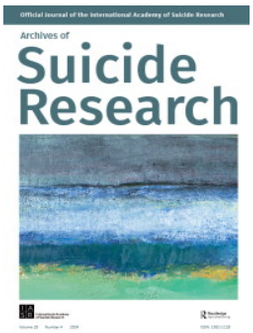

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ABSTRACT

Background: Suicide and self-harm are global disease burden that contributes significantly to years of lost life and mortality. Despite the increasing rates of suicide and self-harm in Nigeria, this topic is understudied.

Methods: A mixed-methods design was adopted. Study 1 interviewed $n = 18$ participants ($n = 11$ clinicians; $n = 5$ patients with a history of self-harm and suicide ideation; and $n = 2$ caregivers). All interviews were audio-recorded, transcribed verbatim, and analyzed using IPA. Study 2 surveyed $n = 562$ non-clinical sample about their tolerance toward self-harm and the data was analyzed using One-way ANOVA in SPSS.

Results: Study 1 qualitative findings showed substance use, perceived rejection and social isolation were considered predisposing factors for suicide and self-harm. Cultural and religious beliefs shaped help-seeking behaviours. Although Study 2 found no significant differences in demographic characteristics concerning public tolerance toward persons with a history of self-harm, 64% believed that individuals who died by suicide would face punishment after death; 51% believed that victims of attempted suicide are a source of shame to their families; and 33.8% agreed that dying by suicide is the correct behaviour.

Conclusions: Patients with a history of self-harm and suicidal ideation consider family members and close friends as valuable sources of support. Due to the potential clinical implication of cultural and religious beliefs, as shown in the present study's findings, the authors recommend a co-development of culturally appropriate psychological intervention for persons with a history of self-harm and suicidal ideation to be tested in randomized control trials.

KEYWORDS

Clinicians; family caregivers; Nigeria; psychological intervention; self-harm; suicidal ideation

BACKGROUND

Self-harm and suicidal ideation represent a significant global public health concern (Knipe et al., 2022), affecting about 14.6 million people yearly (Nichols et al., 2021). Globally, over 700 000 people die by suicide annually (World Health Organization,

2023). Suicide remains the second leading cause of death among individuals between the ages of 15 and 29 (Arensman et al., 2020). In Africa, suicide is considered a psychiatric emergency (Knipe et al., 2022), given the high mortality rates and a prevalence of 34,000 suicides annually and an incidence of 3.2 per 100,000 (Mars et al., 2014). A recent systematic review on self-harm with suicidal and non-suicidal attempts in Sub-Saharan Africa found considerable empirical gaps in the literature, with a dearth of research emanating from less than 40% of the countries within the studied region. Most research disproportionately stemmed from South Africa (Quarshie et al., 2020). From an epidemiological stance, about 77-85% of suicides globally emanate from low and middle-income countries (LMICs) (Necho et al., 2021; World Health Organization, 2023), including Nigeria, with very little research stemming from the regions. Despite such staggering statistics, suicide remains grossly under-reported in LMICs partly due to stigma and discrimination faced by lived experiences, their family members and carers. Yet, there is a shortage of evidence-based psychological interventions dedicated to treating and preventing behaviours of suicide and self-harm within the Nigerian culture and context. In this paper, we have defined "self-harm" as a deliberate injury to oneself whilst "suicidal ideation" as persistent thoughts of dying by suicide due to psychological distress (Harmer et al., 2022).

Understanding public attitude is important to inform suicide and self-harm prevention strategies. When individuals react negatively to people who engage in self-harm, such reactions often worsen the outcome and lead to more episodes of self-harm (Nilsson et al., 2020). Most literature that explored attitudes toward individuals who engage in self-harm largely focused on healthcare professionals. Healthcare providers' attitudes toward individuals engaged in self-harm are reported to be negative, with doctors holding more negative attitudes than nursing staff (Saunders et al. (2012).

