

# Channeling the Right Path-to-care: Improving Religious Leaders' Knowledge and Beliefs about Suicide Prevention in South West Nigeria

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## Research article

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## **Channeling the Right Path-to-care: Improving Religious Leaders' Knowledge and Beliefs about Suicide Prevention in South West Nigeria**

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### **Abstract**

#### **Background**

In African societies, the path-to-care that the ill and their relatives seek via consultation of traditional and religious healers is related to the concept of the causation, nature and origin of mental illness. There is a shortage of mental health personnel and facilities in Nigeria; hence, alternative healthcare providers such as Religious Leaders are often sought first. This intervention research was conducted with the aim of improving knowledge, beliefs and practices of Religious Leaders in relation to depression and suicide and their understanding of their role in suicide prevention.

## Methods

This comparative cross sectional study with 102 Religious Leaders was conducted in two states in South West Nigeria. Religious Leaders were invited for a day medico-religious training on depression and suicide prevention among their congregation. Measures for inclusion comprised of correctly filled and completed semi-structured questionnaires pre and post training.

## Results

Out of 102 Religious Leaders, 58.8% were 50 years and above, 76.5% were males. The average years of clerical experience as Religious Leaders was 15.9 years. Most of them (82.4%) had no previous training in suicide prevention and the average congregation size of Religious Leaders in Lagos was larger than Ile-Ife (Osun) (256 vs 113). Only a few Religious Leaders (21.6%) counseled at least an individual with suicidal thoughts, 3 months preceding the training, while most (57.8%) of them noted that there are penalties for members of their congregation who attempted or died by suicide. The average knowledge score at pretest and post-test were 3.37 and 5.98 respectively out of a total score of 8. Percentage difference in knowledge scores from pretest to post-test showed a drop in low and fair scores by 19.6% and 54.9% respectively and an increase in good and very good scores by 46.1% and 28.4% respectively.

## Conclusion

The outcome of this intervention in improving Religious Leaders' knowledge about depression being a medical condition and a major contributor to suicide has far-reaching implications on suicide prevention. In particular, through their involvement in this

medico-religious collaboration, Religious Leaders have the right information required to preach and counsel towards encouraging their congregation to seek appropriate mental health care.

**Key words:** suicide, depression, Religious Leaders, knowledge.

## **Background**

Globalization, culture and religion may influence the patterns of occurrence of suicide globally and these may affect the way suicide is viewed across the globe. Some local literature portray evidence of these changing times[1,2]. It was reported in an earlier study of suicide in Western Nigeria that depressive forms of mental illness were rare in Africans[3]. Today, we know that they are no longer rare in Africans[4]. A lot has evolved as shown in local literature where estimates of lifetime prevalence of suicidal ideation, plan and attempts among the general population are put at 3.2%, 1.0% and 0.7% respectively. It has also been found that two-thirds of those with suicidal ideation who had planned the act go on to attempt suicide[4].

Researchers have shown that a psychiatric conditions is associated with a higher risk of suicide attempts, with the highest risk being found for mood or affective disorders, followed by personality disorders and schizophrenia, however the strongest single predictive factor for suicide attempts was prior history of attempts[5]. Other psychiatric conditions are also linked to suicide in different ways; for instance, panic disorder and substance abuse in parents have been associated with suicide ideation in their children, also, panic disorder among parents predicts the onset and persistence of suicide ideation and attempts[6].

This link between mental disorders and suicidal ideations and behaviours, as well as for completed suicide, is supported by results from a recent World Health Organization (WHO) project on suicidal behaviours in several countries including Nigeria[7]. This project interestingly found that among the mental disorders associated with higher risk of suicide, in developing countries, the association is higher with diagnoses other than affective disorders, (such as Substance Use Disorders and Post-Traumatic Stress Disorders), whereas in developed countries the association with affective disorders stands out.

Alcohol and drug use predicts subsequent suicide attempts and the number of substances used appears more important than the types of substances used[8]. Alcohol misuse has been found to be more associated with male suicide attempts[9]. Interestingly though, Borges et al found that the effects of substance use are largely on suicidal ideation and non-planned attempts among those with ideation[8].

