitating conditions for SH.

A study in Nigeria conducted by Mfon & Osinowo (2015), in prison settings, used a focus group discussion to help develop a psychological instrument to detect an individual’s urges to SH. The focus group discussions involved 32 purposively selected in-mates and four purposively selected staff, to help them to develop the tool. They did back translation of the tool and the inventory tools were translated to Yoruba language and back translated into the English language. The findings showed that restricted patients reported higher levels of SH than non-restricted patients.

2.6 Studies on Self-harm in Ghana

In developing countries, such as those found on the continent of Africa, the cultural perception and practices of some ethnic groups involves the act of seeking pain as pleasure and men are not allowed to cry (Osafo et al., 2015). This stereotypical behaviour and experience may contribute to the lack of research into SH. Whilst Western studies have focused on the lived experiences of people who SH in secure settings, this is in its infancy in Sub-Saharan Africa, and more specifically in Ghana (Smith & Kaminski 2016; Alder & Alder 2013; Sandy & Shaw, 2012).

The experience of SH and/or suicidal ideation relates to culture and mental illness (Adinkrah, 2014). In Ghana, studies undertaken by Akotia et al., (2016); Opare-Henaku (2014); Asante & Mazama, (2009) revealed that cultural beliefs have been identified as central factors in the conceptualization of health. According to Akotia et al., (2018), cultural beliefs, such as the belief in spirits, tends to influence individuals' understanding of mental illness, SH and suicide-related problems and death (Adinkrah,2008; Adams & Salter,2007).

The cultural and religious beliefs of Ghanaians towards health, life and death shape their coping mechanisms and experiences of health promotion, illness prevention and risk-taking behaviours, such as SH and suicide. Akotia et al. (2018) conducted a qualitative study in Ghana examining the role of religion on in-patients (n=30: 12 men & 18 women) who attempted suicide. Semi-structured interviews were used to collect data with IPA being used to analyse it. The findings suggest that religion provided a context within which participants' experiences could be understood. All participants acknowledge God as the owner of life and death. When talking about suicide, most of the participants held the perception that God was the creator of humans and he is the only one to take life and so attempting to take their own life was immoral, and they therefore asked for forgiveness from God. However, a few expressed anger and disappointment in God for not protecting them or allowing them to be in such a predicament. The findings of the study resonated with other studies on suicide and religion (Akotia et al.,2018; Osafo et al., 2015; Opare-Henaku; 2014; Asante & Mazama, 2009) indicating that participants' perceptions of suicide were linked to their ability to communicate with God for forgiveness and support (Osafo et al., 2015). The study used IPA, but focused on suicide rather than SH and it did not detail any specific religious or ethnic group with their unique cultural practices.

To date, there have been no studies carried out in Ghana exploring the lived experience of a people who SH in secure mental health/locked hospitals. There is, therefore, the need for future qualitative studies focusing on individual accounts of those who use SH behaviour in secure mental health/locked hospitals in Ghana.

2.7 Discussion of Extant Literature included in the Review

Research using qualitative and quantitative approaches has been employed to explore SH, with the aim of gaining a better understanding of this phenomenon from the perspective of service users. Themes that emerged regarding participants' experiences of SH and the care they received, include staff misunderstanding their SH, SH was not always synonymous with suicidal intent, but rather it was a form of maladaptive coping or a means communicating a need for help and SH is often a hidden experience (Barker et al., 2013; Fish & Freshwater, 2012; Brown and Kimbal, 2013). Findings suggest staff-client relationships are pivotal to SH behaviour and being or not being supported by staff tended to have an impact on participant's coping skills (Brown and Beail, 2009; Fish & Duperouzel, 2008; James & Warner, 2005).

The antecedents to the individual's SH behaviours were varied (Barker et al., 2013; Fish & Freshwater 2012, Brown and Beail, 2009). Common themes that emerged from the studies were, abuse, rejection, loss and relationship breakdown (Selenuis et al., 2016; Baker et al, 2013; Brown & Kimball, 2013). In addition, it was also established that multiple previous abusive events had a stronger effect than a single previous event and perceived rejection from others could lead to individuals experiencing low-self-esteem, guilt and shame. Experiences underlying SH can be traumatic to deal with, thereby resulting in suicide ideation (Owen-Smith et al., 2014 Barker et al., 2013; Fish & Freshwater, 2012, James & Warner, 2005). Coping with powerlessness and abuse, was portrayed as being caught up in conflict between their experience, such as abuse, and an inability to voice how they are feeling (Baker et al., 2013; James & Warner, 2005).

It is proposed that SH is common in institutions such as secure hospitals, where people may have limited coping skills and/or poor emotional regulation, rigid institutional regimes and encounter negative attitudes on the part of staff (Brown & Kimball, 2013). Themes that appeared in the literature relating to people who SH in secure settings involved varied perceptions of SH, positive and negative views about coping strategies and the care received (Baker et al, 2013). Some participants were noted to have externally directed their SH towards others, such as vulnerable peers, and/or the use of physical and verbal aggression directed at staff (Selenuis & Strand (2017). Themes such as difficulty in regulating emotions and unmet physical needs played a role in an individual's SH, while others reported SH as being a means of having their needs addressed. Some participants who use SH noted their perceived powerlessness in a secure setting as being an antecedent to their SH (James & Warner, 2005)

One of the overarching themes from studies related to therapeutic encounters with health professionals, suggesting individuals use SH as a way of exerting some form of control over their personal situation (James & Warner, 2005). For example, fear of intense feelings exploding as aggression and using SH as an alternative, instead of harming others, such as staff, who may be controlling in their interventions (James and warner, 2005). In contrast, staff attitudes, demonstrated by gestures/body language/tone of voice, can convey a caring attitude and the perception of experiencing a positive future through having a good relationship with staff can help clients to try to stop their SH behaviour (Fish & Duperouzel's, 2008).

2.8 Summary of Literature Review

Several authors in western countries have explored the lived experiences of people who SH in secure settings. Most authors identified SH as being a coping mechanism and/or a way to communicate difficulties in their personal lives. It was a means of expressing their emotional stress and/or it was a form of relief (Owen-Smith et al., 2014; Fish & Duperouzel's., 2008). The reasons for their SH were related to interpersonal issues relating to past experiences; relationship issues, unresolved events, abuse and loss, as well as issues of control and protection (Brown and Beail 2009; Fish & Duperouzel's., 2008; Brown and Kimball,2013). Additionally, studies identified that SH was employed as a coping strategy for dealing with powerlessness and abuse issues. The above studies serve as a point of reference to the complexity of SH and call for further research in harm minimisation. Qualitative research exploring in-depth the lived experiences of people who SH is necessary to provide a holistic understanding of the act of SH, as well as its implications for health professionals. Hopefully, the current study will address such limitation.

2.8.1 How this study will address the gaps identified

Through the process of undertaking a literature review, central issues related to the perspectives of people who SH, have been revealed. Reviewing the literature has illuminated insights into areas where knowledge and understanding about the lived experience of people who SH are scarce. While this review demonstrated that the notion of lived experience of SH has been explored in Western countries, evidence suggests there is no research regarding lived experience of SH in secure mental hospitals in Ghana. Existing evidence is either anecdotal (Avevor, 2007) or its impact limited as it is included within the literature affiliated to isolated, but related topics (Akortia et al,2016; Osafo et al, 2015; Doku, 2012). The Sub-Saharan African studies presented above (Akortia et al., 2016; Osafo et al., 2015; Doku, 2012) focused on suicide and briefly explored SH. All researchers identified a lack of literature focusing on the lived experiences of people who SH in secure settings and the need for further research. This study therefore seeks to address this omission by exploring the lived experience of people who SH from a service user-led perspective. Additionally, the current study is underpinned by phenomenological commitment, ensuring the foregrounding of the experiences of those who SH in secure setting in Ghana. In relation to the clinical setting, research of this kind can illuminate understanding of the lived experiences of people who SH in secure settings. It is anticipated that the outcome of this study will inform health professionals who support this client group, by gaining insight into their unique, in-depth personal perspectives of people who SH and being able to apply such information in their therapeutic encounter to benefit all.

The study seeks to answer the following questions:

- How do people who SH make sense of their experiences in hospital, at home and in the community?
- What negative perceptions and experiences do people who SH have of care in hospital, at home and the community?
- What positive perceptions and experiences do people who SH have of care in hospital, at home and the community?

The purpose of this study is to conduct qualitative research using IPA exploring the knowledge and understanding of lived experiences of people who SH in secure mental health hospital in Ghana. IPA attempts to explore personal lived experiences, the meanings of those experiences to individuals, and how individuals make sense of their experiences (Smith et al., 2009; Quinn & Clare, 2008).

The literature reviewed in this chapter indicates that these issues have not received previous academic attention. Providing this evidence will enable a unique contribution to be made to the extant body of knowledge and understanding of service users' lived experience of people who SH in secure settings in Ghana. It will also provide a point of reference for future research into the phenomenon of SH in in-patient settings in Ghana.

2.9 Reflections on the Review

This review of the literature has raised my awareness of the lived experience of people who SH being unique, regardless of some common issues such as low self-esteem and distressing emotions. Additionally, other themes from the literature regarding the attitudes of health professionals also made me think about my own practice and how over the years I have approached people who SH.

Reflexivity in this literature review was attained in various perspectives. Firstly, my professional background is mental health practice, including supporting people who SH. I was therefore cautious about my professional background regarding assumptions about extant literature, my beliefs, and the validity of knowledge regarding SH. Given that, instead of suspending my preconceptions regarding extant literature on people who SH, I approach the review process with an attitude of reflexive awareness (Konradt et al., 2016; Hayness, 2012).

During the selection of relevant articles pertinent to the phenomenon under study, I narrowed down the selection to focus on qualitative studies in secure settings (see section 2.1), but with the conscious aim of remaining objective. This was a challenging aspect when trying to find pertinent extant literature, especially relating to qualitative studies of SH in Ghana where such research is still at its infant stage.

My reflective diary was useful in reflecting on the start and end date for my search strategy and this process enabled me to keep track of the ongoing activities involved (see section 3.8), my research process and supervision meetings. The entire process enhanced my ability to self-reflect on my research journey. Additionally, I recorded brief written memos that captured my responses, scrutiny and processing of the materials read. The memos dwelled on my thoughts and feelings whilst I was reading the texts which helped in separating my own perspectives and experiences in my personal and professional practice and helped me to manage myself in not over-reacting to the positions claimed by various researchers whose studies I was reviewing.

It is also worthy to note that it was not an easy task with regards to challenges in the search strategy, review of extant literature and discussion of papers reviewed. It is impossible to remain ‘outside’ the research topic and the target population. However, I did my best to use ‘mind games’ with self, telling myself I have not lived in Ghana for some time and have developed different customs and ways of thinking, influenced by living in a Western culture, and therefore I am not in a position to make assumptions, particularly in relation to Sub-Saharan African papers. I made rough notes of my thoughts and feelings following closing reading of each article and used these as a personal challenge when doing discussion of papers reviewed.

The review and discussion stages of the entire literature review required considerable effort of critiquing various literature and identifying their strengths and limitations ((see section 6.5. 4). As a researcher, I adopted the notion of reflective thinking and listening during supervision sessions with my supervisors and developed writing skills to enable me to situate myself in the review process. As part of the review process, I examined broader views and perspectives about how other researchers have positioned themselves in terms of their beliefs, scrutinising the data, their interest in interpretations and drawing conclusions, which may have emphasised one aspect of their study over another.

In all, this literature review has sought to situate this investigation in relation to extant body of knowledge about people who SH in secure settings in Ghana. It has shown that the phenomenon has failed to attract academic or scholarly focus and therefore exposing a gap in extant knowledge, which this study will seek to fill. Relevant themes uncovered from this literature review that are related to the study will be employed (See chapter 2.5.2) in the formulation of the interview approach in this current study. The next chapter describes the methodological approach and methods adopted to explore the lived experiences of people who SH.

Chapter 3: Methodology and Methods

3 Introduction

The methodology and design chosen for this study evolved from the literature review. It can be deduced that most extant studies reviewed in Chapter two in relation to the experiences and perceptions of people who SH, adopted a qualitative research approach. As the Introduction and the Literature Review chapters have indicated, available evidence regarding the experience of people who SH in secure settings in Ghana is still in its infant stage. The purpose of this chapter is to discuss the theoretical viewpoint and/or methodology in relation to this study. The term methodology relates to a theoretical underpinning to understand plans and/or a set of strategies that can be applied to study a phenomenon (Creswell, 2015; Hesse-Biber & Johnson, 2015; Franklin, 2012; Howell, 2013). Silverman (2013) expand this approach further, advising that methodology gives guidance to the nature and processes needed to attain the objectives and outcomes of a research study, but does not define specific methods to follow. Arguably, it encompasses concepts such as paradigms, theoretical models, phases and quantitative and/or qualitative approaches to attain the outcomes of a research study (Creswell, 2015; Hesse-Biber & Johnson, 2015). The overall aim of this chapter is to discuss the research paradigms and their associated philosophy, followed by the methodology used in this study and a description of how the research was carried out and completed.

3.1 Research Paradigms

A paradigm, like a methodology, is a constructive framework for the phenomenon under study (Creswell, 2010). A research paradigm denotes the philosophical framework that is derived from, a world view or belief systems about the nature of knowledge and existence, and serving as guidance in research inquiry (Bryman, 2012). Research studies usually fall into one of two paradigms; positivism and subjectivism; the former being associated with quantitative research and the latter qualitative research. The term positivism relates to objectivity and the search for truth. Positivism evolves around facts and values which are distinct dispositions, in order to carry out objective and value-free inquiry (Teherani et al., 2015; Richards, 2003). In contrast, subjectivism focuses on lived experience rather than a single truth and acknowledges the existence of multiple realities. In addition to these basic differences, beliefs that define a research paradigm tend to focus on certain domains. That is, the research paradigm is characterised by an underpinning philosophy, the facets of which include epistemological, ontological, axiological and methodological issues (Bryman, 2012).

In all, the pursuit of a suitable theoretical orientation for exploring experiences of people who SH involved reflection on the assumptions underpinning the project. The quest for ensuring academic rigour and research trustworthiness (see sections 3.9.2) serves as a point of reference as to how I, as a researcher, perceive the structure, scope and validity/ trustworthiness of knowledge (epistemology) and the understanding of the nature of the social world under investigation (ontology). Together with the methodology and methods employed, these beliefs formed an underlying set of assumptions (the research paradigm) that underpinned and guided the research process (Creswell, 2014; Bryman, 2012).

3.2 Philosophy

Philosophy attempts to explore general and fundamental questions, such as those about existence, reason, knowledge, values, mind and language. Such questions are usually posed as problems to be studied or resolved (Henderson, 2019; Chalmers, 1995).

3.2.1 Epistemology

Epistemology relates to the nature of knowledge. Epistemology is the theory or knowledge pertaining to the overarching research paradigm, and the theoretical viewpoint is the specific philosophical stand that provides a basis for the research approach. Crotty (2002) suggests that epistemology is a way of perceiving the world and making meaning out of it. The sort of epistemological assumptions individuals make about knowledge tends to affect how they navigate uncovering knowledge through their research (Richards, 2003). In this direction, the decision that a researcher will apply in choosing a methodological approach will be based on their epistemological assumptions. For instance, if knowledge is perceived as objective, hard and tangible, then the inclination of the researcher will be affiliated to natural science methods that requires descriptive and inferential statistics. (Bryman, 2012). In contrast, if knowledge is viewed as personal, unique and subjective, then the researcher will align his/herself with the social sciences and subjectivism.

Some authors are of the view that epistemology is a continuum of positivism and subjectivism, about ways of knowing (Teherani et al., 2015). Positivist epistemology assumes meaning and meaningful realities already reside in objects, awaiting discovery and intact, irrespective of any kind of consciousness (Crotty,2002). Objectivism holds that individuals must abandon their position when making judgements on a situation and that meaning exists independently of human thoughts and consciousness (Silverman, 2011; Devitt, 2005). That is, objectivism holds that reality is separate from human consciousness and no matter what individuals might want to believe, reality will always be what it is, with no consideration for subjective views (Teherani et al., 2015; Devitt, 2005). As such, the ‘truth’ is static and is always objective and so when researchers perceive objects around them, then, they are simply discovering meaning which have been lying in them all along. Therefore, positivists believe researchers must distance themselves from their research findings (Bryman, 2012).

In contrast, subjectivists argue that individuals will apply their own subjective meaning to their lived experience of a phenomenon, leading to the existence of multiple realities. In addition to accepting, participants apply subjective meaning to their lived experiences, subjective researchers also acknowledge their presence in the research encounter (Silverman, 2011; Devitt, 2005). To address this, subjective researchers adopt a process of reflexivity when trying to make meaning of the phenomenon under investigation (Silverman, 2011). Reflexivity enables the researcher to become aware of how their subjective experience, emotions, and beliefs can affect the research process. The need for reflexivity is absent in objectivism, as there is an assumption that the researcher will not affect the research process (Silverman, 2011). Table 4 shows the main differences between positivism and subjectivism.

Table 4: Key Philosophical Research Positions and their Underlying Assumptions

EPISTEMOLOGICAL POSITIONS (nature of knowledge and how it is acquired)	
Position	**Assumptions**
Positivism	- Objective and value-free inquiry is attainable - Knowledge is produced through the senses based on careful observation - Knowledge is viewed as hard, tangible and objective - Knowledge is derived through data collection of facts - Facts and values are distinct - The world is independent of and unaffected by the researcher - Social world is approached through the explanation of human behaviour
Subjectivism	- Facts and values are not distinct - The researcher and the social world impact on each other - Objective and value-free inquiry is impossible as findings are inevitably affected by the researcher’s perceptions and values - Social world is approached through understanding of human behaviour. - Knowledge is viewed as personal, subjective and unique - Knowledge is derived based on exploration and understanding the social world of the people being investigated - The investigator understands the social world by using their understanding as well as that of research participants

In social science, where the aim of a study is to explore the lived experiences of the research participants, subjective research is considered the most appropriate paradigm (Silverman, 2011; Devitt, 2005). As the intention of this research was to explore participants’ lived experiences of SH, subjectivism appeared to be the most appropriate approach. Meaning making is formed through everyone’s subjective views and perspectives of the phenomenon under investigation. However, as the researchers’ access to the participants’ personal world is affected by their own conceptions, care needs to be taken when interpreting ascribed meanings (Smith et. al, 2011). To address this, I took account of my own pre-existing knowledge, assumptions and views that could impact on my interpretations of the multiple realties of those who engaged in this research process. I achieved this by reflecting on my role in the interview process, data analysis and eventual writing up of the research (Heidegger, 2002; Crotty, 1998) (see sections 3.9.2).

3.2.2 Ontology

The term ontology denotes ‘being’ and it is about ‘what is’, in relation to the nature of existence and structure of reality as such, and/or what is possible to know about the world (Crotty, 2002). According to SAGE online Dictionary of Social Research Methods (2006), ontology is a concept concern with the existence of, and relationship between different aspects of society such as cultural norms, social actors, and social structures. In research the concept of ‘social ontology’ is concerned with the nature of social entities (Bryman, 2012). Social entities can be objective entities which exist independently from social actors or can be viewed as social constructions in themselves; built up from the perceptions, actions, and interpretations of individuals in society (Bryman, 2012).

The ontological conception of objectivism is that of objective realism. This concept assumes that reality is determined by laws, with the notion that causality rules occur out of the possibility of ‘chance’ events with the notion that everything has a cause (Silverman, 2011; Crotty, 2005). That is, objectivism and/or realism denotes that there is an underlying objective reality which is perceived in different ways (Paul & Miller 2008*).* Such epistemological and ontological assumptions are commonly adopted in quantitative methods of research (Kumar, 2014; Paul & Miller 2008; Greenspan, 2007).

Within qualitative research subjectivism and constructionism are the preferred view (Paul & Miller 2008). Subjectivism denotes that the individual’s own mental activity is the only unquestionable fact of their experience, and there is no external or objective truth (Paul & Miller 2008*).* Subjectivism holds that reality is what individuals perceive to be real, and that there is no underlying true reality that exists independently of perception. Indeed, it is consciousness rather than perception that is reality; often termed ‘*subjective idealism*’ *(*Paul & Miller 2008; Greenspan, 2007).

Constructionism considers that there can be no meaning without the mind, and that meaning is constructed by individuals as they engage in their lived world experiences (Paul & Miller 2008; Crotty, 2005). Arguably, the constructionists note that there is no such thing as objective truth awaiting and/or to be discovered. Rather, meaning is constructed and therefore individuals may encounter meaning in differing situations (Creswell, 2014; Saunders et al, 2012 Paul & Miller 2008; Greenspan, 2007).

Some authors used the term constructivism interchangeably with interpretivism (Smith, 2009; Saunders et al, 2012), the latter being my preferred terminology as this is the process I engaged in when undertaking my research. The ontological and epidemiological strands of these proponents are the existence of multiple realities relative to differing situations, with the former being dependant on various ways of making meaning, presenting a challenge to interpret in terms of fixed realities (Paul & Miller 2008*;* Lincoln & Guba, 1988). Therefore, the goal of the constructivist and/or interpretivist researcher is to understand the motives, meanings, reasons and other subjective experiences and interpret the meaning and/or make meaning out of data, rather than to generalise and predict the outcomes of the study (Paul & Miller 2008; Lincoln & Guba, 1988).

Table 5: The Main Differences of The Ontological Positions on Positivism And Subjectivism

ONTOLOGICAL POSITIONS (nature of the world and existence)	
Position	**Assumptions**
Objectivism	- Only material or physical world is perceived as 'real' - Reality can be observed directly and accurately - Social phenomena and their meanings cannot change - Reality exists independent of our beliefs or understanding - Events have causes and measured by other circumstances - The concepts of freedom, individuality, choice, and moral responsibility are excluded
Constructionism/ interpretivism	- Reality is subjective - Social phenomena and their meanings are derived through social engagement and are dynamic - External reality exists but is only known through human mind and social constructed meaning. - Researchers understand the social world based on their understanding simultaneously with the understanding of research participants

In this current study, one of the questions asked was: how do people who SH make sense of their experiences? The philosophical underpinnings and methodological approaches of this study were based on an epistemology and ontology associated with phenomenology. That is, this study was evolved from the phenomenological understanding of the social world. Phenomenology is the philosophical study of human experiences and of how things are experienced (see sections 3.4.5). It focuses on a framework of experience and enunciates the essential meanings phenomena hold for individuals experiencing them (Smith, 2016; Bryman, 2021). That is, the study aimed to capture the constructed meaning of SH for those in secure settings, by engaging the participants in reflective interpretation of their lived experience of SH (Smith, 2009). By exploring the intersubjective lived experiences and/or idiographic views of the research participants I was able to make sense of what it means to SH in two secure settings in Ghana (Paul & Miller 2008*)*.

3.2.3 Axiology

Axiology in relation to philosophy is associated with making judgements about the role of the researcher's own values in all stages of the research process and what value has been placed on the findings by the researcher (Camaghan, 2013). To explore lived subjective views and experiences of people who SH, trustworthiness of the research was ensured so as not to bias the findings of the study (Saunders et al, 2012) (see sections 3.9.2).

3.3 Determining a Research Methodology

The research paradigm situated the reality of people who SH as a phenomenon perceived and experienced by those individuals. To attain the aims and objectives of the research, methodology will now be considered. The critical issue about methodology is focused on the values and philosophical underpinnings between the quantitative and qualitative research paradigms (Hertzog, 2008; Smith, 2003). In considering the concept of quantitative methods, some scholars are of the view that it attempts to uncover general laws and theories from which empirical data can be explained (Bowling, 2014; Fox, et al, 2007). Quantitative data is analysed by statistical tests, and it will avoid interview bias (Bowling, 2014). In contrast, qualitative data are 'richer', with social science researchers being concern with social and cultural phenomena (Silverman, 2013). The researcher becomes more subjectively immersed in the subject matter by examining and reflecting on perceptions to gain insight or understanding of social and human activities, including lived experiences of sensitive issues such as SH. In considering both approaches, qualitative methodology fits more with the current study which is concerned with personal and sensitive issues which the participants had experienced (Hussey & Hussey, 1997). That is, in exploring human experiences such as SH behaviours, in-depth data needs to be established to accurately understand the meanings associated with the phenomenon. Therefore, qualitative methods using in-depth interview technique appears to have advantage over quantitative method when exploring human experiences, such as SH behaviour (Silverman, 2013).

3.4 Differing qualitative approaches

My chosen methodology for this study was Phenomenology, and in particular, IPA. The decision on the choice of methodological process to use in qualitative research provides a way of thinking about the research aims and questions, data collection and analysis. In this respect the choice of one method over another must be justified. When choosing my methodology, I did consider popular approaches when using qualitative research. Qualitative research is a broad term for a range of research practices and methodological approaches (Leavy, 2014) and each of these approaches is shaped by differing beliefs and principles for methodological rigour (Ritchie et al., 2014). Popular approaches within qualitative research include grounded theory, narrative, discourse analysis, ethnography and phenomenology. Each of these is discussed below, with a brief account of why four out of the five approaches were rejected for use in this study.

3.4.1 Grounded Theory

Grounded theory is systematic methodology that involves the discovery of theory through the analysis of data (Cohen et al., 2007; Glaser, 2005). In this approach, the initial stage of the research process involves data collection, analyses by use of coding, followed by a relevant review of the literature. During data analysis, the researcher engages in various stages of coding which is an analytical process used to find concepts, similarities and conceptual recurrence in the data (Chamaz, 2012; Bryant & Charmaz, 2007). After initial analysis, theoretical sampling is used to guide the collection of additional data that will lead to developing theory/ intermediate coding. The theoretical sampling leads to sampling new participants for added relevant data or to ensure data saturation is attained (Mills et al, 2014). Then advanced coding enables integration of findings into interrelated concepts and the researcher will be able to gain insight into data extracts that are of relevance to the study (Corbin & Strauss, 2015).

Grounded theory does not aim to uncover 'truth', but to conceptualize what is going on, what is the main problem of the participants and how they are trying to solve it. Grounded theory is not a descriptive method, as it attempts to generate concepts that explain the way that people resolve their central concerns. The merit of this approach is that it involves inductive thinking processes, suggesting that participants' experiences are not surrounded by the researcher's assumptions or theoretical biases (Corbin & Strauss, 2015; Mills et al, 2014). In contrast, Silverman (2013), advised that the process of carrying out a literature review during a later phase of the research, may lead to duplicating some studies that have already been conducted. For instance, there is a risk of deducing information from pre-existing theories which may lead to the overlooking of other issues relating to the phenomenon being studied. This may be done by using the pre-existing information as the analytical lens. Also, problem situations can be in the form of over-interpreting and distorting certain data, shoehorning ideas into the findings, or remaining uncritical towards a theory without examining the empirical validity of the research (Kennedy et al, 2018; Hallberg, 2010).

The aim of this study was not to generate theory, but to explore the experiences of SH for those people who had been admitted to in-patient secure care settings. In addition, I believed it was important to conduct an early relevant literature search to assess where gaps in the field were before carrying out the study. Therefore, grounded theory as a methodological approach was not the best option for the current study, as the research goal was to explore the lived experiences of people who SH, rather than developing a theory pertaining to SH.

3.4.2 Narrative Approach

Narrative inquiry enables a researcher to perceive how individuals construct meaning from within their system of belief; attitudes, values and ideas that shape their sense of self and identity (Gehart et al., 2007; Clandinin & Connelly, 2000). Narrative stories dwell on how the subjective meanings and sense of self and identity are negotiated, as the stories unfold in relation to how they are reconstructions of the person's experiences. In this respect, narrative techniques do guide the researcher in providing deeper meaning about an individual's story of lived experience, such as SH. Hearing the stories can help the researcher to use his/her imagination in visualizing the situations. For instance, the voice, flashbacks, smiles, themes, points of view or perspectives of the individual narrating the story, can help the researcher to have a better understanding of what the individual who SH is attempting to convey.

In data analysis, a narrative approach can focus on the 'content' of stories; or on the 'meaning' making (maybe both) depending on the philosophical position of the researcher (Polkinghorne 1995). Also, data analysis can focus on the stories as knowledge *per se* which constitutes *'the social reality of the narrator'* (Etherington, 2004: p. 81) and conveys a sense of that person's experience is in its depth, messiness, richness and texture, by using the actual words spoken.

One of the advantages in using a narrative approach is that data collection and analysis tends to be unique. Here, the researcher works with the participant in making meaning of the narrative during data collection and can gain insight into the identity/ lived experience of the participant. By so doing, the researcher takes note of what is being said and compares it with his/her personal understandings, without filling in any gaps, but rather inquiring about how pieces of the stories make sense together (Butler-Kisber, 2010; Merriam, 2009). A narrative approach can also be used within a therapeutic context, and this could have been advantageous to myself as a novice researcher, as I planned to carry out this work with a client group, I was familiar with (those who SH) and are in-patients (Merriam, 2009; Holloway & Freshwater, 2007; Wosket, 1999).

However, the limitations of narrative techniques outweighed the advantages it presents. The limitations include the potential for over-exaggeration within the narrative. Over-exaggerated statements, not meant within the literal sense, have the potential for misinterpretation and can be misleading for a novice researcher and others. Also, the use of imagination might be unique in what appeals to the participant's senses, but this might not help others to visualize and make meaning of the narrative in that context. Also, data analysis can be very slow and laborious which may not be feasible for the limited time span for my academic programme. As a novice researcher I had concerns regarding these limitations of the approach and therefore rejected it as a possible methodology for my study.

3.4.3 Foucauldian Discourse Analysis

This approach focuses on how the social world is expressed through language and influenced by various sources of power. When using discourse analysis, the researcher tries to understand how society is being shaped (or constructed) by language, which in turn reflects existing power relationships (Foucault, 2002; Burr 2006; Gergen, 1985). Data analysis involves understanding how individuals view the world, and takes account of categorizations, personal and institutional relationships, ideology and politics. For example, it looks at how people in authority use language to express their dominance and require obedience and respect from those subordinates to them.

One advantage of this approach is that it can be used to analyse people's discourse in everyday social interactions, and this can be applied in a secure setting where people who SH are managed. Another advantage of this approach is that differing perspectives can provide different forms of knowledge about a phenomenon so that, together, they can produce a broader understanding (Gaventa, 2003; Hayward, 1998; Burr 2006). Discourse analysis can work well using observational methods in data collection.

The disadvantage of this approach is that language may be problematic depending on whether it is seen as structuralist in meaning or post structuralist (transitional), as well as having single or multiple meanings (Sharp and Richardson, 2001). To believe at face value what one hears, read, or sees as truth can lead to the serious error of overlooking how particular sets of ideas are produced, circulated, and maintained. Therefore, discourse analysis can illuminate insight into how particular knowledge can lead to common sense and become dominant discourse, while concurrently silencing other interpretations of the world. Although this approach may be used by some researchers to illuminate the phenomenon of SH, I did not believe it to be appropriate to use in this study. This approach is based on the use of language and ideally this should be observed, it was not feasible to use discourse analysis. Firstly, I questioned my familiarity with the Ghanaian language and particularly dialects. Secondly it felt morally wrong to observe people who were already being observed and experiencing a level of distress at being confined to hospital. Although Foucault focuses on individuality and the sense of an autonomous self, the current researcher does not believe this approach would be suitable for this study.

3.4.4 Ethnography

This approach intends to provide a detailed, in-depth thick description of everyday life, practices, and interactions of people (Creswell, 2007; Geertz, 1973). This approach requires the researcher to explain the learnt patterns of values, behaviours, beliefs and language of a culture that is shared by a group of people (Silverman, 2013; Richardson, 2000; Geertz, 1973 *p27*). In this approach, the researcher goes beyond reporting events and details of experience (Geertz, 1973, *p 27*), the cultural constructions, in which the group being studied live. Also, the researcher generates an understanding of the culture through representation of an *emic* perspective; often described as the *'insider's point of view'* (Lichtman, 2013, *p75*). An ethnographic approach involves engagement between the researcher and participants (Lichtman, 2013).

One of the merits of this approach is that it is field based. It is conducted in the settings in which real people live. Doing this enables the researcher to develop their understanding of the culture through close exploration of several sources of data. Here, the researcher can play a dual role of participant-observer in data collection. By doing this the researcher can develop an understanding of what it is like to live in a setting, whilst maintaining the stance of an observer. The aim is to describe the experience with a measure of 'detachment' (Flick, 2010; Van Maanen, 1998)

One of the challenges of this approach is that it requires a long-term commitment. Also, anonymity of the research participants tends to be compromised. Having worked in the UK for the past 17 years it was not feasible for me to adopt this approach. Again, ethnography raises moral dilemmas relating to participant-observer, particularly in a secure environment where those detained may already be mistrustful of others. It would also have been difficult to focus only on those who used SH which was the focus for the research. Therefore, this approach was not adopted for the current study.

After considering the above approaches to qualitative research, I decided that the one best suited to my study was that of phenomenology. Phenomenology as an approach is complex, as its epistemology and ontology have been refined and added to over the years. One of the more recent machinations of phenomenology is that of IPA (Smith, 2009), and this is the approach I chose for my study.

3.4.5 Phenomenology

This study used IPA (Smith et al., 2009) to explore the knowledge and understanding of lived experiences of people who SH in secure (forensic) in-patient settings in Ghana. IPA involves an interpretive process whereby the researcher attempts to interpret how the participants make sense of their experiences (Crowther, 2013). It also enables the researcher to understand the experiences of the participants. Furthermore, IPA aims to explore individuals' perceptions and experiences by taking an idiographic approach, focusing on the individuals' cognitive, linguistic, affective and physical being. It is this concept of exploring the lived experiences and interpreting such experiences of the participants' that distinguishes it in part from other approaches of phenomenology, such as descriptive phenomenology (Crowther, 2013; Husserl,1988). IPA focuses on understanding experience with the belief that there is no clear pathway into people's lifeworld:

> *IPA recognises that there is not a direct route to experience and that research is about trying to be 'experience close' rather than 'experience far' (Smith, 2011a, p. 9).*

As that is, IPA is of the view that it might be challenging to describe something without adding an interpretation to it at the same time (Backstrom & Sundin, 2007). Nonetheless, IPA does interpret beliefs and accepts participants' stories (Pringles et al., 2011). Therefore, IPA will be used as the underpinning methodology of this study.

IPA requires the researcher to interpret experiences and meanings, as principal researcher for this study I do need to acknowledge my background. As a practising mental health nurse, I do work with people who SH and I am aware of the phenomenon of SH based on my prior experiences. Consequently, the phenomenon can never disclose itself in its entirety so interpretative work is required to understand the meaning of the participants' SH experiences, while remaining cognisant of my own biases (Crowther, 2013; Moran, 2000). There are a range of philosophical positions within the phenomenological paradigm. Five of the main philosophers of phenomenology, Husserl, Heidegger, Gadamer, Merleau-Ponty and Recoeur will be discussed below as their theories are usually applied to phenomenological nursing research (Hennink et al., 2014; Zahavi, 2003). Table 6 summarises various proponents' ideologies within the conceptual frame of phenomenology.

Table 6: Exponents of Phenomenological Ideology

Prominent Philosophers	Perspectives	Applications
Edmund Gustav Husserl (1859-1938) German philosopher who established School of Phenomenology	Focused on ideal, essential structures of consciousness. He noted that individual's experiences are pre-reflected without interpretation	Asserted that knowledge of 'real meaning' would only be possible by 'bracketing' all assumptions about the existence of an external world and/or a phenomenon. Termed 'epoche'
Martin Heidegger (1889-1976)	Doctrine of apriority of philosophy. Ontology is conceptualised in terms of unfolding of 'being'.	Argued that the 'being' must be understood before all encounters, to understand the 'being'. That is the aprioiri Interpretive process based on hermeneutics and challenged the idea of bracketing as proposed by Husserl
Hans-Georg Gadamer (1900-2002) German philosopher Truth and Method on Hermeneutics	Uncover human understanding /human experience	Based his argument on the tenet of prejudices of the researcher to interpret situations and/or experiences
Maurice Merleau-Ponty French philosopher 1908-1961	Existentialism	It revolves around our interactions with the world around us and how this influences us
Jean Paul Gustave Ricoeur 1913-2005	Human experience with time (Time and narrative)	Combined phenomenological description with hermeneutics Human subjectivity is primarily linguistically designated and mediated by symbols

3.4.5.1 The development of phenomenology as a research approach

The origin of phenomenology started around the early twentieth century and it was based on the work of Edmund Husserl (1995). Phenomenology is the study of the structures of experiences and consciousness. Phenomenology attempts to create conditions for the objective study of topics usually viewed as subjective; consciousness and the content of conscious experience such as judgement, perceptions and emotions (Smith et al., 2009). Although phenomenology attempts to dwell on scientific perspectives, it does not attempt to study consciousness from the perspective of psychology, but rather through systematic reflections to determine vital features and structures of experience (Menon et al, 2014). Phenomenology is central in gaining insight into the lived experience of phenomena, within and without the lived world (Husserl, 2014). Phenomenology attempts to explore health and social care issues. Phenomenologists note that experience is not merely sense data, rather it is the combination of relationships between individuals and the world and between an individual and other people, and these experiences are perceived to have an inherent structure of meaning (Husserl, 2014). Consequently, phenomenology was used to explore and understand the meaning of the lived experience of people who SH in secure mental hospitals.

3.4.6 Phenomenology and Husserl

To adopt a phenomenological methodology, one must lay the foundation on which the method is built. The central figure in the development of the phenomenological movement was Husserl (1859-1938). The earlier phase of phenomenology involved emphasis on subjective and objective aspects of experience and their essential correlation. Husserl's (1995) focused on pure phenomenology as the source of all objectivists. That is, Husserl's phenomenology is epistemological in nature, with the focus on scientific knowledge. Husserl (1995) proposed that the world of objects and ways in which we direct ourselves towards, and perceive those objects is normally conceived in what he called the *'natural standpoint'*. This is characterized by a belief that objects exist distinct from the perceived subject and exhibit properties that we see as emanating from them (Husserl,2014). In order to better understand the world of appearances and objects, phenomenology attempts to identify the invariant features of how objects are perceived and pushes attributions of reality into their role, as an attribution about the things we perceive and/or assumptions underlying how we perceive objects (Zahavi, 2003; Husserl, 1995). The major dividing line in Husserl's theory is the introduction of transcendental idealism.

