JOURNAL OF CLINICAL CARE AND MEDICAL ADVANCEMENT

https://doi.org/10.58460/jccma.v1i1.124

Open Access

ORIGINAL ARTICLE

MJM BIOLABS

Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at Africa Inland Church (AIC) Litein Hospital in Kericho County

Loraine EKISA[*1], Eli HORN[2] and Matthew LOFTUS[2]

Authors' Affiliation

[1] Department of Family Medicine, School of Medicine and Health Sciences, Kabarak University
[2] Department of Family Medicine, PCEA Chogoria Hospital

[*] Corresponding author: loraineidionyi@gmail.com

Article History
Submitted: 25th November 2024
Accepted: 23th January 2025
Published Online: 30th September 2025

To read this paper online, please scan the QR code below:

ABSTRACT

Suicide is a serious public health problem, with a previous suicide attempt being the greatest risk factor for repeat and completed suicide. Household members of a person who attempts suicide are key gatekeepers in prevention of suicide; hence their experiences and support needs cannot be ignored. However, there is a paucity of data on the effects of a suicide attempt on household members in Kenya and their support needs have not been explored or exhaustively included in existing local mental health policies. This study's objectives were to understand the experiences of household members following a suicide attempt presenting at Africa Inland Church (AIC) Litein Hospital and to explore the existing and desired support structures following the event. A qualitative phenomenological study design was used and purposive sampling used to select 16 participants. In-depth interviews were conducted using a semi-structured interview guide, audio-recorded and analyzed thematically. Participants experienced a range of negative emotional and psychological responses with shifts in social dynamics at family and community level. Physical and practical impact including physical harm, additional responsibilities and financial burden was reported. Support structures available included good healthcare provision, practical, spiritual and moral support from religious leaders and community. Household members desired mental health and professional support and expressed the need for education and information on suicide at hospital and community levels. Support groups at community level was desired and role of community leaders in addressing suicide triggers and advocating for the needs of affected households expressed. Considering the crucial role of household members and the adverse effects of a suicide attempt, healthcare institutions must institute well-structured counseling services for these households. Moreover, addressing the needs of affected households is not only the mandate of healthcare workers but also the clergy, the government, community leaders and the larger community working collaboratively.

Keywords: Suicide, suicide attempt, experiences, support, household members

How to Cite this Paper: Ekisa, L., Horn, E., & Loftus, M. (2025). Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at Africa Inland Church (AIC) Litein Hospital in Kericho County. Journal of Clinical Care and Medical Advancement, 1(1), 74–83. https://doi.org/10.58460/jccma.v1i1.124

INTRODUCTION

Suicide, a global health menace, refers to harmful actions done intentionally that result in one's own death (World Health Organization, 2014). About 700,000 deaths by suicide are recorded every year, with up to 77% of these occurring in Low- and Middle-Income Countries (LMIC) where most of the world's population is found (WHO, 2021). According to WHO (2021) suicide is currently the 4th leading cause of death in the age group of 15-29 years, with the global age standardized rate of 9.0 per 100,000 compared to the higher rate in Kenya which stands at 11.0 per 100,000 deaths. Suicide and suicide attempts have many risk factors, including individual factors, familial factors, psychological factors, and larger societal factors (World Health Organization, 2014). Personal factors include age, whereby higher rates have been established in the youth and in older individuals above 70 years, and sex, with higher rates of completed suicide in men and suicide attempt rates up to 4 times higher in women (Bengoechea-Fortes et al., 2023). Presence of mental illnesses including depression, schizophrenia, bipolar mood disorder, and substance abuse among others have been associated with an increased risk of suicide and suicide attempts (Bengoechea-Fortes et al., 2023; Carballo et al., 2020). Of the many risk factors for suicide and suicide attempt, a previous suicide attempt is considered the strongest risk factor for repeat attempts or successful suicide (Bengoechea-Fortes et al., 2023; Greenfield et al., 2021). In line with the United Nations Strategic Development Goals, the World Health Organization (WHO) aims to achieve a reduction in suicide mortality rates by one third by the year 2030 (World Health Organization, 2021). Being that suicide attempt is the single most important risk factor to a completed suicide; suicide attempts must be well addressed if this goal is to be achieved.

Families are greatly affected when a loved one attempts suicide and yet studies report unsatisfactory support (Juel et al., 2021; McLaughlin et al., 2016). The family has an important role in preventing suicide through support of the suicide attempt survivor (Edwards et al., 2021). Ignoring the experiences and needs of this population will weaken what is considered a crucial support structure to individuals attempting suicide, hence hampering efforts towards suicide reduction. This makes it important to understand what families go through as they live with and support individuals who have attempted suicide as it provides a basis for targeted interventions.
Although studies around the world, mostly from Western countries, have endeavored to explore the experiences of family members, and their support needs, there is a dearth of knowledge surrounding this topic in Africa and particularly in Kenya. Differences in beliefs, cultural diversity and resource availability may play a big role in how a similar event is perceived and experienced in the LMIC and will inadvertently influence the support structures available.