Suicide may also be associated with general medical conditions[10,11] comorbid with psychiatric disorders as some studies suggest that patients who suffer with medical conditions such as diabetes and who also have a psychiatric illness receive poorer care from medical practitioners than other medical patients and so they are more likely to have poor long-term glucose and lipid control[11]. Patients with chronic medical conditions are also at increased risk for developing a major depressive disorder at some point during their lifetime, with between 10% to 30% of them having concurrent depression[12,13].

Studies have found that suicide attempts are higher among females compared to males[14], with one of such studies reporting that significantly more suicidal thoughts and suicide attempts occur at younger age among females than males[15]. Aghanwa

found that factors such as younger age, lack of employment, marital problems were more influential in female suicide attempts, however, he reported that male attempters were more likely to have the intention of dying[9].

Also, highlighting demographic attributes, Nock et al in a systematic review of studies on suicide epidemiology published between 1997 and 2007 found that non-fatal suicidal behaviours are more prevalent among women, young unemployed, unmarried individuals with low levels of education and suffering from a psychiatric disorder[16].

Harriss and colleagues measured suicide intent among cases of self-harm using the Beck Suicide Intent Scale (SIS) and found that suicide was more strongly associated with scores on the circumstances section than the self-report section of the scale. They also found that suicidal intent was associated with risk of subsequent suicide, especially within the first year and among female patients[17].

Psychosocial stressors identified as contributing to suicidal intent, include unemployment, medical illness and relationship challenges and family conflicts[18,19]. Religion has been explored in terms of its relationship with suicidality[20,21], with some studies finding that religious service attendance may have some protective effects among some, but not all groups of samples[22,23]. Protective factors cited in literature include having a job and living with a partner, especially in a confiding relationship[22].

The understanding of the attitudes of the populace towards mental illness is believed to help researchers identify cultural and spiritual connotations of mental health in Nigeria[24]. These cultural and spiritual beliefs influence the attitude of Nigerians towards the mentally ill and determining how people relate to those with mental illness[25]. Furthermore, inaccurate labelling and discrimination of those with mental

disorders is linked to negative societal attitudes[26], such as, portraying them as dangerous, unreliable, irresponsible or homicidal, among others[24]. Also, poor knowledge and inadequate healthcare funding contribute a major hurdle to proper treatment-seeking behavior for mental illnesses in Nigeria. A change in perception towards mental illness will result in a better demand for mental health care services in Nigeria[27].

### *Spirituality and mental health.*

In African societies, the path-to-care that the ill and their relatives seek via consultation of traditional and religious healers is related to the concept of the causation, nature and origin of mental illness[28,29]. These unorthodox sources of care remain unchecked because there is a paucity of adequate mental health care services in Nigeria. This is largely due to shortage of mental health personnel and facilities in the country. There were eight psychiatric hospitals to serve a population of over 150 million[30] and also low ratio of psychiatrists 0.09 per 100,000 population[31], hence, increasing the likelihood for alternative sources of care. This is conspicuous in the rural regions, where their belief systems influence their practices and the remedies they offer for mental illnesses[32,33]. These remedies are often provided by Herbalists and Religious Leaders, making them alternative healthcare providers and gate keepers who are often sought first[29]. This pattern is commonly reported in Africa, as well as in Asia[29]. It would be unwise to ignore the role these alternative care providers play in a society considering the dire shortage of trained orthodox mental health care providers. Hence, it has become imperative to engage and collaborate with these care providers through training and their enlistment as gate-keepers. Therefore, educating Spiritual Leaders, such as Islamic

Clerics and Christian Clergy about mental illnesses and suicide, especially in the rural regions may provide a panacea for reducing the prevalence of suicide.