Husserl proposed a radical new phenomenological way of looking at objects by examining how we, in our many ways of being, intentionally '*constitute'* them (to be distinguished from materially creating objects or objects merely being figments of imagination). Regarding the concept of 'intentionality', Husserl implied that consciousness is always intentional and that 'consciousness is always consciousness-of-something' (Husserl, 1995, p.33). Supposed there is a directness of consciousness towards an object, that experience has meaning (Christensen et al, 2017). As noted by Chelstrom (2013, *p*.8); *'there could be no social world if there were no beings with consciousness to constitute it and experience it'*. In the natural standpoint the object ceases to be something simply *'external'*. The object ceases to be seen as providing indicators about what it is, and instead becomes a grouping of perceptual and functional aspects that involves one another under the idea of a particular object or *'type'.*

Husserl (1995) holds an objective and/or experimental view of phenomenology and what it means to '*bracket'* the natural attitude (Husserl, 1988). According to Husserl, mental and spiritual reality possess their own reality, independent of any physical basis, and that a science of the mind must be based on the natural sciences. Husserl (1995) used logical investigation to distinguish between judgment and experiences, and then cited the difference between meaning and object. He further stated that meaning is a *'concept* ', referring to a series of objects as an extension of the concept and the way meaning is made from them through sensible intuition. That is, when considering mental acts, such as the act of judging and/or analysing mental representation, existence is '*undoubted'.* The objects judged, however are for the most part, leaving out acts of self-consciousness, transcendent, and therefore not beyond doubt. Therefore, in scientific enquiry, the researcher must search for perfect evidence and to attain that, one must bracket his/her natural attitude which he termed '*epoche*' (Crowther, 2013; Husserl 2014).

The core of phenomenology is to employ human lived experience of phenomena to illuminate those phenomena. Husserl argued that in relating phenomenology to lived experiences regarding the health and well-being of the individual, it is appropriate to derive structure and meaning of the experience towards gaining an in-depth understanding of the phenomena in question.

The driving branch of phenomenology deemed feasible for application in this research is hermeneutic phenomenology as influenced by proponents such as Martin Heidegger and Hans-Georg Gadamer. The next section elaborates on Heideggerian and Gadamerian phenomenology.

3.4.6.1 Hermeneutic Phenomenology and Heidegger

Another exponent of phenomenology was Martin Heidegger (1889-1976). Heidegger's (2002) phenomenology departed from the Husserlian way of analysis of consciousness. Heidegger (2002) focused on the doctrine of apriority of philosophy, with a unique conception regarding the way time functions as the source of apriori. According to Heidegger (2002), *'being in the world'* must be understood before all encounters, in order to understand the '*being*'.

Heidegger's phenomenology focused on ontological and hermeneutic stands. From this perspective, Heidegger explored self-understanding of activities of existence in the lifeworld of people, or self-interpretations of their everyday ordinary '*being*' in the world. In this direction, 'humans' will perpetually be interpreting the world around them and live within a world made up of interpretations. Heidegger further stated that philosophy is a science of *'being'* and it is cyclical in nature. In general, individuals can act upon and change the world around them, however the world into which they are born also impacts and changes them.

The challenge of Heidegger's ontology is the problem of the meaning of *'being'* in general. Therefore, researchers are presented with the challenge of *'being'*, in trying to explore all aspects and/or components of '*being*'. Despite this challenge, hermeneutic phenomenology has been chosen in this current study. As a mental health nurse my experience and interpretation of people's behaviour has informed my clinical judgement/reasoning, but using hermeneutic phenomenology paves the way to explore the lived experiences and interpretations of those I am providing care for from their perspectives.

Heidegger argued that people's contact to live time and engagement with the world is through interpretation (Heidegger, 2010). Therefore, Heidegger suggested the way in which individuals make sense of their lifeworld and its structured meaning emanates from the individual's account or language. As such, through language our thoughts, feelings and actions about the world are expressed and individuals make meaning pertinent to self and others. Other exponents of phenomenology such as Hans-Gadamer have derived inspiration from Heidegger and extended Heidegger's hermeneutic phenomenology that appeals to this study.

3.4.6.2 Gadamer's Philosophical Hermeneutics

Another prominent exponent of phenomenological beliefs was Hans-Georg Gadamer (1900-2002). Gadamer was a German philosopher, and his influential writing was on exploring a *'truth'* and *'method'* based on Hermeneutics. Gadamer's aim was to uncover the nature of human understanding and/or experiences. Gadamer asserted that *'truth'* and *'method'* were at odds with one another. Gadamer criticised pure sciences which sought the truth based on objective views (Cesare, 2007; Gadamer, 2006). Gadamer held the notion that meaning as an object can be explored within a text, through a particular process that allowed for a connection with the author's thoughts, leading to the creation of text and/or a situation that facilitated an expression of human life (Gadamer, 2000). Gadamer argued that meaning and understanding are not objects, to be found through a method. This implies that there is no prescriptive way, such as hermeneutics, to understand human experiences, but suggests the influence of text, artwork and/or experience (Cesare, 2007; Gadamer, 2000). Gadamer speculates that *'intended truth'* and *'method* 'can be a description of what humans' usually do when they interpret things knowingly. Therefore, individuals do not come to any given thing without some form of pre-understanding established by historical links (Gadamer, 2000). The tradition in which an interpreter establishes *'prejudices'* affect how they will make interpretations. While such prejudices are not something that hinders the ability to make interpretation, both are integral to the reality of being, and are the basis of our being able to understand history (Cesare, 2007; Gadamer, 2006).

The work of both Heidegger and Gadamer resonates with hermeneutics being vital to human experience and what it means to be human. Gadamer initially described hermeneutics as a philosophy of historical understanding, and later described the linguistic component of hermeneutics. Gadamer is of the view that hermeneutics is central to modern philosophical challenges such as the *"relationship of language to being, understanding, existence history and reality*" (Palmer, 1969*, p.43*). Gadamer further described hermeneutics in terms of dialogue and text among people. For instance, individuals engage in a text, of which they may prefer to make meaning; and everyone has a horizon of understanding which comes from their culture and experiential social world.

In this study it is presumed that the lived experience of people who SH is a dialogue and interpretive engagement in the care setting. Although participants who SH are from diverse ethnic backgrounds and

SH may have vernacular uniqueness and be unique to each of them, it is interesting to note there are similarities. For instance, the word ‘cutting’ or ‘unpicking’ have commonalities in the differing cultures. Another exponent to phenomenology is Maurice Merleau-Ponty, particularly in relation to meaning making of human experience and his underlying premise is presented in the next section.

3.4.6.3 Maurice Merleau-Ponty and Phenomenology

Maurice Merleau-Ponty (1908-1961) also made a seminal contribution to philosophical views of the constitution of meaning in human experience (Merleau-Ponty, 1961). Merleau-Ponty did not affiliate himself to idealism or realism but dwelled on phenomenology. He noted that the perceived life world is primarily realist. One’s way of exploring the truth is a true perception of reality. Merleau-Ponty (1961) argued that individuals’ make meaning of their lived world and/or world view which is based on their perception and engagement in the world (Merleau-Ponty, 1961).

3.4.6.4 Ricoeur’s Hermeneutic of Text

Paul Ricoeur (1913-2005) also made a seminal contribution to philosophical views of phenomenology focusing on text and translation (Ricoeur, 1976). Ricoeur built on Gadamer’s interpretive phenomenology through to the growth of his theory of hermeneutic translation. Ricoeur suggested that symbolic meaning is evident through consideration of a whole text, rather than in units, paragraphs, or sentences. Ricoeur noted that a holistic approach to human experiences is central to meaning making of such experiences (Ricoeur, 1976). Also, Ricoeur argued that to understand and interpret phenomenon, one must do so through the body and the mind. Ricoeur advised that for individuals to understand their lives, they need to interpret their life as one would do in a narrative (Ricoeur, 1976). Ricoeur used an eclectic approach to understanding a phenomenon and this appears to have helped in various situations such the use of a fluid literature review process that can apply any type of review approach that fits well at various stages of the review process.

3.5 The Choice of Phenomenological Approach

A phenomenological methodology appears to offer a feasible way of exploring and understanding the lived experience of people who SH in secure settings in Ghana. Nonetheless, regarding the research paradigm and underlying beliefs that guided this study, the reviewed literature suggests the nature of the lived world of people who SH is complex and dynamic and that the act of SH would have both obvious and implied meanings. Therefore, it was likely that such meanings could not be immediately accessible and that exploring them would necessitate an interpretative perspective. In this direction, rather than describing what people who SH ‘know’ about the phenomenon of lived experience of SH, I believed that by exploring the accounts of people who SH I would be more likely to uncover the implicit meaning they attach to their lived experiences of the phenomenon. To achieve this an interpretative phenomenological approach would be necessary, as this would provide a suitable in-depth scrutiny of the data. The specific phenomenological approach adopted in this study was Interpretative Phenomenological Analysis (IPA). The next section offers a discussion of Interpretative Phenomenological Analysis (IPA).

3.5.1 Interpretive Phenomenological Analysis (IPA)

Some scholars speculate that to explore human experiences, researchers ought to bracket their assumptions about those experiences (Husserl, 2014). However, Heidegger argued that human existence is embodied in the world, a world of people, things, language, relationships and culture. Also, the human or lived world consists of various forms of meaning (Heidegger, 2002). By engaging in the lived world, one tends to explore the experience of being conscious of surroundings, often termed *'Dasein'* or '*being there',* referring to the dialogue between the person and her/his world or what is important to the individual. Therefore, it is impossible for a researcher to opt to transcend or disconnect from these indelible facets of their lives, to reveal some fundamental truth about lived experience (Larkin et al., 2011). In committing to this philosophy, all enquiry starts from the enquirer's perspective, from the basis of their experience, rather than setting aside or bracketing preconceptions and assumptions in advance of an enquiry (Heidegger, 2002). IPA advocates that those researchers must identify their basic understandings of a particular phenomenon but acknowledge that an awareness of these pre-conceptions may not come to light until work has started in the interview or analysis stage of the research process (Heidegger, 2011; Smith et al., 2009).

The use of hermeneutic IPA can enable researchers to explore a phenomenon which involves engagement and interpretation of the identified phenomenon. By so doing, IPA researchers will be able to closely experience how people who experience a phenomenon make meaning of their experiences (Smith et al., 2009). This involves the participant's meaning-making by interpreting their own experience, followed by the researcher's sense-making by interpreting the participant's account (Heidegger, 2002; Smith et al., 2009).

There are differing ways of gathering qualitative research data which will focus on the meaning and experiences related to the phenomenon being studied (Collis & Hussey, 2010). Examples of primary sources of data include interviews, narratives, direct observation, participant observation, questioning and focus groups (Bryman, 2012; Bleakley, 2005). Secondary data involves publications, annual reports and archival records. Bryman (2012) stipulates that interviews are among the more popular strategies of gathering qualitative data about personal and sensitive issues. Qualitative interviews have been described in modern terms as being in-depth, with texts loosely differentiating the three major approaches as unstructured, semi-structured and structured.

Unstructured Interviews- There is no interview that can totally be viewed as unstructured (Bowling, 2014; Doody & Noonan 2013; Bolderston, 2012). Common examples of unstructured interviews are in the form of guided conversation, and they are more akin to ethnographic studies (Doody, & Noonan, 2013; Bolderston, 2012). Unstructured interviews can be carried out simultaneously with observational data collection.

Semi-Structured interviews- These are usually organised around a set of themes, with other themes merging from the dialogue between the interviewer and the interviewee (Doody, & Noonan, 2013; Bolderston, 2012). It can take the form of a group and/or individual interview. It is noted that an individual in-depth interview enables the interviewer to explore deeply into personal and sensitive issues of the individual (Bowling, 2014; Doody, & Noonan, 2013).

Structured interviews- In this approach, the researcher dwells on predetermined open-ended and standardised questions which are identical (Bolderston, 2012; Bryman, 2012).

Interview is a method of collecting data in which selected participants are asked questions or prompted to talk about their thoughts, feelings, and actions (DiCicco-Bloom & Crabtree, 2006; Seidman, 2006). Interviews can be undertaken voice-to-voice, face-to-face or screen to screen and can be conducted with groups of people or with individuals. In conducting in-depth interviews, the researcher ought to be mindful of relevant ethical issues with regards to rights and protection of the participants (Bryman, 2012; Hennink, 2011; Seidman, 2006).

The purpose of using the interview approach in this study was to explore in depth lived experiences of people who SH. Considering the ontological perspectives of Heidegger's hermeneutic phenomenology, by listening to lived experiences of people who SH and interpreting their responses, researchers will be able to gain insight into their lived world and its relationship to their SH. While using a phenomenological approach to guide the exploration and interpretation of participant's meaning making of their lived experience of SH, semi-structured interviews facilitated the exploration of participants' specific experiences of SH and within that process they were encouraged to tell their own story (Smith et al., 2009).

The iterative and inductive process of questioning, uncovering meaning and further questioning involved in interpreting and understanding a phenomenon is termed a '*hermeneutic circle'*. That is, the researcher's way of understanding the text, is established by reference to the individual parts (Hennink, 2011; Waever,1996). Neither the whole text nor any individual part can be understood without reference to one another, hence, it is a circle. However, the meaning of a text must be found within its cultural, historical and literary context (see section 3.5, for details) (Smith, 2007; Smith et al., 2009). These approaches were employed in this study.

IPA is idiographic, valuing 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 phenomena being studied (Smith & Osborn, 2008; Reid et al., 2005; Smith, 2006). That is, the idiographic focus of IPA is to illuminate how individuals who SH in each context, make sense of the phenomenon of SH as an entity before moving on to more general claims (Smith, 2011; Finlay, 2011; Brocki & Wearden, 2006). Using IPA to analyse my data and the process for doing this is presented later in this chapter (see section 3.6.1). To demonstrate how the aims and objectives of the study were attained and the quality of the study maintained, the research methods will now be considered.

Recently, the application and literature of IPA base has also expanded. Most IPA research has been in nursing and health psychology and has had a focus on the lived experience of illness (Meaney et al 2017; Holland et al, 2016). It has been identified that the theory and practice of IPA is less clearly defined than other qualitative research approaches. This suggests that IPA is an emerging concept, rather than a prescriptive methodology (Smith et al, 2009). Given that, IPA is evolving from the descriptive to the interpretative stage, it is proposed as a methodological framework that can be adapted by researchers and tailored to their research focus (Smith et al, 2009). Therefore, there is the possibility that IPA research might differ from one researcher to another, based on the application of the identified IPA principles (Smith & Osborn, 2015; Larkin et al 2011; Reid et al, 2005).

In all, this section provided justification for the choice of IPA to investigate the lived experience of people who SH and provided an in depth theoretical and practical background for the study. The next section deals with ethical considerations for the study and describes identification of participants, data collection techniques, data management and analysis and describes the processes used to ensure the quality and trustworthiness of findings of the study, as well as the chapter summary.

3.6 Ethical considerations

In this research, I adopted a risk-analysis approach as proposed by Long & Johnson (2007) in identifying the potential risks and then addressed them accordingly. The focus of the risk assessment was on unauthorised access, accidental loss and accidental and/or deliberate destruction of data provided by the participants. In preventing such situations, I complied with rules and procedures of the University of Salford, and I also complied with the protocol of the proposed sites where data was to be collected (Rumbold et al., 2011). Such protocols required me to maintaining confidentiality of personal and sensitive information in relation to patients, and to protect such information from unauthorised access, loss, damage, or destruction. Data obtained had to be solely used for this specific study and would not be processed in a manner that was not compatible with the research purpose. In this research participants were informed about their right to complain and/or to take legal action if they perceive that their data was not protected during the research process. I also ensured that data gathering materials, such as reflective notes, maintained the anonymity of the participants.

In addition to the above, all participant data was anonymized, and I was protective of their confidentiality in keeping with the Data Protection Act (DPA) (1998). Participants' personal data was coded, and details of their interviews were only known to me as the researcher and my supervisors. However, no other person apart from myself will be able to track the information to the participants. A copy of my approval letter and amendment from the University of Salford Research Ethics Panel can be found in (Appendix 1a and 1b respectively).

Research advised that individuals who SH can be profoundly hurt and traumatised by significant events that happened to them in their life, including being victims of childhood sexual abuse trauma (Rayner & Warne 2015). Talking about such lived experiences during the interview process can lead to re-traumatization due to revisiting those painful experiences. To minimise the possibility of re-traumatization, I put strategies in place during and after the interview to reassure participants that they could stop the interview at any time when feeling uncomfortable. I also offered each participant time/ debriefing session at the end of the interview to say how they were feeling and if they needed any further support. The debriefing session did not form any part of the research interview and the tape-recorder was switched off. Also, I put arrangements in place for further support if a participant needed it. For instance, support from their named nurse, psychology team or any familiar staff that they felt comfortable talking to.

3.6.1 Ethical Barriers and Negotiation of Access

Initially I attempted to carry out the study in the UK, but regardless of gaining ethics approval from the Northwest- Greater Manchester Central Research Ethics Committee and Health Research Authority and securing initial informal agreement to carry out the research in one of the hospitals I had worked at, I was faced with numerous barriers. After approaching and writing to several hospitals without success, I eventually had to rethink the study and where I might recruit participants and make a meaningful contribution to existing knowledge. In returning to my literature review and thinking about where the studies involving service user experiences had come from, namely Western society, I started to question if these would be shared experiences with those living in the developing world. As my country of origin is Ghana, I then did a second review of the literature to ascertain what research had been undertaken on this topic in Ghana and, more broadly, in Sub-Saharan Africa. The literature I found was at best was limited (please see Chapter 2, section 2.5, for details of this).

The schedule of my research activities such as negotiation of access for field work, recruitment of participants and the data collection process involved the following. I made initial telephone contact followed by email contact with the human resource division and research units of the three main psychiatric hospitals in Ghana. I introduced myself to them and outlined my mission of conducting academic research in each of their hospitals respectively. The prepared introductory document I sent to each of them included an outline of the benefits my input as a qualitative researcher could bring to their psychiatric services. As part of my introduction process, I was linked with a hospital manager/ Responsible Clinician (RC)/ local registrar to discuss my request to do research within the locked service provision. Two of the three hospital agreed in principle and gave me guidelines as to the process involved for gaining ethical approval. However, after a few attempts to link with the third hospital I believed that it would not be possible to do the research there. The two hospitals that agreed requested various documents as evidence of my registration with the identified university for the field work. This was discussed with my supervisors during a supervision session, and I was given an introductory letter by my primary supervisor to present to the two Ghanaian hospitals. I then submitted various documents such as my initial ethical approval documents from the University of Salford. I was also asked by each of the hospitals to submit my research proposal.

As part of the process, I had to register with the research division of Hospital Komfo Anokye Teaching Hospital (‘B’) by making a down payment. The fee assessment was based on whether a researcher is a foreign student or local resident (Ghanaian citizen). Based on my dual nationality, I was classified as being in the category of local resident with its fee payment. At the next level, I was invited to submit my research proposal which had to be tailored to their research proposal format. The proposal was then assessed by the research division of both hospitals. A review of the proposal was undertaken by the research division of Hospital ‘B’ as well the research ethics committee of Kwame Nkrumah University, Ghana. The proposal was reviewed by the Research and Development Unit of Hospital *‘B’* on the 16th of March 2018, and by the Research Ethics Committee of Hospital *‘A’* and on 21st April 2018, and I was granted approval to carry out my research in each hospital (appendices 2a, 2b, and 3 respectively). In addition to the above approvals, the proposal was also reviewed by the Kwame Nkrumah University of

Science and Technology, College of Health Sciences Committee on Human Research, Publication and Ethics, and on 6th July 2018, they too granted approval for the research. (appendix 4). Following these approvals, the University of Salford's Post-Graduate Research Ethics Panel required an amendment to the ethics approval, and this was given a favourable opinion for the study (appendix 1b).

After gaining ethical approval, I then set off on the 9th of May 2018 for a two week's field work in Ghana. As part of my time management. I had to work between the hospitals simultaneously. Day one involved initial contact with the ward manager(s)/ RC/ Contact and the local Caldecott at hospital 'A'. I was then required to attend ward meeting/ Patient Council meeting where I had the opportunity to brief the client group of my intention to carry out the research. Individual client groups were also presented with information about the research (appendix 5a) and I put-up study poster (appendix 5b) on ward communal areas. By day two in Ghana, I moved to the hospital 'B' to make similar arrangements for my research study. Eligibility checks (inclusion/ exclusion criteria)/ RC/ Named nurse / ward manager/ward representative involvement was ensured. I scheduled my time between the two hospitals during my field work in Ghana and I was able to complete my data collection process within my two weeks' stay in Ghana.

3.7 Research Methods

3.7.1 Aims and Objectives for the Study

The aim of this study was '*to explore the lived experiences of people who Self-harm (SH) in two secure/locked mental health hospitals in Ghana'.* The aim of this study (Please see Chapter 1, section 1.9.3**)** prompted three research questions:

- How do people who SH make sense of their experiences in hospital, at home and in the community?
- What negative perceptions and experiences do people who SH have of care in hospital, at home and the community?
- What positive perceptions and experiences do people who SH have of care in hospital, at home and the community?

To achieve the aim of the study and answer the research questions the following research objectives were addressed:

- To explore the knowledge and understanding of SH from the perspective of those who use this behaviour and are being cared for in secure setting/locked mental health hospitals in Ghana.
- To discuss the experiences leading to SH of people in secure setting/locked mental health hospitals in Ghana.
- To ascertain which aspects of care people who SH in secure setting/locked mental health hospitals in Ghana consider to be negative.
- To elicit which aspects of care people who SH in secure setting/locked mental health hospitals in Ghana describe as positive.

- To recommend ways in which experiences of people who SH in secure setting/locked mental health hospitals in Ghana might be improved.

3.7.2 Sampling

In qualitative research it is presumed that people with lived experience of a phenomenon, their beliefs, opinions and perceptions, can help illuminate the core characteristics of the phenomenon under study, regardless of sample size (Malterud et al 2016; Bowling, 2014). In this study my intention was to use a sample size of ten participants who would be a convenience sample of people who SH (n=5) from each of the two hospitals in Ghana, as Creswell (2007, *p. 757*) recommends a *'long term interview with up to 10 people'* for a phenomenological study. However, I was only able to attain a total sample size of nine participants. This included five participants from Hospital 'A' and four participants at Hospital 'B'. I believed the sample size of nine participants to be acceptable as it is envisaged that the target set for convenience sampling of homogeneous groups of people who SH would be optimal for using the IPA approach, where a sample size of 3-10 adult participants is recommended (Saunders et al. 2014; Smith, 2009). Convenience sampling enables the researcher to deliberately select participants who have experienced the phenomenon under study (Bowling, 2014; Silverman, 2013). In phenomenology, the researcher is more concerned with gaining rich data regarding the phenomenon under investigation. Although a varied and diverse range of participants can help investigate the essence of the phenomenon, data from a few participants who have experienced the phenomenon and are able to provide detailed information about their experience, is thought to be adequate to illuminate the features of the experience (Van Manen, 1998).

3.7.3 Inclusion/Exclusion Criteria

There were four inclusion criteria. (1) People who SH within the age range of 20 to 60 years old. This age group was chosen as it is the age range of people who would be admitted to the secure hospitals. (2) People with psychiatric disorder who use SH behaviour whilst in a secure mental hospital (3) Those who have the mental capacity to consent and are fit to be interviewed. It is worth noting that the UK MHA (1983) is used in Ghana to provide guidance for an assessment to be carried out on detained patients to establish whether they may be fit to be interviewed and/or have the capacity to consent. For a detained patient to be assessed for fitness to be interviewed and/or having the capacity to consent, an application must be made to the Responsible Clinician (RC) of the detained patient in question. This is then considered by the RC, who will support or give a recommendation in accordance with the MHA in conjunction with his/her clinical judgement, as to whether the detained patient has capacity to consent or is fit to be interviewed. Also, in case the detained patient in question is under the Menial Health Act restriction, then it is the responsibility of the RC to liaise with the Home Office and notify them of the intention to declare the detained patient has or does not have the capacity to consent or is fit or not fit to be interviewed by a third party for research purposes. The RC has the overall responsibility in making such decisions. (4) Those who have used SH within the last 12 months

The exclusion criteria for people who SH were all other service users who did not meet the inclusion criterion and all people who did not give or withdrew their consent to participate. In using gatekeepers (ward staff who have knowledge of the people eligible to participate) those deemed not in a position to give informed consent were not included in the study. Also, people who appear distressed/ unable to consent, or if a person was deemed too ill to engage in a research interview, were excluded from the study. There were some patients who came forward to volunteer to be involved in the study but were not able to participate as they did not meet the inclusion criteria. As such, I thanked them for their interest, acknowledged their disappointment and offered a short explanation as to why they were not eligible to contribute to the study. I then suggested to them to consider sharing their experiences with other people they have contact with (hospital management and/or referral services) and reassured them that their experiences and perceptions of services are valuable. I informed the ward senior management team of their interest in the project and them not being able to contribute at this time, as they might require further support.

3.7.4 Recruitment

Recruitment for this study was voluntary and focused on people who SH in two secure hospitals in Ghana. My already established experience in this area of mental health did facilitate my ability to assure potential participants about my background and qualifications and the purpose of the research. My initial contact with the two-hospital managements teams was via an email and telephone discussions about my research topic and proposal to recruit participants. When recruiting people who SH, I sought the opinion of the participant's consultant RC in collaboration with their interdisciplinary care team. I did this in order to find out whether their participation in the study would adversely affect the individual's health, particularly their mental health, and/or whether they had the capacity to consent and/or were fit to be interviewed (MHA, 2005, HRA, 1998).

To aid recruitment, posters were put up on the walls of each unit, as well as an information sheet (appendix 5a) for those eligible and interested in the study. I attended a patients' community meeting and introduced myself and the study. The discussion at the meeting emphasised the nature of the study, its purpose and inclusion and exclusion criteria. This was followed by me attending another meeting to become familiar with potential participants and to clarify any issues related to the study.

It was important for me to assure potential participants of their confidentiality, both verbally and in the information sheet (appendix 5a). The information sheets provided offered an overview of the study and the name of a person within the hospital who would provide post-interview support when, or if, needed. Potential participants were also informed that data from the study may be presented at research conferences or published in an academic journal or on an academic website, but that their data would be anonymised so that they would not be identifiable (Burns & Grove, 2009). For some, SH is done in secret, as they believe it to be a sensitive topic and one that is difficult to disclose (Favazza, 1998). As such, they might have perceived themselves as being harmed if their identities are exposed in relation to reports of their perceived high-risk behaviour.

There was time given for potential participants to consider any written or verbal information provided, and they were also given opportunity to ask questions, before making their decision (Pope & Mays, 2006). Follow-up information was sent to each person who volunteered and was eligible to participate, confirming the date, time and venue for their interview. Following these procedures participants were recruited and given the opportunity to make their contribution to the research from their unique lived experiences (Scotland, 2012; Greig et al., 2007). All those participating in the study did so voluntarily and prior to data collection, participants had to sign a consent form (appendix 6).

3.7.5 Data Collection

Some scholars argue that qualitative data sets are likely to contain references to specific places and persons that may be difficult to disregard, because they vary across respondents and occur randomly throughout transcripts or notes (Stringer, 2012; Sweeney, 1996). To disseminate the findings and outcomes of the study, everything shared with me (the researcher) was anonymised and I was careful to ensure the participants were not identifiable through places or names being left within the transcripts.

3.7.6 Interviews

When dealing with personal and sensitive issues, using interviews considered an appropriate data collection method as the priority is to illuminate in-depth insight into an individual’s perceptions, experiences and feelings (Silverman et al., 2013). Interviews allow the researcher to *‘’probe beyond the what, of change, and get into the subtleties of why and how’’* (Pettigrew, 1990, p 279). However, there are challenges in determining the most appropriate method of recording interviews as each of them has its merits and demerits (Saunders et al, 20007). It is presumed that note taking during interview is feasible as interviewees may be less self-conscious than in the presence of a tape recorder. Nonetheless, a note taking approach by the researcher has the tendency to disrupt the sequence of the interview process (Silverman, 2013). To minimize disruptive behaviour in the interview environment, researchers are encouraged to take notes after the interview process (Bryman, 2012 Creswell, 2007). The limitations of doing this, are that the interviewer can forget some key points and may confabulate memory gaps with their own ideas which can confound the data and the interpretation process (Bowling, 2014; Creswell, 2007). Audio-recording, used simultaneously with note taking, enables the researcher to concentrate on the interview process with less disruption (Creswell, 2007).

In this study, face-to-face semi-structured interviews were used to explore participants’ specific experiences of SH, whereby research participants were encouraged to tell their own story in their own words (Smith et al., 2009). Also, the interview 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). (appendix 7 Interview schedule).

3.7.6.1 Formulation of Interview Guide

Through a process of reflection on the aims and objectives of the study, my review of the literature, discussions with my supervisors and others an interview guide was developed.

Table 7: Sample Interview guide formulation process

Interview Guide	Example of an interview schedule/or additional probe (See appendix, 7)
Descriptive	- could you tell me about yourself
Account	- Can you tell me about how …
Structural	- could you describe ….
Contrast	- How does your experience
Evaluate	- what are the best/worse things…
Circular	- What do you think…
Comparative	- How would you approach…. Differently if you were

Adapted from Smith et al., 2009*, p.* 60)

IPA study interview schedules are exploratory, open-minded and guided towards meaning making and process rather than outcomes (Finlay, 2011). In this direction, as part of the initial stage of the interview process, a researcher would adopt strategies that could establish rapport with the interviewee and then build on it to undertake an in-depth exploration of their experiences. At times a structural approach can be used to guide them through processes that will encourage them to describe their interactions with others, to motivate interpretation of the lived experience and to place it in the context of daily care practices and engagement with others (Smith et al, 2009). Evaluation of, and reflection on the interview guide, employed within other IPA studies such as Hamill et al (2010) and Osborn and Smith (2006), enabled the formulation of a related interview guide (appendix,7). Appropriate prompts including short open questions (probes) were included within the interview schedule to motivate participants to elaborate on pertinent issues and explore responses (SeeTable 7).

Table 8: Interview prompts and probes

Prompts	**Probes**
- What do you mean by ….? - Tell me what you were thinking? - How did you feel - You mentioned earlier that… can you tell elaborate more on it?	- What, for you, defines an appropriate response, bad or a good care? - What were your thoughts in relation to lived experience of SH

It is assumed that the interview schedule will enable a flexible dialogue between the interviewer and the interviewee. Ultimately, by questioning, probing, seeking clarification and summarising, people who SH would be able to reflect on and explore their lived experiences.

In this study the interviews were audio-recorded simultaneously with note as I wanted to avoid unnecessary disruptions to the flow of participants' narratives. Also, as a novice researcher, I deemed it appropriate to record the interviews in conjunction with note taking to avoid situations that might have led to me filling in memory gaps with my personal bias. Using audio-recordings in qualitative research is pivotal in ensuring truthfulness of the research findings (Boeije, 2010; Bazeley,2009; Baxter & Jacks, 2008). Also, jotting down notes during the interviews enabled me to record non-verbal cues and gestures that could not have been captured by using an audio-recording (Silverman, 2013).

At the onset of each interview, I established rapport with each participant and reiterated that participation was voluntary and ensured informed consent and right of withdrawal at any stage was understood. One to one or face to face interviews were used and most of the interviews lasted about 1 hour 45 minutes to 2 hours. The period of interview enabled individual participants to have time to share their thoughts, feelings and experiences in relation to the phenomenon under study. This time also enabled them to express their experiences without restriction (Bowling, 2014; Smith et al., 2009). Although participants could talk freely about their experiences, thoughts and feelings in relation to SH behaviour, I also used prompts and reminders where needed in keeping with the semi-structured interview guide.

I knew that giving account of the lived experience of SH could bring painful memories to the fore and I needed to put precautionary measures in place that would support the ethical and moral notion of 'doing no harm.' Careful consideration had to be given as to how I could address any eminent distress and act in the best interest of the participant by supporting them before, during and post interview. This awareness enabled me to put advanced directives and/or precautionary measures in place.

Prior to commencement of the interview, I allowed time to check with each participant that they were aware of the topic area the interview would concentrate on, whether they still felt happy to proceed in participating in the research and also what support networks were accessible to the participant if they had a need for support following the interview. Aside this arrangement, I devoted a debriefing period of about 30 minutes at the end of each interview to allow participants the opportunity to deliberate on any unresolved emotional challenges they encountered during the interview, and what they might need in relation to support to deal with these issues post interview. The debriefing period was not recorded or used to form any part of the analysis. Also, I used my background as an experienced mental health nurse and interviewer with some years of experience in working with people who SH, to support the participants when needed.

All interviews took place in the ward manager's office. Prior to the start of the interview process, I was provided with a member of staff who acted as my point of contact during the interview process. I notified them of the approximate duration for each interview so they could check on the room as a protective measure/best interest in relation to health and safety of the interviewer and the interviewee during the interview period (Bowling, 2014; Boeije,2010). After completion of each interview, individual participants were given exactly £10 (GBP) each as a token of gratitude for participating in the research, each signing a receipt to that effect.

3.8 Data Management and Analysis Process

The process of data analysis is never linear in interpretive research and in this study the IPA data analysis was carried out on a case-by-case basis using an inductive coding approach (Smith et al., 2009). There is no single way to analyse qualitative data, and as such, 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; Benner, 1994). Also, 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, 2007).

The transcripts from the audio-recorded interviews and the notes that I jotted down during the interview process with each of the participants generated a substantial amount of data for analysis. The focus of qualitative study is how to condense raw data into a meaningful conclusion. To arrive at a meaningful conclusion, Bowling (2014) advised that the researcher needs to organise, summarise and structure the data. To familiarise myself with the data, I engaged in reading my notes repeatedly and I also listened to the audio- recorded interviews several times.

Qualitative research can produce large amount of textual data in the form of transcripts and field notes. Given that, the merits in using popular computer assisted qualitative data analysis software such as an NVivo package in aiding the data analysis process can lessen its time-consuming and labour-intensity (Pope & Mays, 2006). In the current study, the sample size was small and I, as the analysist, felt the sample size was small enough for me to analyse the data manually. I had ample time to read all transcripts thoroughly and I was able to do this in a timely manner, enabling me to attain an accurate and transparent data analysis. (See appendix 9, for an annotated interview transcript).

In this study, I transcribed and analysed the interviews using the principles of the seven steps of IPA (Smith et al, 2009). How the seven steps of IPA were used is described under the sub-headings below:

Stage 1: Transcribing the Interviews Verbatim

During this stage I transcribed the whole interview, including my interview questions and the notes I made during the interview. This initial step of data analysis ensured originality of the transcript during the entire process.

Stage 2: Becoming Immersed in the Data

As the sample size was small (n=9), I decided to begin by looking in detail at the transcript of one interview before moving on to examine the others: a case-by-case approach. In doing this, I read the transcript line by line repeatedly, as well as listening to the audio-recording repeatedly. The aim was to gain in-depth understanding of what SH meant to people who use this behaviour whilst in secure services. I tried to look for themes emerging in the first interview specific to that person. This process of looking for subjective meaning-making signifies immersing oneself in the data (Simth,2009). Also, through examining the brief notes I made during the interview, I gained an understanding of the context of the observed non-verbal cues and gestures of the participant in relation to the telling of their narrative during the interview process. This process was carried out for each of the nine interviews. As part of this process, I returned to the interview audio-recording periodically for clarity and to ensure that the originality of the interviewee's narratives remained uncontaminated. The participant's narrative was central to the entire process, and I therefore took due diligence to read and re-read the transcript and reflect on some of the non-verbal cues and gestures noted during the interview stage (Smith et al, 2009).

Stage 3: Initial Noting

At this stage, there was deeper engagement with the initial transcript to illuminate the subjective views and lived experience of the participant embedded in the transcript. To achieve this, I left a margin at the right side of the printed transcript in order to make my analytical comments of the participant's responses during the interview. The aim of this stage was to understand the content and the meanings the participants attributed to the phenomenon. I then engaged in an interpretive relationship with the transcripts (Smith, 2009).

Stage 4: Further Development of Themes

To derive themes for the first participant, I carried out a deeper reading of the interview transcript. Short statements or phrases that depicted core ideas or perspectives within the participants' narrative about what it means to SH were noted as potential themes. Following this process, I engaged in assigning labels to the potential themes from the first participant's transcript using abstract terms (Creswell, 2013). Again, this process was repeated with each participant's transcript.

Stage 5: *Identifying Connections Across Themes*

As part of the analytic process, the next stage was to look for connections between the emergent themes within each interview and then list them. This was followed by further analytical ordering of the themes to make sense of the connections between them that appeared to be emerging. During this process I kept a record of the occurrence of themes, and in doing so I found some of the themes appeared to cluster together. Themes that did cluster had the potential to emerge as superordinate themes/concepts. As part of this process, I also discovered some themes did not answer the research questions and had to be discarded.

During the entire process, I ensured that my interpretation and experience did not deviate from the accounts of lived experiences of the participants. Also, to avoid the implications of analysing one script straight after another, and imposing the perceptions of one person onto another, I engaged myself in other activities to distance myself from earlier identified themes. This was to ensure that the identification of one participant's themes was not superimposed on another, and thereby keeping fidelity to the interpretive approach of analysing IPA data (Silverman, 2010). (See Chapter 4, reflection box1).

Stage 6: ***Analysing the Rest of the Interviews***

This step involved a deeper level of interpretation and identification of connections and differences across themes. In order to ensure iterative data analysis, themes that emerged were checked with the transcript in order to ensure that they related to the actual words of the participants. Doing this ensured close interaction between myself as analyst and the text, to make sense of what the participant was saying. At the same time, I was constantly checking my own sense-making against what the participant said. Also, to enhance the clustering of themes I used various techniques, including moving materials round and condensing and editing them. The clustering of themes captured what appeared to be important issues for the participant in relation to their SH. Each cluster was then given a name capturing the essence of the cluster and having the potential to be a superordinate theme. Identifiers were used to indicate where in the transcript each theme could be found. Identifiers used key words from the extract plus the page number within the transcript. Furthermore, certain themes were dropped as they did not fit with the emerging story. The superordinate list from the first participant's account was used to inform and/or help orientate subsequent analysis of the other transcripts (Smith et al., 2009).

Stage 7: ***Identifying Patterns Across all Scripts***

This phase involved more thorough interpretation and identification of connections and differences across the themes identified within the individual transcripts. During this stage I discerned repeated patterns, and acknowledged new issues emerging, as I work through the transcript with the goal of taking note of convergence and divergences in the data. That is recognising means by which accounts from participants are similar, but also different. This led to the identification of superordinate and subordinate themes across all participants' data.