Whilst attitude toward self-harm has been extensively researched in the healthcare and criminal justice systems, very little is known about it in the general population. Exploring the social context of self-harm within non-clinical settings is particularly important since individuals who engage in self-harm spend most of their time outside hospital settings (Nilsson et al., 2020). To the best of our knowledge, no study has previously investigated the lived experiences of persons with a history of self-harm and suicidal ideation, including clinicians/carers and the public tolerance toward persons with a history of self-harm and suicidal ideation in Nigeria. Thus, this study presents an original unexplored niche in literature. The present study adopts a mixed methods design to investigate self-harm and suicidal ideation among clinical and non-clinical populations.

Study 1 (qualitative) aims to investigate (i) the lived experiences of patients with history of self-harm and suicidal ideation in Nigeria and (ii) the lived experiences of family caregivers and clinicians supporting patients with history of self-harm and suicidal ideation.

Study 2 (quantitative) aims to build on study 1 to further examine a non-clinical population's tolerance toward self-harm and opinions about suicidal ideation. Furthermore, study 2 hypothesized that participants' tolerance toward self-harm

would vary across sociodemographic outcomes such as gender, age, employment, and marital status.

METHOD

Design

The study adopted a mixed-methods design, which combines quantitative and qualitative approaches to explore lived experiences and perspectives of self-harm and suicidal ideation among clinical and non-clinical samples. In Study 1, a qualitative approach was employed using interviews to examine the lived experiences of individuals who engaged in self-harm and suicidal behaviours, including the experiences of clinicians and family caregivers, using interpretative phenomenological analysis (IPA). IPA is most appropriate for examining participants' lived experiences.

Study 2 was built on the findings of Study 1 which cross-sectionally surveyed the public to understand their perspectives about individuals with a history of self-harm or suicidal ideation. The quantitative data from the survey was analyzed using One-way Analysis of Variance (ANOVA). One-way ANOVA is most appropriate for comparing means of independent variables on the dependent variable. The overreaching aim of using a mixed methods design is to ensure robust and comprehensive coverage of the study's aims and objectives (Jidong et al., 2022) following the Medical Research Council's recommendation of mixed methods studies for examining mental health topics in preparation for sustainable interventions (Skivington et al., 2021).

Ethics Approval and Consent to Participate

Studies received ethical approval from the Jos University Teaching Hospital Research Ethics Committee in Nigeria (Ethics Ref: JUTH/DCS/IREC/127/XXXI/2579). Participation in both studies was voluntary, and participants were informed of their rights to withdraw participation without being obliged to give reasons. Participants in Study 1 signed written informed consent, while participants in Study 2 gave verbal consent. Participants were all assured of confidentiality and anonymity, among other ethical rights.

Study 1: Participants, Interview Questions, Data Collection and Analysis

Purposive and snowball sampling techniques were adopted to recruit and interview $N = 18$ participants ($n = 11$ clinicians [$n = 5$ clinical psychologists, $n = 4$ psychiatric doctors, and $n = 3$ psychiatric nurses]; $n = 5$ patients with a history of self-harm and suicide ideation; and $n = 2$ family caregivers). These semi-structured interviews were conducted face-to-face (see Table 1). The semi-structured interviews lasted approximately 70 minutes each and qualitative data saturation was reached. Data saturation was determined during interviews when no new information was forthcoming from interviewing the 17th and 18th participants.

Interviews were conducted and transcribed verbatim by four (4) experienced clinical research assistants with MSc-level training in clinical psychology (i.e., CF, SM, JD, &

TABLE 1. Sample interview questions.

S/n	Patients and Service users	Clinicians and Caregivers
i.	Please, can you tell me anything about self-harm and suicidal ideation?	What are your experiences of working with patients experiencing suicidal ideation or engaging in self-harm?
ii.	What do your community/family members think about people with a previous history of suicide and self-harm?	What do you think are the drivers or causes of suicidal ideation or self-harm?
iii.	Do you think cultural/religious beliefs play any role in understanding suicide/self-harm and its treatment?	Can you tell me about the available treatment options at your disposal for treating/supporting patients with a history of suicidal ideation or self-harm?
iv.	What kind of health support do you think can be beneficial for the better mental well-being of people suffering from self-harm or suicidal ideation?	Do you think the cultural/religious beliefs of the indigenous patients you support/treat here play any role in your service provisions?
v.	Following your experience of self-harm and suicide, what do you think could be essential in enhancing better mental well-being for people suffering from self-harm or suicidal ideation?	What could be unique/peculiar about the patients you treat/support that is different from the mainstream western perspectives?