The third sustainable development goal (SDG)[34], which is good health and well-being, targets to reduce by a third, those who die prematurely from non-communicable disease as well as to promote mental health and well-being by 2030[34]. The WHO's target to reduce suicide by 10% by 2020[35] is in keeping with this sustainable development goal[34]. Based on the aforementioned, this medico-religious intervention research was organized with the aim of promoting awareness, improving knowledge and role of Religious Leaders in depression and suicide prevention in Lagos and Osun States, South West Nigeria. This medico-religious intervention research was achieved by establishing a collaborative relationship between Religious Leaders and Mental Health Specialists. It was aimed at enabling Religious Leaders identify suspected suicide cases and link them to Mental Health Specialists in the communities.

## **Methods**

### **Participants and Setting**

This comparative cross sectional study was conducted at Idi araba in Lagos State and Ile-Ife in Osun State. One hundred and two Muslim and Christian Religious Leaders were recruited for the medico-religious training on suicide prevention held simultaneously at Idi-Araba and Ile-Ife. Measures for inclusion comprised of correctly filled and completed semi-structured questionnaires pre and post training.

### **Pre-intervention phase**

Scoping meetings were conducted in Idi-Araba in Lagos State and Ile-Ife in Osun State through engagement of Leaders of Christian and Islamic Civil Organizations. The Religious Leaders were sensitized and informed of the purpose of the intervention at three meetings arranged in the study locations. The focus of the training was to equip Religious Leaders with knowledge about suicide and its prevention, to enable them provide correct information to their congregation, spot cases of depression and potential suicide among them and others in the community.

Medico-religious training on suicide prevention was approved by the Heads of Religious Civil Societies. Training logistics such as date, venues and content were communicated to the Religious Leaders. Training was publicized through social media, radio jingles and invitation letters sent to religious bodies in Lagos and Osun States.

### **Intervention phase**

The trainings were conducted as scheduled in the Teaching Hospital premises in Lagos and Osun States. Lectures were delivered by Mental Health Specialists and the following areas were covered;

- suicide epidemiology,
- signs, symptoms and treatment of depression,
- warning signs of suicide and factors contributing to suicide and
- suicide prevention.

## Study instruments and data collections

Fifteen item generic questionnaires were administered to Religious Leaders before and after the training. The questionnaire obtained basic bio-data information, assessed their beliefs and practices about suicide and depression. This 15- item questionnaire was a modified adaption from the Suicide Opinion Questionnaire (SOQ)[36], which is a 100- item questionnaire measuring opinions about suicide, as well as the 63- item Suicide Attitude Scale (SUIATT)[37]. SOQ also has some items assessing knowledge and belief and is a widely researched suicide questionnaire. The SUIATT measures attitudes towards suicide. The SOQ was not used in its entirety because it has been critiqued that it may have a drawback of assessing too many constructs, thereby making it difficult to establish stable factor structures[38]. The SUIATT addressed some of the concerns about the SOQ.

The components related to depression were adapted from questionnaires previously used by researchers with good psychometric properties[39,40]. The resulting 15 items also related to the content of the training described above and their belief, practices and roles were assessed based on their response to eight items on the questionnaire related to depression (4 items) and suicide (4 items). The responses to these items were scored 1 for a correct answer and 0 for an incorrect answer, yielding a total score of 8. The knowledge was categorized as Low = score 0-2 (up to 25% correct answers), Fair = score 3-4 (above 25% to 50% correct answers), Good = score 5-6 (above 50% to 75% correct answers) and Excellent = score 7-8 (above 75% correct answers).

The questionnaire was reviewed by seasoned Religious Clerics and seasoned experts and researchers in the field for its appropriateness, before being administered. The Religious Leaders were also engaged in group discussions (not reported in this article).

### **Data analysis**

Descriptive analysis was employed to summarize responses from the one hundred and two Religious Leaders who correctly and completely filled both pre and post-test questionnaires. Data were analyzed using IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp[41].

The baseline socio-demographic characteristics of respondents, clerical attributes, perceived psychosocial contributors to suicide, knowledge about suicide, attitude towards suicide and item responses for pretest and post-test were summarized using frequencies and proportions. The pretest knowledge and post-test knowledge were compared against respondents' belief about suicide not being a spiritual attack, using McNemar's chi square tests. A p-value of less than or equal to 0.05 was used as the threshold for significance.