3.8.1 Ensuring the quality of qualitative research

To ensure the quality of qualitative research, the study needs to demonstrate credibility and dependability, rigour, transparency and coherence and subjectivity and reflexivity. In demonstrating each of these principles, the trustworthiness of the findings will be established (Webster et al., 2016; Elo et al, 2014; Merriam, 2009). There are differences in the theoretical orientation of quantitative and qualitative designs and therefore the terms used to measure the quality of those designs tend to differ (Hamilton, 2020; Baillie, 2015). The term used to measure the quality of a qualitative study is trustworthiness or authenticity (Hamilton, 2020; Johnson et al, 2020). Researchers engaged in qualitative research must therefore ensure trustworthiness of their study by following laid down principles in order that other practitioners and researchers can gain confidence in their study (Hamilton, 2020). In this study, I have used a fluid approach by applying various terminologies from various proponents of research theories to demonstrate the rigour and trustworthiness of my research. The subsequent sections elaborate on the authenticity or trustworthiness of my study.

3.8.2 Credibility and dependability

The process of ensuring credibility in qualitative research is trustworthiness (Webster et al., 2016; Elo et al, 2014; Merriam, 2009). To establish trustworthiness of the research, the credibility of a qualitative study attempts to find out how congruent the findings are with reality (Pernecky, 2016; Creswell, 2008). To enhance the credibility of the study, I adopted various measures such as ensuring an appropriate data collection method in relation to participants' who SH. Also, I liaised with the RC of the participants to check if they were fit and/or had the mental capacity to provide informed consent. As this study involved the lived experiences of people who SH, the idiographic views of participants through data collection illuminated invaluable insight to help explain their perceptions/meanings of SH and to enhance the contextual data related to the secure setting (Smith, 2009; Van Manen,2001).

All data that was collected about the participants during the research has been kept strictly confidential, with all identifiable information being removed at the transcribing stage so each participant could not be recognised. Each person who was approached was informed that participation in the study was voluntary to ensure that data was collected only from those who were genuinely willing to take part.

As noted by some scholars (Savin-Baden & Major, 2013; Creswell, 2008), in research methods, background, qualifications and experience of the researcher is crucial in ensuring the credibility of the study. In this study I am the principal investigator in relation to data collection and analysis and I do have the added advantage of knowledge, skills and experience in forensic metal health nursing and research methodology, the latter being through my MPhil qualification in Nursing. Moreover, I have been supervised by experts in research methodology and the research topic area. To enhance trustworthiness, a semi-structured interview guide was used to direct data collection and I have employed reflexivity to enhance my interpretation of the subjective views of the participants. For example, checks relating to the data took place 'on the spot', during and at the end of each interview. Also, another element of checking involved verification of the emerging themes and inferences, as these were formed during the process of analysis (Van Manen, 2001).

This IPA study sought to be both credible and dependable. That is, through a process of reflexivity, I continued to question my personal and professional experiences and how these may have impacted the interpretations I made within the study. The researcher's personal experiences, logs of independent analysis and open deliberation of biases led to debate and acknowledgement of how my own subjective, constructed world may limit the research. The changing nature of the phenomenon to be scrutinised, as in the case of people who SH, in a qualitative study can render dependability problematic (Marshall & Rossman, 2004). To address issues of dependability in the process of undertaking this study, I have reported in detail the processes used in the research design. This includes information on the research design, data collection and analytic strategies and evaluating the effectiveness of the process of the inquiry undertaken (Denzin, & Lincoln, 2011).

3.8.3 Rigour

The notion of rigour in research is to ascertain the strength of the research design and the appropriateness of the method used to answer the study research questions. Rigour in qualitative studies demands constant authentication achieved through following step by step guidelines to ensure trustworthiness of the research (Smith et al., 2009). There are various criteria that can be used to evaluate qualitative or phenomenological research and central to this is assessing the quality of the analysis. Baillie (2015) reiterated that evaluating and ensuring the quality of research is a vital consideration for practitioners who are appraising evidence to inform their practice. Also, in this qualitative study, I have used the term ‘rigour’ to depict attainment of trustworthiness, authenticity, quality and/or truthfulness of the study (Johnson et al., 2020; Morse, 2015).

My commitment to ensure rigour is demonstrated through the clarification of my epistemological and ontological position regarding the study ontology (see chapter 3, section 3.2.2). All data that was collected about the participants during the research has been kept strictly confidential, with all identifiable information being removed at the transcribing stage so that they could not be recognised. Each person who was approached was informed that participation in the study was voluntary to ensure that the data was collected only from those who were genuinely willing to take part and prepared to offer data freely. To collect my data, I travelled to Ghana and carried out face to face interviews with the participants and this enabled me, not only to hear their stories first-hand, but also to capture their other non-verbal cues and gestures. I presumed my presence gave confidence to the participants about being in the same physical environment during my engagement with them during the data collection stage. Throughout the presentation of this study, I have offered the reader explicit information regarding how each aspect of the study was carried out.

3.8.4 Transparency and Coherence

In this study, transparency occurred through conducting procedures as described by Smith et al. (2009). That is, data collection from the participants was through semi-structured interviews which were audio-recorded and transcribed verbatim. I developed an audit trail from reading and rereading transcripts, noting pertinent items in the margin. I had my supervisors, who are experts in the subject area, provide me with challenges, discussion and guidance throughout the research process, enabling me to achieve coherence in my study. I have also attended academic conferences, seminars and peer reviews, where I received structured feedback which provided me with further insight in the quest of my research journey.

3.8.5 Subjectivity and Reflexivity

As a researcher, I am aware of potential issues that were related to collecting data in a familiar field setting. As noted earlier, (see chapter 2, section 2.6.1**)** addressing subjectivity and reflexivity appears to be a rather ambiguous task especially when considering carrying out qualitative research. For example, it is impossible to remain ‘outside’ the subject matter; as my presence, in whatever form, will affect data gathering and the process of analysis (Guenther & Champion, 2012; Johnson & Duberley, 2003; Finlay, 2002; Lincoln & Gaba, 1985). By recognising our beliefs, we can think about how we may be influencing the research process, rather than trying to be objective and ignoring the interpersonal nature of this type of research (Smith, 2009). That is, as the researcher I am aware of my effect on the process and outcomes of the research based on the premise that *‘knowledge cannot be separated from the knower’* (Steedman, 1991, *p 227*). The current research assumption is that bias and/or skewedness in a research study is undesirable. As argued by Malterud, (2001) the researcher’s p*reconceptions are not the same as bias, unless the researcher fails to mention them"* (p. 484). As the interview process could lead to emotional change or new insight for the participants, which may require them having further support, I was cautious not to deliberately instigate new self-interpretation or emotional change (Kvale & Brinkman, 2014).

In order to address any biases in this study, I have allowed member checks during the research process by experts. For example, in developing a semi-structured interview schedule, I allowed my supervisors to look at the raw data that had been collected in order that my interpretations could be challenged. Also, I developed a reflexive journal noting down my beliefs, values, experiences, assumptions and emotions during the research journey (Denzin & Lincoln, 2011). The field diary enabled me to make regular entries during the research process. In these entries, I have kept records of the methodological decisions and the reasons for them and reflected upon what was happening in terms of my own values and interests. Doing this allowed me to consider how best to act on them to improve my research skills and fore ground the voices of the participants.

3.8.6 Chapter Summary

This chapter has informed the reader of the methodology, the achieving of ethical approvals, processes of data collection, management and analysis and the strategies used in ensuring trustworthiness of the research study. The aim of my research was to explore the lived experience of people who SH in secure in-patient care in Ghana. As part of my study, I chose a qualitative approach and formulated clear and focused research questions which led to the selection of an IPA approach. I used convenience sampling to recruit those people who had experienced the phenomenon under study and data was collected from the study participants in their real environment. The exploration of SH tends to delve into personal and sensitive issues for the individual and, being aware of this, prior to the study, I cross-checked with each person’s RC if they were well enough to give consent or to be interviewed.

My choice of a hermeneutic phenomenological approach enabled me to explore subjective views of lived experiences of what SH means for people who use this behaviour. To achieve this, I used face to face semi-structured interviews to gather data and the analytic process involved me engaging in an iterative approach to answering the research questions. I also engaged in researcher reflexivity to gain insight into my own biases and rationale for making decisions as the research progressed. All these practices demonstrate my sensitivity to my study topic, minimise any inherent bias and add credibility to my research. Ultimately, this has enhanced trustworthiness of my research. The next chapter presents the research findings.

Chapter 4: Research Findings

4 Introduction

This chapter presents the findings of my study carried out in two secure mental hospitals in Ghana. The findings were derived from thematic analysis following face to face semi-structured interviews with the nine participants. The analysis illuminated rich, in-depth descriptions and interpretations of participants' experiences of what it means to SH and the care provided by staff working in in-patient services in either of the two Ghanaian hospitals targeted. Demographic information regarding the nine participants who took part in the study can be found in Table 8 below. All names have been changed and pseudonyms given in the form of initials, to protect participants' anonymity. AMP and KATH related to the hospital they had been admitted to, followed by the initials allocated to each participant.

Table 9: Participants' Information

Pseudonyms	Age	Gender	Ethnicity	Educational Background	Employment
AMPAN	33	Male	Bawku (AER) Kusasi	JHS (Junior High School)	Farming
AMPVS	32	Male	Anum-Bosso(ER) Guan	Diploma level	Unemployed
AMPJM	29	Female	Kade(E/R) Akan	Primary 6 level	Self-employed
AMPVN	34	Female	Nkwakwa (A/R) Akan	Not Specific	*Petty trader
AMPKM	42	Male	Somanya (E/R) Ga-Adagbe (Kobo)	JHS	Carpentry & Farming
KATHPA	35	Female	Kumasi (A/R) Akan	JHS	*Petty Trader
KATHPO	29	Female	Akan (A/R)	SHS (Senior High School)	Unemployed
KATHNYO	48	Male	Akan (A/R)	JHS	Shoemaker & Farmer
KATHSED	26	Female	Ewe (V/R)	Bachelor's degree	Midwife

4.1 Demographic Information

Table 8 above provides basic demographic information of the study participants. This section provides a detailed description of the participants in the study, providing a background and context for the research findings. This demographic information was gathered at the start of each interview with the participant. The participants who took part in the study were from varied cultural/ethnic backgrounds, and with unique and distinct lived experiences. Four males and five females engaged in the study and the age range of the participants was 26 to 48 years old. The educational level of most participants was Junior High school, with two having attained senior high-level qualifications. One participant had a diploma, and one attained an undergraduate qualification.

Whilst the participants' work experience was not explored in detail, two of the participants were engaged in petty trading and one was a shoemaker. In Ghana, a *petty trader is someone who engages in an economic venture involving selling and/or buying goods and services on a small scale, this includes agricultural products, as well as imported consumer items. The petty trader's activities can be carried out in a marketplace or any identified small space in a locality. These participants gave a personal account of the initial support they received to start their business.

Eight of the participants in this study had SH prior to their admission to hospital. One participant had used SH since the age of seven years. The onset of SH of one participant was during hospitalization. Most of the participants had suicidal ideation and/or attempted suicide in between their episode of SH. Collectively, personal stories told by the participants in this study suggests they had experienced; relationship problems, poor upbringing, domestic violence, related substance misuse issues and/or problem with the criminal justice system.

4.2 Overview of Analysis

The preceding chapter outlined the process of IPA which proposes two approaches to writing up the analysis of data; an idiographic and/or a thematic approach (Smith et al., 2009). Smith et al. (2009) proposed that the notion of the write-up can be based on the researcher's preference and/or creativity. For instance, when adopting an idiographic approach, the researcher will present each individual participant's themes. The thematic approach involves the presentation of themes across all participants' data (Smith et al., 2009). In this study the results are presented by adopting the thematic approach.

Smith (2009) recommends when conducting IPA studies, the analyst should progress steadily by initially seeking subordinate themes and then finalising the analysis with superordinate themes. Initially, 20 subordinate themes were identified, but after re-examining these and discussing them with my supervisors these were coalesced into 14 subordinate themes. Following this process, I was able to identify four superordinate themes from across all participants' data, with a subset of subordinate themes being intrinsic to each of them.

The four superordinate themes that emerged using IPA were: (1) Being let down, (2) Living with the negative self, (3) Forces of the supernatural and religion, (4) Living with the positive self. Each of these themes consisted of a cluster of subthemes (see Table 9***)***. Within this chapter the findings will be presented under the four superordinate theme headings, with excerpts from transcripts being used as evidence underpinning the analytic interpretation. The presentation of the four super-ordinate themes is not in any order of priority.

Table 10: Super-ordinate and Subordinate Themes

Super-ordinate themes	**Sub-ordinate themes**
Being let down	Can’t get answers & inappropriate responses I am not getting what I need Hopelessness, helplessness & disappointments Abuse; being unsafe and feeling insecure.
Living with the negative self	The badness within me Being confined & suicidal ideation Who am I? Managing me through challenging times
Forces of the Supernatural & Religion	Ghost of mental illness Sharing the Stigma Shame & guilt
Living with the positive self	Helpful conversations & kindness characteristics Supportive healing & medication Empathic valuing & feeling wanted

Table 11 Reflection Box 1:

Thematic analysis and developing Super-ordinate and Subordinate themes

After choosing to use thematic analysis I was faced with several challenges. (1) Firstly, as a mental health practitioner and having had experience of people using SH in the forensic setting, I did have some preconceived ideas about the topic. When setting out on this research journey I did not give much thought to this, but when choosing my methodology, collecting data and during the process of analysis, it made me conscious of my own ideas and how these experiences and ideas may be influencing my research. (2) Secondly, in analysing the interviews I tended to do this as an individual process; analysis of interview one, then analysis of interview two, etc., but in doing this I initially found myself using what I had discovered in the first interview as a blueprint for subsequent interviews. After analysing interview three and realising that this is what I was doing, I knew I had to develop a way of moving away from this as I might have been overlooking some important data. (3) Thirdly, I share a culture with the participants and when this occurs there is always a risk of 'knowing and understanding' without listening to what is being said. I may have taken for granted what was being said and therefore needed to keep questioning myself re my interpretations of the data.

Addressing such subjectivity as noted above requires reflexivity on the part of the researcher. This is not an easy task. With regards to challenges 1 and 3, it is impossible to remain 'outside' the research topic and the target population. However, I did my best to listen carefully to the participants. I used 'mind games' with self, telling myself I have not lived in Ghana for some time and have developed different customs and ways of thinking, influenced by living in a Western culture and therefore I am not in a position to make assumptions. I made rough notes of my thoughts and feelings following each interview and used these as a personal challenge when doing the analysis. Finally, I used my supervisors as independent analysts who could challenge some of my thinking during our supervisory sessions. Regarding the second challenge, I approached this using practical means. I took to reading something totally different as a distraction before analysing subsequent interviews. This enable me to put some time and space between analysing each interview, allowing me to look at each interview with fresh eyes and draw out what appeared to be important themes for that person. Using distraction techniques enabled me to put aside previously identified themes and ensure that all themes generated related to the transcript that was unique to each participant. Although I opted to look at themes across all interviews, this was an important step in the process of analysis. Using these processes has given me more insight, personally and professionally, into the different meanings SH has and being a researcher.

4.3 Theme 1: Being Let Down

Figure 3 below offers an overview of the superordinate theme, 'Being Let Down', and the four related subordinate themes. The number in brackets indicates the number of participants who experienced the phenomena represented in the subordinate and superordinate themes.

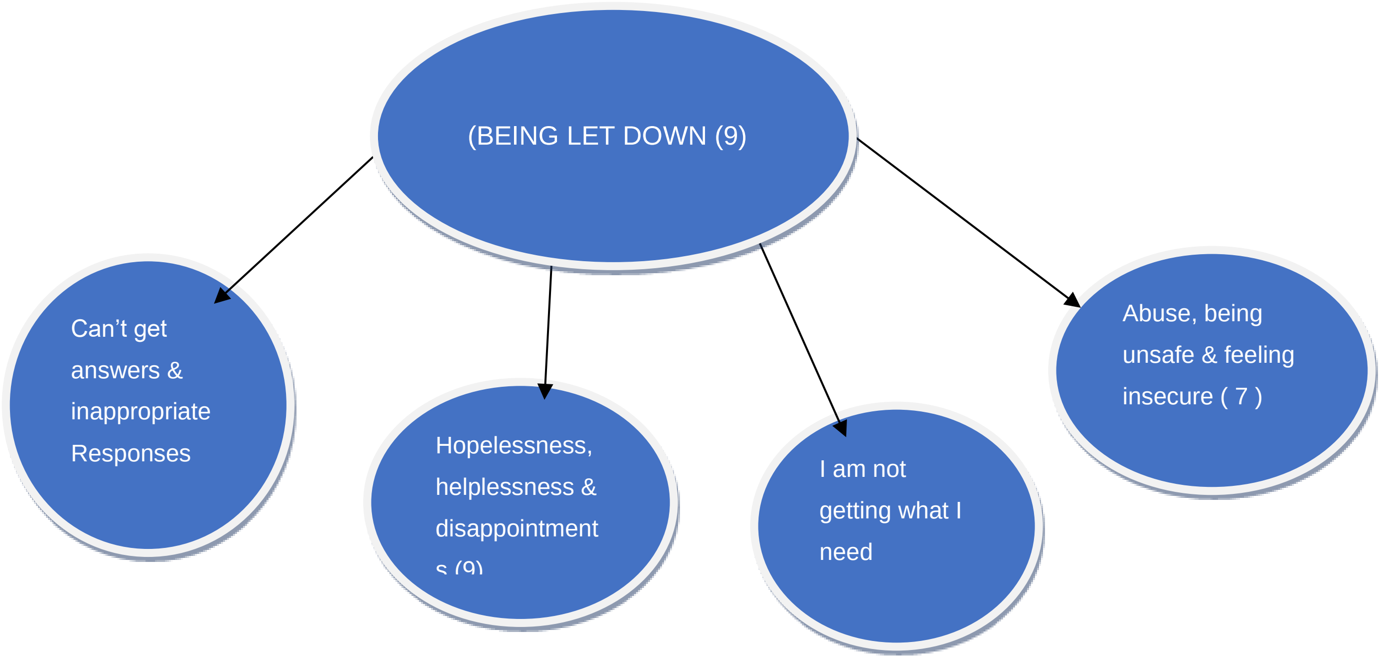


Figure 3: Being Let Down

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'*. Their experience of using SH, the emotionality attached to it, how others may perceive it and the ways in which they carry out SH were all discussed during the interview.

The superordinate theme of 'Being let down' describes how situations in the participants' personal lives changed and brought about disappointment. Change that brings about disappointment can be a challenging process to navigate and/or cope with. Also, 'Being let down' related to how perceived failure to respond in such situations appeared to have a detrimental effect on the overall quality of life and well-being experienced by the participants. All the participants noted that they were *'let down'* in their personal lives by family, wider society and/or as a patient in the hospital setting.

AMPVN shared her experiences of how she was let down in her marital relationship, as well as during her upbringing. AMPVN's husband appears to have wrongly suspected her of infidelity, theft and/or misappropriation of his money. Her husband also segregated her from others by not allowing her to interact with people in the neighbourhood or to do any income-generating work. She felt '*let down'* by her husband and her family, none of whom visited her whilst she was in in-patient care.

AMPVN stated:

'' You know ……. I was in a marriage relationship, and my husband wanted to divorce me. According to my husband, he was fed up with me for spending too much of his money. When I went and complained to my mum about what was going on in my family/marital life, she rather became mad at me. My mum only started confronting me and questioning me about why I was not respecting my

husband. According to my mum, when you are a woman and in marriage life, you should not challenge your husband. Our tradition does not allow women to be disrespectful to their husbands. I used to work as a petty trader, but when I got married, my husband will not allow me to work anymore. He convinced me to stay at home and take care of the house and that can be boring. When I need something too, he will not provide for me. Meanwhile, he does not want me to work. That can be frustrating because I used to be in a gainful employment, I am no more working because of him. There is no other source of income for me except from him, but he has also been ignoring me or will not meet my demands or needs. It makes me to wonder if he is a true husband who loves his wife.'' (42: 7-15)

"Also, When I was a baby, 'kuraa', my mother threw me away (abandoned). Now, my family don't come to visit me. I wanted to go to school, but my parents did not allow me." (39: 18-23)

It could be suggested that after being abandoned as a baby and then denied opportunity to attend school as a child, AMPVN may have experienced little control in her life. However, when marrying her husband, who is perceived in Ghanaian culture as the figure head and authority within a marital relationship, he exercised excessive control over her life. Regarding AMPVN's earlier experiences, in Ghana, the United Nations Convention on the Rights of the Child Policy; article 44 of the Convention (2005) and the Ghana Constitution (1992) and the Children's Act (1998) defines a child as someone under the age of eighteen years. The Act makes provision for the health and safety of a child in ensuring the best interest of the child; having the right to live with his/her parents and family and grow up in a caring and safe environment, unless for legal reasons this is not possible. Moreover, every child has the right to life, dignity, respect, leisure, liberty, health and safety, education and shelter from their parents. Some of these rights appeared to be absent from AMPVN's life during childhood and it appears those Acts were not in place, or not adhered to, during AMPVN's formative years.

In Ghana, due to issues such as poverty, teenage pregnancy, giving birth to a disabled child and other socio-cultural factors, most biological parents and/or custodial parents tend to not want to, and/or are unable to take care of the child's health and welfare (Kofigah, 2008; Assimeng, 2007; Nukunya, 2004). Such parents may relinquish interest and claims over his/her child with the intent of never again resuming or reasserting parenthood. At times, upbringing and education by surrogate parents can shape the lives of the children positively and/or negatively. These situations can have short and/or long-term impact on the health and well-being of the child (Kofigah, 2008; Assimeng, 2007; Nukunya, 2004). Although education is applauded in Ghanaian society, some ethnic groups perceive female education as a '*waste of time'*, as they can disappoint the family by getting pregnant during their education, and/or may not be an asset to the family as they may be taken away to another family when they get married. Such socio-cultural issues may have adverse effects on a person's mental health and well-being to the point at which they are admitted to hospital.

While these may have resonated with AMPVN's experiences during her childhood, it appears that she also felt '*let down'* during her stay as an in-patient, as staff appeared to offer attention to another patient who used SH behaviour by readily caring for them. It was this that prompted AMPVN to resort to SH to receive similar attention and care from staff. AMPVN verbalised that:

“I decided to SH because another inmate does it and staff will be going around her and talking to her, so I also want them to do the same to me.” (43:4-9)

Like AMPVN, KATHPA was ‘let down’ when she was abandoned in her marital relationship and later divorced by her husband:

‘’Me (KATHPA) *and my husband stayed in the US for about 5 years. During that time, we were trying for a child, but that did not happen. We attended various fertility hospitals and clinics, but with no good result. By the sixth year, I started seeing gradual changes in my husband’s attitude towards me. He tends to be cold toward me, snappy at times, he will not eat my food and tends to come back home very late. By the eighth year, one day out of the blue, he just said our marriage will not work and so I can decide for myself and may look for another man if I want to do so. During that year, he then decided to travel to Ghana and went on his own. He then stayed in Ghana for about two and half weeks. Upon return, he notified me that he had gone to perform necessary customary rites to end our marriage.’’ (64:3-7).*

Similarly, KATHPO was in a dating relationship with her first and only boyfriend since being at school, with the aim of getting engaged and married in church. However, she was ‘let down’ when her boyfriend abruptly ended their dating relationship. KATHPO stated:

‘’If he knew he will not take me far, why give the initial excitement for me to feel high and loved. Was it a false love? As I talked about it now, it still hurts by being taken advantage of and it is very painful, and his behaviour does not make sense to me.’’ (70:1-4).

At the initial stage of telling their stories, eight participants gave accounts of what prompted their SH, with seven of them linking extrinsic factors with the behaviour. While the overarching super-ordinate theme was one of ‘Being let down’ it comprises of four subordinate themes; (1) Can’t get answers and inappropriate responses (2) Hopeless, helpless & disappointments (3) I am not getting what I need, and (4) Abuse; Being unsafe & feeling insecure. Each of these subordinate themes are presented below.

4.3.1 Can’t Get Answers & Inappropriate Responses

Trust and honesty from family, friends, wider society and those providing care are important central features of interpersonal relationships within human encounters per se. It is presumed that asking questions and having them answered appropriately provides individuals with knowledge which may manifest in diverse ways; empowering people through promoting confidence, giving assurance for the development of trust, providing choice relating to health & safety issues and finding ways to resolve issues. Individuals tend to be threatened, confused, distressed, frustrated and mistrusting of those in authority if they cannot get answers or receive inappropriate responses to their questions. Getting answers and appropriate responses from others appears to have been a complex and difficult process for each participant within this study. As a result of this, participants may have found the development and maintenance of interpersonal relationships challenging.

This subordinate theme captures participants’ experiences of some of the challenges they faced and how these related to them. When asked about why they SH, all the participants reported that they could not get answers and/or were given inappropriate responses to what they considered to be important questions. This led to distress and frustration, with the latter often being directed at self. The lack of answers and inappropriate responses applied to family, friends, wider society, and those providing care. AMPAN's stated:

''It [SH] *was a way for me to seek comfort and inner peace out of my frustrations. The problem of mum can't give you answers which can make me angry and distressed. I feel lost and I do pity myself. '' (6:6-14).*

"My mates do ask of my dad every now and again and I did not know what to tell them. It was too much to bear so I do enquire about my dad from my mother who then mentioned my uncle's name to me. It was bit of confusion to me because I knew that person as my uncle and we used to welcome him home by shouting uncle, uncle, but I had to accept mum's view.'' (6:17-21).

AMPAN did not know who his father was and was surprised to discover that the man he had always referred to as uncle turned out to be his father. His mother, in not being honest as to who his father is, and his being teased by his peers, led AMPAN to feel '*lost*', and latterly '*confused and distressed*' and not able to trust his mother. This prompted his feelings of frustration and led to his SH behaviour.

Similarly, other participants described their experience of not getting answers whilst in hospital and how that can be frustrating. AMPVS denoted *'not getting answers'* as:

"At times you request for things from staff, and I must wait for prolong periods before staff will attend to me and at times they don't. I want to be discharged, but nothing is happening. You see, it is heart breaking. I hate to wait for things when someone says wait or I do something during the day, and I cannot see the bigger picture of it. Like 'eehh'…., they say like, you cannot go to a place, or take part in an activity off the ward, or something alternative to things and that is when I find it hard to understand. I become upset and frustrated. When I am upset, I can punch or kick the doors, bench, shout and swear at staff. But there are times, I do hurt myself when I want to hurt others, as it does come to a point when I do feel it is better to hurt myself than others." (19:13-16).

Another participant, (AMPJM*),* talked about how she cannot get answers from members of staff and how this frustrates her:

''I want staff to send me to my doctor and/or arrange for me to see my doctor, but the ward staff will not do it. Nonetheless, they have been doing it for some other patients on the ward. I want to be discharged as I have stayed here for far too long. Also, any delays can make me anxious and irritable. When someone has done something to me that I don't like and when I cannot get my head round something or get what I want, then, I can become angry and agitated. It also makes me feel anxious and I do curse others or myself for not attaining what I want. So, to bubble my anger and frustration, I turn to direct it to myself because I don't want to hurt others. But there are times when I do physically hurt staff or verbally abuse staff to let them know how I am feeling." (31: 5-8).

Similarly, participant AMPKM*,* gave an account of how he cannot get answers from members of staff and how this frustrated him. AMPKM stated:

‘’I have asked staff to let my doctor grant me leave so I can go to the inner city and be able to shop for all wants and needs but they will not do so. They rather carried the impression that if I am granted leave to go to all parts of the inner city I might end-up buying illicit drugs and may bring it to the ward for other patients. They have not been allowing me to go for shopping in the city or go far away from the hospital and that can be frustrating and distressing. One way for me to SH is to display my anger and frustration on others by engaging in a fight with people to let them know how I feel.’’ (50:6-15).

The first three examples above demonstrate how not getting answers and inappropriate responses led to dissatisfaction, resulting in developing an outlet for their frustration, aimed at self rather than others. However, while the fourth example (AMPKM) also verbalises frustration with not getting what he deemed to be an appropriate response, his frustration was directed at others rather than self, although his actions, **‘***engaging in a fight with people’***,** could be construed as risky behaviour, sometimes associated with SH.

Whilst the examples above demonstrate ‘can’t get answers’ at a pragmatic level, participants also introduced the notion of ‘inappropriate responses’, through data garnered at a more emotional level.

KATHSED verbalised:

“My dad had repeatedly sexually abused me and there were a few occasions when I was sad, angry and frustrated and I called my biological mum on the phone and I was tearful and weeping but was not brave enough to disclose any secret information to her. She then called my dad and enquired if I was OK, and my dad said there was nothing wrong with me. My mum then called me and reassured me of how trustworthy my dad was and based everything on his professional integrity and stated that he was the right person to take custody of me. Based on my mum’s comment and advice, I just concluded that even if I say anything, my mum will not believe me so there was no point in telling her. It’s like my biological mum believes my dad so much that even if I said anything to her, she would rather blame me and may challenge the authenticity of my words.” (95: 15-19).

This participant appeared to convey that she did not get the response she was hoping for from her mother. This resulted in her not finding an outlet for her feelings of anger and frustration, raising self-doubts about her relationship with her biological mother; whether she would be believed and who she could trust.

Similar comments were found in six of the transcripts, giving a sense of ‘Being let down’ through not getting answers and/or being given inappropriate responses by care givers and family alike. In addition, *KATHNYO* referred to ‘Being let down’ when speaking of his pregnant daughter failing to name the father of the unborn baby in good time, and by the time she did, the man had already run away. According to KATHNYO:

“When it happens like this, the parents are then blamed for being a weak disciplinarian leading to the adolescent pregnancy.” (82: 21-28)

The example above demonstrates how people can also feel let down by wider society, KATHNYO *‘knew*’ he would be blamed as a parent for his daughter’s misdemeanour.

Table 12 Reflection Box 2:

Can’t get answers and inappropriate responses as a subtheme

Reflecting on this particular theme, ‘can’t get answers and inappropriate responses’, made me aware of some challenges in relation to my professional background. For instance, at the end of the interview with participant AMPAN, I enquired if there were any questions, or if he would like me to clarify anything in relation to the interview. In response to my question AMPAN said he would like to ask me about a health-related problem that he was experiencing whilst in care. Rhetorically, AMPAN asked that as I am a nurse from abroad, would I be able to get him treatment for his health condition (priapism) which had been an on-going problem for some time. My response comprised of advice and reassurance, and I also sought his verbal consent to relay his clinical problem to the health team which I did. This experience challenged my boundaries in terms of being there as a researcher and not in my more familiar role as a nurse. In the Western world such medical conditions could be referred to urology which made me question if I had answered the question adequately and/or responded appropriately. This was noted in my field diary, and I knew that I had to work through and resolve this issue, something that I tried to do through supervision with my supervisors.

Similarly, during the interview with participant AMPVN, she noted that she was on medication ‘’Risperidone’’ which she perceived as not being good for her, *‘’the medicine risperidone is not good*’’. AMPVN asked me if I could change it for her. My response was again one of advice and reassurance, and, with her consent, I also relayed her concern about her medication to the health team. However, I also then adopted my nursing role and enquired from the duty staff if there were any assessment tools in place for identifying/ monitoring side effects of service user’s medication. The response was that in the main observations are used to monitor side effects, and they did not identify any evidenced based tools to ensure a more methodical approach. I thought this was an inadequate answer to my question and it left me feeling frustrated. It also made me wonder how I could give appropriate answers and/or responses to those who have experienced being unable to get answers and/or have received inappropriate responses. My own frustration in relation to this also made me question if this mirrors the frustration experienced by the participants who could not get answers and/or appropriate responses to their questions.

In summary, the subordinate theme of ‘can’t get answers and inappropriate responses’ highlighted a diverse range of triggers, meanings and perceptions that participants attributed to their SH behaviour. The participants’ experiences suggested they were not able to ‘get answers’ from significant others. Instead of being protective, supportive and honest with them, participants’ felt ‘let down’ and being emotionally and physically hurt, by their significant others. Some participants also expressed ‘being let down’ through not getting answers or being given inappropriate responses on the part of staff when they were admitted to hospital, causing further hurt when they were perhaps at their most vulnerable. Perceiving or believing that they had ‘been let down’ led to participants’ experiencing/ or perceiving not getting what they need, further impacting their mental health. These experiences are presented in the next subordinate theme.

4.3.2 'I Am Not Getting What I Need'

Participants gave accounts on their experience of not getting what they need and how such unfulfilled desires were upsetting and frustrating. In this study, participants were able to recognise and make sense of their needs/desire. However, some participants articulated how their desires, or unmet expectations, are ever-present in their environment. These unmet needs tend to frustrate them which at times lead to SH which they identified as being an effective coping mechanism. Six of the participants noted that they *'could not get what they needed'* from family, wider society and/or as a patient in the hospital setting. AMPAN gave account of how he was not getting what he needed from staff. According to AMPAN:

'*I need to engage myself in activities in order to relieve my boredom because at home I used to farm and look after my siblings but in this hospital, there is no help as I cannot do any farming here and I cannot go out. Also, I need a peaceful environment to settle down, but the place is crowded and full of periodic arguments and shouting by some patients and there is no peace of mind (6: 3-6).*

Like AMPAN, AMPVS talked in his narrative of how he could not get his needs met. AMPVS said:

We are crowded here and so some of us cannot get access to some services such as watching TV channel of our choice during certain times. I like viewing TV sports programmes and playing football and there is ongoing world cup football match, but I cannot get access to view it as there is only one 14-inch TV set for the whole patient group on the ward (16: 12-17).

AMPVN gave account of how she cannot get what she needs. AMPVN said:

I needed help for my neck pains, but help was not coming and when I am in pain and holding my head, some staff will question me about it, but some will ignore me' (40: 7-10).

KATHPO gave account of how she was longing for a dating relationship that will result in future marriage, but desire had not come to fruition, resulting in self-doubt and low self-esteem. KATHPO said:

''I am growing up and now 29 years and may not be attractive to anyone in the future to marry me'' (66: 1-3)

Like KATHPO, KATHSED stated.

"I wanted a bond between me and my dad, so I decided to reconcile parent-child bonding relationship with my dad, but the expectations kept on changing ……………. Also, ''I needed to be a dating relationship with my boyfriend, but I tend to be paranoid of men and people in general and I find it challenging and difficult to trust people'' (91: 12-16)

KATHNYO revealed how staff approached him during therapeutic sessions when he needed and expected dignity and respect as an individual, but that did not happen. KATHNYO said:

‘*’During session times, some nurses will be judgemental and talk to me roughly with no respect’’ (79:13-15).*

In summary, the subordinate theme of ‘I am not getting what I need’ highlighted a diverse range of triggers, meanings and perceptions, participants attributed to their SH behaviour. The participants’ experiences suggest they were not able to ‘get what they needed’ from significant others. Also, ‘not getting what they need’ can be frustrating and discouraging, perhaps affecting their motivation towards achieving an optimal level in their self-fulfilment of their personal goals. Such situations appeared to have had a detrimental effect on the overall quality of life and well-being experienced by the participants, resulting in the possibility of using high risk behaviours such as SH. The next subordinate theme of hopelessness, helplessness and disappointments are discussed below.

4.3.3 Hopelessness, Helplessness and Disappointments

This subordinate theme is concerned with participants’ meaning making in relation to triggers and/or lived experience leading to SH. In general, individuals may go through challenging situations in their personal life which can lead to negative perceptions of self-and/or others, and this can be distressing and difficult to cope with. As a result, individuals may feel hopeless, helpless and disappointed in life. Such negativity can trigger maladaptive coping such as SH. This subordinate theme captures participants’ distress about their situations. AMPVN said,

“Look at me, since I came on admission, my skin colour became darker in complexion. I have been telling staff to help me go out so I can buy some skin bleaching agents and be smearing them so I can look more beautiful and a bit brighter in complexion and be attractive to my husband who tends to admire light fair skin-coloured women.” (42:15-18).

“Staff did not listen to me. I used to ‘’bleach my body’’ (42:18-22)

‘Bleaching’ is retained in this study as it is the vernacular expression commonly used in Ghana and is ‘phenomenologically representative’ rather than ‘officially accurate’. In the Ghanaian context, AMPVN’s need is in keeping with someone who uses some type of body cream/lotion to make their skin colour change to brown/fair. AMPVN’s experience suggests a faulty body perception, but one that aligns itself with a cultural belief in Ghana; women with lighter skin are more attractive. This belief also aligns with her husband’s positive attitude towards women with fair or lighter skin, leading her to trying to lighten her skin colour.

Similarly, another respondent, KATHPA, verbalised:

‘’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 in the US. Since I got to know of the unannounced divorce, I became unwell. As a result, I started seeing life as not worth living and I had nothing to eat for about a day or two. I do use my personal times to read the bible and reflect, which takes my troubles away, but after a short period I get into a cycle of thinking about my past failures, disappointment and bareness.” (61: 10-18)

KATHPO felt disappointed by her boyfriend in their dating/courtship.

‘I felt like my fiancée has defiled me and later dump me for nothing and we couldn’t fulfil our dream of getting married. Such a disappointment makes me feel like I am no better or unclean for my real future man.’’ (65:1-8).

Another participant, AMPJM, 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 future expectations. This resulted in her SH and suicidal ideation. AMPJM’s stated:

I do feel hopeless, helpless, and frustrated and at times, it does occur to me to commit suicide (30:10-15).

Similarly, KATHNYO expressed hopelessness and disappointment in relation to the daughter who got pregnant which, he believed, will ultimately impact her academic journey, coupled with failures such as financial difficulties. The impact on KATHNYO as a father was palpable:

‘’I do SH as a form of punishment for my failures in life which was distressful to me. I then drank poison (snake killer/ weed killer) *to kill myself, to cut from all troubles in life.’’ (77:14-19).*

KATHPO perceived her SH as a means of coping with disappointments regarding the breakdown of her relationship with her boyfriend. KATHPO said:

‘’My boyfriend’s behaviour made me feel very low and depressed at one stage. One day, he came back from town and then informed me that he does not want our relationship to continue, and I felt hopeless and disappointed.’’ (64:15-19).

KATHSED verbalised how she felt helpless and in a hopeless situation when she had no control over her SH behaviour and could not trust her mother to believe her whilst she was in an abusive situation at the hands of her father. KATHSED noted:

‘’Based on my mum’s comment and advice, I just concluded that even if I say anything, my mum will not believe me so there was no point in telling her. Is like my biological mum believes my dad so much that even I if said anything to her, she will rather blame me and may challenge the authenticity of my words.’’ (89:16.22)

In summary, the subordinate theme of ‘’ hopelessness, helplessness and disappointment’’ highlights participants’ loss of trust in significant others. 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. However, by using SH and harbouring suicidal thoughts they also developed a sense of shame and guilt.