JJ). Both audio and transcribed data were cross-checked for accuracy and analyzed by two senior academics (DJ & TI). All interviews ($n = 18$) were audio-recorded, transcribed verbatim and analyzed using interpretative phenomenological analysis.

Study 2: Participants, Instruments, Data Collection and Analysis

We utilized convenient/snowball sampling techniques and recruited $n = 562$ samples of non-clinical participants from mostly urban areas of Oyo and Ekiti states located in the Southwest and Plateau state in the North-central parts of Nigeria. A compact questionnaire was administered face-to-face using the pen-and-paper approach. Eligible participants verbally consented before they participated in the research. The questionnaire captured demographic data such as gender, age, employment, and marital status. The subsequent questionnaire sections include the Lund Tolerance Toward Self-Harm Scale (LUTOSH) (Nilsson et al., 2020). All completed and valid paper/pen questionnaire data were entered into an Excel sheet by the field clinical research assistant (CRA). Another independent CRA conducted validity checks to ensure the accuracy of the paper data entered in the Excel sheet in preparation for analysis in the Statistical Package for Social Sciences (SPSS). An SPSS version 25 was used to analyze the quantitative data in Study 1. Specifically, descriptive statistics using frequencies and percentages were employed to analyze participants' sociodemographic data, and tolerance toward self-harm. One-way analysis of variance (ANOVA) was used to analyze the survey data.

RESULTS

Study 1: Qualitative Findings

Analyzed data sets revealed the following overarching themes (i) predisposing factors for self-harm and suicidal ideation (iia) Help-seeking behaviours of patients with a

history of self-harm and suicidal ideation (iib) Cultural and religious beliefs in help-seeking behaviours, and (iii) Clinicians' perspectives of sustainable intervention for self-harm and suicidal ideation. Direct verbatim data extracts support each theme with participants' pseudo names to help retain the ideographic theoretical element of interpretative phenomenological analysis.

Theme 1: predisposing Factors for Self-Harm and Suicidal Ideation

Data sets showed various contributing factors predispose individuals to self-harm and suicidal behaviors. Stephaney (25-year-old female patient) said:

> "So many people have different reasons- and some people as a result of them giving up on life and some other reason for depression that it's chronic, which would have led him to want to commit suicide. There's a reason to that-"

Stephaney referred to depression as a contributing factor in the development of suicidal ideation and self-harm but acknowledged that a wide range of reasons might predispose someone to have suicidal thoughts. Reference to "giving up" may speak to hopelessness in individuals who experience suicidal ideation and self-harm. Importantly, Stephaney recognized that these thoughts are a reason to occur. Emphasis on this point could be interpreted as her highlighting to us that the cause or origin of the problem is external or beyond the fault or control of the individual. Even though Stephaney is a patient with a history of self-harm and suicidal ideations, she seems to dissociate herself from the extract using third-person pronouns, which may depict feelings of self-guilt or stigma associated with her current state.

Similarly, Simon (a 27-year-old male patient) speaks of mental illness, particularly depression, as a predisposing factor for suicide. Simon further speaks of rejection from close friends and family as an important factor in developing depression.

> "Depression, rejection as they say, cannabis, I don't know about but that's what the psychologist told me that cannabis is also contributing to my depression. But the main thing is depression- is depression and loss of items [fortunes or assets] and rejection by your close friends, family or loved ones".

The interpersonal conflicts in Simon's extract mentioned that rejection from loved ones contributes to mental distress, suicidal ideation, and self-harming behaviour. Rejection is powerful in that it can trigger difficult, strong emotional reactions such as anger, sadness, anxiety, and depression. If a person has difficulty regulating emotions, this may lead to poor impulse control, using unhealthy coping strategies such as drug use or engaging in risky self-harming behaviour.