### **Results**

#### **Response rate**

All the Religious Leaders completed the questionnaire in this study, giving an overall response rate of 100%.

More (59.8%) of the Religious Leaders were 50 years and above. The mean age was 51.6 years (S.D. 10.16) with the Ile-Ife group being slightly older with a mean age of 53.3 years (S.D. 11.17), compared to the Lagos group with mean age of 49.3 years (S.D. 8.13).

The Religious Leaders were mostly male (76.5%) and majority of them belonged to the Yoruba tribe (85.3%). Almost all of them (92.2%) were married and they were mostly of the Christian faith (66.7%) (Table 1). Most of them had completed tertiary or secondary education (65.7%). About half (51.7%) of the respondents had more than 10 years clerical experience as Religious Leaders, with the average years being 15.9 years. (Table 1) Cumulatively most of them (82.4%) had no previous training in suicide prevention, more so for Lagos Religious Leaders (93.0% vs 76.3%) (Table 1).

The average congregation size of Lagos Religious Leaders (256) was larger than Ife Religious Leaders (113). The Religious Leaders believed that the top ranking contributors to suicide were economic and financial issues (69.6%), marital problems (43.1%) and mental illness (38.2%) (Table 2).

Attitude of Religious Leaders towards suicide showed that, most of them (88.2%) felt obligated to help people who have suicidal ideation, also, 90.2% believe that religion aids suicide prevention, while 97.1% believe suicide is a sin and 66.7% believe that religious counseling can help prevent suicide. Few of the Religious Leaders had counseled anyone with suicidal thoughts in the past 3 months (21.6%) and were aware of any suicide attempt among their congregation 3 years preceding this research (16.7%). Less than a fifth of them (17.6%) were aware of completed suicides among their congregation in the past 3 years and less than half (41.2%) had resources in their places of worship to prevent suicide. Only a few of them (29.4%) had mentioned suicide during service in the past 3 months and they (57.8%) recommended penalties for the members who attempted or died by suicide. Fifty-nine Religious Leaders (57.8%) were also willing to counsel non-members of their congregation on suicide prevention (Table 3).

### **Pre-test and Post-test suicide knowledge scores**

The average pretest and post-test suicide knowledge scores of Religious Leaders were 3.37 and 5.98 respectively, out of a maximum obtainable score of 8 (not shown in table). Pretest scores showed that twenty Religious Leaders (19.6%) had good/ very good knowledge about suicide, while the post-test scores showed that almost all (94.1%) had the good/ very good knowledge. The percentage difference in pretest and post-test knowledge scores were 19.6% (a drop) for low, 54.9% (a drop) for fair, 46.1% (an increase) for good and 28.4% (an increase) for very good (Table 4).

The association between pre and post-test suicide knowledge scores among Religious Leaders was statistically significant. Overall, there was improvement in post-test suicide knowledge scores. The proportion of Religious Leaders that had low/fair suicide knowledge scores reduced from 80.4% for pretest to 5.9% for post-test, while the proportion with good/very good knowledge score improved from 19.6% for pretest to 94.1% for post-test; these differences were statistically significant ( $p= 0.006$ ) (Table 5).

### **Discussion**

The Religious Leaders are mostly male, as it is not unusual as Religious Leadership is still largely male dominated in many parts of the world[42]. It is also not unexpected that they are mostly married which puts them in a good position to counsel their congregation on marital and relationship issues which are common psychosocial stressors[18,19,25]. Same applies to their relatively educated status which can also serve them in good stead. Their experience as Religious Leaders is considerable and vast enough, averaging over a decade and a half, to make them good authorities in their field.

The fact that over four-fifths of the Religious Leaders had no previous training in suicide prevention, underscores the importance of such trainings. Religious Leaders have already been identified as key stakeholders in suicide prevention and they will benefit from the requisite training to be able to play such a role at all and effectively[43]. There had been a number of suicides in the South West Nigeria and Religious Leaders could play an important part in prevention of such cases. This is particularly important considering the large average size of their congregation.