The next subordinate theme will demonstrate how these two themes, ‘hopelessness, helplessness and disappointments’ and ‘abuse, being unsafe and feeling insecure’ are closely linked, as the former appeared to lead to the latter through internalisation on the part of the participants. That is, the way participants integrate the attitudes, values, standards and responses of others into their own identity and/or sense of self, can impact their health and well-being. Where an individual deals with his/her internal stressors in a negative way this can result in disorders/behaviours such as SH.

4.3.4 Abuse: Being unsafe and feeling insecure

Seven of the participants gave a narrative of how they were verbally, physically, emotionally, or psychologically abused by staff, fellow patients, and/or family members. For these participants, their ill-treatment and/or abuse caused them *'hurt'*.

AMPVS became emotional when he recalled his frustration and the emotional pain he experienced as an in-patient. AMPVS was escorted and restrained by fellow patients without his consent and because they used unacceptable techniques for his restraint, he was physically hurt. AMPVS stated:

''If you don't follow their instructions, then some of them can punish you (seclusion*). When they are taking you to the seclusion room, it is usually done by the stronger patients, but not staff, and those who don't like me at times do hold me too strong.'' (18:23-25).*

While AMPVS has some sympathy for there being a shortage of staff, he uses inappropriate behaviour, *'head banging'* to try and get what he wants. While it could be argued that '*head banging'* is a behaviour he needs protecting from, seclusion does not seem to be an appropriate intervention as, depending on the level of observation, this action could have put him at further risk of harm. In AMPVS situation, he was not continually observed in seclusion which could increase the risk of him harming self. Likewise, getting other patients to do the restraining is the antithesis of acceptable practice, as the nature of the relationship may influence how the restraint is carried out, as in AMPVS's experience highlighted above. Restraint techniques and/or being secluded was perceived by AMPVS as '*punishment'* rather than being therapeutic. While AMPVS told of his behaviour when he could not get what he has asked for, this still requires empathic understanding rather than restraint and seclusion.

Table 13 Reflection Box 3:

Abuse within hospital settings

I experienced mixed feelings as I listened to AMPVS account of how he was abused in one way or the other by staff and other patients, the latter through staff involving them by asking them to restrain him. This apparently gave those fellow patients the chance to abuse him during the restraint process. I was shocked about the clinical approach of allowing other patients, who probably had not receive any training to act as health practitioners, to restrain him. I did bring this to the attention of the nurse in charge of ward shift and the ward manager. Also, the helpless nature of another participant (AMPAN) after being sedated by medication gave the chance for other patients to take advantage of his weakness and sexually abuse him. I sought the permission of AMPAN and discussed it with the nurses on duty.

I thought a lot about the negative implications of staff member's level of clinical judgement and strategies they use to deal with certain situations. I also became disappointed and emotional in relation to both above stories, but I tried not to overreact in response to their experience. I thought, any obvious expression of emotional sentiments from me could be construed as an affront to my professional etiquette both as a nurse and a researcher. In contrast, I felt a duty of candour in undertaking this study, as the outcome of this study can be shared with staff at the local hospital. It is envisaged that in sharing the outcomes could have implications for clinical teaching and learning, acting in the best interest of service users and supporting staff to adopt safer practices in the clinical settings. I did report both these incidents of bad practice to the ward manager with the permission of AMPVS and AMPAN, and they took it in good faith. They also shared their lack of, and/or little knowledge, as well as a lack of an adequate communication system, radio equipment, to call for assistant in dealing with violent and aggressive patients.

Similarly, AMPVN appears to have gone through other traumatic experiences of being hurt during her hospitalisation. She gave account of how, when she SHs, some members of staff immediately give her medication, including injections, without finding out about the triggers for the incident. She had reported to staff that one of the medications she was given was not good for her, as a side effect she experienced was one of neck pain, but nothing was done about it. AMPVN verbalised:

"Some staff will just go straight to give me medication to let me sleep and they will not even talk to you or find out about anything before giving the medication or inject you and it hurts. I noticed one medication, Risperidone, is not good for me which they do give me, and it is not good, but they keep on giving it to me.'' (41:9-13)

This statement suggests she was not listened to and she had no collaborative involvement in her care. A similar hospital experience was shared by AMPJM who said:

''There were some staff who will shout at you and scold you and cautioned me that if I did that (SH) *again, they will beat me. As a result, those members of staff might have felt frightened and threatened about my behaviour* (29: 18-20; 42-6-10)

AMPJM also talked of how the ward dynamics had changed and how abuse can sometimes be from other patients. AMPJM seemed to presume that other new patients who attack her should be dealt with and/or managed by staff, to create a safe environment for all of them:

''Really, the ward has changed, and some new patients will fight you and they can 'hurt' you and me too, I will not like that.'' (30:17-20).

AMPKM, who believed poor care was keeping him in hospital unnecessarily, became low in mood when he narrated the emotional and psychological pain of his experience:

''At times, some members of staff will verbally scold me when I am brought back from leave without authorisation. At times, after absence from leave without authorisation and when I am brought to the

ward, staff will beat me. I don't like seclusion, but they do force me into seclusion with their view of deterring me from future absconding.'' (55: 18-19).

AMPKM was physically beaten and unnecessarily secluded without his consent. His seclusion appears to be used as a punitive rather than a therapeutic intervention and he had no control over what he experienced in hospital.

The abuse which led to participants being unsafe and feeling insecure was not only confined to that which occurred during their in-patient stay. KATHSED was hurt by the sexual abuse she experienced from her father during her formative years. During the narration of her story, there was a brief pause and deep breath taken, followed by facial grimacing and odd body gestures when talking about the abuse.

''*Whenever my step-mum is away and I am watching TV programme at home, dad will then come and join me to watch the TV programme. My Dad will force himself on me and be rubbing his erected penis on my vulva and I will push him away. Because he was stronger than me, he tends to overpower me. There were a few times that I managed to escape from his hands, and I went outside the house crying. He then came to me and telling me to stop crying and said if I am crying and someone comes to see me, what will I tell the person? So, I should stop crying. He also cautioned me not to disclose any information about what has been happening between us to anyone.''* (95: 8-15)

KATHSED was in tears as she described her experience:

"How disgusting 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." (95: 5-9).

"I have experienced childhood abuse, 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." (94: 6-19)

KATHSED was hurt by being sexually abused by her father during her formative years, an age when she was helpless, unable to make an informed choice and/or give consent and had no control over what she was experiencing. KATHSED's lived experience demonstrates lack of protection or safeguarding during childhood. Her abuser prevented her voice from being heard and when she did tell someone, her mother, her voice still went unheard, and she had no control over her situation. She experienced inhumane treatment by someone who was deemed as being responsible for her health and safety. The abuser forced her to stay silent by not disclosing the abuse to anyone. The abuse KATHSED experienced during her formative years is likely to have negatively impacted her development of self and parent-child relationship, possibly resulting in maladaptive behaviours and/or high-risk unhealthy behaviours, including her SH and suicidal ideation.

Also, KATHSED told of how, when eventually reiterating her experience of abuse to a doctor, she again felt hurt by his response:

"One of the Drs said something to me which hurt my feelings so much. They should not generalise people. The Dr asked of the ethnic group of my Dad and I mentioned it and he asked of the ethnic group

of my mum and after stating it, the Dr then said; so, men of my dad's ethnic group do abuse women? There was no empathy from the Dr and that hurt me a lot. They should not be saying things like that to people who are distressed." (99:2-6)

KATHSED's narration suggests she was experiencing flashbacks of her childhood experience of sexual abuse by a male adult. When finding her voice to tell the doctor about these experiences she was rebuffed, the doctor attributing it to her father's ethnic group and its acceptance within that culture. Such a dismissal of her traumatic experience could have led to her experiencing secondary trauma.

KATHPA became emotional and was wiping away her tears as she narrated her ordeal:

"My husband arranged and sent me to go for treatment in Ghana. However, by the third month, there was no contact with him and when I phone my husband, the call will only go into answering machine with the hope that he will call back, but to no avail. Months passed by and I was waiting with no contact from him, and it appears he blocked me from his contact list because, when I phone it will just indicate that it was a wrong number." (60:17-23)

The behaviour of KATHPA's husband of abandoning her in Ghana may have caused her emotional pain and hurt and could be interpreted as a form of abuse.

KATHPO gave account of how, when she was emotionally and psychologically 'hurt' by her boyfriend, this manifested as guilt and the need to punish herself:

''When I feel ''hurt'', then I tend to display it on my body by inflicting punishment onto myself for not listening to my mum and took a personal decision into engagement into intimate relationship and moving to the man's home prematurely.'' (65:27-29)

KATHPO referred to how the emotional pain and hurt she experienced led to her feeling insecure and not knowing who to trust:

''As I talked about it now, it still hurts, and it is very painful, and his behaviour does not make sense to me………. Some members of staff were saying to me there are a lot of men out there and why did I want to take my life because of one man. It is not about other men, but when you put all your trust and love into someone and suddenly there is no equal love, but rather a change in attitude towards you, it hurts a lot." (66-17-18).

The subordinate theme of 'Abuse; Being unsafe & feeling insecure' provided insight into participants physical and psychological pain associated with their abuse, albeit on the part of family members, staff within the hospital and other patients. Participants believed their basic human rights had been infringed during times of vulnerability leaving them unsafe and feeling insecure, and this may have resulted in, or contributed to, their SH and suicide ideation.

In summary, this super-ordinate theme of 'Being let down', has captured participants' experiences related to the triggers and/or meaning of their SH and some of the challenges they faced. These experiences have impacted their psychological and emotional self in terms of their relationship with family and hospital staff and led to the questioning of self.

‘Being let down’ describes how situations in the participants’ personal lives changed and brought about disappointment. Change that brings about disappointment can be a challenging process to navigate and/or cope with. Also, ‘being let down’ related to how perceived failure to respond in such situations appeared to have a detrimental effect on the overall quality of life and well-being experienced by the participants. All the participants noted that they were *’let down’* in their personal lives by family, wider society, and/or as a patient in the hospital setting.

‘Being let down’ by others highlighted participants’ experience of a range of emotions and some of them seemingly contradictory in relation to how they reacted and how they felt. For example, a few participants who experienced relationship break-up became overwhelmed by the new direction their life had taken. While some struggled to come to terms with this, others appeared to eventually be able to use it as an opportunity by having the ambition to pursue academic qualification and/or return to former trades. Also, although participants anger and frustration at being let down through abuse by family members and staff alike, they found themselves to still hankering after these relationships, albeit in a more acceptable format

The next super-ordinate theme of ‘Living with the negative self’ and subordinate subthemes of (1) ‘Managing me through challenging times’ (2) ‘’The badness within me’ (3) Who am I’ and (4) ‘Being confined & suicidal ideation’ perhaps highlights some of the consequences of ‘being let down’.

4.4 Theme 2: Living with the negative self

An individuals’ sense of self defines the way an individual knows who he/she really is (Baumeister, 2011; Rogers, 2008; Ellis & Dryden, 2007). Self-concept describes the individual’s knowledge of themselves in relation to their thoughts and feelings and/or their bio-psychosocial state, and it is influenced by nature-nurture interactions. According to Rogers (2008) self-concept has three elements: self-image, self-esteem and the ideal self. In essence, self-image is the way individuals perceive themselves, self-esteem is the value we put on ourselves and the ideal self is the self we would like to be (Rogers,2008), Any imbalance between one’s self-image and the ideal self can have negative and/or positive implications for the individual regarding their quality of life and/or health and well-being (Baumeister, 2011; Rogers, 2008; Ellis & Dryden, 2007). If an individual has a negative perception about himself/herself, then such perceptions can compromise their mental health and quality of life. Therefore, the meaning that individuals attribute to their lived experiences will be associated with certain emotions and when similar situations occur, the same emotional responses are likely to be triggered (Myers, 2007). It is noted that most mental health problems are linked to our beliefs and sense of self about lived experiences (Shin, 2018; Rogers, 2008). Figure 4 below provides an overview of the second superordinate theme, ‘Living with the negative self’, and its four related subordinate themes. The numbers in brackets indicate the number of participants who experienced the phenomena represented in the superordinate and subordinate themes.

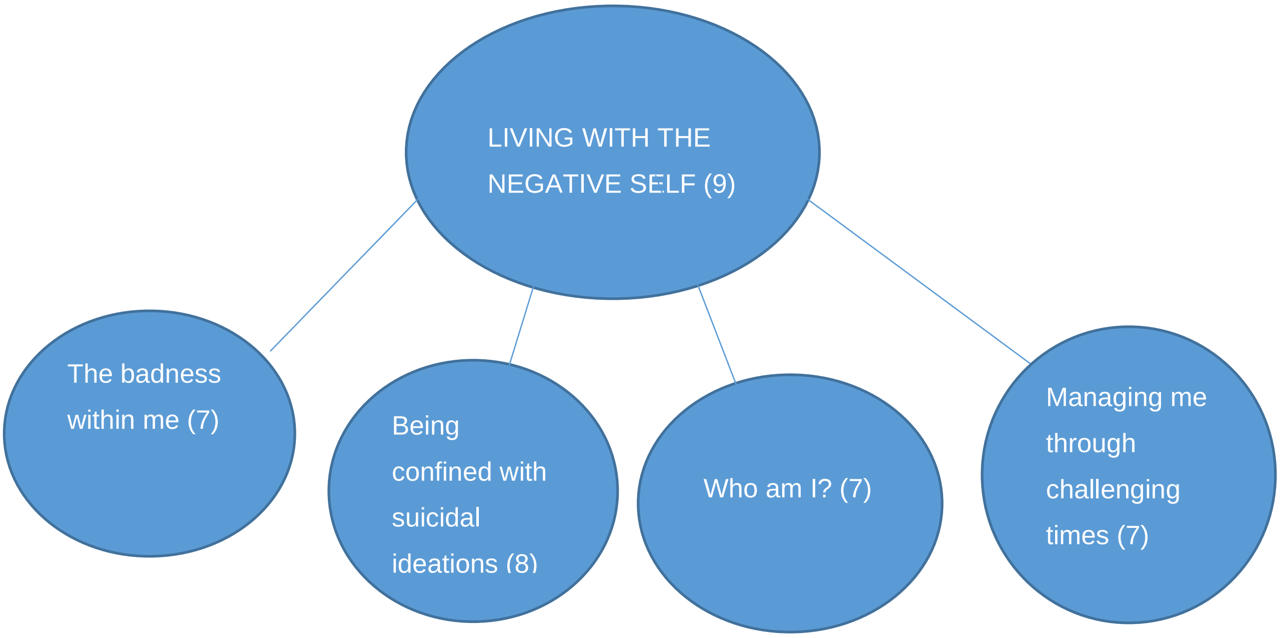


Figure 4: Living with the Negative Self

In this super-ordinate theme, nine respondents verbalised how their SH contributed to their negative perception of self. Within this superordinate theme four subordinate themes were identified, these include the badness within me', 'being confined with suicidal ideation', 'who am I'? and 'managing me through challenging times.

4.4.1 The badness within me

Seven participants talked of their perceptions of 'badness within' prompted by, or as a result of, a negative self-belief and/or low self-worth. AMPAN's story conveyed a sense of labelling himself as bad and how this impacted his self-concept and self-esteem. He stated:

''Someone calling you bastard, you are a lost child, and you don't know your family……. I don't see my discharge from hospital coming as some of us are ''bad'' because of what I have done before my admission…… Now I know, fighting is not good, it will only land you into trouble. So, when I remember my incident, then I do punish myself (through SH) *for been the cause of my admission."…. ''I used to scratch my chest with my fingernails, which gives me some sense of relief. It blocks my mind from any unpleasant experience.'' (5:8-10; 6:6-8*).

AMPVS described the badness within him and how this has affected his memory and untoward behaviours toward others, as well as his ability to process information. He stated:

''The badness within me started with taking illicit drugs such as 'weed' when I was in school and that appears to have affected my memory and triggered my illness. Also, I do hurt staff when things don't go my way and I'm distressed or I hurt myself and there will be no pain only numbness, which appears to have impact on the threshold of my pain perception.'' (17:3-14).

Similarly, AMPKM talked of how he uses SH to address his badness, of previously using illicit drugs. Using illicit drugs appeared to have led to his mental illness, a symptom of the illness being the hearing of voices that instruct him to SH. AMPKM 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 used cutlass to cut myself to expel the badness in me.''* (48:7-13).

AMPJM reflected on the badness within her in relation to the killing of a boy, thereby leading to emotional breakdown and SH. In AMPJM's account, she told of being involved in a scuffle with a boy and in the process, she stabbed the boy which led to his death. She was later arrested and taken into custody. Whilst in custody, AMPJM became unwell. AMPJM stated:

''My incident of killing the boy can be very worrying and disappointing, and I do feel like cutting myself to expel the badness in me. After that, then I will feel angry for cutting myself. Also, I feel some members of staff do have some strange attitude towards me just because of my incident of killing the boy.'' (29:8-15).

KATHPO blamed the badness within for her relationship breakdown with her boyfriend. KATHPO said:

"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. I do use my fingernails to scratch my body. There were some occasions or days when I will feel very low in mood and fed-up with life and I do think of running in front of a car for the car to run over me. I see SH as self-punishment to myself for not listening to my mum…………What he has done to me made me feel dirty and defiled (KATHPO took a deep breath)*." (64: 19-24; 65: 1-6).*

For AMPVN her SH related to what she described as her 'menstruation badness' as this causes her pain and distress. AMPVN recalled:

''I do have menses and going through it can be difficult for me. So anytime I am going through challenging times, then I cut my body to ease out the badness, distress and pressure, the pain, and challenging times that I am going through. The emotional relief and numbness is usually brief, and I will be sorry for myself, but in that moment it helps.'' (38:17-24)

Similarly, KATHSED gave account of how she has been thinking about the sexual abuse she experienced from her father which makes her feel dirty and distressed and how she believes it resulted from the badness within her. KATHSED went on to say:

"So anytime I am going through post traumatic experiences of the sexual abuse then I will SH to let blood…badness out of my body or to revive my thinking.'' (90:5-9)

In summary, this super-ordinate theme gave account on how participants tend to use high risk behaviour/maladaptive coping mechanisms to deal with their arousal state and/or emotional and psychological frustrations such as abuse, relationship breakdown and seemingly bullying behaviour by others. For instance, when participants reflected on the psychological effects of their traumatic experience, such instances tended to result in negative self-belief and/or low self-worth and they appeared to assume that their life was threatened with a sense of bleakness, emotional pain, self-hate and vulnerability. Perhaps, such self-victimization or internalised self-blame could result in becoming so emotionally overwhelmed resulting in high-risk behaviours (SH or suicidal ideation). Alternatively, the SH could be construed as a probable means of healing or gaining self-control over one's own 'self' or life in the environment.

4.4.2 Being confined & suicidal ideation

In this subordinate theme, participants expressed how continued hospitalisation had impacted upon their freedom of movement, self-esteem and self-worth; all of which led to self-blame. This appears to have resulted in some participants resorting to suicidality. AMPAN and AMPJM had been detained in hospital based on directives from the court and they had no visits from their family, no supervised community access and no defined and/or detailed information on their care pathway. Both participants perceived this to be unfair. Some participants verbalised suicidal ideation during their hospitalisation, with seven having experienced feelings of undue confinement because of their continued hospitalisation against their will. AMPJM 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." (30:11-17)

When asked if she had made plans for suicide, she stated that she had planned to do it by drinking poison (Parazole), as this would expedite the outcome of her suicidal ideation. Like AMPJM's experience, AMPAN's narrative portrayed changes in his lifestyle and restrictions in his movements. Due to perceived high restrictions and his confinement to hospital. AMPAN' said:

"Hmmm, as if I have just been dumped over here and no detailed information from the court people or ward staff. If I asked ward nursing staff about my discharge, they would just say my case is in the court and so I am not even allowed to go off the hospital. I do not even know how they are doing about the case so far. I would like staff to allow me to go for a walk, do shopping in the locality so that I will not feel so much confined to this environment. I would like staff to find more activities for us to do on the ward." (7:9-18)

As a result of relationship problems, AMPVN became distressed and *'fed-up with life'* and had wanted to *'end it all'*. AMPVN stated:

'' I did try various means to hurt myself such cutting myself with any sharp object and I also climbed a tall bridge in Nkwakwa area and had wanted to jump from the bridge onto the ground in front of a moving vehicle in order to kill myself.'' (40: 5-13).

As a result of being admitted to hospital, AMPKM believes his work life in the outside world has been restricted. AMPKM said:

''I want staff to know how they are hurting me by keeping for too long in hospital. I feel cured now to be discharged and carry on with my work. Staying in the hospital environment can be frustrating which can make me SH. Therefore, what I have been doing is to abscond to the locality: I do abscond in order to

do my carpentry work so as to complete people's work and hand over to my customers that I was serving before I came here." (51: 18-21, 52: 10-14).

In summary, some participants identified activities and services that have been challenging and unhelpful to them regarding care and support from staff. Participants recounted several negative experiences of care/service such as being confined in hospital. This was one of the major challenging experiences for some participants. In general, some participants expressed frustration due to lack of information on their discharge plans or care pathway. Also, they needed leave for community access, but this was not granted. The next subordinate theme of 'who am I?' is interrelated to the two previous subordinate themes.

4.4.3 Who am I?

This subordinate theme describes participants' reflections of ''who they are' and/or identity development. Six participants discussed the notion of 'who am I' in relation to their experience of SH. Other themes such as 'hopelessness, helplessness and disappointments' and 'abuse, being unsafe and feeling insecure', 'shame and guilt' and 'managing me through difficult times' are also closely linked to 'who am I? as the former appeared to lead to the latter through internalisation on the part of the participants. Most of the participants were going through a period of maturation in their lives and they wanted to identify their values, aspirations, interests and skills and sense of belongingness. However, this appeared to be challenging within the secure settings. Nevertheless, through difficult times such as hopelessness, helplessness, disappointments, abuse, being unsafe and feeling insecure, striving toward these things can be overwhelming and this itself can lead to feelings of frustration, unworthiness and loss of vision, leaving participants with thought-provoking situations such as 'who am I' and 'what is my purpose' in life? For instance, participant AMPAN 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. Such lived experience appears not only to have led AMPAN to question his identity, but it impacted on how he labelled himself. His labelling of self may also have been influenced by how his friends/peers labelled him and, having no response to their taunts, this could have negatively impacted his mental health. AMPAN said he felt *'lost'* and '*pitied himself*'. AMPAN's stated:

''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 no nothing to say and some of them do call me names such as a bastard and I tend to ask myself ''who am I?'' (7:6-14).

Like AMPAN, AMPVN was unable to fulfil her dream as a working woman. For instance, AMPVN's husband will not allow her to work. Additionally, during her admission to the secure ward, at times, some staff prevented her from SH by removing items that she used to enact the SH behaviours. AMPVN said: ''*This can be boring & frustrating as I used to make my own money (41:12-16). Additionally, my mother abandoned me when I was a baby and now, she does not want to visit me in hospital, and I wanted to go to school, and they will not allow me. Since I came on admission, my skin colour became darker in completion. I do perceive myself as ugly, of no value and inferior'' (43: 16-22).*

Perhaps, AMPVN would like to focus on a career or trade that will be meaningful and rewarding. Not having the opportunity or the encouragement to achieve her goal can be frustrating and distressing and may have contributed to her low self-esteem and loss of direction. AMPVN appears to believe herself trapped and her self- beliefs of being *'ugly'*, of *'no value*' and being *'inferior'* could have led to her use of poor coping mechanisms such as SH.

Additionally, AMPJM appeared to have experienced boredom and frustration when she had wanted to visit the occupational therapy (OT) department to engage in meaningful activities such as making bracelets which can be fulfilling and serve as a form of coping within the secure setting. Nevertheless, she was not given the chance to work towards her aspirations. In AMPJM stated:

''*When I requested to be taken to the OT department, the OT staff stated that they will not be able to accommodate me which is very worrying and disappointing. There is no work or activities on the ward for us to engage in'' (31:19-23).*

Perhaps, AMPJM's inability to fulfil her unique and special talent of bracelet making in the secure setting, and not being permitted to engage with the rest of the group to gain a sense of belongingness, may have had added to her mental health problems.

In Ghanaian culture, the family unit plays a major role in the individual's identity development, but in the case of KATHSED, she experienced an abusive relationship with her father which perhaps made her question her understanding of who she was. KATHSED stated:

"I said to myself what are children 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. In my case, I am being sexually abused by my dad which often makes me feel lost, sad, and at times angry.'' (90:3-9)

Like KATHSED, the dream of KATHPA is to have a successful marriage and children. In Ghanaian culture, the family unit values large families to perpetuate the family tree, and this is expected to manifest in the married couple's life by having children. Any failure becomes an overwhelming issue for the woman who will be blamed for not being able to produce children for the man. KATHPA experienced barrenness and later divorce. For KATHPA, the concept of 'who am I' is linked to being let down, disappointments, self-depreciation and low self-esteem, all of which made her question her sense of purpose in life and may have been a pre-cursor to her suicidal ideation. KATHPA 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 as this seemed to be the root cause of everything. (63: 6-15).

When AMPVS is in a harmonious mental state he can think and process information effectively and is able to cope and adapt to situations. However, if AMPVS is not mentally well, he finds it challenging to focus on dealing with situations and believes he loses control of his thinking and his identity.

AMPVS’s stated:

‘’When I am not mentally well, I find it had to process information which makes me to lose control of my thinking and identity and I tend to be frustrated and angry’’ (20 1-11).

Perhaps, AMPVS inability to think and make informed decisions leads to self-doubts or question his purpose and values in life. Additionally, being in a restricted setting may highlight his lack of control over situations, such as not able to view world football match at a defined time, resulting in distress, and perhaps disappointment over loss of his autonomy. Subsequently the use of ineffective coping mechanism such as SH may be used as a way of asserting some control over his life.

In summary, this subordinate theme of ‘who am I’ is interconnected with previous theme of ‘’the badness within me’’. It is noted that individuals tend to find answers to their unique identity in relation to their values, aspirations, skills, and purpose in life. When questioning such aspects of life, individuals tend to ask rhetorical questions about ‘who am I’’ and their self-fulfilment. Participants appeared to encounter overwhelming situations that often led to feelings of frustration, a perceived lack of autonomy in secure setting in dealing with their day-to-day activities and their aspirations and hopes being dashed. As a result, participants tend to use high risk behaviour/maladaptive coping mechanisms to deal with their emotional and psychological frustrations such as lack of fulfilment and perceived loss. In the next subordinate theme, ‘managing me through challenging times’ I will discuss how participants coped with these issues.

4.4.4 Managing me through challenging times

AMPAN’s narrative portrayed changes in his lifestyle and restrictions in his movements due to his perceived confinement and limited ward activities for him to engage in. However, the experience of confinement appears to have been insightful for some participants. AMPAN said:

‘’In this hospital, they will only give you medicines, and you would feel drowsy and sleepy. They will not allow you to go out and what you witness is people shouting and at times fighting……. I have now realised that fighting is not good as it will only get you into trouble.” (5:23-25; 6:1-2)

KATHPO said:

‘’This is not their direct fault but there are no long-term plans in place that will enable patients to continue having medication when discharged from hospital. You know, I did relapse and had to be brought back to hospital. The medications that the doctor has prescribed for me are expensive and I do pay for repeat prescriptions on my own. Now, I find it very difficult to work as the medications that I am on makes me feel sleepy and drowsy which tends to hinder my work performance. As I could not work, I tend to default with getting repeat prescription which led to my relapse and readmission. When you are discharged, staff of the ward or the care team do not follow up on you in order enquire about how you are getting on. They will rather refer you to local therapist and they charge a lot, 50 Ghana cedi so some of us are not able to attend sessions post discharge from hospital. Inconsistency with medication compliance might have contributed to my recent relapse and re-hospitalisation.’’ (66:15-22)

Furthermore, while reflecting on her experience in hospital, KATHPO stated that she had benefited from the care and support she received from staff on the ward. However, she also talked about her *'distressing'* experience in the ward environment which seemed to be compromise her dignity and privacy, as well as the privacy of others in a seemingly ill-structured ward design. KATHPO said:

"At times when the male patients are awake and not fully dressed or unsettled on their unit where there could be chaotic fighting and various forms of unsettled ward environment, staff will ask you to wait for their privacy to be ensured before you can go through the ward and vice versa. There were situations when one, if not fully dressed, and a male patient may knowingly or unknowingly will just walk through our unit in order to exit through to the main entrance. At times, you are quite distressed and wanting to get to your bed but had to wait and such times can compound your situation." (67:23-25).

AMPJM appeared to have gone through numerous situations which made her conclude that she was going through challenging times during her hospitalisation. AMPJM felt *'stuck'* on the ward and frustrated when staff would not grant her leave for community access. According to AMPJM she would have benefited from '*standing by the main gate of the hospital (roadside) to view the outside world, before returning to the ward'*, but her request was denied.

KATHSED talked about having mixed feelings when benefiting from a form of therapy, but not being able to afford it.

'*'They will collect 50 Ghana cedi for each therapy session with me and some of us are not working so it makes your treatment compliance difficult. If you don't have the money, it can make you default treatment. Luckily for me, one of the doctors decided to foot that bill on my behalf so, I had the first three sessions free. But when I went for the fourth one, the doctor was not there so I had to pay for it. The Ghana health insurance does not cover all treatment for mental health.'' (93:5-8).*

The Ghana health insurance scheme has attained significant success but is plagued by lack of free universal care for all health conditions/ disorders (See Chapter 1, section 1.5.2 for details). Given that the overall aim of the scheme is universal coverage of free services for health problems and interventions, in practice, the insurance covers management of only selected health conditions/illnesses and interventions, with lack of focus on mental health care services.

In summary, this subordinate theme describes participants' experience of the challenges they face in managing self through difficult times. The subordinate theme of 'managing self through challenging times' captures participants' descriptions of the relationship between being confined and suicidal ideation, within the context of their hospitalisation. Their confinement is often associated with the staff providing care, some of which raises ethical concerns. Also, some participants questioned the rationale behind their confinement in secure psychiatric in-patient care.

Within the super-ordinate themes of 'Living with the negative self' participants reflected on the psychological effect of their traumatic experiences which resulted in negative self-belief and low self-worth. Participants characterised their lives as being threatened with a sense of bleakness, emotional pain, self-hate and vulnerability. Perhaps, such acknowledgement of self-victimization, internalised blame of self, and/or a belief of not being good enough, could lead to high-risk maladaptive coping behaviours such as SH. Within this same context SH could also be interpreted as a probable means of a healing process, gaining self-control over one's own 'self' or life in a restrictive environment. Also, such self-blame can lead to negative, self-sabotaging behaviour. For the participants in this study this appeared to cause them to become hurtful to others, such as members of staff or other patients, and could result in unprovoked attack in the care setting.

4.5 Theme 3: Forces of the supernatural and religious beliefs

The next 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' will reveal participants' perspectives of life beyond their SH. Figure 5 below offers an overview of the third superordinate theme.

The numbers in brackets indicate the number of participants who experienced the phenomena represented in the superordinate and subordinate themes.

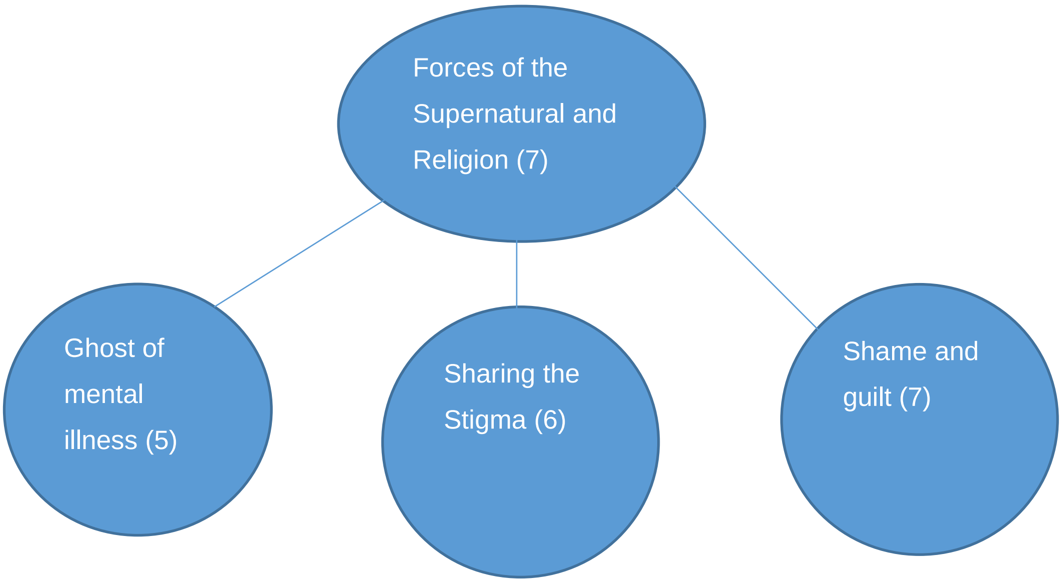


Figure 5: Superordinate Theme 3

In this super-ordinate theme, seven participants' stories centred around a belief in supernatural forces as a contributing factor to their SH. The participants held the notion that those around them did not believe in their plight and/or were not listening to them. Instead of listening and supporting them, participants felt they were being labelled, and subsequently became lost. Within this superordinate theme, participants' experience of supernatural forces could be divided into three subordinate themes 'of ghost of metal illness', 'sharing the stigma' and 'shame and guilt'

4.5.1 Ghost of Mental Illness

Within this superordinate theme, participants described their subjective assessment of spirituality, namely the 'ghost of mental illness', and how they attribute this to their current mental illness and its possible treatment. In Ghanaian culture it is believed that an individual’s personality and/or life is influenced by free actions or choices made, and by spiritual forces (Roxburgh, 2018; Nanewortor, 211; Cimpric, 2010). Spiritual forces are often referred to as; ghosts, demons, devils and/or negative energies (Nanewortor, 2011). In Ghanaian culture it is believed that the world of ghosts and negative forces are like a mafia, around and within societies, using their powers over humans in controlling their personal positive and/or negative gains. Generally, the spiritual forces or a component of the personality is in the form of a ghost and/or subtle bodies (spirits) of our departed ancestors, who determine the individual’s personality and destiny. The spiritual domain operates on the principle of ‘as one sows, so shall one reap’. Therefore, Ghanaians often believe our deeds and past events do influence the constitution of our personality.

In light of such beliefs, some incidents, thoughts, actions and behaviours are considered to be under the control of the individual’s personality, while all major events such as marriage, birth, serious accidents and illnesses are believed to be influenced by the spiritual realm of the personality. For instance, the spiritual forces can lead to a person having mental health problems, suicidal thoughts and illness. Likewise, it is believed any of these spiritual forces, often interpreted as root causes, can be cured only by specific spiritual healing remedies. As such, one way to prevent the evil forces of the ghost is to carry out traditional practices by seeking support from the traditional medicine man and/or seeking interventions from healing centres and prayer camps that are an integral part of Ghanaian society.

In this study, participants held the belief that illness and calamity are caused and alleviated by a variety of invisible spirits, ghosts, saints, evils, demons and gods. Also, some participants describe their lived experience of SH within the context of religion. For example, participants held a belief in the existence of a supernatural being, whereby there is a reliance on God Almighty as the supreme being and controller of their health and well-being. Religious sacrifices, such as letting blood out of their body, can be a means of proving their existence, and/or the dispelling of their sins or badness (see section 4.5.3. for examples of this).

AMPJM held the belief that her illness was *‘spiritual’* and that the voices and spirits tell her to follow their instructions and if not, they will attack her. AMPJM’s understanding was that she felt her illness was a ‘*curse’* imposed on her. Therefore, she had 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 and head banging until I will not see him again …… or It will make me as if I am going to die so I must be running around.” (27:6-15).

AMPJM also noted that she;

“Does read the bible and do pray to God for deliverance from my sins and would like to go back to a spiritual prayer camp for healing.” (28:13-16).

This suggests AMPJM's believes in praying to God, perhaps indicating this might be a protective factor for her mental well-being and part of her healing process.

KATHPA's husband convinced her to believe in supernatural forces being the cause of her illness and she would only be healed or get better 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.'' (60:14-18)

Participants described how counselling from church elders, reading the bible and prayer enhanced their healing process and well-being. KATHPA's believed and trusted in the supernatural, doctrines of the bible and engagement with significant others in the church for prayers, fellowship and counselling sessions. In addition, she also talked of how support from family and hospital staff gave her hope and assurance of a speedy recovery. She expressed her hope through singing gospel songs and praises:

''I do sing religious songs which tend to uplift my spirit and mood. They do organise church in the hospital where staff take me to and at times to the local church for fellowship with others and I do receive counselling sessions. I do use my personal times to read the bible and reflect which takes my troubles away. The church and some family members helped me and with the little money that I made whilst in the US, I then used it to make a ''small kiosk'' all this help me feel better and rebuild my life.'' (60:18-25; 61:10-15)

Like KATHPA, KATHPO has found consolation, faith and hope in reading the bible and she has benefited from attending counselling sessions from church elders and interactions with others during prayer sessions:

''I do listen to religious gospel music, attend prayer camps to prayer over our relationship, and seek counselling sessions from my pastor and church elders.'' (71:11-14)

KATHNYO shared his experience in relation to the impact of his teenage daughter's pregnancy on the family and his own beliefs as to how religion has helped him:

'*'My daughter initially declined to name the father of her unborn child, but when I got my church elders involved and through prayers and support, my daughter was able to name the potential father of her pregnancy, but by the time she did so, the man had already run away from our locality …. I do go to the multi- faith room in the hospital to meet people like me and we do share problems together and that tends to relieve me.''* (77:20-23; 79:15-17)

In summary, this subordinate theme illuminated participants' beliefs in spiritual beings. For instance, some participants held the belief that illness and calamity are caused and alleviated by the powers of a variety of invisible spirits and/or Gods within oneself. Participants described how getting closer to God through counselling sessions from church elders, reading the bible and prayer enhanced their healing process and well-being. Their spirituality and/or a belief in God appeared to instil hope during their healing process and/or they appraised their health status based on the supreme spirituality of God.