Theme 2a: Help-Seeking Behaviours of Patients with History of Self-Harm and Suicidal Ideation

While it is commonly considered that the stigma around suicidal ideation and self-harm may be a barrier to help-seeking, participants reported reaching out to a healthcare professional or a family member for support. Similarly, this idea of social support also has other benefits as described by Stephaney:

> "Okay, what will help in reducing suicide is avoiding isolation because mostly whenever someone is always isolated. The thought of committing suicide will come in" (Stephaney, 25-year-old female patient).

Stephaney acknowledges that isolation is a major risk factor for suicidal thoughts and recommends avoiding it where possible. Isolation can lead to strong impulses to act on suicidal thoughts. Those at risk in a society of extreme isolation, such as the elderly, disabled or mentally unwell, are at increased risk of suicidal thoughts. The sense of belonging and being able to speak to a trusted individual about distressing thoughts can significantly reduce the sway of suicidal thoughts. Importantly, a person lacking meaningful connection with others can hinder or reduce the likelihood of help-seeking, particularly when in crisis.

A further extract from a family caregiver also offers insight into the benefits of help-seeking within a friendship or family network:

> "Close observation, how to help them because of addiction. Because if such person behaves abnormally, within you, you know that this man is abnormal what you do quickly is to help the person reach out to a close friend or sisters or relation is very important" (Hannatu, 37-year-old female family caregiver).

Hannatu illustrates that the company of others is useful in the form of observation particularly if the person experiences an addiction. It is apparent that the emphasis on the importance of family systems and close connection in the Nigerian cultural context is highly valued and meaningful and where help is most likely to be sought.

Theme 2b: Cultural and religious beliefs in Help-Seeking Behaviours

Alongside the value of having a supportive family social network, the data sets also revealed belief systems that inform why an individual may choose a particular route for help-seeking. A common theme was the participants' strong religious and cultural identity roots, which are a resource for knowledge and perceptions and most crucially influence the type of support and treatment sought.

> "For our cultures that belief that no! this person has sinned against their gods that is why the person can start thinking like that or even start harming or even harm himself [cultural beliefs] also affect the patient's acceptance of treatment because some of the patients will still be telling you is because is my religious leader that said that I have sinned so now God is punishing me because of sin so it will also take a lot of efforts for the patient to get an insight of the problem to accept treatment" (Timothy, 32-year-old male clinician).

Timothy expressed that in his experience as a clinician, patients often make sense of their illness through religious and cultural means. Namely, mental illness is a punishment from God and for the person to appease their God. Timothy, however, felt that these belief systems sometimes conflict with the care the services offer and negatively impact treatment adherence. There seems to be dissonance between religious and cultural ideas of mental illness, particularly within understanding illness origin and treatment.

As a result of cultural unfamiliarity with Western medical treatment methods, individuals may help seek elsewhere as Simi (33-year-old female clinician) explained:

> "Many patients go around seeking other helps, going to traditional healers, going to one prayer centre or the other before coming here to the hospital- it means it takes more days and months for us to stabilize the patient. Or sometimes the prognosis becomes very bad.

Like Timothy, Simi mentioned that mainstream treatment adherence is impacted when patients seek other forms of help via traditional or religious healing processes which are sometimes unhelpful. This causes a delay in seeking help from mainstream healthcare services in hospitals and complicates stabilizing the patient(s). Simi emphasizes early mainstream intervention as having better outcomes than those who delay treatment, illustrating that if mental health problems are left untreated by mainstream professionals, it gradually degenerate and the persons wearing them down further as each day passes.

Theme 3: Clinicians' perspectives of Sustainable Intervention for self-Harm and suicidal ideation

Delay appears recurrent in help-seeking as patients seek more familiar forms of help through traditional healers, perhaps more in line with their perceptions of illness. Therefore, providing culturally sensitive treatment and community-based therapeutic options could improve adherence and treatment outcomes for Nigerian patients.