The Religious Leaders ranked economic/financial problems, marital problems, mental illness and a lack of support as the top contributors to suicide based on their experience drawn from interactions with members of their congregation. This is again in keeping with past findings by some authors[25,26]. Their attitude towards people who may be suicidal reflects their religious beliefs, as most of them felt obligated to help and believe that religion can help prevent suicide. Despite this, most of them had not been involved in suicide prevention counseling, which is probably related to the fact that most of them reported lack of suicide prevention resources in their institutions. This may be connected to the lack of previous training on the topic, including the cultural denial and stigma associated with suicide.

Suicide is still associated with stigma and discrimination[44,45], thus, the finding that most of the Religious Leaders reported having penalties for members who attempted or died by suicide. This calls to attention, the need to reduce stigma associated with suicide and mental illnesses in general[44,45]. Such punishments tend to include not performing religious burial rites for the deceased and can trigger shame and stigmatization among the family of the deceased, therefore, exposing them to the same fate suffered by the

deceased[27,46]. This inhibits help-seeking behavior among others. It has been estimated that suicide affects at least six other people[28] and all these people need support rather than stigmatization or ostracizing exclusion[46]. To address this problem, the Religious Leaders no doubt need to be involved. Their gain in knowledge of mental illnesses will help them offer the necessary support, which in turn will promote appropriate treatment-seeking for such conditions like depression, for which ,most of the Religious Leaders had also never received training.

The outcome of the training is evident from the gain in the knowledge of the Religious Leaders that depression is a medical condition and that it is caused by abnormal serotonin levels, hence it can be managed medically. This understanding of causation is very important. It has been reported that a better understanding of mental illnesses can help ameliorate the high levels of stigma associated with them[29,47]. This shift in attitude may potentially influence how they manage cases of mental illness among their congregation and as such, a better understanding can go a long way in promoting the appropriate medical treatment and ultimately, preventing suicide. It is noted that some of the Religious Leaders are fastidious about their belief of a spiritual causality of suicide. This is connected to their erroneous traditional and cultural beliefs about suicide in Nigeria. Therefore, Suicide and depression prevention trainings should be advocated and implemented nationwide. It has been stated by the WHO that effective preventions can occur at the individual, sub-population and population levels[48]. The Religious Leaders' appreciation of the fact that depression is a medical condition and a major contributor to suicide, can have positive and far-reaching implications on suicide prevention through

their preaching, counseling and involvement in a medico-religious collaboration towards improved mental wellbeing of the populace.

## **Conclusions**

The outcome of this intervention in improving Religious Leaders' knowledge about depression being a medical condition and a major contributor to suicide has far-reaching implications on suicide prevention. In particular, through their involvement in this medico-religious collaboration, Religious Leaders have the right information and knowledge required to preach, counsel and encourage their congregation to seek appropriate mental health care. This will improve mental and wellbeing of the populace.

## *List of abbreviations*

WHO	World Health Organization
SIS	Suicide Intent Scale
SDGs	Sustainable Development Goals
SOQ	Suicide Opinion Questionnaire
SUIATT	Suicide Attitude Scale

## **Declarations**

### *Ethical approval*

The ethical review board of the affiliated health institution, Lagos University Teaching Hospital approved the study.

### *Consent for publication*

Written consent for participation, use of photograph and test scores was sort from the participants.

#### *Availability of data and materials*

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

#### *Competing interests*

There is no competing of interests to declare.

#### *Funding*

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#### *Authors' contributions*

The workshop was led by principal investigator, REO. The facilitators of the workshop for Lagos and Ile-Ife training were MYI, OAA and BO. Participant logistic was done by MYI, AO, OAA and PA. All the facilitators participated in the data collection and collation. The data management was done by REO and OAA. Manuscript preparation was done by all co-authors. All authors have read and approved the final manuscript.