This subordinate theme described participants' lived experiences in terms of a ghost of mental illness; supernatural forces they associate with illness and wellness and being able to embrace personal preferences for healthcare choices. The ghost of mental illness appears to be culture bound, where in the 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. Some participants attributed visits to church/ multi-faith centres and/or prayer camp, and being prayed for, contributed to their recovery process. Participants suggested that they experienced being valued and having inner peace through problem-sharing at the multifaith centres. Participants held their faith and trust in God/ supernatural beings with the assurance that they will be healed by their maker. Apparently, this gave participants some sense of relief and hope of life. The next subordinate theme is **'**Sharing the Stigma'.

4.5.2 Sharing the Stigma

This subordinate theme provides an explanation of participants' experience of rejection, discrimination and stigmatization. Six participants gave narratives of how they experienced either stigmatization and/or discrimination from family members, the public, or by staff during their in-patient care. The six participants noted that their illness and/or their behaviour appears to be construed and labelled by others in relation to various Ghanaian cultural views: antecedents to their condition leading to their hospitalisation. Some participants were subjected to unconventional medical treatment, not listened to, and/or ignored by those who were supposed to be their care givers.

AMPAN noted that he was involved in a fight and the other person died. In Ghanaian culture, the one who causes death, such as through fighting, can be labelled and/or stigmatised. Also, AMPAN appeared to be ignorant about his biological father. This would be problematic for AMPAN, as he accepts the notion that in his tribe or ethnic group, paternal lineage is important and not knowing about such a figure head made him feel angry, distressed and envious of others. Instead of his peers checking on AMPAN as a way of providing support or being empathetic towards him, they were calling him names or labelling him as 'a bastard child'. In Ghanaian culture, being a 'bastard' can be construed as a bad omen to the individual and/or the family. This appears to have distressed AMPAN, and he adopted SH as a mal-adaptive coping strategy:

''I tend to be jealous of my peers and any provocation from anyone can easily lead into a fight to let them realise how I feel.'' (5: 13-16)

Fighting could be construed as both SH and harm to others. For AMPAN it appears to be his way of communicating his distress to others.

The Code of Ethics within the Ghana Health Service (GHS) is to provide high quality care and support to patients in their care. However, this can be compromised by their prejudice and perceptions toward the very individuals that they are caring for. For example, the attitude of some staff toward AMPAN made him feel uncomfortable. He said:

''Some members of staff will talk to me nicely, but some of them can be a bit funny with strange looks and attitude which might be related to my past. It is a taboo to kill someone. When it happens like that, then you don't feel like coming to join other inmates in the day area. There are some staff who will force you out of our cubicle, but some of them will overlook it.'' (7:18-21).

Similarly, AMPJM said:

‘*’Some members of staff do not show me any respect as they can talk to you anyhow, maybe because of my incident of killing the boy.’’ (29:7-10).*

AMPVN experienced a similar attitude and behaviour on the part of staff when she was hospitalised. AMPVN said:

‘*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.’’* (41-9-11)

Another participant, AMPKM, gave an account on how he used to take illicit drugs which later compromised his mental health and his behaviour, and led to his hospital admission. While in hospital, he was discriminated against by his family whom he perceived had labelled and/or stigmatised him as an ‘*outcast*’ and a ‘*nuisance*’. AMPKM also perceived his incidents of absconding from hospital, without authorization by his doctor, to have had an impact on his therapeutic relationship with staff. He was discriminated against and stigmatised by ward staff for not been complaint with his care pathway.

In KATHPO’s account, stigma appears to have resulted from experiences of negative attitudes, derogatory comments, and prejudice from his neighbours about his family. Also, the genesis of the problem lay with his initial interpretation, blaming his neighbours for his illness.

‘’My neighbours laughed at me and made derogatory comments about the family. Later, I suffered from a mental and emotional breakdown where I was hearing voices telling me to kill myself.’’ (77: 14-20)

Like KATHPO, KATHNYO revealed how others might be labelling him for not bringing his daughter up well, leading to her teenage pregnancy without a potential father. KATHNYO said:

‘’In this culture, it is a taboo to get pregnant without being properly married and no father for the child. People would laugh at the family and can make derogatory comments about the family. All burden of mother and childcare has now shifted to me.’’ (77:20-26).

In summary, this subordinate theme described participants’ lived experiences of prejudice and discrimination on the part of family members, wider society, staff within the hospital and other patients. Participants perceived this to be damaging to social relationships, resulting in social exclusion and their mental health being compromised. The next subordinate theme, ‘’shame and guilt’, further examines the potential impact of stigma.

4.5.3 Shame and guilt

This subordinate theme illuminates participants' emotional trauma associated with their SH. AMPAN referred to his experience of guilt and shame when stating:

"I do punish myself (through SH) *for being the cause of my admission to hospital and that gives me some sense of relief. ……I feel some of us are perceived as bad because of what I have done before my admission. This was because of a fight and the other person died. When I look into other people's eyes, I can tell that people see me as a bad person. When I feel guilty of what had happened and now to be stuck here for a long time, then that guilt and hopelessness within me makes me feel like ending it all. Such reminders of what I had done by some perceived inmate 'close friends' that you think you can trust and confide in them and when they make such revelation to others can bring me down with guilt and hatred for myself."* (8: 5-12)

AMPAN is aware he has killed someone during a fight and because of this he believes he is perceived as a '*bad*' person by others. Being incarcerated for a long period of time had led to him feeling '*hopeless*' and the guilt he experiences causes him to feel suicidal.

Another participant, KATHPA, became ashamed when following her divorce, neighbours were still asking her when she would be going back to join her husband abroad. KATHPA became low in mood (and low in tone of voice) when narrating this part of her story:

"It was so frustrating, and the problem becomes compounded when people who knew me will asked me of when I will be returning abroad to join my husband which made me to feel ashamed, lonely and worried. It makes me feel ridiculous, demeaned and with some sense of guilt and shame. I see myself as not a complete human being as I cannot fulfil my role as a woman in order to give birth for my husband, as that seemed to be the root of all this problem and made me to come back home." (61:22-28).

AMPVN's voice also changed when she verbalised:

''I thought I could win my husband's heart as he appears to be attracted to some type of women whenever we are in town or in church, and his eyes will be fixed on them for some time, 'and he will be comparing them to me which can be embarrassing. It makes me feel ashamed with some sense of guilt of being ugly which might be attributed to my husband's relationship breakdown with me.'' (42-16-20)

KATHPO appeared depressed by a failed relationship with her boyfriend. She reflected on her boyfriend's attitude:

'*'One day, I woke-up in the morning and something dawn on me as if something did not feel right as there seemed to be a problem with our relationship. Since then, I started to question myself as to whether there was any fault from me.''* (65: 15-20)

Within KATHPO's story she indicated feelings of disbelief, guilt, shame and embarrassment. She believed the breakup with her boyfriend had devaluated her dignity, as well as causing her psychological and/or emotional turmoil. KATHPO stated:

''What he has done to me made me feel dirty and defiled. (KATHPO took a deep breath.) *Hummmm, it seems like I have replaced my cultural values for love which did not work and now I feel guilty about what I may not have done well, and it was a challenging future for me.'' (66:15-18).*

In summary, the subordinate theme of ''shame and guilt'' illuminated participants' perceptions about their self-esteem and their experience of feeling dehumanised, ashamed, guilty and treated with no respect, the latter compromising their dignity. Such feelings, together with some of the situations they found themselves in, caused physical and/or emotional hurt, at times leading to feelings of being abused. The interplay of the three subordinate themes appears to have impacted on participants' mental health which led to untoward coping mechanisms with high-risk behaviours such as SH. That is some participants internalised their untoward behaviours and did make sense of it by accepting it as a personal norm to live with for the rest of their lives.

The next super-ordinate theme of ''Living with the positive self'' and subordinate subthemes of ''Helpful conversations and kindness characteristics'; 'Supportive healing & medication' and 'Empathic valuing & feeling wanted' will reveal participants' perspectives of life beyond their SH.

4.6 Theme 4: Living with the Positive Self

Regardless of the adversity many of the participants had experienced, one of the emergent themes was 'Living with the positive self'. Figure 6 below offers an overview of this fourth superordinate theme, and its three related subordinate themes. The numbers in brackets indicate the number of participants who experienced the phenomena represented in the superordinate and subordinate themes. This is then followed by an in-depth explanation of the results, with each subordinate theme being illustrated by various extracts from participants' transcripts.

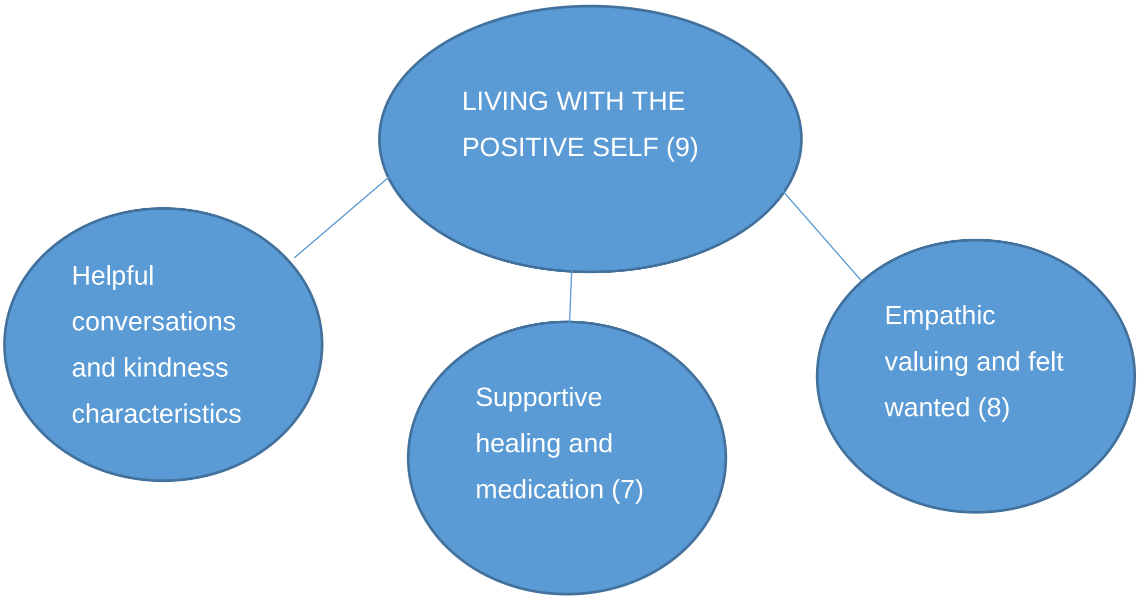


Figure 6: Living with the Positive Self

A positive sense of self is paramount for mental health, promoting recovery from traumatic experiences and helping to build resilience (Shoemaker, 2015). This research found all participants were living with a positive sense of self, regardless of the challenges and adversity they had experienced. In part, participants' positive sense of self was achieved through helpful conversations with, and the kindness characteristics of hospital staff, family members and wider society. In addition to 'helpful conversations and kindness characteristics', 'empathic valuing and feeling wanted', and 'supportive healing and medication' were related themes that culminated in participants' being able to adopt a positive sense of self.

4.6.1 Helpful conversations and kindness characteristics

All nine participants expressed how pleased they were at benefiting from helpful and motivating conversations within their care process with either members of staff and/or significant others. AMPAN verbalised helpful conversations that he had with some members of staff:

''Now I do talk to some of the staff who will support me. They do tell me that our cases are different and when I am cleared with the court case and I am healthy, they can sort out my discharge plans. It is not all of members of staff that talk to me, as some of them will only give you more medication which can make me feel dizzy.'' (7: 3-8).

AMPVS stated that he uses coping strategies such as talking to someone to divert his mind from distressing thoughts that can lead to SH:

''I do talk to my peers and do make occasional phone call to my family which helps me to prevent SH, but it is not always that I do get my family on the phone.'' (19:8-10)

When AMPVS was asked if there was anything that staff did that was helpful to him, he stated:

''Some members of staff do talk to me and support me to make choices that I cannot make on my own. Some staff including the nurses and my doctor do help me to make the right choices. I can't seem to make some of my own choices, and I do get support from staff in making my choices Some of them are polite in talking to me and they do show respect.'' (19: 16-19)

AMPJM said: *''Some staff do talk to me and comfort me following my incident of SH and that helps to deal with the SH''* (29:14).

"Also, the hospital matron has been allowing me to make wrist bands and key handles and which I do sell them, and she has good attitude and respects me and does reassure me and talks to me with respect." (30:14-16)

When AMPVN was asked if she uses any coping skills, she talked about helpful conversations that she has been having with staff:

''The doctor, psychologist and other staff have been telling me to let them know if I do have the urge to SH. When I tell them, some of them will sit down with me and talk to me or give me medication. But some nurses will come and sit by me and find out about why I had wanted to do so, and they will support me." (41-21-23, 42-6-10).

For AMPVN, a range of staff used different approaches in helping her deal with an urge to SH, ranging from medication to therapeutic intervention. AMPVN also appears to make a distinction between staff *‘’sitting down with her’* and those who *‘sit by her and explore what had led to the urge’.*

KATHPA was delighted and overwhelmed, and demonstrated a sense of disbelief, when she talked about helpful conversations from significant others and members of staff:

‘’I do receive one to one session from the nurses and counselling from the therapist. There was even a time when my doctor gave me money from his own pocket for me to buy my prescribed medicines, and I could not believe it.’’ (62:8-14).

KATHPO said.

‘’I do attend prayer camps to pray over our relationship and seek counselling sessions from my pastor and church elders.’’ (67:10-13)

KATHPO’s narration was suggestive of mixed feelings about staff conversations:

‘’Some members of staff seemed to be in a state of disbelief and shock and some staff were comforting. Some members of staff expressed their genuine willingness and availability to help and support when needed which can be seen from their facial expressions and interactions’’ (68:1-7).

The latter statement could be interpreted as staff being let down in her relationship with her former boyfriend, but KATHPO was keen to acknowledge:

‘’Staff were available to talk to whenever I am in emotional distress.’’ (69:6)

KATHSED acknowledged helpful conversations from staff:

“The matron of the ward and other ward staff were supportive and reassured me when I was distressed.” (98: 13-17).

KATHNYO recalled:

‘*’Some staff were very sympathetic with me and were supportive with words of advice and encouragement not to give up in life………. and this comforting word really helped, but some staff expressed anger & resentment.”* (80:8-12)

KATHPA said:

‘’I was receiving counselling sessions from the church people, and it came to a point when I decided to put those problems aside and rebuild my life’’ (61:21-24).

Whilst the above extracts focus on the participants being offered space and time to talk about often traumatic situations and the emotional turmoil associated with them, it was also evident that many of the people supporting them actively demonstrated kindness. Seven participants expressed how they experienced *‘kind characteristics’* of health professionals, family members, religious leaders and acquaintances, all of whom helped to enhance their recovery process. Some respondents described kind characteristics as a unique experience when their level of distress and the urge to SH was at its peak.

KATHPA said:

"The church and some family members helped me and with the little money that I made whilst in the US, I then used it to make a small kiosk by the family house and I started trading on a small scale." (61:23-28)

AMPJM stated:

"There is respect there (spiritual healing centre) *than here* (hospital)*. I like it more there than the hospital because they were able to provide me with my needs."* (66:14-19)

KATHPO stated:

''One of the doctors was very nice to me. The day that I had wanted to take my life, he came to spend some time with me on one-on-one basis which was very supportive''……………Staff were available to talk whenever I am in emotional distress (66:14-18; 68:2-6).

KATHNYO expressed his gratitude for the support and kind gestures from staff and family members:

'*'One of the doctors* (name) *is an extended family member and he works at this hospital and the doctor's sister* used *to look after me, but she has also passed away recently. There is also another family relative who has been helping me. It is not every burden that I can carry to them or asked for.'' (79:7-10).*

KATHSED was pleased about how some staff had offered her their personal contact detail so she can get in touch with them, even if they are off duty, for support and/or advice:

''*Some members of staff have gone out of their way to provide me with their useful contact telephone number to reach out to them when I am distressed.''* (92:12-18).

Table 14 Reflection Box 4:

Participant and staff generosity

I experienced guilt when one of the participants offered me a wrist band as a kind gesture from her. I had to turn down the offer and hand it over to hospital staff. I also felt uncomfortable, worried, and had mixed feelings when members of staff were providing their personal contact telephone number and giving financial support to patients. In a way I thought patients would like to keep in contact with staff, to let staff know how they were getting on. One way of ensuring this would be by providing one's cell phone number, perhaps in an attempt to reassure patients of the trust that was evident in the therapeutic relationship they had built with staff whilst an in-patient. They may have also considered it an action that would prove to patients that they would be listened to and/or supported when needed. Also, staff may like to make sure that patients are getting timely care if their mental health or situation deteriorates. Nonetheless, I felt for both parties', security, and confidentiality could be compromised. My concerns I believe are due to working in a Western healthcare system. In the UK health care delivery system, staff are not allowed to use their personal telephone numbers to be in contact with individual patients as compared to the Ghanaian health care system where there appear to be no, or very few boundaries.

In summary, all nine participants used SH to enable them to cope with the traumas and challenges they had faced in their lives. However, they found helpful conversations and the kindness characteristics of those providing care enhanced their mental well-being. Those providing care included hospital staff, members of their religious affiliations and family. All these people appeared to have had a positive effect in promoting a positive sense of self. Kindness characteristics were highlighted as an overwhelming support in their recovery journey. They commented on how good some staff were, making token donations such as money, and going out of their way to give them their phone contact number to call whenever in crisis/ distress and in need of someone to talk to for support. The next subordinate theme provides in-depth detail of how participants found ‘supportive healing and medication’ as being particularly helpful during times of distress.

4.6.2 Supportive healing and medication

Seven participants perceived supportive healing as a major influence in enhancing their recovery process in the care environment. This included positive experiences in relation to facilities in the environment, and support systems from health professionals, friends, and family. Also, participants stated that medication compliance used simultaneously with other support services in the environment was integral to their healing process and well-being. AMPAN (AN) said:

“My Mum gives all her children equal love and attention during our upbringing which was supportive. Also, some member of staff gave me medication, some talk and educate me about my care process which is very supportive. Staff do keep eye on me so that I do not do anything stupid to myself.” (4:11-15)

These actions on the part of his mother and hospital staff appear to have provided AMPAN with a sense that he is valued and cared about.

AMPJM said:

‘*’Some members of staff are very supportive and comforting and some nurses do help me to dress my sore following incident of SH.’’* (29:15-19)

AMPKM stated:

‘’Some members of staff gave me medication. Talking to me and trying to divert my attention with board games and arranging for car wash on site for a small fee. Some staff will approach me nicely, respect me and educate me about drug use and its implications which can keep me here longer, and they [staff] *talk to me as a brother.’’* (52:18-21).

Like AMPKM, KATHSED recounted:

‘’Some staff will spend time with me and make sure I don’t do anything to hurt myself anymore. Also, they will make sure I take my medications regularly and this was helpful in my recovery’’ (92: 10-16).

AMPKM went onto say:

‘’I am happy with having three square meals. I like the special ward where we have therapeutic community that I like here. But I like admission ward, one ward. On the admission ward, they can include more patients in group activities such as car washing and variety of activities.’’ (53:6-8)

KATHPO said:

‘’I did receive treatment from the health team including doctors, nurses, and psychologist. The nurses are also very caring on the ward. I do request for extra medication from staff to help control my symptoms.’’ (66:12-18).

Like KATHPO, KATHNYO said:

‘’Now that doctor has put me on medication, the voices are less controlling. The nurses usually seem to know my relapse symptoms such as when I am getting quiet and trying to hide myself and they will come and take me to another place and that prevents me from hurting myself. And this gives me a sense of experience that I am in a safe environment in my healing process.” (79:2-4)

In summary, most of the participants believed supportive healing, including positive effects of medication compliance, enhanced their recovery process and alleviate the emotional pain that had led to their SH. Participants talked of the positive contribution staff made in educating them on indications for medication, its actions and possible side effects, providing insight into part of their treatment. Supportive healing in its various guises can lead to participants having a sense of being valued and wanted. The next subordinate theme illustrates the notion of ‘Empathic valuing & Being Wanted’, which is integral to, and may be the result of, supportive healing and medication.

4.6.3 Empathic valuing & being wanted

Eight of the participants shared accounts of how empathic valuing and the sense of being wanted was paramount in their healing process. Within this subordinate theme participants interpreted the meanings of others in their social networks; family, members of staff, and other care givers, and talked of how this engendered them with a sense of worth and feelings of acceptance. The participants felt that empathic valuing and being wanted by staff, family and/or other members of society instilled a sense of hope in their care pathway. AMPAN: shared experience of his everyday interactions with staff and others, and how they showed him empathy and valued him as an individual. AMPAN stated:

Some members of staff gave me medication when I am distress, talked to me and tried to divert my attention with board games and some will help me clean my wound and show me what I need to do’’ (7:14-19).

AMPJM described empathic valuing and being wanted that she was able to garner during her in-patient care. AMPJM stated:

I was involved in my rehabilitation and retraining which included making wrist bands to sell, and I enjoyed fetching water to supply to various units whenever there was shortage of water on the wards and kitchen.’’ (28:22-24)

AMPKM felt a sense of belonging, empathy and being valued when he was on the admission ward and involved with other patients in such a way that it provided a structured rehabilitation programme which he was able to add too:

On the admission ward they can include more patients in group activities, I was also happy to educate some of my inmates who decided to be climbing the roof of our ward as I see that as a risky encounter.'' (52: 2-6)

KATHPA decided to occupy herself with something which may be considered reflective, as well as a therapeutic experience, by engaging in Christian fellowship with others. That seemed to be a means for KATHPA to reflect on her lived experiences and learn lessons for the future. KATHPA said:

'*'I do go to church to fellowship with others and I do use my personal times to read the bible and reflect which takes my troubles away.''* (61:10-20)

KATHPO narrated how she had developed a sense of value and self-motivation, and she had *'moved on'* in life aiming to become a midwife. She believed that by doing this, she can overcome all the negative challenges she has had to face.

''My long-term goal is to be a Midwife, so I am working on writing some remedial Senior High School certificate examination in order to meet the requirements of midwifery school in order to prove to my previous boyfriend about the values in me. May be, he thought I am a useless person. My dream now is to get a man that I can always trust, and feel being loved, and I can give equal love back. I have deleted all his contact numbers and text messages, so I do not have anything to do with him." (66:11-13)

KATHNYO used maladaptive coping by resorting to a hunger strike when first admitted to hospital. This behaviour enables him to gain staff attention and inadvertently provided him with a sense of belongingness and perceived assurance that some cared about him:

''On admission, I tend to refuse to eat, and staff will come and spend time with me, it gives me some form of encouragement that someone cares and can listen to me and perhaps make meaning of what was happening to me and not only blame me or label me.'' (78:17-20)

Being pre-occupied with reading the bible and engaging in trying to help others enabled KATHNYO 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. However, there are times when I will have no control over voices that tell me to hurt myself or do something silly because I am not worthy to live anymore.'' ….. ……some staff are very supportive and sympathise with me. They do talk to me and ask how I was feeling.'' (79:1-6; 80:1-3)

Table 15 Reflection Box 5:

Stories and interpretation

Listening to the narratives of the participants gave me in-depth insight into knowing and understanding their lived experience of SH and how important empathic valuing & feeling wanted by people who support them in their care process was to them. During the write-up, I continued with the iterative and interactive process of data analysis. In this write-up process, there was ongoing interpretation of the participants' own interpretations and/or how they made meaning from their situations. Knowing and understanding their lived experience of SH enabled me to make meaning of their subjective views of their experiences and helped me move closer to entering their lived world. As the participants talked about their experiences, it illuminated a lot about their SH. As a researcher and mental health practitioner, this knowledge and understanding enabled me to gain deeper insight of the phenomenon and it helped in the reassessing of my original thoughts about SH.

In summary, this subordinate theme illuminated the important roles of empathic valuing and the part instilling a sense of being wanted plays in the lives of the participants. Most of the participants valued the empathic support given by staff and significant others. All the participants were able to pinpoint situations where they felt they did not matter but were then able to identify the valuable help that they were accorded by staff which was beneficial to them. Feeling dignified and valued as individuals who deserved to be cared for, appeared to act as a central buffer to their distress. Such a buffer enabled them to use effective coping mechanisms to adapt to the environment and improve their mental health.

4.7 Conclusion

The findings of this study evolved around four discrete super-ordinate themes in relation to people who SH in two secure mental hospitals in Ghana. Participants described a diverse range of triggers for, and meanings they attribute to, their SH behaviour. The superordinate themes illuminated; the meanings the participants' attributed to their SH behaviour, often being described as an *'illness'* and/or '*condition'*. Their experience of using SH, the emotionality of the behaviour and how others may perceive such behaviour were all evidenced.

In the first super-ordinate theme 'being let down' by significant people in their lives through not getting answers to what for them were important questions, and/or being subjected to inappropriate responses, resulted in disappointment, helplessness, hopelessness and despair. Helplessness, hopelessness and disappointments compromised their ability to trust others and believe they had no control over the situations they were in. For some this prompted SH or suicide ideation. For example, some participants talked about how they felt helpless in certain situations, such as being put into seclusion by staff which the participants' perceived as punitive. Within the first superordinate theme, participants also described their physical, psychological, and emotional pain, particularly regarding abuse, being unsafe, and feeling insecure. One central revelation was that one participant was sexually abused by her father (and custodial guardian), who was supposed to take care of her during her formative years. For this participant, it was the flashbacks of the abuse, that led to her using the high-risk behaviour of SH. She interpreted the SH behaviour as being a way of expelling the *‘dirt’* that was introduced into her, and to numb the emotional pains of abuse. Some participants experienced marginalisation, discrimination and stigmatization. The stigmatization resurfaced in their everyday interactions with others and led to self-questioning and self-doubt on the part of the participants, and perhaps blame, from others, associated with their SH behaviour. As a result, guilt and shame were well-rehearsed responses to the perceived judgement by staff. Such perceived judgements lead participants to associate their feelings of shame and guilt to their SH, perceiving themselves as a social outcast. Being judged and stigmatization, coupled with their feelings of shame and guilt, resulted in participants feeling insecure within themselves and the environment in which they were in. This could be construed as emotional abuse and would have the potential to negatively impact their mental health.

The second super-ordinate theme focused on participants lived experience of ‘’Living with the negative self’’. Participants gave accounts of what they described as the ‘badness within me’, ‘being confined and suicide ideation’, ‘who am I? and ‘managing me through challenging times’. Participants recounted negative experiences of their care pathway. Being confined to hospital was one of the major challenging experiences for some participants. In general, some participants expressed frustration due to lack of information on their discharge plans or care pathway. Also, they needed leave for community access, but this was refused. Participants expressed challenging times when some members of staff did not show empathy to their distress. One participant talked of how one of the doctors asked about the ethnic group of her parents which she found hurtful and uncaring.

Participants talked about how the government mental health care system is not affordable to individuals who are self-employed or people who are out of a job whilst they are in-patients in care services. For example, some participants talked about having mixed feelings when benefiting from a treatment, prescribed medication, or therapeutic sessions, but how these may not be affordable. This situation appeared to be further exacerbated when having received treatment in a mental health care facility, the associated stigmatization is reflected in your health records, and employers will denounce you from gainful employment.

Staff not being accessible during peak periods of their emotional distress. One participant talked about how she was assaulted by another patient, and nothing was done about it by duty staff, whilst another participant gave account on how he felt ignored, following incident of SH/ suicidal ideation and this appeared to have aggravated his distress. Participants talked about being prescribed medication but when they reported side effects of the medication, nothing was done about it. Most participants indicated how some members of staff were biased in their code of conduct and practice with regards to the use of seclusion as a punitive measure, rather than as a last resort, and the lack of using effective therapeutic approaches. Participants also gave account of been physically beaten and unnecessarily secluded without their consent. Such forced isolation of patients does appear to be used as a punitive rather than a therapeutic intervention, with the participants having no control over what they experienced in hospital. The abuse which led to participants being unsafe and feeling insecure was not only confined to that which occurred during their in-patient stay.

Other negative experiences in connection with other patients and family during hospitalization were discussed. Following informal talk with other patients whom he trusted, one participant felt betrayed and ridiculed by them. Talking about their past experiences to someone was something that some of the participants found challenging and difficult to do, as they presumed talking to others would make things worse or may fall on deaf ears. A few participants recalled how social networks, in terms of family support, during hospitalization was disconnected. One participant perceived himself as a family outcast which might have resulted from family not visiting him in hospital. Another talked about being abandoned since childhood and this feeling being brought to the fore when in hospital. Such experiences tend to have impact on their mental health and coping mechanism thereby exacerbating their high-risk behaviours.

The subordinate theme of ‘Who Am I’’ led some participants to described how they reflected on ‘’who they are’ and/or their identity development, as well as in relation to their experience of SH. One central finding of this study was how one of the participants [AMPAN] grew up not knowing his biological father which caused him to be confused about his paternal lineage, and subsequently led to him to question his identity. Such lived experience appears not only to have led AMPAN to question his identity, but it impacted on how he labelled himself. His labelling of self may also have been influenced by how his friends/peers labelled him and, having no response to their taunts, this having a negative impact on his mental health.

The third superordinate theme focused on ‘’Forces of the Supernatural and Religion’, with participants expressing the notion that those around them did not believe in their plight and did not listen to them. Participants described their subjective assessment of spirituality, namely the ’ghost of mental illness’, and how they attribute it to their mental illness and its possible treatment. Also, some participants describe their lived experience of SH within the context of religion. The supernatural influence or fear of the unknown in their everyday interactions with others led to self-questioning and a belief in fate. Considering such beliefs, some incidents, thoughts, actions and behaviours are reasonably indebted to the Gods and would have the potential to negatively impact mental health.

Some participants attributed their visit to the church/ multi-faith centres and/or prayer camp and being prayed for, enhancing their recovery process. They also experienced being valued and inner peace when problem sharing at the multi-faith centres. Participants held their faith and trust in God/ supernatural being with the assurance that they will be healed by their maker. Apparently, this gave them a sense of relief, belongingness, and hope of life.

The final superordinate theme: ‘’Living with the positive self’’ elaborated on their meaning making of their experiences within the context of their illness. Participants defined positive experiences in relation to resources in the hospital environment, society, and support systems from health professionals, friends and family. Within this superordinate theme, participants were noted to have experienced empathic valuing and feeling wanted, these being paramount experiences in their healing process, quality of life, health and well-being. Also, most of the participants, commented on the positive effect of medication compliance in their recovery process and/or the alleviation of pain. They commented on the positive contribution of staff support; counselling them regarding the situations that had brought them into hospital, as well as educating them on the purpose of medication, its actions and possible side effects. Although, participants indicated that contemporary medicine was paramount in their recovery, some participants identified the role of traditional healing, such as attendance at the '*prayer camps',* as complementary in their recovery. Furthermore, most of the participants, talked about 'kindness characteristics' as a means of support in their recovery journey, during in-patient care and/or at home by their family, friends and wider society. They commented on how staff were good in supporting them, making token donations such as money, food, and going out of their way to give them their phone number to contact them whenever they found themselves in crisis. Participants talked about positive support given by staff, which led to them feeling valued and accepted as *'normal*' individuals. Also, some of the participants accredited the vital part played by both their families and friends in their care pathway and their recovery process.

These findings contribute to increasing knowledge regarding SH in Ghana. This knowledge is not complete in its totality, therefore further discussion about these findings and how they connect with existing literature about the phenomenon of interest will be explored further in the next chapter.

Chapter 5: Discussion

5 Introduction

The preceding ''Findings'' chapter of this study illuminates an in-depth understanding of the lived experience of people who SH in two secure mental hospitals in Ghana, and the meanings that they attribute to such experiences. Emergent findings were classified into four super-ordinate themes and 14 subordinate themes, all of which were underpinned by participants' subjective views, perceptions, and experiences of the phenomenon SH (Larkin et al, 2011; Smith et al., 2009). In this chapter a discussion of the findings, reflecting the super-ordinate and subordinate themes and their place within existent literature, will be presented.

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 (WHO, 2015; NICE, 2011). Explanations relating to the triggers for SH evident within existing literature include struggling with intolerable distress or unbearable traumatic experiences such as physical or sexual abuse, stigma and shame, relationship problems, feeling bad about self, hopelessness, helplessness, powerlessness, or lack of control of one's life, disappointments and mental illness (NICE, 2016; Bennett & Dyson, 2014; Gibson et al., 2014; Hawton et al., 2014). Two participants (AMPJM & KATHPO) in this study used the terms self-injury and SH interchangeably, but there were similarities across descriptions of SH behaviour, and these were in keeping with the literature (Asare et al., 2012; Baker et. al., 2012; Sinclair & Green., 2011).

Some of the explanations and/or definitions offered in the literature are in line with the findings of this study (Nguyen, 2020; James & Stewarts, 2018; Mumme, et al., 2017). For example, SH was perceived by participants as a way of coping with, and/or communicating, emotional distress such as abuse. At times some of the participants used it as self-imposed punishment for failures in life. Existing literature from western countries suggest SH is usually carried out without suicidal intent (WHO, 2014; Brown & Kimball, 2013). 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. The above findings are in keeping with an earlier five-year longitudinal study of patients who used SH in Ghana (Roberts & Nkum, 1989). Roberts & Nkum (1989) reported that most patients used ingestion of a poisonous substance as the most common method of SH (81%) with simultaneous suicidal ideation. Common methods of SH by participants in this study were superficial cuts on the body with sharp objects, head banging or slapping of the face or body with a hand or an object, and some participants adopted starvation behaviour. However, two participants had considered drinking poison.

Participants had mixed perceptions of SH ranging from considering it a '*normal behaviour'* to an illness. Participant AMPVN explained her SH as a *"normal behaviour to seek attention''* from staff. For AMPVN there was a desire to copy this behaviour, which she had seen a fellow patient use, with the anticipation of receiving similar care and support from staff. A similar finding was noted in the literature where SH was perceived as learned behaviour in secure settings (Sandy, 2012; Muehlenkamp, 2014; Klonsky, 2007; Pembroke, 2006). In contrast to SH being perceived as *'normal behaviour'* it could also be construed as being an illness. The DSM-5 (American Psychiatric Association, 2013) uses diagnostic criteria to guide clinicians so they can share a common point of reference in relation to meaning making of terminologies, diagnosis and/or management of SH. Nonetheless, some exponents are of the view that relying on DSM 5 as a common way of diagnosing and/or meaning making of SH/self-injury, is likely to lead to the medicalisation of SH (Grandclerc, at al., 2016), with little attention being paid to the underlying causes.

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, a cry for help and/or a form of gaining attention, regardless of its positive or negative implications. While it is possible that an individual may use SH behaviour to get attention from staff, it is paramount to note that this might not be the main motive; some individuals may find it challenging to talk about their SH and particularly the reasons underlying the behaviour. Given this, it is essential for staff to explore the issues underlying the individual's SH behaviours to collaboratively find other means for managing and/or coping with their distressing situation.

The findings of this study suggest the context and/or situation the individual experiences at any given moment contributed to how they made sense of their SH experiences. This finding is in line with previous studies (House, 2019; James & Stewart 2018; Muehlenkamp et al., 2012). NICE (2011) suggest:

''*The nature and meaning of SH, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion and should not be presumed to be the same.'' (p.8*).

The next section focuses on discussions reflecting the super-ordinate and subordinate themes and their place within existent literature.

In keeping with the super-ordinate themes this chapter is divided into four main sub-headings:

a) 'Being let down'
b) 'Forces of the supernatural & religion'
c) 'Living with the negative self'
d) 'Living with the positive self'.

5.1 Participants' Experience of 'Being let Down'

The first superordinate theme of 'being let down' reflects participants' perceptions and experience that led to, and/or maintained their SH behaviour (Larkin et al., 2011). It is of interest to note that some of the participants stated their SH started prior to their hospitalisation, and when connecting lived experiences with their SH, it was evident they were 'let down' in other settings such as home and/or community, and this will form part of the discussion.

In relation to the hospital setting, participants talked of how healthcare staff engaged with them during their in-patient stay and/or how there were limited activities to engage in during their hospitalisation.

According to the participants, some experienced negative staff attitudes which triggered their SH, whilst for others it caused a re-enactment of past traumatic distress, resulting in the use of the behaviour as a maladaptive coping strategy. In this study, participants encountered frustrations and distress when dealing with the negative emotional experience of 'being let down' by staff. Moreover, at a pragmatic level, their distress was reinforced when they *'couldn't get answers from staff,'* but receiving *'inappropriate responses'* appeared to garner a more emotional level of response. As a result, participants used poor coping strategies, such as SH, to deal with their emotional turmoil. For example, AMPJM made several appeals to members of ward staff to update her regarding her care pathway, as well as requesting to be seen and reviewed by her doctor. However, AMPJM could not get answers or was given inappropriate responses from staff. This finding is consistent with the findings of others (McDonald et al., 2020; Chandler, 2016; Owens et al., 2016; Brown & Kimball, 2013; Hunter et al., 2013; Osafo et al., 2012; Kmietowicz, 2009). For instance, in Kmietowicz's (2009) study, participants felt 'let down' whilst receiving hospital care; at times they felt unsafe when in hospital, with two third of the participants stating they were not as involved in their care and treatment as they wanted to be, and some of them complained there were too few activities during their stay. Similarly, Brown and Kimball (2013) reported participants being let down following their traumatic experience of SH, rather than receiving the help they needed. Participants reported negative experiences in relation to the type of help they received from professionals, and they also felt misunderstood by staff when they engaged in therapeutic interactions (Brown & Kimball, 2013). In the current study participants also perceived a lack of awareness regarding SH on the part of staff, and perhaps because of this the interventions that were provided were not believed to be helpful. Patients' experiences remain a vital focus for ensuring continued improvement in clinical practice and the provision of quality care. However, the evidence suggests that those who SH during their hospital admission are likely to encounter negative experiences, and therefore may be less likely to engage with staff (James and Warner, 2005). In the current study, participants expressed frustration and distress at being let down by staff and how such negative experience may increase future SH behaviour.

Similarly, several studies (Anderson, 2018; Hausmann-Stabile et al., 2017) reported findings of how patients who used SH behaviour were *'let down'* by staff who were not able to meet and/or deal with their needs. Participants in this study reiterated being let down by insufficient help from staff who were more concerned with their index offence rather than addressing the underlying reasons for the offence and their subsequent SH behaviour. Being locked up in an environment and having no control over the way you are treated can be frustrating. For AMPJM, who's index offence was of manslaughter, and who has been referred from the court to hospital, believed she had no control over her care pathway. For AMPJM, being let down by staff was distressing and frustrating and led to her using SH as a coping strategy. The emotional effect of being let down appears to have evoked anger, fear, and distress for participants, with some having suicidal ideation. AMPJM talked of feeling hopeless and frustrated and at times she had thought of drinking poison (Parazole) to ensure her suicide.