> "We plan treatment bearing in mind the people's culture and religion. All we need is to enlighten our patients according to the medical profession we're practising. That becomes important so we use our own cultural things here; even if we learn in class aboutWesternn clinical practices, we modify it to fit our own cultural practices, not traditional healing though. But we speak as Africans, give you examples from African practices, and make it fit you. Even though there are evidence-based statements, but we still modify them to fit our African ways of life (Marcy, 28-year-old female clinician).

Marcy, a clinician, speaks to upholding the patients' values and not judging them. She explains that medical knowledge must be delivered in the context of local cultural and spiritual beliefs. The above extract demonstrates that the medical model must adapt to the patient's internal cultural belief system. Clinicians tend to hold positions of power within statutory healthcare services. Marcy's attempt to reduce the power difference between two epistemic systems (religion versus medicine) could create a more inviting space for patients with a sense of meaning regarding the presenting problem. With Marcy's approach, the clinical space that can sometimes be restrictive and hostile for patients can become more accommodating and nonjudgmental and facilitate a bidirectional relationship between the patient and clinician, which fosters trust and reduces discord between statutory healthcare services and patients with suicidal ideation and self-harm. This suggests that clinicians like Mercy modify evidence-based practices to align with patients' cultural beliefs. Thus, intervening in culturally responsive ways and in line with evidence-based practices.

The following extract focuses on community and connection and further details what cultural adaptation in combining religious knowledge and Western treatment methods might look like. One clinician said:

> "I'll emphasize the community meetings, which we are contemplating to even make it a communal therapy, where the treatment is not a one-sided thing involving only the

> therapist and patient, but a community-based thing. So that communal therapy has been really helpful. For example, the Bible and the spiritual scriptures against suicide that are often quoted and found in the Bible have been helpful. I think those are the unique things that are different from the Western perspective" (Helen, 39-year-old female clinician).

It seems that medication and Western models of treatment can be alienating for many patients in Nigeria. Helen suggests that looking through the Western lens is limited concerning the cultural context. A community-based approach is perhaps more appropriate and necessary to incorporate religious and cultural knowledge in intervention, for example, with reference to Biblical scripture where 'death by suicide results in the individual going to hell' (which seems to be what Helen referenced in the above extract). From another perspective, "prayers and connection to God will help patients find strength when they feel hopeless" which could be a potentially better approach to treating religiously oriented individuals who are preoccupied with suicidal ideation. This may further suggest that patients who get the message that "death by suicide results in hell", may potentially stop the person from making a suicide attempt. Overall, incorporating spiritual/religious aspects into treatment for patients with suicidal ideation seems highly beneficial within the Nigerian context. However, there might be a need for preventive measures relating to the timing of the intervention and a good understanding of the function of the patients' spiritual beliefs.

Study 2: Quantitative Findings

Table 2 reveals a roughly equal distribution of female (48%) and male (51.6%) participants. The participants' age ranged from 18 to 65 years, with most falling within

TABLE 2. Study 2 demographic information of the sample ($n = 562$).

		Frequency (*n*)	Percent (%)
Gender	Male	286	51.6
	Female	267	48.4
	Unknown	9	
	Total	562	100
Age	18–24 years	321	57.4
	25–34 years	205	36.7
	35–44 years	23	4.1
	45–54 years	6	1.1
	55–64 years	4	0.7
	Unknown	3	
	Total	562	100
Employment Status	Working full-time	75	13.6
	Working part-time	126	22.8
	Unemployed and looking for a job	38	6.9
	Stay-at-home parent	19	3.4
	Student	294	53.2
	Other	1	0.2
	Unknown	9	
	Total	562	100.0
Marital Status	Married	144	26.4
	Living with a partner	14	2.6
	Widowed	17	3.1
	Divorced/separated	2	0.4
	Single	368	67.5
	Unknown	17	
	Total	562	100.0

TABLE 3. Study 2 descriptive table showing public opinions about suicide ($n = 562$).