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**Table 1 Socio-demographic Characteristics and Clerical attributes of Religious Leaders**

<b>Socio-demographic characteristics</b>	<b>n</b>	<b>(%)</b>	<b>Total</b>
	<b>= 102</b>		
<b>Age</b>			
20 – 39 years	10	(9.8)	
40 – 49 years	31	(30.4)	
≥ 50 years	61	(59.8)	
<b>Sex</b>			
Female	24	(23.5)	
Male	78	(76.5)	
<b>Tribe</b>			
Yoruba	87	(85.3)	
Igbo	5	(4.9)	
Hausa	3	(2.9)	
Other	7	(6.9)	
<b>Marital Status</b>			
Single	5	(4.9)	
Married	94	(92.2)	
Divorced/Separated	0	(0)	
Widowed	3	(2.9)	
<b>Religion</b>			
Christianity	68	(66.7)	
Islam	34	(33.3)	
<b>Educational Level</b>			
None	1	(1.0)	
Complete Primary	13	(12.7)	
Complete Secondary	29	(28.4)	
Complete Tertiary	38	(37.3)	
Complete Post – Graduate	17	(16.7)	
Other Forms	4	(3.9)	
<b>Year of Clerical Experience</b>			
1 – 5 years	13	(12.7)	
> 5 – 10 years	21	(20.6)	
> 10 years	52	(51.0)	
Not stated	16	(15.7)	
<b>Any Previous Suicide Prevention Training?</b>			
Yes	18	(17.6)	
No	84	(82.4)	

**Table 2 Perceived Psychosocial Contributors to Suicide**

<b>Variables</b>	<b>n</b>	<b>(%)</b>	<b>Total</b>
	<b>= 102</b>		
Financial	71	(69.6)	
Mental Illness	39	(38.2)	
Lack of Social Support	36	(35.3)	
Ageing	12	(11.8)	
Marital Problems	44	(43.1)	
Tribal Issues	7	(6.9)	
Alcohol Abuse	23	(22.5)	
Other Drug Abuse	34	(33.3)	
Medical Illness	17	(16.7)	

\*There multiple representations of opinions

**Table 3 Attitude towards Suicide**

	Yes	
	n	(%) Total = 102
• Obligated to help those who are suicidal?	90	(88.2)
• Can Religion prevent suicide?	92	(90.2)
• Is suicide a sin?	99	(97.1)
• Can Religious counseling help prevent suicide?	68	(66.7)
• Have you counseled someone with suicidal thoughts in the past 3 months?	22	(21.6)
• Are you aware of any suicide attempts among your congregation or their relatives in past 3 years?	17	(16.7)
• Are you aware of suicide deaths among your congregation or their relatives in past 3 years?	18	(17.6)
• Does your religious body have resources for suicide prevention (e.g. books, leaflets)?	42	(41.2)
• Have you ever mentioned suicide during service in past 3 months?	30	(29.4)
• Are there any penalties for your members who attempt suicide?	59	(57.8)
• Are you willing to counsel a non-member of your religion who is having suicidal thoughts?	59	(57.8)

\*There were multiple representations of opinions

**Table 4 Knowledge about Suicide**

<b>Pretest</b>	
Low Knowledge	20 (19.6)
Fair Knowledge	62 (60.8)
Good Knowledge	19 (18.6)
Very Good Knowledge	1 (1.0)
<b>Post- test</b>	
Low Knowledge	0 (0)
Fair Knowledge	6 (5.9)
Good Knowledge	66 (64.7)
Very Good Knowledge	30 (29.4)
<b>Percentage Change (Pretest – Post-test)</b>	
Low Knowledge	19.6 – Fewer Respondents
Fair Knowledge	54.9 – Fewer Respondents
Good Knowledge	46.1– More Respondents
Very Good Knowledge	28.4 – More Respondents

**Table 5 Association between pre and post-tests suicide knowledge scores among Religious Leaders**

<b>Knowledge</b>	<b>Pretest n (%)</b>	<b>Post-test n (%)</b>	<b>Statistics</b>
Low/fair	82 (80.39)	6 (5.88)	P = 0.006 McNemar's chi square=7.54
Good/very good	20 (19.61)	96 (94.12)	