In all, participants' experience was that they were let down and perhaps their distress was reinforced when they *'couldn't get answers from staff,'* but receiving *'inappropriate responses'* appeared to garner a more emotional level of response.

5.1.1 Can’t Get Answers and Inappropriate Responses

In secure hospital settings SH is often used as a means of coping, as well as gaining a sense of having control of something; one’s own life and/or emotional pain and frustration (Brown & Beail, 2009; Oldershaw et al., 2008). Previous studies indicate that patients’ unmet needs, such as lack of trust in staff prompted by being unable to get answers and appropriate responses, made participants feel unsafe and distressed, and contributed to their perception of being let down. Participants AMPVS and AMPAN gave accounts of how they were ‘*not getting answers’* or were given ‘*inappropriate responses’* from staff. This finding is in keeping with Wadman et al. (2018), who reported participants in their study believed they could not get answers or were offered inappropriate responses from staff in relation to clinical services, and who were only provided with *‘empty promises’* (Wadman et al., 2018, *p. 34*).

One of the novel findings in this study was that participants expressed the need for staff to be available and offer help and emotional support. Ultimately, provision of answers and appropriate responses may instil hope, help alleviate participant’s’ emotional turmoil, anxiety and apprehension, and prevent and/or minimise any further SH. In Ghana, SH is highly stigmatised and in some religious groups it is a taboo subject and a sin to indulge in SH behaviours. Hence the stigma experienced by participants, especially within the context of their religious beliefs. Meaning making of the individuals’ lived world in relation to everyday events and how they are perceived by others is central to quality of life and emotional and psychological health and well-being (Akotia et al, 2013; NICE 2011; Sandy, 2012; Burton, 1990; Goffman, 1969; Rogers, 2008). For some of the participants in this study their SH behaviour was interpreted within the context of their religious and spiritual beliefs. Where an individual believes they have not been able to live up to their own or societal expectations then their meaning making maybe threatened, thereby leading to distress and/or anxiety provoking situations. This in turn may perhaps result in the use of maladaptive coping strategies by using high risk behaviours such as SH (Osafo et al., 2015).

5.1.2 ‘I am not getting what I need’

Existent literature provides evidence that meeting the needs and providing holistic support is central to the recovery of people who SH within in-patient setting (Sandy, 2012; Fish & Duperouzel, 2008;). In this study, participants gave accounts on their experience of not having their needs met, and how such unfulfilled desires were upsetting and frustrating. Six of the participants noted that they ‘*could not get what they needed’* from family, wider society, and/or as a patient in the hospital setting. AMPAN needed a peaceful environment to settle down, engage with staff in a safe and open way and be able to talk about things that were causing him some level of distress. Nonetheless, the care environment was crowded and full of periodic arguments and shouting, and lack of activities to engage in. Similarly, ensuring service user needs are met through an effective therapeutic relationship brings about meaningful recovery and effective use of coping mechanism for people who SH within in-patient setting (Sandy, 2012, Goffman, 1969). Participants in this study gave account of how their needs were not met and therapeutic relationships not offered, causing them to feel frustrated and distressed. This lack of therapeutic intervention could have perhaps exacerbated their mental health problems leading them to adopt SH behaviours to cope with their frustrations and disappointments. AMPVN used SH to get the attention she craved from staff which she perceived as being accessible to other patients. KATHNYO recalled what was meant to be a therapeutic session when the nurse was *'judgemental'* and talked to him *'roughly with no respect'*. Participants linked not getting what they needed to a state of being 'let down'. Participants needed to know and have assurance that care and support was available to them, whether from staff, family, or wider society. Staff should empathically explore the needs and preferences of services users, and show understanding of the functions of SH. Such support may facilitate patients feeling comfortable in engaging in therapeutic relationships where their needs could be met. It is also vital that service users should not think they will be judged or scolded when in need of care and support from staff. Not being listened too and given respect may reduce the likelihood that will seek out support when they need to manage their distress and frustrations.

5.1.3 Hopelessness, Helplessness and Disappointments

The findings of this study revealed that individuals may go through challenging situations in their personal life and often have backgrounds which generated a sense of hopelessness and helplessness. This can lead to negative perceptions of self-and/or others, which can be disappointing, distressing and difficult to cope with. Such hopelessness and disappointments often lead to low mood and negatively impacts one's perception of self, other people, and the environment; such individuals tend to have pessimistic expectations and/or no expectations for the future (Wang et al., 2020; Ali & Soomar, 2019; Jenny et al., 2015; Neufeld et al., 2010; Smith et al., 2006). As a result, individuals may feel hopeless, helpless and disappointed in life (Smith et al., 2006). In Ghana, the essence of an effective support system and helpfulness enhances an individual's self-esteem, hope and self-worth (Andoh-Arthur et al., 2018; Akotia, et al., 2013). However, where there is lack of help and loss of hope a deep sense of despair may ensue, such negativity can trigger maladaptive coping such as SH and suicide. This notion is central to supporting and caring for people who SH (Rehman, 2018; Hewitt et al., 2014; Chen et al., 2011; Neufeld & O'Rourke, 2009). In the current study, AMPJM, expressed her thoughts and feelings of hopelessness, helplessness and disappointment triggered by the attitude of care providers. AMPJM wanted staff to arrange for her to see her doctor but noted that staff were not willing to facilitate that request. This led to her perception of the future being '*gloomy*' and resulted in her SH and suicidal ideation. KATHPO felt disappointed by her boyfriend in their courtship, and this led to her believing that she was unclean to engage in a future relationship. Similar findings are reported in previous studies. Lindgreen (2011) found participants experienced and expressed hope and hopelessness simultaneously in diverse ways. For instance, participants hoped for 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 (Lingreen, 2011). KATHSED was helpless when being abused by her father; the situation being made worse when her mother would not believe her. This led KATHSED to develop a negative view of herself with some level of frustration, disappointment, feelings of worthlessness and self-hatred. It was these negative emotions that resulted in her using faulty coping strategies, namely SH, to deal with her distressing situation. This finding echoes those of previous studies (Sojo et al., 2016; Quick et al., 2014; Tracy 2012; Bagley & Ramsay, 1986), all of whom suggest that being exposed to sexual abuse in childhood may be linked to low self-esteem and self-worth, prompting SH and suicidal behaviour in adult life (Ennis et al., 2020; Valencia-Agudo et al., 2020; Hailes et al., 2019; Pillsbury, 2019; Bradley et al., 2018; Khadr et al., 2018; Ellis ,2015; Smith et al., 2014; Swannell et al., 2014; Brown et al., 2013; Mann, 2013; Casement & Swanson, 2012; Campbell et al., 2011; Behnken et al., 2010; Gladstone et al., 2004) .

In Ghanaian culture sexual abuse of children is sometimes normalised, creating further distress for those who experience it. In a study undertaken by Markwei and Osei-Hwedie (2019) the acceptance of child sexual abuse within Ghanaian society was found to cause the exacerbation of hopelessness, helplessness and disappointment in individuals who were victims of abuse. The findings of my study resonate with those findings. The findings of both these studies clearly demonstrate the need for a well-structured child abuse preventive programme, and to put in place safeguarding measures to protect and support children who are victims of sexually abusive relationships (Robinson, 2016; WHO, 2014; Hawton et al., 2012).

In addition to the above, a previous study (Bradley et al., 2018) identified survivors of sexual abuse tend to experience difficulties in regulating the emotions of sadness, disgust and fear, and this can result in repeated SH with an increased level of Post-Traumatic Stress Disorder (PTSD). They recommended strategies that might reduce incidences of SH and PTSD among childhood sexual abuse survivors (Bradley et al., 2018). It has been suggested that assessing SH and PTSD among trauma-exposed individuals, or those with family dysfunction or adversity, early intervention from social care support and early family interventions may be of benefit (Ennis et al., 2020; Valencia-Agudo et al., 2020; Smith et al., 2014; Campbell et al., 2011).

In this study, AMPVN expressed her deep sense of helplessness and disappointment in her mother when she reflected on how she was abandoned as a baby, and her secondary trauma of not being allowed to go to school in later life. Such sense of disappointment caused her to struggle to cope in later life and she attempted to jump from the top of a bridge to end her life. This finding regarding helplessness, hopelessness and disappointment reiterates the findings of previous studies, especially those conducted in non-western countries where hopelessness, helplessness, disappointments and negative future expectations have been identified as significant predictors of SH and suicide-related ideation (Rehman, 2018; Hewitt et al., 2014; Chen et al., 2011; Neufeld & O'Rourke, 2009; James & Warner, 2005). For instance, some studies have evidenced the presence of hopelessness and disappointments in individuals in relation to; long-term health problems, negative attitudes of staff, such as not showing dignity and respect towards patients, stigmatisation, financial constraints and family conflict, all of which are major risk factors for SH and suicide (Adnan, 2017; Shidhaye et al., 2016; Knizek et al., 2010; Sokero et al., 2006). In keeping with other studies (Osafo & Hjelmeland, 2018; Akotia et al., 2013), participants in the current study linked their hopelessness and disappointment to various emotional challenges; abandonment, abuse, marital and relationship breakdown and financial difficulties. 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.

5.1.4 Abuse, Being Unsafe and Feeling Insecure

This study illuminates the narratives of how most participants were verbally, physically, emotionally, or psychologically abused by staff, fellow patients, and/or family members; highlighting how such circumstances led them to believe they were unsafe, and subsequently generated feelings of insecurity. One participant, AMPVN, talked of how she was rebuked, verbally threatened, and medicated following an incident of SH, without the nurse exploring the circumstances which led to the behaviour. Previous studies suggested medication in conjunction with other therapies can play a role in reducing the risk of SH or suicide among patients (James et al., 2019; Smith & Attenburrow, 2016; Hawton et al., 2015; Dickinson et al., 2009). Although some participants in this study concurred with this, others felt abused and not listened to, basing these observations on the way they were medicated by some members of staff. For instance, AMPVN reported to staff that one of the medications (Risperidone) she was given was *'not good for her'*, as a side effect she experienced was one of neck pain, but nothing was done about it. The use of Risperidone in the treatment of SH and suicide has been viewed with caution (Thomson et al., 2017; American Academy of Child and Adolescent Psychiatry (AACAP), 2016; Hawton et al., 2015; Tofthagen et al., 2014). For example, although Risperidone can be indicated in the treatment of people who SH and present with aggression, the extrapyramidal side effects include Akathisia (where one experiences feeling of restlessness with constant desire to move) or acute dystonia (where one experiences involuntary muscle contraction, often in the neck). Considering this, there is the need for caution when prescribing, and for closely monitoring side effects when people who SH are treated with Risperidone. Further studies may be needed to identify clinical factors or links between use of Risperidone and self-injurious behaviour (Oshikoya et al., 2019; Thomson et al., 2017; AACAP, 2016; Hawton et al., 2015).

For some participants, the way in which medication was given and/or the lack of being listened to, reignited their feelings of being unsafe, insecure and vulnerable on the ward. AMPVS became emotional when recounting his physical and emotional pain when being restrained by fellow patients without his consent, but at the request of staff. His experience of being restrained by fellow patients could be considered akin to Zimbardo's 1971, Stanford prison experiment, whereby some participants acted in the roles of prisoners while other played the part of guards. While the aim of the experiment was to investigate the psychological effects of perceived power, the experiment had to be stopped after six days due to emotional turmoil of the prisoners and the excessive aggression on the part of the guards (Askew et al., 2019; Adjorlolo et al., 2019; Brophy, 2015; Ling et al., 2015; Zimbardo, 2015; Larsen & Terkelsen, 2014; Dickinson et al., 2009; Ntsaba & Havenga, 2007). Asking patients to do the restraining is the antithesis of acceptable practice, as the nature of the relationship may influence how the restraint is carried out, as AMPVS's experience highlighted.

Restraint techniques and being secluded was perceived by AMPVS as '*punishment'* rather than being therapeutic. While AMPVS told of his *'head banging'* behaviour when he could not get what he wanted, this still requires empathic understanding rather than seclusion. Other studies (Chieze, et al., 2019;

Hern et al., 2018; Brophy et al., 2016; Ling et al., 2015; Larsen & Terkelsen, 2014; Ntsaba & Havenga, 2007) have reported on the ethical, legal and technical implications of clinical effectiveness or outcomes of coercion and/or use of seclusion. The findings of these studies indicate that seclusion and restraint can have detrimental physical and psychological consequences. Chieze, et al. (2019) and Hern et al. (2018) further compared restraint techniques and seclusion, and concluded the latter appears to be more acceptable, with the view that seclusion is a non-invasive encounter. However, both studies concluded that such interventions should be used with caution and as a last resort, as well as ensuring the safety of all those involved (Chieze, et al., 2019; Hern et al., 2018). Moreover, the preferences of individual service users should be considered as an advanced directive in their risk management protocol (Krieger et al., 2018; Fugger, et al., 2016), this did not appear to be the case for participants in this study.

5.2 Participants' Experience of 'Forces of the Supernatural and Religion'

5.2.1 Ghost of mental illness

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. Belief in spirits and supernatural forces tends to influence individuals' meaning making about mental illness, SH and suicide-related problems and death. The concept of the supernatural is reflected in Ghanaian perceptions about Supreme Beings (Nyame or Mawu) who are noted to have sometimes punished people with health problems such as mental illness, SH and barrenness. It is essential for clinicians to have insight of this concept when providing care for those people with pluralistic health-seeking behaviours, and who have lived experience of SH or suicidal ideation. Almost all participants in this study were either Christians or held beliefs in the forces of the supernatural and spirits, having faith in religious leaders, including traditional medicine men/healers.

A study conducted in Ghana by Opare-Henaku (2014) was based on the Akan ontological belief that the universe is unitary, and as such there is no clear distinction between physical and spiritual occurrences in relation to illness and health. This led to complex pluralistic help-seeking behaviour among the Akan people (Ae-Ngibise et al., 2010), It is important for healthcare professionals to acknowledge that individuals tends to seek treatment for illness from various sources such as; orthodox/conventional medicine, traditional healers who use herbs for treating different ailments and spiritualists or faith healers who base their treatment on invocation of God/ gods and spirits in their healing powers (Ae-Ngibise, et al., 2010). It is worthy to note that participants (AMPJM and KATHPA) are from the Akan ethnic group of Ghanaians. This group comprises of approximately 20 sub-ethnic groups of which the Asante and Fanti are two, with 15% and 10% respectively representing the total Ghanaian population. These are the two largest sub-ethnic groups in Ghana (Agyie-Mensah & Owusu, 2010; Aryeetey et al, 2009).

In the current study, AMPJM 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. This implies that she felt her illness was a ‘curse’ imposed on her. In the Ghanaian context AMPJM’s voices could be construed as qualitatively different from the assessment of such voices in a western context., due to cultural beliefs and practices. Therefore, AMPJM had 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.”* AMPJM believes that the only way she will be able to address her ‘sickness’ is if she is taken to a spiritual centre for treatment, where she will be allowed to put herself ‘*on the floor and head bang until the vision of the one she killed has gone’*. From a different perspective, KATHPA told of how her husband convinced her to believe in supernatural forces, and she would only be healed or get better through powers of a supernatural being (God). These two examples demonstrate how the attitudes and behaviours of Ghanaian people are shaped and influenced by the socio-cultural context in which they live.

The above finding in this study is consistent with other studies regarding the relationship between the conceptualization of supernatural forces and religion and SH (Osafo et al., 2015; Akotia, et al., 2013; Exline & Bright, 2011). Meaning-makers who invest in the supernatural are of the view that God’s intervention is how protection from an illness could be attained. They believe an explanation or sacred view in the Bible will come to pass, and the fact that scientist have not been able to arrive at authentic diagnoses for various mystical health problems such as SH, mental illness and suicide, points to the supernatural forces/spiritual nature of disease/illness

Other research in the South-Saharan Region of Africa have cited SH/suicidal behaviour along with other complex health problems such as depression, cancer, mental illness and barrenness being linked to supernatural forces and religion (Lindeman & Svedholm, 2012; Krause, 2010; Berenbaum et al., 2009). For instance, Akotia et al. (2018) conducted an IPA study in Ghana with 30 participants exploring their reasons for SH and/or attempting suicide. Five main themes emerged: lack of support, abandonment, shame, existential struggles and the supernatural. One participant noted that the supernatural forces were beyond their control and pushed them into SH and suicidal attempt; *“it was like a spirit entered me to do it” (*Akotia et al., 2018, p 24). Participants denied responsibility for their actions, but rather put the blame on powerful external forces such as magic, witchcraft and sorcery. It was suggested that denying responsibility and blaming their actions on external forces perhaps can save them from mockery by others (Akotia et al., 2018; Adinkrah, 2010; Nukunya, 2016). Whilst 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 disturbance.

AMPJM made comments such as ‘*’my sickness is not psychiatric illness’’*. AMPJM talked of the perceived benefit of her previous admission to a spiritual healer’s camp where she was taken through some rituals [chained, hitting her body, fasting from food] to drive out spirits which were perceived as the cause of her *‘sickness’*. In African culture, there is a belief in the existence and activities of supernatural forces, ancestral spirits, ghosts and diviners; and it is strongly believed that an individual’s health and well-being can be influenced positively and/or negatively by use of those forces within the individual’s psychosocial environment. However, it has been suggested that treating Ghanaian people with mental health problems at a traditional fetish [In Ghana, a fetish priest is a person who serves as a mediator between the spirit and the living] and prayer camps is a form of abuse, and such practices are now stigmatised (Mfoafo-M'Carthy & Grimshaw, 2017).

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. Also, participants described their lived experiences in terms of a '*ghost of mental illness*', supernatural forces they associate with illness and wellness, and being able to embrace personal preferences for healthcare choices. In Ghanaian culture the spirits and ghosts of various health problems and disorders, such as mental illness, SH and suicide, are perceived to be directly and/or indirectly attributed to a person's ill health. The belief about spirits and ghosts being the cause of one's illness are at times shared among family members or communities which can impact the recovery process. In this study some participants attributed visits to church/ multi-faith centres and/or prayer camps and being prayed for, contributed to their recovery process. Participants suggested that they experienced being valued and able to gain inner peace through problem sharing at these places. One prominent story shared by participants was that they held their faith and trust in God/ supernatural being with the assurance that they will be healed by their maker. Apparently, this gave some of the participants a sense of relief and hope for their future life. 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 delivery for individuals (Osafo et al., 2015).

5.2.2 Sharing the Stigma

Sources of stigma can be initiated from; health professionals in the care settings (Gibson et al, 2019; Masuku, 2019), within the self and from family members/society (Staniland et al., 2020; Long, 2018; Favazza,1989). This study provides evidence that individuals who SH can be adversely affected by the interplay of stigmatising attitudes and behaviours, and the treatment approaches by people who would be expected to provide support. In this study such people included health staff, other patients, family and/or society, as well as the participants' themselves. Similar findings were indicated in previous studies, whereby participants reported how they experienced stigma from health care staff, patients, and others (Johanna et al., 2020; Staniland et al., 2020; Long, 2018; Penelope, 2018; Mitten et al., 2016; Urquhart Law et al., 2009).

The situations participants in this study attributed to feeling stigmatised, and/or prompted self-stigmatization, were disappointment in relationships or relationship breakdown, perceived ridicule/blame by neighbours about poor upbringing of children in relation to teenage pregnancy and negative attitudes from staff. In this study, AMPAN gave account of how he experienced self-stigmatization following his index offence of manslaughter. KATHPA, became ashamed when following her divorce, neighbours were still asking her when she will be going back to join her husband abroad. This participant could not cope with the ridicule emanating from her divorce and barrenness, resulting in feelings of shame and guilt. In response KATHPA used SH to communicate her ordeal to her neighbours. In Ghanaian culture a woman's virtue is associated with successful marriage and fertility in that children are perceived as an asset to the family. In addition, a woman who has been married and taken abroad is perceived as privileged, bringing pride to the family, and is bestowed special honour and respect in the neighbourhood (Adinkrah, 2010). In contrast, a woman who has suffered a marital breakdown in a foreign land, coupled with barrenness, suffers embarrassment, humiliation, ridicule and stigmatisation. Such circumstances perhaps led KATHPA to adopt maladaptive coping behaviours such as SH. The above findings can be considered akin to labelling theory whereby self-identity and the behaviour of individuals may be determined and/or influenced by the terms used to describe or classify them (Opare-Henaku et al, 2017; Nukunya, 2016; Osafo et al 2015; Awenva et al, 2010). This can be linked with the concept of self-fulfilling prophecy and stereotyping. As such, it is proposed that deviance is not inherent in an act, but instead focuses on the tendency of most people to negatively label an individual and/or those seen as deviant as determined by societal criterion and such description can influence a person's self-concept and societal identity (O'Grady, 2011; Wright et al., 2000; Link et al., 1999; Goffman, 1969).

It is evident that social stigma surrounding SH contributes to self-stigma and exacerbates existent feelings of shame. Shame can lead to carrying out the act of SH in secrecy and/or prevent seeking help from staff (Witt et al, 2019; Claw & Turker, 2018; Glenn et al., 2009). This study has implications for health professionals and service providers in terms of raising awareness regarding the varied nature of stigma, and how it can have a devastating effect on the lived experience of people who SH. Goffman (1963, P144) described stigma as '*a spoiled identity'* and referred to this being a pre-cursor to mental health problems, depression, somatoform disorders, SH, possession and hysteria. Goffman (1963) also noted that stigma and/or self-perceived stigma is a strong indicator for early detection and management of such conditions. Therefore, the need for health professionals to be aware of stigmatisation, on their own part or that of others, is important if there is to be early detection and effective management of mental health problems. For example, when communicating with each other, health professionals should use common, non-stigmatizing language (Westers & Plener, 2019).

5.2.3 Shame and Guilt

The theme of guilt and shame were attributed by participants in this study to their SH behaviours. Issues of mental illness, forces of the supernatural, 'stigmatization' and 'shame and guilt' are closely linked, the former appearing to lead to the latter on the part of the participants. These negative emotions appear to be mediated by the way participants internalise attitudes, values, standards and responses of others into their own identity and/or sense of self, impacting their health and well-being (Hewitt, 2009; Rogers, 1961). Where an individual deals with his/her internal stressors in a negative way this can result in behaviours such as SH. From the data collected in this study these processes can occur in hospital and community settings. Shame and guilt within each of these setting is discussed below.

In summary, the beliefs and conceptualization of mental illness and SH could influence the attitudes individuals adopt towards people with these conditions. Such attitudes may lead to stigmatization, shame and guilt among people who experience mental illness and/or those who SH, and at times their families. Participants have typically associated causes, such as supernatural forces, with inherent stigma, shame and guilt. Because of this, participants requested that they be taken to traditional healers and/or sought healing through their religious affiliations. The causal attributions associated with the supernatural are rational and understandable, given the cultural perspectives of the Ghanaian people, and a relative lack of insight into mental illness. For those who have a mental illness this can exacerbate their stress and vulnerability, thereby leading to use of faulty coping mechanisms such as the use of SH behaviours.

5.3 Participants' 'Experience of Living with the Negative Self'

This study revealed that the driving force to participants' experiences of SH were connected and/or influenced by staff, fellow patients and/or family members and the interplay of the care environment. How some of the participants were treated by staff in the care environment impacted the participants' self-esteem. Some participants talked of feeling '*dehumanised'*, *'ashamed'*, '*guilty'* and treated with no respect, the latter compromising their dignity. Such feelings, together with some of the situations in which they found themselves, caused physical and/or emotional hurt, at times leading to the experience of being unsafe, feeling insecure and/or living with the negative self (NICE, 2016; Saunders et al., 2010). Extant literature such as Sandy, (2012) indicates that the attitude portrayed by staff towards individuals who SH, as well as their knowledge about SH, can lead to positive and/or negative implications in their clinical judgements and decision-making processes. This can impact an individual patient's recovery in various care settings (Sandy, 2012; NICE, 2011; Wheatley & Austin-Payne, 2009; Oldershaw et al., 2008). It was evident within the findings of this study that participants experienced living with the negative self. This was reflected in various situations such as managing the self through difficult times, shame and guilt, all of which led them to question the self. These aspects of self are discussed below.

5.3.1 Managing Me Through Difficult Times

Most participants identified struggling to adjust and adapt everyday living in the secure settings where they are separated from family, no family or family visits are not consistent, and they are unable to access the community due to not being granted community leave

5.3.2 In the Hospital Setting

In the hospital settings, staff attitudes and behaviours following an individual's incident of SH can reinforce the negative beliefs towards those who use this behaviour (Warne & McAndrew, 2007). For example, in the current study, AMPJM gave account of how, following her experiences of SH, ward staff *"scolded her and pointed out to her that SH behaviour was wrong and unacceptable during their shift*." Such negative comments from staff made her feel angry, humiliated and ashamed, prompting her to have a sense of guilt. While negative reactions from staff made the participant angry and experience feelings of guilt, these were turned inwards to the self, and may have potentially led to more SH behaviour. Similar findings were reported by McHale and Felton (2010) in their study of people who SH. They found negative experiences associated with care delivered by staff were linked to; lack of education and training, differences in perceptions of health professional's roles and the influence of clinical culture, as well as how SH was perceived as a health need. A study carried in Ghana (Osafo et al., 2015), supports the notion that being labelled with SH can have negative implications for the individual in relation to their self-worth. This can lead to self-blame and emotional distress which can subsequently result in ineffective coping such as an increase in their SH behaviours.

In this study, AMPAN gave account of his shame and guilt in the hospital setting; *“when I remember my incident that led to my admission to hospital, then I do feel guilty and ashamed as in Ghanaian culture, one is stigmatised as a result of manslaughter’.* In Ghana, manslaughter/homicide is illegal, stigmatised and against societal norms which can have its repercussion for the individual and is often viewed as a bad omen for the family. Internalising such views may invoke feelings of guilt and shame, embarrassment, distress and perhaps, echo negative self-evaluation which can lead to high-risk behaviours and/or maladaptive coping strategies such as SH (Andoh-arthur et al., 2018; Adinkrah, 2010; Nukunya, 2016).

5.3.3 Community setting

In community settings the attitudes of friends and family following an individual’s incident of SH can reinforce the negative beliefs about people who use this behaviour. Participants in this study narrated a variety of emotional and psychological distressing experiences that led to their admission to hospital. Participants attributed a feeling of ‘*failure’* in such situations, and this had a detrimental effect on their overall quality of life and well-being. Participants described how ‘*feeling a failure’* exacerbated their SH behaviour and led to their eventual admission to hospital. It has been proposed that favourable and conducive settings promoting good mental health and well-being, enable individuals to cope effectively (Sandy, 2012; NICE, 2011; O’Grady, 2011; Goffman, 1969). For participants in this study, the experience of negative labelling by others appears to have negatively impacted their self-worth, self-identity (see chapter 4, section 4.5.2) and/or relationships with others in the community, possibly resulting in maladaptive behaviours and/or high-risk unhealthy behaviours, including their SH and suicidal ideation.

5.3.4 Getting rid of the badness within me

The findings from the study highlighted the participants’ negative self, such as individual’s subjective evaluation of their own worth, which they associated with the badness within. Their beliefs of their own self-worth, often founded on not managing self in difficult times, being abused and feeling insecure, appear to invite guilt and shame which reinforce feelings of getting rid of the ‘badness within me’. The narratives from participant interviews identified several issues, including personal situations in their life, being linked to the ‘badness within them’. For instance, participants experienced distressing thoughts and feelings, resulting from experiences of being bullied, relationship problems, perceived memory failure, abuse and rape, lack of trust and their inability to voice how they were feeling. Participant’s lack of self-worth was in some instances reinforced by staff attitude, especially in relation to the way in which they were managed during difficult times in the secure settings. Such traumatic experiences resulted in poor emotional regulation. Coping with guilt and self-blame in terms of feeling worthless, having low self-esteem and internalising stigma, may offer insight into the ‘badness’ they feel within. For some participants it also resulted in feelings of entrapment, self, others, or both, and they used SH as a way of getting rid of the badness within themselves. In essence, SH was an escape and means of dealing with preoccupation with being worthless that took over their life. Based on experience of being let down, and feelings of worthlessness and blaming self for this, participants did not believe they were deserving of the attention they needed. Nonetheless, some participants did receive '*one to one' sessions* and other therapeutic approaches from staff. Opening-up to therapist/staff, they learned how to cope effectively with their distress, and perhaps this helped eradicate the badness within and eventually led them to having an opportunity to pursue their ambitions; academic qualification and/or return to former trades. Similar findings were indicated in previous studies, whereby participants reported how getting rid of the badness within them enabled them to move towards a more positive future (Mangnail & Yurkovich, 2010; James & Warner, 2005).

5.3.5 Who Am I?

This study revealed that participants were conflicted regarding having a sense of self-worth and questioning ''who am I?' Many of the participants ponder over navigating and negotiating their sense of self through their therapeutic interactions with staff and peers, which can be distressing and challenging (James et al, 2012; Goffman,1963).

In Ghanaian culture the family unit plays a major role in the individual's identity development. The findings from this study suggest that because of participants' prior experiences of abuse, incest, being labelled as a thief and infidelity, such individuals may come to experience their self-image, belongingness, and self-worth as being compromised. This, in turn, may impact on their concept of self; questioning 'who am I?' and impacting their coping mechanisms. This finding echoed those of Wells et al. (2015), who explored the process by which individuals perceive what others think about the way they are labelled and therefore anticipate how others might perceive and/or react to them as a result of how they are defined. Their findings suggest the symbolic interactions of others such as attitudes, opinions, perceptions and judgements, may play a role in the way individuals interpret the 'self' and their response to others and situations within the environment (Tofthan et al., 2017; Aakre et al., 2015; Goffman, 1963).

In summary, growth in an individual's mental and emotional intelligence towards a more secure self-image, mastery of their emotions, gaining insight into antecedents for their SH behaviours and the use of effective coping mechanism can enhance positive perceptions of the self and well-being of the individual (Tofthan et al., 2017).

5.3.6 Being confined and suicidal ideations

The findings of this study revealed that patients were hospitalised in a challenging environment with limited resources for rehabilitation, financial support and/or recreational facilities. Such lack of basic infrastructure, or human and material resources, tends to have an impact on patients' health and well-being. Such situations can evoke anger, frustration, and challenging behaviours, especially for those who have inherent poor coping mechanisms and/or poor emotional regulation problems (WHO, 2012; NICE, 2011). For example, being locked up in an environment where there is lack of control can be frustrating. For AMPJM, being in a restrictive environment was distressing and frustrating and led to her using SH as a coping strategy.

There is evidence in the participants' stories that the nature of care and support they received from staff in both secure settings had enabled them to improve their coping strategies, mental health and well-being. Nonetheless, participant AMPAN commented on the restrictive nature of the care environment which made it frustrating. AMPAN would have liked staff to be more flexible in their care approach. Similarly, AMPKM raised concerns about how he felt hurt by the care team and would like staff to use a collaborative approach in their care process. Services providing care in non-restrictive environments, with adequate human and material resources, including routine training for staff about in-patient care, have been associated with positive outcomes for all who SH (Sandy, 2012).

Participants in this study discussed their emotional and psychological distressing experiences whilst receiving hospital care and in their community settings. This may have compounded their emotional turmoil, evident in their SH behaviour. As such, the individual may experience shame and guilt, and may feel stigmatized both by themselves and by others (Mitten et al., 2016; Rimkevicience et al., 2015). Furthermore, health professionals' perceptions and attitudes towards individuals who SH can either serve as a mediating factor of self-harming behaviour and/or negative attitudes may reinforce the SH and/or endanger the effectiveness of interventions associated with these behaviours (Timson et al., 2012).

5.3.7 'Living with the positive self'

This study revealed that regardless of the adversity many of the participants had experienced, all had experienced moments of 'Living with the positive self' in relation to care and support from family members, staff within the hospital and other patients. Studies suggest that attributes such as knowledge about SH, emotional responses and helping behaviours of care staff within in-patient settings can be mediating factors of SH behaviours. Such factors have been associated with enhancing patients' positive experiences (Wheatley & Austin-Payne, 2009).

In this study participants associated living with an enhanced experience of positive self through; emotional and psychological support from staff, one to one session with health professionals, engagement in activities, financial support, instillation of hope, medication, religious faith and companionship with peers. These positive experiences are thought to promote; hope, happiness, optimism, having a sense of being valued, self-worth and high self-esteem and belongingness (James and Warner,2005). As a result, some of the participants were able to use effective coping strategies when dealing with challenging and thought-provoking issues. For instance, AMPAN verbalised helpful conversations that he had with some members of staff made him feel '*supported*' Similarly, other participants talked about how some staff were *'very sympathetic'* with them and were supportive with *'words of advice and encouragement not to give up in life'* and they found these words *'comforting'* and *'helpful'.* However, while some staff demonstrated positive attitudes and behaviours, others expressed anger and resentment. These findings are in keeping with previous studies regarding the attitudes and behaviours of care staff towards people who SH. In previous studies findings suggested health care professionals have positive and sympathetic attitudes towards individuals who engage in SH behaviour, although variations exist between the attitudes of different professional groups (Hauck et al., 2013; Koning et al., 2017; Martin, & Chapman, 2014; Colon & O'Tuathail, 2012; Gibb et al., 2010). However, some studies reported that there is little evidence to show that providing support for those who SH within in-patient settings is affective in promoting a positive self (Sandy, 2012, Hawton et al, 2014). Most participants in this study expressed their positive experience of communication and/or therapeutic relationships and helpful interactions with staff. AMPVN talked of nurses and a doctor helping her to make the right choices. KATHPA was *‘delighted’* and *‘overwhelmed’* with the positivity shown to her through the explanations and financial support she was accorded by staff.

One significant positive experience identified by participants in this study was the ‘*emergency telephone help line’* that was offered by staff. Although participants in this study expressed their positive experience of staff willingly giving their telephone contact details, it raises ethical and moral concerns which can compromise their therapeutic relationship (Iyengar et al 2020; Van Galen & Car, 2018). In contrast to findings in this study, in Western countries such as the UK where I currently practise, such approaches can raise conflict of interest, and may have moral, ethical and confidentiality implications for all. For participants in this study living with a positive self within in-patient care, appeared reliant upon health professionals’ attitude, support and positive interactions within the care settings (NICE, 2016; Sandy, 2013; WHO, 2014; Goffman, 1969).

5.3.8 Helpful conversations & kindness characteristics

Existent literature provides evidence that people who SH do value the support network and companionship offered via peers, friends, and family and this perhaps contributes to their experience of living with the positive self within in-patient settings (Boyce et al., 2018; Sandy, 2012; Timson et al., 2012; DoH, 2011; McHale & Felton, 2010). In this study, the essence of care appeared to be staff spending time to engage in conversation with the participants. For example, a few participants gave accounts on the relevance of having a support network from friends and family, as well as companionship from other patients, which helped in diverting their attention from thoughts of SH. AMPVS talked of the benefits of using coping strategies, such as talking to someone, in order to divert his mind from distressing thoughts that can lead to SH. Similar findings were reported by Taylor et al. (2009), who stated staff knowledge about SH and their effective communication with patients enhanced service user satisfaction and treatment adherence.

During my data collection, some of the participants talked of their personal experience of other health related conditions and health seeking behaviours. AMPAVN talked of suffering from a peculiar health condition for which he needed support. AMPVN also talked about the side effects of her medication and its untoward implications, affecting her compliance with treatment. With the permission of both AMPVN and AMPAN, I used my professional experience as a nurse to discuss with the nursing team to further assess their needs; someone providing time to talk and a review of medication, respectively. Feedback was given to AMPVN and AMPAN who were satisfied with my supportive measures. Reflecting on the self, illuminated the value of helpful conversation in reducing their high-risk behaviours and increase level in their tolerance during distress (Dauer & Hedvig., 2021; McHale & Felton, 2010).

5.3.9 Supportive Healing and Medications

Most participants in this study highlighted some sense of enhancement of their experience of living with the positive self when they received support from their religious faith, peers and family support. This included prayers, and psychological and emotional companionship. They described living with the positive self in terms of benefiting from fellowship, social inclusion and prayers from religious leaders and peers in the multi-faith room. KATHPA talked about the reading of the bible which was *'inspirational'* and *'consoling'*. AMPJM recalled her faith in the traditional healers/spiritualists and how she benefited from healing at the prayer camp in her recovery process. Additionally, participants reported on companionship on the ward, and positive experiences in relation to facilities in the environment, also helped to restore and reinforce their sense of belongingness, self-worth, hope and happiness. The presence of staff indicating that they care and available for support when needed was reassuring and helpful.

KATHPO talked of living with the positive self in relation to the support and comfort she received from the nurses who helped her to dress her sore following incidents of SH; another participant talked about resources such as having three square meals per day in an environment where he felt happy. One to one counselling and having their request for medication to control symptoms of their illness met, also led to their perception of hospital being a positive experience. The latter, regarding hospital being a positive experience, supports evidence that a combination of medication and therapy for treating people who SH within in-patient settings may be effective in minimising incidence of SH behaviour (NICE, 2012; Willig, 2013; Taylor et al., 2011; Rayner et al., 2005).

The findings in relation to financial support from staff to individual or needy patients with little or no financial resources is not a practice in keeping with Western countries. In the UK people living with long-term conditions, such as mental illness, often receive disability living allowance. In Ghana, the Government has a Health Insurance Scheme in place for various health conditions, but it does not fully cover mental illness (Blanchet et al., 2012). Considering this, various ethnic groups resort to an extended family system of insurance and/or family-based care and support (Dzramedo & Amoako., 2018; Nukunya, 2016). That is Ghanaian culture revere and arrange their lives around the extended family system where members provide welfare services to one another during times of need. This is viewed as an investment in economic and social security, as by looking after and supporting family members who are less endowed, a family member will also invest in you in times of need. Participants in this study seemed to be overwhelmed with financial support from significant others. For instance, KATHPA became financially established through support from *'the church and some family members'* while KATHNYO expressed his gratitude for *'the support and kind gestures from staff and family members'*. KATHYO, was referring to one of the doctors, who was an extended family member, and his sister who had looked after him.