	Yes		No		DNK		MD	
Questions	*n*	%	*n*	%	*n*	%	n	%
In your opinion, should the phenomenon of suicide be discussed among friends?	380	68.3	148	26.6	28	5.0	6	1.1
In your opinion, are the persons who kill themselves by committing suicide mentally ill?	294	53	233	42.0	28	5.0	7	1.3
Do you believe that a person has the right to kill him/herself by committing suicide?	219	39.5	300	54.1	36	6.5	7	1.3
In your opinion, can suicide be a solution to some problems?	228	41.0	301	53.6	27	4.9	6	1.1
In your opinion, is a person who kills him/herself by committing suicide a source of shame to his/her family and surroundings?	286	51.5	218	39.3	51	9.2	7	1.3
Do you believe that the persons who attempt suicide should be punished by isolating them out of society?	249	44.9	266	47.3	40	7.2	7	1.3
Do you believe in life after death?	341	61.3	181	32.6	34	6.1	6	1.1
Do you believe that a person who killed him/herself by committing suicide is going to be punished in the other world?	357	64.2	160	28.8	39	7.0	38	6.8
Can you say that you have good enough knowledge about suicide?	273	49.2	240	43.2	42	7.6	7	1.3
Should persons who want to commit suicide be allowed?	210	37.8	320	57.7	25	4.5	7	1.3
In your opinion, is committing suicide the right behavior?	187	33.8	343	62.0	23	4.2	9	1.6
"Nobody should be friends with persons who attempt to commit suicide." Is this statement true?	203	36.6	331	59.6	21	3.8	7	1.3

Note: DNK = Do Not Know; n = frequency; DNK = Do not know; MD = Missing data.

TABLE 4. ANOVA summary showing the influence of sociodemographic variables on tolerance toward self-harm.

	LUTOSH *M (SD)*	*F*	*p*
Gender		.959	.328
Male	27.6 (7.9)		
Female	27.0 (7.3)		
Age		.994	.371
18–24 years	27.2 (7.6)		
25–34 years	27.5 (7.9)		
35–44 years	25.4 (7.3)		
Employment status		.897	.465
Working full-time	26.8 (7.7)		
Working part-time	28.2 (7.3)		
Unemployed	27.5 (7.1)		
Stay-at-home parent	25.6 (8.5)		
Student	27.0 (7.9)		
Marital Status		1.715	.163
Married	26.7 (8.1)		
Living with a partner	30.9 (5.7)		
Widowed	25.3 (10.1)		
Never been married	27.41 (7.5)		

Note: LUTOSH: Lund Tolerance Toward Self-Harm Scale; M: median; SD: Standard deviation.

emerging to mid-adulthood. More than half of the participants (53%) identified as students. Nearly two-thirds of participants (67%) reported never being married.

Further descriptive statistics were performed to reveal public opinions about suicide, summarizing the results in Table 3. As shown in Table 3, most participants (68%) believed that suicide should be discussed among friends. Also, more participants (53%) believe that individuals who die by suicide are experiencing mental health distress; and individuals do not have the right to die by suicide, as suicide cannot be a solution to some problems. 51% of participants believed that individuals who attempted suicide are a source of shame to their family or surroundings. With regards to the consequences of suicide attempts, there seems to be ambivalence, with roughly equal proportions of yes (44%) and no (47%) and a small percentage (7%) not being sure. 61% of participants believe in life after death, and a further 64% believed that individuals who died by suicide would face some form of punishment after death. More participants (49%) reported having good knowledge about suicide and the majority (57%) believe that individuals with suicidal ideation should not be allowed to execute their plans. 33.8% agreed that dying by suicide is the right behavior. Lastly, 36.6% of participants agreed, "Nobody should be friends with persons who attempt to die by suicide."

A one-way ANOVA was performed to test the study's hypothesis that participants' tolerance toward self-harm will differ significantly across certain sociodemographic variables; see Table 4. The results showed no statistically significant differences in participants' tolerance toward self-harm across gender F (2, 572) = .959, p = .328; age, F (2, 572) = .994, p = .371; employment status, F (2, 572) = .897, p = .465; and marital status, F (2, 572) = 1.715, p = .163. While we observed no statistically significant differences in participants' tolerance toward self-harm, across the various sociodemographic variables, the results indicate that participants generally have average degrees of tolerance toward self-harm regardless of their demographics (as shown in the means in Table 3).

DISCUSSION

This research utilised a mixed-methods approach to examine suicide and self-harm from a multi-level perspective, comprising patients, family caregivers, clinicians and the general public. The study examined the lived experiences of individuals with a history of self-harm and suicidal ideation, family caregivers, and clinicians. Substance abuse and depression were common predisposing factors for self-harm and suicidal behaviours. Rejection and isolation were also significant factors that may contribute to suicidal ideation. This suggests that people who feel alienated from society often have fewer opportunities to learn and adopt helpful coping strategies to regulate distressing emotions better. These risk factors are consistent with the study of Alabi et al. (2015), who reviewed the evolution of suicide and suicidal behaviors in Nigeria over the last five decades. They concluded that increasing rates of suicides are grossly underreported and need legislation for efficient records of deaths caused by self-harm and suicides.

Patients with self-harm and suicidal behaviour place importance on family members and close friends as a valuable source of support to reach out to in times of crisis. Family members as a source of support were also demonstrated in Jidong et al. (2021b) which shows the helpful role of cultural practices in which older mothers provide physical and emotional support to their adult daughters who gave birth and experience postnatal depression or maternal distress.

The findings further illustrated that religious and cultural values shape decision-making regarding help-seeking behaviours. More specifically, help-seeking was influenced by beliefs around mental distress as a form of punishment from God for their past sins (Jidong et al., 2021a). Thus, patients subsequently prioritize help-seeking from religious or traditional healers before going to mainstream services. These findings are congruent with those of Jidong et al. (2021b) who explored Nigerian cultural beliefs about mental health conditions and traditional healing. Jidong et al. (2021a) found traditional healing as the first treatment modality for mental health conditions, including severe depression, and coping with bereavement (Makgahlela et al., 2022). Delays in seeking treatment can worsen mental health problems and exacerbate suicide risk (Jidong et al., 2021a; Knipe et al., 2022). Qualitative findings suggest clinical consensus of culturally adapted psychoeducation and community-based practices would be relevant for the Nigerian context (Jidong et al., 2021c; Notiar et al., 2021). Considering the extensive patronage of religious and traditional healings, a collaborative approach where medical practices integrate religious and cultural values may be beneficial (Jidong et al., 2021a; Sodi et al., 2022) in meeting the healing needs of the patients with a history of self-harm and suicidal ideation.

There appeared to be definitive patterns of public attitudes and opinions toward suicide among the Nigerian population. It is believed that persons who died by suicide were experiencing mental health distress. This shows a considerable knowledge gap as the literature suggests that several reasons other than a diagnosed mental illness could lead people to die by suicide, such as economic deprivation, poverty, and low socioeconomic status (Kar et al., 2021; Shoib et al., 2022). It seems the public has considerable knowledge about suicide. Findings also showed that dying by suicide is a major source of shame to the victim, their family, and the community. This indicates the prevalent

widespread stigma associated with suicide, particularly among LMICs, as reported by previous studies (Beattie et al., 2020).

Finally, the present study's quantitative findings showed no statistically significant differences in participants' tolerance toward self-harm across socio-demographic variables, including gender, age, employment status, and marital status. However, this is slightly contrary to the findings in Pereira & Cardoso (2019) cross-sectional study of the Portuguese population ($n = 344$) which found that men have more stigmatizing attitudes toward suicide than adolescents – and these effects were more in the female gender. In terms of similarities, both Pereira & Cardoso (2019) and the present study findings suggest that all persons with a history of self-harm and suicidal ideation should receive some form of psychological intervention with the cognizance of socio-demographics (e.g., age, gender etc.) as essential variables. Moreso, both studies acknowledged the relevance of community-based and culturally appropriate psychological intervention that reduces mental health stigma and discrimination and promotes help-seeking behaviors for people at risk of self-harm and suicidal ideation.