An interesting finding from this study was that some appreciative participants expressed a *'kindness characteristic'* in staff which helped alleviate their distress and perhaps minimise their risk of SH. For example, KATHPA talked of some members of staff volunteering to give her money. While in Western society such an act of kindness by staff can raise complex moral and ethical issues (Caddell & Hazelton, 2013; Anderson, 2011), in Ghanaian culture, there are no definitive regulations regarding service users accepting gifts such as money from care staff and/or vice versa, with some supporting this practice (Collins et al., 2018). Some studies (Caddell & Hazelton, 2013; Anderson, 2011) suggest care staff should never give or accept gifts of any kind from service users, as it might impact on the standard of care or compromise the therapeutic relationship (Abbasi & Gadit, 2008). In contrast, Collins et al. (2018) state that accepting or giving out gifts in some situations may allow staff to support patients who are in poverty. Perhaps further exploration is needed to consider whether giving or accepting gifts from any individual in the therapeutic encounter may be influenced by factors such as nature and duration of the staff-patient therapeutic relationship, timing of the gift, type of gift and the apparent motives behind the provision/acceptance of the gift (Caddell & Hazelton, 2013; Anderson, 2011). From a Ghanaian perspective, without financial help many patients would not be able to afford treatments. There is therefore a need for the Government to achieve equity within the Ghana National Health Insurance Scheme to boost universal coverage for all health conditions in the country (Navarrette et al., 2019; Blanchet et al., 2012).

5.3.10 Empathic valuing being wanted

Most of the participants in this study expressed the experience of living with the positive self in relation to empathic valuing, and feeling wanted by staff, family and/or other members of society. These experiences increased their self-esteem and instilled a sense of hope in their care pathway. For instance, AMPAN shared his everyday interaction with staff and others, and talked of how they showed him empathy and valued him as an individual. AMPJM described empathic valuing and a feeling of being wanted that he was able to garner during his in-patient care. KATHPO narrated how she had developed a sense of value and self-motivation, and she had *‘moved on’* in life to moving towards being a midwife. Similar findings are reported in previous studies (Ellis et al., 2012; Allen, 2011; Doering et al., 2010; Linehan et al., 2006) where participants experienced empathy and effective therapeutic relationships with their therapist. There was a collaborative identification of problems which made participants feel wanted and they were assured that there was support available in a crisis (Allen,2011). Such trust in the therapeutic alliance enhanced participants’ feelings of self-worth and hope for the future, reducing the risk of SH and/or suicide. In summary, positive attitudes were linked to the understanding of experiences of SH and perhaps this calls for improved training for staff. There is therefore the need for staff training that will focus on promoting and improving staff attitude in care settings to enhance the quality of care for those who SH (Tofthagen et al., 2014 Sandy & Shaw., 2012).

5.4 Conclusion

Four superordinate themes evolved from this study carried out with people who used SH and, at the time of interview, were in-patients in two secure mental hospitals in Ghana. This chapter discussed the study findings; the four superordinate themes in conjunction with their subordinate themes in relation to extant literature. While the experiences of SH were perceived as unique and distinct to the individual participant, there are commonalities within the findings of this study and existent literature, most of the latter coming from Western society.

In summary, it was evident participants in this study believed they were *‘let down’* with some experiencing negative staff attitudes which triggered their SH, whilst for others it caused a re-enactment of past traumatic distress resulting in the use of a maladaptive coping strategy. Participants gave accounts of how they were *‘not getting answers and inappropriate responses’* from staff and it was noted that individuals experienced challenging situations in their personal life, often generating a sense of helplessness and hopelessness. Hopelessness negatively influences one’s thoughts, feelings and perception of self and others. When a state of hopelessness is observed it is vital for health care professionals to engage in a therapeutic relationship with the patient in order to explore where their sense of hopelessness has come from, and to enable staff to gently challenge the negative beliefs patients harbour.

Stigma from various sectors can lead to the labelling of individuals which can affect their mental health and well-being, as well as negatively impacting therapeutic relationships with care staff. Strategies need to be put in place to change societal beliefs and attitudes towards those with mental health problems, and perhaps this process needs to start with those health professionals working in the mental health arena. Communication with each other using common, non-stigmatizing language when engaging with patient groups may contribute to improving their confidence, self-esteem and promote more effective coping.

Lack of resources within in-patient facilities and financial difficulties are often challenging for Ghanaian people who SH and are admitted to hospital. There is the need for stakeholders to put strategies in place that will offer financial support and other resources that will meet the health and care needs of people who SH in in-patient care.

Participants in this study have experienced moments of ‘Living with the positive self’ in relation to care and support from family members, staff within the hospital and other patients. Participants associated living with an enhanced experience of a positive self through; emotional and psychological support from staff, one to one session with health professionals, engagement in activities, financial support, instillation of hope, medication, religious faith and companionship with peers. That is, participants experiencing the feelings that although they do carry out high risk behaviours such as SH they were still valued, understood, and supported and that was critical to learning to cope effectively. These positive experiences promoted; hope, happiness, optimism, having a sense of being valued, self-worth, high self-esteem and belongingness.

The next chapter is the final chapter of this thesis and will focus on the implications from the findings of the study, recommendations, limitations of the study and my unique contribution to new knowledge.

Chapter 6: Conclusions and Recommendations

6 Introduction

The concluding chapter of this thesis echoes the research aim and related objectives and provides answers to the research questions as stated in Chapter One (see section 1.9.3). In this chapter a conclusion of the overall outcomes of the thesis will be presented, reflecting all aspects of the study. This chapter is divided into five main sub-headings: (1) Research aim, questions, and objectives, (2) the implication for knowledge, (3) Research limitations, (4) Research appraisal (5) recommendations/implications for research, education and practice and conclusion.

6.1 Research Aim and Objectives

In this section, the way in which the aim and objectives of the thesis have been attained is demonstrated, as well as providing answers to the research questions.

The aim of this study was '*To explore the lived experiences and perceptions among people who self-harm (SH) in two secure/locked mental health hospitals in Ghana'.* The aim of this study prompted three research questions: 'How do people who SH make sense of their experiences in hospital, at home and in the community?'; 'What negative perceptions and experiences do people who SH have of care in hospital, at home and the community?'; What positive perceptions and experiences do people who SH have of care in hospital, at home and the community?'.

To achieve the aim of the study and answer the three research questions the following research objectives were addressed: Meeting the research specific objectives for the research has been the lynchpin of the entire research process and the research objectives were as follows:

- To explore the knowledge and understanding of SH from the perspective of those who use this behaviour and are being cared for in secure setting/locked mental health hospitals in Ghana
- To discuss the experiences leading to SH of people in secure setting/locked mental health hospitals in Ghana
- To ascertain which aspects of care people who SH in secure setting/locked mental health hospitals in Ghana consider to be negative
- To elicit which aspects of care people who SH in secure setting/locked mental health hospitals in Ghana describe as positive
- To recommend ways in which experiences of people who SH in secure setting/locked mental health hospitals in Ghana might be improved.

6.2 Meeting the objectives and answering the research questions

Therefore, to meet the first four objectives, there was a critical review of extant literature in relation to the phenomenon of SH, and the collection of primary data. While there was little research of this topic carried out in Ghana, some of the literature was useful in developing an understanding of the phenomenon prior to preparing a schedule for semi-structured interviews that would be used as a means of data collection for the study. Once this process was completed one to one semi-structured interviews were carried out with nine people who were in-patients of two secure hospitals in Ghana. These interviews allowed me, as a researcher, to gain an in-depth understanding of the lived experience of people who SH and are confined to hospital. Analysis of each of those interviews was undertaken using IPA, followed by an analysis across all interviews to generate and develop subordinate and superordinate themes. After presenting the themes, these were then discussed in text taking account of the extant literature, especially that originating in Sub-Saharan Africa.

Finally, the analysed data has been used to make recommendations to improve the experience of those who SH and are admitted to secure setting /locked mental health hospitals in Ghana. Table 10 below depicts a summary of how the findings of this study, embedded within the super-ordinate and subordinate themes, answered the research questions.

Table 16 Research questions, super-ordinate & subordinate themes

The Research questions	Findings: Super-ordinate & subordinate themes
How do people who SH make sense of their experiences in hospital, at home and in the community?	1) Feeling overwhelmed by ‘’Being let down’’ 2) Can’t get answers & inappropriate responses (How one defines SH, lack of trust, can’t get what I want, Hopelessness/helplessness & disappointments 3) Changed self (shame and guilt, who am I?), distress of abuse/traumatic experience linked to SH as a coping means. 4) Forces of the supernatural & religion as a trigger to their illness/SH and its place in treatment. 5) SH as a way of getting rid of the badness within me
What negative perceptions and experiences do people who SH have of care in hospital, at home and the community?	6) I am not getting what I need 7) Abuse, being unsafe and feeling insecure 8) Being confined & suicidal ideations 9) Managing me through difficult times & feeling of lack of control over their destiny/lives. 10) Feelings of hopelessness and helplessness & being let down and disappointed 11) Being stigmatised and internalising stigma 12) Who am I? – losing a sense of self and identity
What positive perceptions and experiences do people who SH have of care in hospital, at home and the community?	13) Supportive healing/conversations & kindness characteristics and medication 14) Empathic valuing, feeling wanted & influence of religion and culture

Within this section, the final conclusions of the study will be presented under the three research questions with salient points from the findings and discussion above being used as evidence underpinning the conclusion.

6.2.1 How do people who SH make sense of their experiences in hospital, at home and in the community?

The research offered in-depth insight into how people who SH make sense of their experiences in secure setting. The subordinate theme of being let down supports the research question of how people who SH make sense of their experiences and it opens a dialogue for clinical practice and research. For instance, participants described how situations in their personal lives changed and brought about disappointment. Some of them were let down in their marital relationship or through abusive situations. Some participants also faced situations where they could not get answers and/or were given inappropriate responses to what they considered to be important questions. This led to distress and frustration, with the latter often being directed at self. Change that brings about disappointment can be a challenging process to navigate and/or cope with. Participants also made meaning of the culture and supernatural forces, these having a positive or negative impact on their health. This is an unexplored aspect of the experience of SH, and one that relates to the current research question of how do people who self-harm make sense of their experiences in hospital, at home and in the community? In exploring the meaning(s) of SH, this study has provided insight into the implications of holistic interventions, advocating for the collaborative intervention of orthodox medicine and traditional medicines, such as faith healers and spiritual healers, as an innovative way of dealing with SH.

6.2.2 What are peoples who self-harm negative perceptions and experiences of care in hospital, at home and in the community?

The research revealed individual lived experiences in meaning making in relation to SH from differing standpoints. For instance, all participants talked about feeling overwhelmed by ‘’Being let down’’ and not being able to ‘get answers & inappropriate responses. They talked about the need to get answers and appropriate responses to build and establish relationships with others that could facilitate effective therapeutic and support relationships and enhance their effective coping mechanism. Participants identified several occasions when they could not get answers from staff, family and wider society, this highlighting inconsistency in people’s responses to them. This led to the mistrust of others, and such situations served as a hindrance to building effective therapeutic relationships and/or effective support. As such, therapeutic relationships and support that may be crucial for these participants in developing effective coping strategies to deal with challenging distressful situations could be compromised.

Additionally, some of the participants linked being in secure setting with boredom and were preoccupied by lack of activities. This contributed to negative experiences such hopelessness, helplessness and disappointment and these feeling were reaffirmed by negative staff attitudes. Such negativity can make it difficult to cope and adjust and adapt to the secure settings. Such frustrations led some participants to use maladaptive coping strategies such as SH, attempted suicide and/or suicidal ideation. These individuals will require support and instillation of hope to prevent further SH or suicidal ideation. Other experiences were negative emotional experiences of guilt, shame, anger and frustration, internalised stigma and loss. At times, they display their anger and frustrations by carrying out assault on others to convey the distress they have been going through or in order not to hurt others, they will direct the anger and frustration towards themselves through SH. The above has implications for clinical staff to show authentic interest, non-judgemental and open-mindedness when providing support to people who SH and by so doing, they can support and instil hope in them.

Stakeholders (including hospital staff, family and communities) would need to know that incidents of SH may manifest in different forms and each incident may vary with antecedents to the behaviour. Also, some individuals who SH may hide their behaviour and others may not. Health professionals, people who work with individuals who SH, the public and families who suspect any individual of SH should not hesitate to ask the person directly but must also demonstrate a willingness to help or listen to them or engage in conversation with them. Although people who SH may be reserved or be unwilling to engage initially, continuous effort and a tactful approach may pave the way.

Perhaps the effect of bullying and abuse in various forms in the community, by family and/or in care settings can be distressing and devastating thereby leading to emotional and psychological breakdown. One way of dealing with this is SH, and health and social care services including schools and communities should endeavour to deal with discrimination, bullying and prevention of abuse, and support individuals who are in such situations. Psychological input or interventions including counselling sessions, psychotherapy, mindfulness, emotional regulation, instillation of hope and other relevant approaches aimed at enhancing individuals’ coping mechanisms, self-esteem and positive self-concept should be offered to people at affordable prices or to be factored into the government health insurance scheme. Education of the public, including children, about emergency referral system or 24-hour telephone line system for people who may be in any form of crisis. There could also be the establishment of a young person-friendly service in the voluntary sector or community watch groups that people can approach for support and perhaps early prevention of SH behaviour.

People who SH can perceive themselves as having stigmatizing traits or behaviours. For some SH is done in secret as they believe it to be a sensitive topic and one that is difficult to disclose. The findings of this study have some implications for a varied range of services. The participants in this study shared experiences and events in relations to their home environment, cultural perspectives and resentment, and the attitude of staff and other people that they might have encountered during their lives. Awareness of the issues of SH and mental illness should be raised among all these people to reduce stigma.

There must therefore be governmental, public and private campaigns against discrimination and stigmatization of those who are mentally ill, including people who SH and individuals with debilitating health conditions. School curriculums could include the topic on stigma and its prevention, while workplace policy should identify this and ensure preventive measures are in place to address it. Preventive measures may include regular mandatory training and safeguarding within the workplace. Media could also be used to bring this topic to the attention of the public. Organizations and various ethnic/ cultural groups may also need to update or review their policies and practices regarding SH and mental illness and could develop education packages which are supportive of people who suffer from mental health problems or people in distress, rather than labelling or stigmatizing them. A package of training should be developed and delivered in consultation with people who use SH and are likely to be stigmatised.

6.2.3 What are the positive perceptions and experiences of people who self-harm of care in hospital, at home and in the community?

Regardless of the adversity many of the participants had experienced, one of the emergent themes was ‘Living with the positive self’. This research found all participants experienced helpful conversations & kindness characteristics from staff, family and the wider community. The finding supports the above research question. In exploring the positive perceptions and experiences of care in hospital, at home and the community, the study offers innovative or collaborative care by blending conventional health practices with cultural practices. Participants also emphasised value-based care where they felt wanted and respected. This finding supports the positive sense of self, which is paramount for mental health, promoting recovery from traumatic experiences and helping to build resilience (Shoemaker, 2015). Most participants in this study have experienced supportive healing and medication, and this appeared to contribute towards their journey of recovery.

6.3 Implications for Knowledge, Practice, Educational and Policy makers, Stakeholders and Management of the Secure Hospitals

This section presents the implications for management of the two secure hospitals where the research took place, the Ghanaian Health Service and other stakeholders. The findings of this research, could contribute to policy and guidance in relation to the following areas:

Financial limitation was a challenge to most participants in this study. One problem was the prescribing of medication, which while useful during the acute phase of illness, the long-term effects impacted performance and made it difficult to engage in any gainful employment. Additionally, some of the participants had to pay for some of their therapies and/or medication which are not covered by the nation’s health insurance scheme. At a time when people are vulnerable and insecure in terms of their financial situation, such difficulties may aggravate their emotional distress leading to high-risk behaviours such as SH and/or suicide, as a way of managing their compounding problems. Due to the inequality in the Ghana Health Insurance system towards mental health care, the government should promote equity within care services for all individuals. This would ensure a financial support system for people with long-term conditions such as mental illness, covering all aspects of mental health care. Equity should also be reflected in the national fiscal budget, with a focus on promotion and maintenance of the physical and emotional well-being of all citizens of Ghana.

Participants in this study raised concerns about the overcrowded nature of the care settings. I witnessed this myself with facilities at the hospital appearing not fit for purpose in ensuring security and meeting the health and safety needs of patients and care providers. The seclusion room did not meet international standards, there was no lounge for patients, and due to the lack of office space staff were compelled to use the corridor or forecourt area to do their documentation, thus compromising privacy and raising data protection issues. Regarding standards for seclusion rooms, unless clinically contra-indicated, an ideal seclusion room should have seclusion mattress (durable form, but not fibre or other substances), seclusion blanket and custom clothing which the patient could not use for SH purposes. Clothing may consist of paper gowns or suicide smocks which are tear-resistant, or blankets that are designed to be worn as clothing. Room temperature should be regularly monitored with adequate ventilation facilities (Metzner et al., 2007).

Perhaps seclusion can be seen as a therapeutic modality necessary to control violence. The findings revealed a recommendation for adequate resources and infrastructure such as buildings, facilities for rehabilitation and provision of a package that can create opportunity for ongoing learning to update staff on contemporary mental health issues. Also, recommendations are necessary for an effective communication system and the provision of a semi-automated phone or telecommunication system for service users with least restrictive measures and one that can be monitored regularly. For instance, hospital management can liaise with various tele-communications networks in the country to install telephone booths. These could be used with pay as you go telephones which accepts coins, and/or a system to buy credit units. The booths could be placed at vantage points in the hospital, with control measures, a key and locked system, and with structured supervised use. Also, staff may benefit from having a radio alarm system across site or emergency personal alarm systems that they can activate in emergency situations. Having such a system in place to call for assistance during crisis situations/ medical emergencies may eradicate the poor practice of asking other patients to restrain those who are distressed.

The research revealed ineffective liaison between service users and their families and/or social networks. Some participants had not been in contact with their families for some time and this appeared to have exacerbated their emotional distress. The hospital management need to consider developing a policy that would ensure contact with relatives and/or a patients' social network is maintained during their stay in hospital. One way to attain this could be to make a contract with the identified family members/ relative or next of kin during the initial admission process. This may reassert people's responsibility for their relative, thus reducing their chances of escaping the system. Probable reason why some family members may decide to escape the current system could be to evade payment of hospital expenses if they cannot afford it. Also, because of the stigma attributed to mental illness, people may see the hospital as a 'dumping ground' so no one can link them to the idea of having a family member who is mentally unwell. This could also be a way to banish stigmatisation and the idea of the family member being a bad omen. From personal experience, such a system worked very well during Ghana's revolution (used by the government/community watch groups to trace suspected people) during the 1980s. Confidentiality issues can be compromised, but the result could be beneficial.

6.3.1 Implications for Knowledge

As described in Chapter 3 (Section 3.23), the overall aim of this study was to contribute to the understanding of lived experiences and perceptions among people who SH in two secure/locked mental health hospitals in Ghana and to complement existing knowledge from this perspective. The findings illuminated four overarching themes of people who SH which are pertinent to understanding of lived experience of people who SH in secure mental hospitals in Ghana. One of the pivotal findings in the study was 'forces of the supernatural & religion' as a reason for their illness/SH and a finding that is complementary to existing knowledge.

Research into the lived experiences of people who SH in secure settings in Ghana is still in its infant stage and the findings and discussions suggest this is a ground-breaking study. This study has illuminated new light on how people who SH in secure settings in Ghana experience learning to cope without using SH behaviours, and what can create a barrier to this process, and/or enhance their coping mechanisms in their day to day living.

In demonstrating how people who SH make sense of their experiences in hospital, at home and in the community, the focus of meaning or sense making of their lived experiences of SH captures the in-depth knowledge and insight in how individuals, and the people they encounter in hospital, family, and wider society, positively or negatively affect their behaviour. Participants held differing views of why they had SH, suggesting it may have been influenced by individualised perspectives and/or the challenging situations they faced. This thesis adds to existing knowledge through the identification of the super-ordinate and subordinate themes as representations of participant's lived experiences of SH and the care, in its widest sense, they encountered.

Exploring what negative perceptions and experiences people who SH have of care in secure hospitals, at home and the community encompassed negative attitudes of staff and significant others in terms of how they were managed through difficult times, and participants' believing they had a lack of control over their destiny/lives. Being confined to hospital appeared to be associated with suicidal ideation, whilst external stigma was internalised and led to low self-worth. These negative aspects of their lived experienced compromised the knowing of self and their identity.

Additionally, by enhancing the understanding of positive perceptions and experiences can have on people who SH in secure hospitals, at home and the community has the potential to improve mental health. Central to engendering a positive experience were, supportive healing conversations, kindness characteristics and timely help and support. These positive aspects of experience appeared to enhance empathic valuing and belongingness. The influence of supernatural forces and religion in Ghanaian culture also contributed to the recovery process and needs to be considered within a framework for care, alongside more orthodox care pathways.

This study was the first to qualitatively explore the experiences of SH in secure setting/ locked mental health hospitals in Ghana from the service user perspective and using an IPA qualitative methodology. Most of the findings mirror many of the findings from western research. For instance, findings related to abuse by staff or family, use of SH as coping mechanism when faced with emotionally distressing situation, relationship problems emanating from lack of trust, shame, guilt and stigmatization, were common themes in this and Western studies (Fish, & Freshwater, 2014; Sandy, 2012; Fish, & Duperouzel, 2011; Favazza, 2009; James & Warner, 2005; Arnold, 1995).

In all, this thesis has contributed to academic knowledge and understanding and may also be of interest to people who SH, care staff, families, health professional, and wider society who, at some point in their lives are likely to engage with people who SH. This study will make an important contribution to the literature on SH in secure settings in Ghana, and in Sub-Saharan Africa.

6.3.2 Implications for Clinical Practice

Based on participants' stories, the therapeutic relationship is central to their recovery. Participants reported being let down, by staff, family and significant others. Therefore, care and support should focus on building a relationship of honesty, trust and empathic understanding of SH. Staff need to know of the unique relationship participants have to their form of SH and be willing to facilitate a process that will replace the SH behaviour with something healthier and sustainable. It is vital to note that it can be challenging when dealing with people who present with emotional distress. Therefore, attempting to eliminate the SH instantly in individuals who have past experiences of being let down, will lead to frustration for staff and patients alike. Given the participants' accounts of using maladaptive coping strategies such as SH, it is evident they did not learn to cope with the emotionality inherent in family relationships or those with significant others. To address this, a collaborative or holistic approach with the involvement of family or significant others may be needed when exploring lived experiences and related factors to the unique experience of SH. Those using SH may feel insecure when discussing their behaviour with staff and others in their therapeutic encounter and may be apprehensive of accessing help and support for this taboo topic within Ghanaian culture. Health professionals can offer a new and positive experience by listening more to the accounts of the participants and help create an enabling environment by developing a positive rapport and appropriately facilitating the therapeutic encounter.

Furthermore, findings from this study suggest implications for clinical practice in terms of both practical and emotional issues. For instance, participants in the study described many key areas that require improvement in patient care. Almost all participants gave accounts of how the secure hospital is faced with challenges such as overcrowding and lack of resources/facilities (Khatib et al., 2018; WHO-AIMS, 2012; Strout, 2012). These included issues related to poor practices due to lack of resources such as recreational facilities. The environmental lay out, and the lack of rooms for patients and staff use, was not conducive to quality care. Participants advised staff to have separate cubicles for females and therapy sessions and/or non-stimulating environments where the atmosphere is calm and might encourage individuals to talk openly about their thoughts and feelings in confidence to a therapist. When undertaking my data collection, the ward manager had to vacate his office for me to use for my interview sessions. During my interviews with the interviewees, both patients and staff periodically accessed the office (interview room). There was a lack of privacy for participants, and this made it difficult to share their thoughts and feelings in a relaxed manner. I am aware that this could have compromised the sharing of their experiences. Due to perceived surveillance or control, some participants might have been guarded in sharing their experiences. In contrast, some participants may have been willing to share their experiences believing that the lack of privacy would not have any consequence. For my part as the researcher, as soon as I saw the cues in the facial and body language of one participant that she was not comfortable to share her experience, I briefly paused the interview until the person who had interrupted the interview left the room. I then provided the participant with reassurance and support regarding the confidential nature of the interview and then asked her if she was willing to continue. The participant agreed to continue, and we were able to complete the interview without further disruption.

Participants in this study expressed their concerns re discrimination and stigmatization in response to their mental health problems, a situation which has the potential to prompt the re-surfacing of their distress and/or emotional turmoil. Such discrimination and stigmatisation on the part of healthcare professionals could be linked to the lack of service user involvement in planning their care or understanding their SH behaviours. Participants wanted those providing care to be non-judgemental and for health professionals to gain more education in working with people who SH. It is important that mental health nurses, who account for a large proportion of the workforce globally, focus on enhancing and promoting the self-esteem of patients, by respecting and accepting all health problems and promoting partnership and collaboration, with the patient being the primary focus of their care and support.

Another implication that can be drawn from this study is the essence of addressing the socio-cultural context of SH in clinical practice in relation to giving and/or accepting gifts from patients and how this is often considered ethically acceptable in the Ghanaian context. The idea of exchanging gifts between patients and health professionals is a common practice in Ghana (Krah, 2019; Bloch,1989). Some scholars advise that health care in Africa should be understood through the lens of a cultural healing system involving the exchange of gifts exchange (Takayama, 2001). It is argued that it is challenging to differentiate between basic reasonable gesture and underlying entrusted interest. This was a complex encounter for me in the context of the western world where I have practised for some time now, in trying to comprehend moral or ethical dynamics of a health care systems in the context of gift exchange. One of the dilemmas I encountered was trying to give a token gift of £10 to the participants for taking part in my study. However, after interviewing one of the participants, she gave me a bracelet and I questioned myself as to whether this practice was acceptable in western culture and/or is it would be considered a boundary violation where I currently practice. I accepted the gift and later passed it on to the ward manager and this was challenging for me to deal with. Firstly, I tend to ponder over ethical issues such as feelings of rejection on the part of the patient if the gift is not accepted and if the essence of gift is a vital component to consider in this engagement. For my own part, by offering each participant £10 I have shown a gesture of appreciation for taking part in my study in the form gift. In all, the debate regarding exchange of gift in health in terms of ethical connotations, nature and cost of gift and its potential influence on the therapeutic relationship may require further exploration.

The stories shared by participants of this study have identified some poor care practices that professionals need to address. One way for health organizations to address poor practice is through reflective practice in conjunction with clinical supervision. Clinical supervision has the potential to strengthen good clinical practice and can be integrated into the wider clinical governance programme affiliated to periodic appraisal and CPD of staff. The use of clinical supervision and reflective practice has been supported by professional regulatory bodies such as the NMC & Care Quality Commission (CQC). This is evidenced in health professionals' codes of conduct, with the aim of being to develop their practices in the best interest of the client group and other stake holders. For instance, one of the core standards of CQC 11 is in relation to advising various care health organisations to uphold safe and high-quality standard at the workplace by supporting front line staff in receiving appropriate training, education, professional development, supervision and appraisal in line with clinical governance framework. It is also noted that reflective practice is a vital component of clinical supervision as it provides a structural framework. Reflection enables health professionals to demonstrate their development and learn from experience to improve their practice in relation to skills, knowledge and experiences.

In relation to the examples of poor practice identified within this study, I believe it will be important to share this information with the hospitals involved through various means; digital means/ health talks, seminars and focus group discussion, one to one talk. However, I also believe it will be important to promote health professionals being supported and encouraged to listen to their service users, apply reflective, and perhaps share their experiences during clinical supervision and appraisal sessions to act in the best interest of their client groups.

Another implication of this study in relation to people who SH is that in Ghanaian culture people who SH are stigmatised by staff and wider society. This is reflected in the attitudes or language used to describe people who SH in the Ghanaian culture (Akortia et al. 2016; Murphy et al.2013). The implications for people who SH of such stigmatization have a negative impact on the support or acceptance they may receive from health professionals and society. This in turn could negatively impact on the therapeutic encounter and the ultimate recovery of people involved in their care, such as staff family and wider society.

6.3.3 Perceived Poor Practice and Implications for People who SH

All participants experienced adversities within the care they were offered, leaving them feeling vulnerable at times. Participants shared their experiences of being in vulnerable situations where other services users, who had no training, were instructed by staff to restraint them, or they were scolded or beaten by staff which they felt, and is, unacceptable practice on the part of staff.

Participants also provided knowledge and insight into their care when they were a danger to themselves but expressed rigid and/or one-way approaches to their care process. This process excluded them from being involved in the planning of their care or they found themselves in a situation where care providers were dominant in the care interactional process (Denzin & Lincoln, 2018; Foucault, 2007; Goffman, 1969). Staff need to know of the unique relationship participants have with their SH and be willing to facilitate a process that will promote and sustain use of effective coping mechanisms. Therefore, care and support should focus on building a therapeutic relation of trust, safety, the instillation of hope and the promotion of health, as well as developing an understanding of their situations. A collaborative care plan may include the use of medication, counselling or helping them develop coping mechanisms to better enable them to deal with the challenges they face and to help build psychological resilience. Also, the spiritual and religious wishes of the patients can be incorporated into their care/risk management plan.

This raises the issue of good assessment, which would include an exploration of what triggered the SH, by actively listening to the person and believing their story. Once the whole story is heard, it then requires healthcare professionals to work in collaboration with the person to work out how best to help address their problems. Therefore, the need for improved resource allocation to ensure adequate rehabilitation materials/tools for patients' care and rehabilitation/activities is evident, for example private spaces where patients can discuss problems, thoughts and feelings without reprisal. This will also involve a structured approached to ensure the inclusion of patients when exploring their needs, skills, capabilities and values, when designing a tailored rehabilitation programme. This will go some way to ensure it is client-focused and friendly and will aim to fulfil individual aspirations.

Another thought-provoking and reflective encounter linked to this study was the notion of shame and probable therapeutic encounters of practitioners and their client groups. Personal stories through interview with the participants revealed how shame and guilt repeated had impact on in which they were stigmatised by people including attitude or negative responses of staff following incidents of SH, which reinforces their beliefs, condemnation, perceptions and perpetuates a cycle SH. I was also entrenched in a dilemma where my presence as a researcher but not a practitioner and shame were a source of my emotional experience affecting my identity and/or consideration for myself.

In summary:

- To further explore the influence that culture and religion have on people who SH in Sub-Saharan Africa and Ghana, establishing how such cultural and religious beliefs may influence the lived experiences of people who SH and their recovery journey.

- To engage in further research to explore the lived experience or influence of culture and the ghost of mental illness has on family and health professionals who support people who SH.

-To do more research on the impact of ethical issues such as shamanism, giving gift and/or receiving gifts in relation to the family, wider society and staff who care and support people who SH.

-To do more work on bridging the gap between faith healers and the health service to inform how, stigmatization, shame and guilt can be recognised as issues to be worked with therapeutically.

-To do more work on by exploring shame and its link to lived experience of SH and/or traumatic experiences and the subjective meaning making of individuals and other subsequent interpersonal and environmental events.

The notion of gift exchange is paramount to explore and explain the nature of social interaction for the Ghana’s health care system. If we acknowledge integrating cultural and orthodox health care in Ghana, then more work to gain insight into these cultural interactions in health care, and how inherent exchange of gifts are locally understood and organised.

6.3.4 Educational Implications

This study has revealed that there are various perspectives of how family, health staff and wider society’s awareness, attitudes and cultural perceptions may be portrayed towards people who SH.

The focus is on how education attributes can be changed or developed, and how it might facilitate in education practices or may usefully contribute to the development of effective coping mechanisms among service users and perhaps guide various stakeholders such as health professions, family and society in supporting people who SH. The key indicators that may translate those instructional activities that may guide health professional, and society towards supporting people who SH are as follows:

6.3.4.1 Life-long learning

In addition, people with lived experience of SH and/or suicidal ideations should play an integral part in lectures, seminars, or forums to share their stories and have opportunity to discuss what helps and what hinders when they are in distress. Evidence from Western societies (Hawton et al.,2015, WHO, 2014; Sandy, 2012; DoH, 2011, Dickenson et al., 2009) suggest this can promote greater awareness for people who provide mental health services by promoting a better understanding of, and support for those who SH. In Ghana there could be the introduction of local organizational policy on lifelong learning for health professionals that would introduce regular or annual mandatory training. This could take the form of short courses/modules focusing on raising awareness of important topics and various therapeutic interventions, including person-centred approaches, that could be beneficial to the people they are providing care for.

Additionally, as part of lifelong learning, there is the need to identify the level of current practice and the pre-determinants that influence it. This information could then be used to bring about improvement and change. Clinical practitioners can engage in further research into SH. For instance, in African culture, there is a belief in the existence and activities of supernatural forces, ancestral spirits, ghosts and diviners. It is strongly believed that an individual's health and well-being can be influenced positively and/or negatively by use of those forces within the psychosocial environment. The integration of these beliefs within orthodox health care would be a useful topic for future research. In addition, it is recommended that the same methodology be used in other similar settings within the same service user group in Ghana, as well as Sub-Saharan Africa.

It is also proposed that educational implications apply to all facets of health and society, including nursing and allied health care staff. Such information may be navigated through virtual encounters in terms of professional courses and continuous professional development days. This can be structured in clinical supervision sessions and local organizational policies and procedure. There can be literacy teaching and learning and/or adult classes for families, and wider society.

In summary:

-Providing educational opportunities for staff, families and wider society. Educational sessions could be provided via thought-provoking scenarios for staff and families and wider society to consider and challenge their thoughts, beliefs and cultural perspectives relating to mental illness per se and more especially SH.

-expand curricula and education to promote and enable broader/subjective meaning making or raising awareness of mental illness and in particular SH.

6.3.4.2 Pre-Registration Training

The basic professional Mental Health Nursing education in Ghana is now delivered at the level of Diploma. It is affiliated to public tertiary health institutions in Ghana and the academic programme is supervised by the Ministry of Education. The Nursing and Midwifery Council (NMC, Ghana) regulates the educational activities, curriculum and examination of candidates. Upon successful completion of a 3-year mental illness nursing training programme, individuals are awarded a Diploma in Mental Health Nursing. Most participants in the present study talked about staff not understanding them, and how some members of staff were terrified and/ or in shock following their incident of SH.

It is also noted that extant data on SH in Ghana suggested there was limited studies on people who SH in secure settings/locked hospitals in Ghana. It is also noted that the nursing educational system in Ghana encouraged critical thinking (Facione & Facione, 2008) in the curricula, and engage practitioners to think on their feet in terms of clinical judgement and decision-making processes. However, health professionals are not always aware of how their attitude can influence clinical judgments and communications (Sandy, 2012, Adshead, 2009). The implications from this study reinforce how the lack of awareness of SH that the current educational system perpetuate is having on health professionals.

To address this there needs to be the development of an educational programme and/or modules focusing on SH, creating greater awareness of the phenomenon of SH, its assessment in terms of patient story and risk management and suicide prevention approaches. It is noted that SH is covered in the curriculum/ module course of the pre-registration nursing programme, but perhaps not adequately.

6.4 Methodological Appraisal/Research Appraisal

In this section, the research methodology (philosophy, approach, design, data collection method and analysis) adopted in this study are critically reviewed. A reflection on the measures put in place to ensure rigour of the study is presented.

An appropriate research methodology was chosen based on an in-depth review of the extant literature. A phenomenological approach was chosen and justified in chapter three, as the most pertinent for this research. In keeping with the area of interest, and what I was hoping to achieve, it became apparent that qualitative research via IPA was the most suitable means of conducting this study. Using IPA would illuminate subjective views and perspectives of people who SH. As a senior mental health nurse practitioner providing care to people who SH, I realised that to explore in-depth the subjective views of service users, an iterative process was required to make sense of their experiences. I had to suspend my judgement, beliefs and values about reality and set aside existing knowledge about the phenomenon (lived experience of SH) and listen and accept the participants stories. Other steps taken to mitigate the limitations were the use of my reflective journal, and an audit trail for my supervisors, who are experts in the field, during supervision meetings.

In addition, through critical exploration of various theorists such as Husserl, Gadamer and Heidegger, I chose IPA, underpinned by Heidegger's double interpretive/hermeneutic approach, to delve into the subjective experiences of people who SH in a Sub-Sahara African country, namely Ghana, where such studies are limited in in-patient care environments. The IPA interview approach was appropriate in order to make meaning of the lived experiences of people who SH. Therefore, I used IPA to find meaning from the data that the participants provided during the interviews. It is hoped that the outcome of this study will inspire other researchers to focus on Sub-Saharan Africa based in-patient studies related to people who SH.

6.4.1 Rigour

The criteria for rigour questions whether the research processes, such as data collection through interview means, transcription and write up, has convinced the reader that the author of the research has followed all steps (Silverman, 2013). The concern is whether the researcher has grasped and understood participants' narratives/ accounts of their story (Larkin & Thompson, 2012). The previous chapters do take the reader through how the data was collected and the process of analysis, providing the reader with insight as to how and why interpretations were made. However, in this study one could question the authenticity of researcher's interpretations of the participants' narratives given in their mother tongue, the popular mother tongue of Ghanaians being Ga, Twi, Fante, Hausa and Ewe. During my previous nursing practice in Ghana, I did encounter clients who spoke those languages, except for Hausa. This is something that I will address in future studies by the involvement of a bilingual interpreter to check the essence of participants' narratives.

6.4.2 Language/Communication

Language is central to participants' lived experience in IPA studies that incorporate interviews, focus group discussions, field diaries and participant observations as mediums to convene participants' thoughts, feelings and actions (Willig, 2013). According to Willig (2013), language constructs rather than describes an experience, bearing in mind that the same person can potentially describe the same issues/scenario in a varied way by using different words each time. This suggests that words do not only verbalise/portray the experience, but also shape it. Therefore, words convene meaning in themselves, so each time that different words are being used, the meaning conveyed is slightly changed. As such, direct access to experience is not possible. This was acknowledged in this research and measures put in place to address it (Smith et al., 2009).

Considering this study, participants expressed themselves in-depth in various Ghanaian languages. In their narratives, participants used metaphor, in-depth descriptions of their experience and reflection. As the researcher I am a native Ghanaian and able to speak various Ghanaian language common to almost all ethnic groups. Recruitment was able to capture participants who were able to communicate their potential experience in an eloquent way and in a language that I would be able to understand and acknowledge, therefore being able to achieve the co-construction of meaning required for IPA (Smith, et al., 2009).

As part of the research process, I was aware of my own beliefs and perceptions to SH research and remain sensitive to the interview process regarding verbal and non-verbal cues of the participants. I applied reflexivity in the data analysis process, as well as remaining sensitive to the audio-recordings and transcriptions.

Another criterion for evaluating this study is confirmability and this relates to ensuring there is an audit trail of the study. This thesis includes audit trail of feedback from my supervisors during my analysis of the transcript. A further criterion for evaluating the dependability of the study was outlined in Chapter 3 of this study which will serve as a benchmark for other researchers to follow. Although future studies may not produce similar findings, this will serve as a point of reference for other studies.