Strengths, Limitations and Recommendations

To the best of our knowledge, this is the first empirical research that made an original contribution using a methodologically rigourous mixed-methods design and examined the lived expereinces of patients, carers, clinicians and the public tolerance toward self-harm and suicidal ideation in Nigeria.

Furthermore, this study provides meaningful inroads into the lived experiences of suicide and self-harm patients, experiences and challenges faced by their family caregivers and clinicians. Utilizing a convenience sampling technique is highlighted as one of the limitations of this study as our findings might not be representative of Nigeria as a whole. Considering the diverse nature of Nigeria, future studies should include a larger and more representative sample to further widen the confidence in the findings' generalizability. Another limitation is the Study 2 cross-sectional design which cannot determine causality of demographic variables on self-harm and/or suicidal behaviors. In addition to the study's limitation, the authors acknowledged the potential data skewness in the qualitative arm ($n = 11$ clinicians; $n = 5$ patients with history of self-harm and suicide ideation; and $n = 2$ caregivers). Thus, the interpretation might have been more heavily based on the opinion of clinicians since they make up most of this sample. The present study has examined "self-harm" as a "blanket" term. There are potential differences in the pathways for non-suicidal self-harm and suicidal self-harm which appear to function differently. This might have constituted a potential limitation for the present study, and therefore, recommend future studies to design and plan data capture that makes provision for the pathway differences between non-suicidal self-harm and suicidal self-harm – considering that the public or service providers' misperception about these two constructs may contribute to patients not getting the right interventions.

The present study also depicted findings on cultural/religious beliefs and traditional healings. Therefore, future studies is encouraged to explore religious and traditional healers' perspectives on self-harm and suicidal ideation. The mixed-methods adopted in the present study are rigorous, strengthening our understanding of suicidal ideation and

self-harm behaviors within the Nigerian culture and context. There is a broader aim of recommending mainstream professionals' training to accommodate culturally appropriate translation of evidence-based practice, and a further need to train traditional healers and the public awareness creation on how to help patients experiencing suicidal ideation and self-harm. This may include community-based stigma-reducing intervention to help friends and/or family members get the appropriate help quickly.

Finally, based on the present study's outcome, we recommend the co-developing and testing of culturally adapted psychological intervention specifically for persons with a history of self-harm and suicide ideation in Nigeria. The co-development and co-adaptation of intervention with inputs from key stakeholders such as individuals with lived experiences of self-harm and suicidal ideation, family caregivers and local clinicians. Interventions should incorporate activities that reduce mental health stigma and discrimination and promote help-seeking behaviors. It may be helpful for further studies to examine the impact of socio-economic deprivation and poverty on attitudes toward self-harm and suicidal ideation in Nigeria. We anticipate that the recommended approach could lead to a scalable and low-cost intervention that will be sustainable for treating and preventing self-harm and suicidal ideation in Nigeria and other African settings.

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AUTHOR NOTES

Dung Ezekiel Jidong and Nusrat Husain, Division of Psychology and Mental Health, The University of Manchester, Manchester, UK. Tarela Juliet Ike, School of Social Sciences, Humanities and Law, Teesside University, Middlesbrough, UK. Christopher Francis, Shadrack Bitrus Mwankon, Maisha Murshed and Pam Patrick Nyam, Department of Psychology, Nottingham Trent University, Nottingham, UK. M. Omair Husain, Department of Psychiatry, University of Toronto, Toronto, ON, Casnada. John Ezekiel Jidong and David Beshel Jack, Research Unit, Dung Jidong Foundation, Jos, Nigeria. Paul Bassett, Pakistan Institute of Living and Learning (PILL), Islamabad, Pakistan. Juliet Yop Pwajok, Department of Psychology, University of Jos, Jos, Nigeria. Maigari Yusufu Taru and Charles Nnaemeka Nwoga Department of Psychiatry, Jos University Teaching Hospital, Jos, Nigeria.

Correspondence concerning this article should be addressed to Dung Ezekiel Jidong, Division of Psychology and Mental Health, The University of Manchester, Manchester M13 9PL, UK. Email: dung.jidong@manchester.ac.uk.

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