6.4.3 Sensitivity/Reflexivity

The focus was on the general principles/guidelines for evaluating text of the research, but not the researchers own ability to be sensitive to the context of the study. It is noted that some individuals tend to carry out their SH behaviours in secrecy and at times talked about their lived experiences in terms of personal and sensitive information that had the potential to re-enact their traumatic experiences. This could have negative and/or positive implications for the interviewer and/or the interviewee during our engagement. Bearing this in mind, I requested for a non-stimulating environment (Ward managers' office) in order to use in-depth interviewing to explore participants' subjective world, while at the same time not compromising both party's security, vulnerability, health and safety. Although I assumed that it was a quiet and non-stimulus interview room, other staff and patients kept on knocking on the door in order to get cold drinks from the only tabletop fridge for the ward staff and services users. Perhaps this interference compromised our privacy and the free flow of information. At one point, a participant started talking about a past incident of SH where staff scolded and threatened to beat her if she should engage in any future SH. During the process of giving the account of her story, she suddenly covered her mouth with both hands and looked round in a state of fear, worried that her story may be overhead by others. Upon further exploration of the participant's account, it illuminated more about her experience of being in hospital. This led me to deduce that the use of a qualitative study using the face-to-face interview as the main means of data collection can enable a researcher to get thick and rich data from participants, particularly where personal and sensitive issues pertinent to them may be discussed (Perrnecky, 2016; Aluruutari, 2010; Creswell, 2008).

6.4.4 Limitations

It is acknowledged that there were limitations in relation to this study, which should serve as a point of reference for any future similar studies. It is presumed that such limitations might have influenced the overall outcome of this study. For instance, the researcher's personal beliefs, feelings, values, perspectives and knowledge about supporting people who SH are sources that have the potential to influence interpretation of participants stories. In IPA analysis, based on hermeneutic phenomenology, Heidegger advises against the researcher's bracketing of self. In essence, the narratives that emerged from the interviews with the participants could be biased in the hermeneutic process of data analysis, as another researcher might have highlighted different themes and/or included other themes. I feel that the methodology adopted has addressed the aims and objectives of the study, and to ensure authenticity, I observed all necessary precautionary measures below to ensure successful outcome of the study:

The use of the semi-structured interview technique as one source of data collection was appropriate to the overall aim of the study. This approach is conducive to exploring sensitive issues and experiences of people who SH. As a precautionary measure, and as a novice researcher, I had to reassess my interview process repeatedly to enable me to feel confident when engaging with the participants as a researcher. Using interview technique, I was able to attain rich data from the participants.

As suggested in other IPA studies, potential researchers can include their perspectives in relation to participants' meaning making of their experiences during the interpretation of data. I tried to ensure a balance between the two and used my supervisors to discuss and check out my interpretations. The personal and sensitive narratives obtained from interviews were overwhelming which made it challenging for me to detach myself/ remain objective. Nonetheless, during supervision, I was able to identify and accept the sensitivity and vulnerability of the participants.

This was a qualitative study, and it was not aimed at generalising the outcomes of the study to other in-patients' mental health settings in Ghana. Nonetheless, this was the first study to explore the experiences of people who SH and have been admitted to secure mental health settings in Ghana, and while the outcomes of the study cannot be generalised to all secure mental health settings in Ghana, it provides a basis for future studies to re-iterate, 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 evidence that can change practice.

Other possible limitations to the study were related to participants demographic backgrounds such as economic status, ethnicity and educational level. Each participant was unique, but most of the participants shared the commonality of not being in gainful economic employment. Being unemployed can impact an individuals' well-being and coping mechanism, the latter exacerbating high-risk behaviours such as SH. All ethnic groups were not represented in the study, but an aspect of the study evolved around cultural belief, values and practices. One of the merits to this study was that IPA informed a detailed and open exploration of experiences of people who SH in two separate secure mental hospitals in Ghana**.**

6.4.5 Recommendations for Future Research

This thesis has exposed various facets relating to people who SH and are admitted to secure mental health settings in Ghana. The findings cannot be generalised due to the nature of methodology chosen. Nonetheless, the study does illuminate insight to researchers in the field. In this study, one of the novel findings was participants' belief in the forces of the supernatural and the part they played in their SH behaviour. In carrying out this research, it was evident that further research is needed. I suggest future research is needed in the following three areas:

- I would recommend that the methodology be used in other similar settings with front-line staff, such as nurses, to explore their knowledge and understanding of SH and their level of confidence in providing care to those who use SH.

Studies on issues related to restraint techniques and seclusion, for example, service users and/or service providers perspectives of SH and the application of such approaches in their management need to be explored.

6.6 My Future as a Researcher

It is recommended that the same methodology be used in other similar settings with those who use SH. I intend to engage in a future research study that would focus on the link between SH and forces of the supernatural or the socio-cultural context of SH, approaching it from a quantitative and qualitative perspective. Most studies into prevalence of SH indicated that more females do engage in SH behaviours more than males. I would like to undertake ethnographic research on a purposefully chosen sample to explore the lived experiences of males who SH in secure settings, as well as examining the prevalence of SH in men. In my study, method of data collection was met with challenges such as not having a quiet room or an environment conducive to enable participants to share their thoughts and feelings. A future study will investigate addressing such shortfalls, whilst bearing in mind the organizational policies and procedures.

As part of my lifelong learning, I would also like to carry out autoethnographic research study. This research methodology users the researcher's personal experience as data, to describe, analyse and understand cultural experiences. It is a form of self-narrative that places the self within a social context. The focus will be to explore lived experiences of individuals' who support and/or work with people who SH in secure settings.

6.5 Dissemination

This study is an academic requirement by the University of Salford as a pre-requisite towards my Doctoral programme. It is my aim to offer to share the research findings with the participants of the host institutions. I believe dissemination of the findings is central in providing the participants with some sense of ownership of the results and may foster trust between researchers and participants. A user-friendly summary of the overall findings will be available to the participants and the host organization upon request.

The outcome of this study may be presented at a research conference and submitted for a potential publication in an academic journal. There appears to be limited literature that explores in-depth experiences of people who SH whilst receiving in-patient mental health care services in Ghana and/or Sub- Saharan Africa.

The findings regarding poor practice of patient restraint and lack of identified tools for the assessment of side effects of prescribed psychotropic medicines needs to be shared with clinicians. This could be achieved by designing an educational package and presenting seminars and/or group discussions in various languages to the two institutions where the study was conducted. This could also provide an opportunity to create awareness among health professionals, to discuss areas of good practice which can serves as a motivating factor to improve and/or maintain such practices. It would be an opportunity for me, as a researcher, to network with the scientific community towards sharing my research experiences with peers and policy makers. All these intentions are in line with other studies that indicate participants' (direct and indirect) willingness to receive the research findings and broaden the scientific communities research knowledge.

6.6 Conclusion

Within this chapter, I have explored the implications of the study in relation to the three research questions. Also, I have explored the rigour and limitations of the study, as well as my reflexivity and the challenges that occurred in my research journey and how they were addressed in the study. This thesis provides in-depth insight into the lived experiences of participants from two secure hospitals in Ghana who carried out SH. In exploring service user experience, this study offered mixed views of care provided by staff. I would like to dedicate the concluding words of this study to the nine participants that made it possible.

6.7 Finally

In all, listening to the narratives of the participants gave me an in-depth insight into knowing and understanding their lived experience of SH and how important empathic valuing and feeling wanted by people who support them through the provision of care was to them. I am a researcher and a mental health nurse practitioner, and this aspect of the study enabled me to gain deeper insight into the phenomenon, as well as helping me to reassess my original thoughts, perceptions and attitudes relating to SH. I am hopeful that the readers of this thesis will gain insight into the experiences of people who SH in two secure in-patient mental health settings in Ghana.

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APPENDICES

Appendix 1a: University of Salford Health Research Ethical Approval

Research, Innovation and Academic
Engagement Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT
T +44(0)161 295 2280
www .salford.ac.uk/

19 October 2016

Dear Andrews Dake,

RE: ETHICS APPLICATION HSCR 16-52 – Self-Harm in Secure Mental Health Hospitals: Experiences of Care Environments.

Based on the information you provided, I am pleased to inform you that application HSCR16-52 has been approved to go forward to NRES. Please send a copy of the NRES approval letter once you have received it.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel

Appendix 1b: University of Salford Health Research Ethical Approval

V2 (02.05.2018)

Amendment Notification Form

Please complete this form and submit it to the Health Research Ethics Panel that reviewed the original proposal:Health-ResearchEthics@Salford.ac.uk

Title of Project:

An Exploration of the Lived Experiences of People who Self-harm (SH) in two Secure/locked Mental Health Hospitals in Ghana.

Name of Lead Applicant:

Andrews Dake *School:* School of Health and Society, University of Salford, Manchester

Reference No: HSCR16-52

Date when original approval was obtained: 19/10/2016

Please outline the proposed changes to the project. NB. If the changes require any amendments to the PIS, Consent Form(s) or recruitment material, then please submit these with this form highlighting where the changes have been made:

Due to difficulty with recruitment of potential participants in the UK for study, I have secured agreement to recruit people from 2 hospitals in Ghana.

Please find appendix (A) for details on the changes made in relation to the above areas

Please say whether the proposed changes present any new ethical issues or changes to ethical issues that were identified in the original ethics review, and provide details of how these will be addressed:

The proposed changes may not cause any significant ethical issues

Deputy Chair's Signature: S. Pearson

Approved: 30th May 2018

Appendix 2a: Komfo Anokye Hospital Research Ethics Committee Approval

From: Ruth Owusu-Antwi

Sent: 14 March 2018 15:33:56

To: Dake, Andrews (UG)

Subject: Re: Site Approval for Research

hello Andrews,

i apologize in the delay of your email. i am happy about your intentions to carry a research in this rather sensitive area and i believe the outcomes of this study will improve patient care.

i am more than glad to give a letter of site approval from my department to the research and development department of the hospital, however, they require that an introductory letter from the candidate's institution introducing the candidate to be attached to my letter.

kindly send a scanned copy of an introductory letter from your school as soon as you get it for my perusal.

many thanks

Ruth

[http://us.i1.yimg.com/us.yimg.com/i/mesg/tsmileys2/01.gif] smile, Jesus loves you -Ruth

Appendix 2b: Komfo Anokye Hospital Research Ethics Committee Approval

KOMFO ANOKYE TEACHING HOSPITAL
RESEARCH AND DEVELOPMENT UNIT (R & D)
CERTIFICATE OF REGISTRATION

REG. NO: *RD/CR18/099*

This is to certify that

Prof/Dr/Mrs/Mr/Ms *Dake Andrews*

has registered his/her proposed study titled *Self Harm in Secure Mental Health Hospitals: Experiences of Care Environment*

……………………… with the Research and Development Unit.

Date *12th April, 2018*

Name of issuing officer *Juliet Ampomah Frimpong(Admin.Manager)*

Signature

K/17/0219922

Receipt No

***This certificate does not constitute ethical clearance for the conduct of the study but proof of registration of study with KATH. Ethical clearance from the Committee of Human Research Publications and Ethics (CHRPE) is required to conduct the study*

Appendix 3: Accra Mental Hospital Research Ethics Committee Approval

Re: APPLICATION FOR SITE APPROVAL TO CONDUCT RESEARCH

I am writing to introduce myself (Andrews Dake) to you as a Ghanaian senior mental health nurse practitioner and a PhD student at the University of Salford. I am conducting research entitled: **''An Exploration of the Lived Experiences of People who Self-harm (SH) in two Secure/locked Mental Health Hospitals in Ghana''.** I believe your hospital provides care for people who self-harm and/or carry out self-inflicted injury and I am therefore writing to you to request access to your hospital to recruit people who self-harm and staff who provide care respectively. The research is designed to explore the• personal experiences of people who self-harm and staff who care for them in mental health hospitals. I am looking to recruit participants who are willing to be interviewed for approximately 60 minutes during working hours of 9 am to 5 pm. Participation in the study is voluntary and all information shared will be anonymised and personal details kept confidential.

The outcome of this study will provide service users, health professionals, policy makers and other stakeholders with valuable insight into experiences of self-harm/ self-inflicted injury in hospitals. In turn il is anticipated that there may be improvements in care for people who self-harm and training for staff who work with them. The outcomes of this study may be presented at research conferences or published in professional journals. A summary of the overall findings will be available to all interested parties when the study is completed,

I would be grateful if you could consider allowing me to recruit and collect data from people who self-harm and staff who care for them in your hospital. I have already gained ethical Approval from the University of Salford (The Research, Innovation Academic Engagement Ethical Approval Panel), and the Health Research Authority, England as well as Favourable Opinion from The Northwest-Greater Manchester Research Ethics Committee, England. If you require all the documentation that has been approved or any other information about the research, I am happy to forward this to you. You may also contact my supervisors (Dr Angela Agnes Cotton and Prof Susan McAndrew of Salford University) for any further information about me.

Thank you for your help

Yours faithfully

Andrews Dake

(Post Graduate student).

Salford

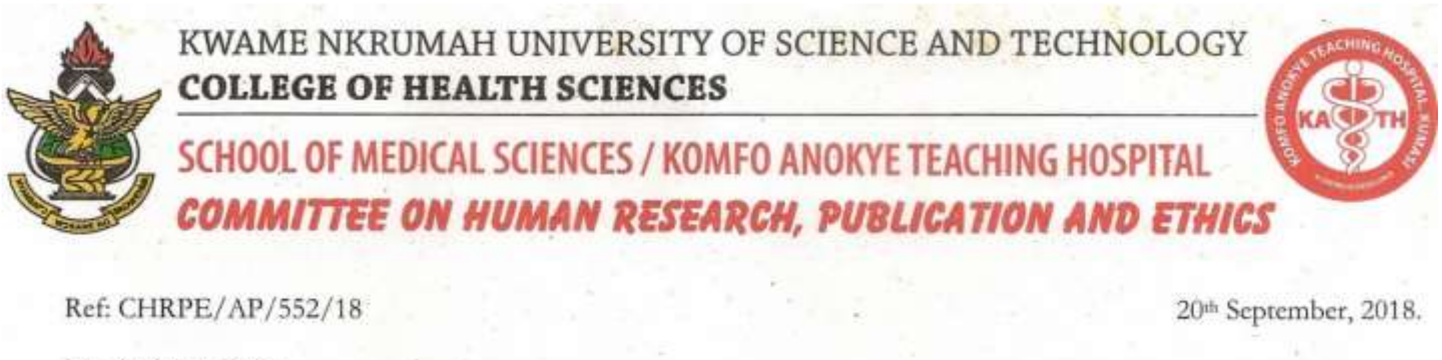
ACCRA PSYCHIATRIC HOSPITAL
P.O. BOX 1095, ACCRA
RECEIVED

Attn. DDNS
23/04/18

UnivCSal

NURSING ADMINISTRATION
RECEIVED
DATE 27/04/18

Appendix 4: KNUST Research Ethics Committee Approval



KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL
COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS

Ref: CHRPE/AP/552/18

20th September, 2018.

Mr. Andrews Dake
School of Health and Society
University of Salford
Manchester
ENGLAND.

Dear Sir,

LETTER OF APPROVAL

Protocol Title: **An Exploration of the Lived Experiences of People who Self-harm (SH) intwo Secure/locked Mental Health Hospitals in Ghana.**

Proposed Site: Department ofPsychiatry, Komfo Anokye Teaching Hospital, Kumasi, Ghana.

Sponsor: Principal In vestigator.

Your submission to the Committee on Human Research, Publications and Ethics on the above-named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 12th April, 2018 from the Komfo Anokye Teaching Hospital (study site) indicating approval for the conduct of the study at the Hospital.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Protocol. •Interview Guide.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, beginning 20th September 2018 to 19th September 2019 renewable thereafter. The Committee may, however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Yours Faithfully

Osomfo Prof. Sir J. W: Acheampong

WACP Chairman Room 7 Block J, School of Medical Sciences, KNUST, University Post Office,
Kumasi, Ghana. Phone: +233 3220 63248 Mobile: +233 20 5453785 Email:
chrpe.knust.kath@gmail.com/chrpe@knust.edu.gh

Appendix 5a: Information Sheet

PARTICIPANT INFORMATION SHEET FOR (People who Self-harm)

Title of study: An exploration of the lived experiences of people who Self-harm (SH) in two secure/locked mental health hospitals in Ghana.

Name of Researcher: Andrews Dake

Invitation paragraph

I would like to invite you to take part in the above research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether to take part.

What is the purpose of the study?

I am interested in exploring the experiences of people who self-harm in secure mental health hospital. A total of 10 participants are expected to be involved in the study.

Why have I been invited to take part?

You are being approached because you are receiving care or self-harm in a secure mental hospital. As a researcher I want to understand your unique lived experiences of self-harm and views. The outcome of this study will provide service users, health professionals, policy makers and other stakeholders with valuable insight into experiences of self-harm in secure hospitals. In turn, it is anticipated that there may be an improvement in care for people who self-harm and training for staff

Do I have to take part?

Taking part in the research is entirely voluntary and it is up to you to decide. I will describe the study and go through the information sheet, which I will give to you. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw your consent to participate in the study up to one month after the interview, without giving a reason and this will *not affect the standard of care you receive.* If you choose to withdraw consent after one month of the data collected, your data will not be included

What will happen to me if I take part?

If you decide to participate in this study, you would be participating in a single interview session lasting for approximately an hour and a half in one of the sessions and/or interview rooms of the hospital. The interview would be audio- recorded. The tape will not have your name on it. The researcher will use a number and/or research code to label it, so that only the researcher can identify which interview is on a tape. The tape will be kept in a locked cabinet and this will be treated as confidential. Allowing the researcher to tape your interview is entirely voluntary. If you decide you do not want the interview to be taped, it will not prevent the researcher from interviewing you. I need to inform you that there are other options of noting down the interview of which you may wish to compare against. If you agree now, but change your mind later, any tape which has been made will be destroyed if you ask for it

Expenses and payments?

Once you have completed your interview you will be given a shopping voucher of £10 as a token of gratitude for participating in the study. You will be asked to sign a receipt for the voucher.

What are the possible disadvantages and risks of taking part?

I would be exploring sensitive issues about your lived experiences of self-harm which may be upsetting. During and after the interview is completed there would be support services available for you to access if further support is required.

It can be self-satisfying for taking part in a research to share personal experiences about your thoughts and feeling of self-harm. Also, it can be a way to showcase your unique and/or distinct way of expressing your personal lived experiences about what is it like to who self-harm

What are the possible benefits of taking part?

I cannot promise the study will help you but the information I get from the study will help increase the understanding of self-harm and may also improve the treatment of people who self-harm.

It can help uncover issues that can affect care processes which can lead to organization of training programmes focused on identified issues. Also, this study may illuminate other ways of studying people who self-harm.

What if there is a problem?/Complaints Procedure

If you have concerns about any aspect of this study, you should ask your primary nurse, Responsible Clinician or line manager to arrange to speak to me (the Researcher) and I will do my best to answer your questions (contact number…..).

Or, if you prefer you can contact my supervisor:

Supervisor's Name: Prof Susan McAndrew

Contact details: Salford University

If you remain unhappy and wish to complain formally you can do this through the complaints officer and/or the RC/ and/or the Registered Manager of your Hospital.

Contact Details: XXXXXXX

Or through the university complaints procedure:

Contact email: *Anish Kurien, Research Centres Manager, G.08 Joule House Acton Square, University of Salford, M5 4WT*

Will my taking part in the study be kept confidential?

All the information that you provide will be stored safely and all data will be anonymous and given a research code, known only to the researcher. A master list identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher. Consent forms will be stored in a locked cabinet, within locked office, accessed only by researcher. Electronic data will be stored on a password protected computer known only by researcher. Audiotapes of the interview will be destroyed once they have been transcribed and the researcher has written up his thesis. The data will be retained for 5 years and will be disposed of securely in accordance with the University's Policy and Data Protection Act (1998).

All information which is collected about you during the research will be kept strictly confidential, and any information about you which leaves the university will have your name and any identifying information removed so that you cannot be recognised. Anything you tell me will be treated confidentially and will in no way affect the care you receive from the hospital.

Anonymised data will only be published in the form of quotes that will not be attributed to any organization or individual.

There are however situations when confidentiality has to be breached and the researchers are obliged by NMC code of conduct

What will happen if I don't carry on with the study?

If you choose to withdraw consent after one month of the data collected, your data will not be included in the study.

Who is organising or sponsoring the research?

This study is an academic requirement by the School of Health and Society, University of Salford as a pre-requisite toward my PhD degree

The outcome of this study may be presented at a research conference or published in journals. A brief summary of the overall findings will be available when the study is completed.

The outcome of this study may be presented at a research conference or published in journals. A brief summary of the overall findings will be available when the study is completed. The anonymised data are only published in the form of quotes that will not be attributed to any organization or individual

Further information and contact details:

Researcher's Name: Andrews Dake

Contact details: Salford University

Appendix 5b: Research Poster Invitation for People Who Self-Harm

People Who Self-harm

Do you SELF-HARM in a Secure Mental HOSPITAL?

- The study of the lived experiences of people who self-harm needs people like you.
- I am currently recruiting volunteers who self-harm to participate in a study. This study will explore the lived experiences of people who self-harm in a secure mental hospital. If you are patient who self-harm and wish to take part in the study, you would be invited for a single interview session lasting for approximately an hour and a half.
- The researcher will be returning to the study setting to share the outcome of the research with the participants after completion of the study. In turn, it is anticipated that there may be an improvement in care for people who self-harm and training for staff. This study may also illuminate other ways of studying people who self-harm.
- Once you have completed the interview you will be provided with a shopping voucher of £20 as a token of gratitude for participating in the study. You will be asked to sign a receipt for this.
- If you wish to take part, please call me on the telephone number (hot line..) or talk to your named nurse, key worker or Dr. who will in turn email me (@ …co.uk) your willingness to participate in the study. I will then contact you again within three working days for arrangement on date and venue at your convenience for the study. Please note, everything shared with the researcher will be confidential and /or anonymised and you will not be identifiable.
- Your consent to participate is voluntary.
- If you agree to take part in this study you can withdraw consent at any time without personal consequences.
- A brief summary of the overall findings will be available when the study is completed.

Appendix 6: Consent Form

CONSENT FORM FOR PARTICIPANTS

Title of study:

An Exploration of the Lived Experiences of People who Self-harm (SH) in two Secure/locked Mental Health Hospitals in Ghana

Name of Researcher: Andrews Dake

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and tick yes or no, as applicable in the box on the right-hand side.

1.	I confirm that I have read and understand the study information sheet (V3 08.06.2017) for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.	Yes/No
3.	If I do decide to withdraw I know the information I have given will not be used in the research unless I state otherwise. The timeframe for withdrawal is one month after the date of interview.	Yes/No
4.	I agree to participate by being interviewed and the interview being audio -recorded. I agree for anonymous quotes to be used in publications of the research	Yes/No
5.	I understand that my personal details will be kept confidential and not revealed to people outside the research team. [If appropriate -However, I am aware that if I reveal anything related to criminal activity something that is harmful to self or others, the researcher will have to share that information with the host organisation (the individual Hospital in Ghana).	Yes/No
6.	I understand that my anonymised data will be used in the researcher's thesis/research report and academic publications and conference presentations.	Yes/No
7.	I agree to take part in the study:	Yes/No

____________________ ____________ ________________

Name of participant **Date** **Signature**

__________________________ ___________________ ___________________

Withdrawal from study

I understand that my participation in the proposed study is voluntary, that I can choose not to participate in part or all the study, and that I can withdraw from the study up to one month after the interview, without giving a reason and this will not affect the standard of care you receive. If you choose to withdraw consent after one month of the data collected, your data will not be included in the study.

Name………………………………………….(Please Print)

Signature………………………………………

Date……………………………………………..

Researcher's signature……………………..

Appendix 7: Interview Guide (Semi-Structured)

Background to Interview Guide

In this study, I have used open-ended and/or semi-structured techniques to explore the in depth lived experiences of the participants in relation to their ill-health, well-being, and treatment they receive as (Van Manen, 1997).

INTERVIEW PROCESS

The interview will be in mainly three phases of introduction, body and conclusion phase.

The introduction phase will enable the researcher to establish rapport with the participant then the main interview and last close-up the session.

Draft Interview Guide

The following key steps will guide the body of the interview of the study:

The key interview guide for participants who self-harm:

Why did you self-harm? – What triggered this?

Have you used self-harming behaviour before being admitted to a secure environment?

How does self-harming make you feel?

.What sort of self-harm have you used?

.Do you use any coping skills to help try and prevent harming yourself?

.How did you manage your 'self-harm'?

.How did the staff react when you self-harmed?

.How did the staff help you when you self-harmed?

.Is there anything that the staff did that was difficult for you?

If you had the urge to self-harm again, what would you like to be done differently?

.Was there anything that the staff did that was helpful to you?

Background/Demographic Information For Participants Interview Guide part

1) What is your gender?
   a) Male b) Female
2) How long have you in this secure environment?
3) What is your ethnic background?
4) What is your age?
   a) under 20 years b) 20-24 years c) 25-29 years
   d) 30-34 years e) 35-39 years f) 40 -44 years
   g) 45-49 years h) 50 years and above
5) How long have you been self-harming?

Appendix 8: Schedule of Research Events

SCHEDULE OF RESEARCH EVENTS/ ACTIVITIES FOR PARTICIPANTS (PEOPLE WHO SELF-HARM)- RECRUITMENT AND DATA COELLECTION PROCESS

STUDY INFORMATION **Short Study Title:** An exploration of the lived experiences of people who self-harm in two secure/locked mental health hospitals in Ghana **PERIOD**: 10th May 2018 TO 22nd May 2018 **PRINICIPAL INVESTIGATOR:** A D **RESEARCH SITE** :…………………..			
Specific Activities	**Duration**	**Under taken by**	**Comments/Definitions/ Description of event**
Apply for site approval	72 hours	Principal investigator	Approach hospital manager/ RC/ Local registrar to discuss request to do research (Provide them with documents eg., ethical approval documents from University and REC/ Invitation letters/ Information sheets.
Contact ward manager(s)/ RC/ Contact with local Caldecott	1 week	Principal investigator	As above
Initial Recruitment of participants(attend ward meeting/ Patient Council meeting	One day	Local research registrar/ principal investigator	Liaise with ward staff/manager/ local research registrar
Put-up study poster on ward (communal areas)	One day	Principal investigator	Liaise with ward staff/manager

One-off reminder(revisit for patient meeting	After one week	Principal investigator	Liaise with ward staff/manager and attend meeting
Eligibility checks(inclusion/ exclusion criteria)/ RC/ Named nurse / ward manager/ward representative involvement.	One day	Local research registrar/ principal investigator	Liaise with ward staff/manager
Provision of PIS & arrangement for consent process	One day	Principal investigator	Liaise with ward staff/manager
Arrange date, venue and time for interview	72 Hours	Principal investigator	Liaise with ward staff/manager
Arrangement for short-term & long-term research distress protocol toward data collection/ interview process	One day	Principal investigator	Liaise with interdisciplinary team/ RC/ ward staff/ named nurse
Data collection process	One day per participant	Principal investigator	Principal investigator to interview participant
Thank you/ token of gratitude/ inconvenience allowance(all must sign to that effect- witness involvement)	One day	Principal investigator/ ask for witness	Liaise with ward staff/manager and request for a witness
Provision of feedback after study	After study completion	Principal investigator	Hospital journal/ newsletter/ local journal/ ward meeting/Conferences /seminar.

Appendix 9: Sample Work of the Analysis

As described in Chapter four (see chapter 3, section 3.9) analysed the interviews using the principles of the seven steps of IPA (Smith et al, 2009). How the seven steps of IPA were used is outlined as below:

- Transcribing the Interviews Verbatim

- Becoming Immersed in the Data

- Initial Noting

- Further Development of Themes

- Identifying Connections Across Themes

-Analysing the Rest of the Interviews

- Identifying Patterns Across all Scripts

Worked examples of each stage are shown below

Stage 1: Initial Reading and Annotation of transcripts

APPENDIX 9 :(Table 1) Below presents the initial stage of IPA which illuminates close reading of the transcript line by line repeatedly, as well as listening to the audio-recording repeatedly. The aim was to gain in-depth understanding of what SH meant to people who use this behaviour whilst in secure services.

In the example shown, the left-hand side of the table depicts a section of the transcript of participant KATHSED interview, a female who had a history of childhood traumatic sexual abuse which led to and/or exacerbated her SH. The interviewer's speech is preceded by an ''I'' and the in the plain text, the participant's speech is led by '' KATHSED'', in bold/colour coded text. Any text in square brackets such as ''[right]'' implies speech by the individual who was not the focus in the dialogue. For example, in this section, I occasionally stated ''ok'' or ''right'', indicating my involvement with participant KATHSED story which has been shown within her text in square brackets. The text bounded by the symbols ''<'' and ''> '' indicates text that has been modified and/or to anonymise the participant's identity.

Appendix 9: (Table 2) Initial Coding of Transcripts - Participant ‘KATHSED’

Section of Interview Transcript	Initial Annotation of Text
I: ok Tell me (or describe) an incident you were involved with where SH was used. ‘KATHSED’: **It was when I felt useless, helpless, hopeless, and worthless and I perceived myself not be a normal person** I: Abuse? **KATHSED’: Yes** **I:** Can you tell me about the sexual abuse and how it started? **KATHSED**: There was a brief pause, deep breathe taking followed by facial grimace and odd body gestures by **KATHSED.** I was informed that my dad and mum were in intimate relationship when they were in their teenage ages and my mum became pregnant and gave birth to me. In our tradition, they were quite young, so they did not marry and the report was that they were partners and separated after giving birth to me and it was an amicable separation. Both went and re-marry different people. So, I had to go and live with my dad and step mum. There were no other children in the house for over 18 years and my step mum used to travel a lot for her business trips. So whenever my step-mum is away and I am watching TV programme at home, my dad will then come and join me to watch the TV programme, As time passed by, he will force himself on me and be rubbing his erected penis on my vulva and I will push him away.	Felt useless and helpless, worthless, hopeless & not a normal child. Flashbacks of sexual abuse by dad. Dad has destroyed my childhood and life (Pg94.5). *What purpose does it serve for her? What use it, for it to be maintained?* I was sexually abused by my dad since age 6 to 7 thereabout and I started to SH.

The right-hand margin shows the initial statements made on this section of transcript. The basic text elaborates the descriptive aspect of the transcript. For instance, KATHSED's story of […….], details [……..] and summaries of the descriptive aspect [……..]. The text, which is underlined provides detailed understanding of the content and the meanings the participants attributed to the phenomenon in relation to extant literature on SH. (reasons/what it means to SH).

Becoming Immersed in the Data and Further Development of Themes

As the sample size is quite small and acceptable in IPA data analysis, the next stage involved the use of manual in depth coding of the participants' transcripts (see Chapter three (see chapter 3 section 3.9). I did not use any data analysis software such QSR International NVIVO 7 or others as I felt I will be able to manage the small sample size. I engaged in assigning labels to the potential themes from the first participant's transcript using abstract terms (Creswell, 2013). This gave me a complete list of codes including quotes. An example is presented in the figure below.

Appendix 9 (Box 1): Extract from Coding Report for Participant KATHSED

MEANING OF SH

Felt useless and helpless, worthless, hopeless & not a normal child. Flashbacks of sexual abuse by dad

-Dad has destroyed my childhood and life (Pg94.5)

TRIGGERS OF SH

Experience of flashbacks of sexual abuse by dad

ONSENT OF ABUSE/TRIGGERS TO SH

Flashbacks of sexual abused by my dad. -Onset of SH was around age 7

-I felt blank, empty, sad, depressed and did not see myself as a normal person who was worth living (When L felt lost, sad & angry & took drug overdose)

Pg 92.2. (Stronger than me & overpower me. When my step mum not at home & I am the only one with dad at home, he then sexually abused me)

MEANING OF SH:

- Feel sad, helpless and hopeless so you want to tell your abuser how hurt you are, and you feel emotionally troubled, and you cannot control your thoughts.

-I felt psychologically empty, suicidal and dirty and at the same time I did not want to take my life

-My mum will not believe me and will rather blame me

-Dad has destroyed my childhood and life (Pg94.5)

COPING WITH SH

-read books

-Live in state of disbelief and fear

-Hatred for all men

-Lonely life-style

-I decided to block that parent-child relationship between us.

-Flashback had impact on my academic performance as well.

-My relationship with others not great

-I am paranoid of people and men

-I find it difficult to give full trust to people.

-I sought medical aid when in distress

-No control over my thoughts (Pg 94.7)

STAFF BEHAVIUR /CARE THAT WAS DIFFICULT

-show that empathy to patients and know how to talk to them

-Not to hurt patient feelings

-comment from staff hurt me a lot

- charges/fee paying for therapy for clients who are not working (Pg. 95.9)

Stigma attached to patients

-Poor ventilation system in the room

APPENDIX 9: MASTER THEME

APPENDIX 9 (TABLE 3): ACCRA MENTAL (Identifiers – Page number and Line)

NO	THEME	Part 1	Part 2	Part 3	Part 4	Part 5		Comments
1	I am stuck over here	Pg7.20, Pg8.14	Pg20.8	Pg32.11,24		Pg54.7,17		
2	Let down/Can't get answers/Disappointment/hopeless	Pg9.15 Pg8.1	Pg19.12	Pg32.22 Pg32 21	Pg42.14.16, Pg44.14;20	Pg53		
3	It hurts & abuse	Pg 5.8, Pg6.8.11;Pg7.12	Pg19.15	Pg31.3,12Pg32.12,Pg33.6	Pg42.12; Pg42.5,7	Pg54.14		
4	(-) No Coping skills/Struggle to cope/faulty, emotional relief	Pg9.10	Pg19.1	Pg31.7	Pg43	Pg53		
5	(+) Coping skills(bible/Prayer/OT/Talk	Pg7.16	Pg 21.10	Pg31.10.,12,13	Pg44	Pg54		
6	Suicidal Ideations/guilt & shame, stigma	Pg8.16;9.2;11.1		Pg33.7	Pg42.5			
7	Forms/Triggers of self-harm (Frustration/nervous, mental, supernatural/ Starve/Head bang/cut	Pg5.12	Pg19.1	Pg30.9; Pg30.12,Pg32.24, Pg30.17,31.1	Pg42	Pg54		
8	(+)Staff Reactions(Sympathetic/respect	Pg7.8;	Pg18.8 Pg20	Pg 25, Pg31.17, Pg33.13	Pg44	Pg55		
9	(-)Staff Reactions(attitude/no respect/disagreement/ignore	Pg8.2; Pg 10.8	Pg19.9 Pg 20	Pg32.2,8,Pg32.12	Pg43.9	Pg55		

MASTER THEME

APPENDIX 9 (TABLE 4) KATH (Identifiers – Page number and Line)

NO	THEME	Part 1	Part 2	Part 3	Part 4	Comments
1	I am stuck over here	Pg6419	Pg72.11			
2	Let down/Can't get answers/Disappointment/hopeless	Pg64.4,9,Pg65.1	Pg69.2,3,27	Pg82.5, 17Pg83.1	Pg94.2	
3	It hurts & abuse	Pg64.4,21; Pg64.6,9,20	Pg69.3	Pg82.7,Pg83.7; Pg83.14	Pg94 13; Pg97.6; Pg94.3,Pg97.7,18	
4	(-)No Coping skills/Struggle to cope, faulty, emotional relief					
5	(+) Coping skills(bible/Prayer/OT/Talk					
6	Suicidal Ideations, guilt & shame, stigma	Pg64.9,13, Pg65.3	Pg69.4,Pg70.7	Pg82.17,Pg83.4	Pg96.8	
7	Forms/Triggers of SH (Starve/Head bang/cut	Pg65.12	Pg69.2,Pg70.3 Pg69.3,3,Pg70.17	Pg83.4 Pg82 15,Pg83.2	Pg94.2	
8	(+)Staff Reactions(Sympathetic/respect			Pg84.8		
9	(-)Staff Reactions(attitude/no respect/disagreement/ignore, anger resentment	Pg8.2		Pg84.9		

Appendix 10 Declaration 1 Form

DOCTORAL SCHOOL

Declaration of Originality by Postgraduate Candidate (for soft bound thesis)

Candidates for postgraduate degrees must present this completed form to askUS, Student Administration, ground floor, University House, when submitting their **two** soft-bound theses. In addition, an electronic version of the thesis (pdf format) should be sent to the candidate's Research Support Officer.

Name of candidate (in BLOCK CAPITAL LETTERS as it appears on the thesis) ANDREWS DAKE

Student number: ……….@00379461. School: SCHOOL OF HEALTH AND SOCIETY

Degree (PhD, DMA, Professional Doctorate, MSc, MPhil, MRes – Please specify):…….PHD……

This is to certify that the copy of my thesis, which I have presented for consideration for my postgraduate degree: -

1. embodies the results of my own course of study and research
2. has been composed by myself
3. has been seen by my supervisor before presentation
4. has been granted the appropriate level of ethics approval

If you have a Student support or reasonable adjustment plan, please indicate if you would like this to be shared with your examiners ……………………………………………………………………………………..

Signature of candidate: …..andydake…………………………………….. ..Date: 05.06.2021……….

Email address (to which information concerning examiners' decision and final binding can be sent):

A.Dake@edu.salford.ac.uk.

The candidate's supervisor is asked to declare here that s/he has approved the submission of the thesis. If the supervisor decides to withhold approval, the candidate shall have the right of appeal to the Associate Dean of Research and Innovation. A candidate may be permitted to submit a thesis despite the Supervisor withholding approval, providing the Associate Dean of Research and Innovation approves submission.

HeCoS codes (please add up to 3 HeCoS codes which best fit with the student's research area). You will find the list of HECOS codes at https://testlivesalfordac.sharepoint.com/:x:/r/sites/DoctoralSchoolHub/Shared%20Documents/HECOS%20List.xlsx?d=w3884f73079bd4766b3571d4e3401e928&csf=1&web=1&e=OagDNA

….HECoS CODE 100287/100473/100476

Signature of Supervisor: ……… Date: ………6TH June 2021…

[For your information the dates of the Postgraduate Research Awards Board are published here https://testlivesalfordac.sharepoint.com/sites/DoctoralSchoolHub/SitePages/Postgraduate-Research-Awards-Board-(PRAB)-Dates.aspx]

Please note that the completed declaration form must accompany the softbound thesis when presented to Student Administration