The Kenya Mental Health Policy and the Kenya Suicide Prevention Strategy acknowledges the need to support families experiencing suicide attempts (Ministry of Health, 2015, 2022). However, they do not clearly acknowledge the effects of suicide attempts and the specific and exhaustive ways in which they ought to be supported, owing to lack of local research on the subject.In view of all these factors, it is of vital importance to explore this subject in a Kenyan context. This study's aim was to understand the experiences of household members following a suicide attempt presenting at AIC Litein Hospital and to explore their existing and desired support structures. The Socio-ecological Model (SEM) and Family Systems Theory were used as the theoretical framework in this study (Bowen, 1966; Bronfenbrenner, 1977). The Family systems theory which views family as one emotional unit in which all members are profoundly affected when one member undergoes a period of heightened stress was used to explore how household members may be affected by a suicide attempt, whereas the SEM was used to understand how larger factors including individual factors, immediate environment, community and larger societal factors may affect the experience of this phenomenon and the resultant support structures.

METHODOLOGY

Study Design

A qualitative phenomenological study design was used in this study as it sought to explain and understand individuals' lived experiences (Renjith et al., 2021).

Study Location

The location of the study was AIC Litein Hospital, a rural faith-based hospital in Bureti Sub- County, Kericho County. It is a Level 5 Hospital serving the local population and acts as a referral hospital to other sub-county hospitals within the county, with an active Mental Health outpatient unit.

Study Population

The population of this study was household members of individuals who had attempted suicide and were admitted at AIC Litein Hospital. According to the Kenya National Bureau of Statistics (KNBS) (2022), a household in Kenya

refers to a group of people related by blood or not, living under one headship whether male or female and share common resources within the unit. Thus, the study population was not limited to nuclear family members or those related by blood but any household member meeting the KNBS definition.

Sample Population

Inclusion criteria

The study included household members who were above 18 years of age and had been living with the suicide attempt survivor at the time of the incident. Household members included had to have continued to live with the suicidal individual following the event and/or participate in their care either at home or during the hospital admission and follow up visits with the incident having occurred within the past 2 years.

Exclusion criteria

The study excluded household members who were unavailable for a physical interview and those who, due to the traumatic experience, were unable to undertake the interview.

Sample size determination

Participants were recruited using a purposive sampling technique with two approaches namely, typical case sampling and maximum variation sampling. The sample size for this study was determined by the point of saturation. It has been estimated that about 12 interviews need to be conducted to reach this point (Guest et al., 2006). 16 interviews were conducted in this study. Data saturation was achieved after 13 interviews and an additional three interviews conducted to ensure no new information arose.

Data Collection Tool

Data was collected using a semi-structured interview guide including demographic data, details of the suicide attempt, the immediate and subsequent experiences following the incident, the experience of care at the hospital, an exploration of the existing and desired support structures. The interview guide was translated into Kiswahili and Kipsigis and pilot tested on household members of suicide attempt survivors presenting at a county referral Hospital in Kericho County.

Validity and Reliability

The principal researcher practiced personal reflexivity allowing journalling of their personal beliefs, values, life philosophies, thoughts and reflections concerning the topic in question to enable them to be aware of and avoid personal bias during the research process. Additionally, regular reflexive discussions were carried out between the principal researcher, research assistant and the supervisors. Conducting a pilot test of the data collection tool ensured the tool was accurate and sufficient. Lastly, a second independent researcher reviewed the transcripts, codes and generated themes to mitigate researcher bias.

Data Collection Procedures

Following obtaining clearance from all relevant bodies, a research assistant was recruited and trained to assist with the process of data collection. Participants who met the eligibility criteria were recruited by accessing the next of kin contact details from hospital records of the attempt survivors, and the date, time and venue of interview set by phone call. Four interviews were conducted at participants' homes and 12 interviews were conducted at the Mental Health Clinic (MHC) in an enclosed room with privacy and minimal distraction. All interviews were conducted physically, and written consent obtained prior to starting the interview.Consent to use an audio recorder was requested and then the audio recorder switched on. To ensure confidentiality, there was no mention of names on either the consent forms or the audio recordings.

Data Analysis

Manual transcription was done followed by translation to English for ease of analysis. Data was then analyzed by thematic analysis as described by Braun and Clarke (2006) using an inductive approach. Dedoose data analysis software was used to facilitate organization of the data. An independent researcher conducted an independent analysis of the data and further reviewed the codes and themes generated by the principal researcher to ensure validity and reduce researcher bias. Audio recordings were transferred to an encrypted storage with a password only known to the principal investigator. After the analysis process voice distortion was applied to the audio recordings for anonymity.

Ethical Considerations

Ethical approval for this study was granted by the Kabarak University Institutional Ethics Review Committee (Reference: KABU01/KUREC/001/20/07/24). A research permit was also obtained from the National Commission for Science, Technology, and Innovation (NACOSTI) (Reference: NACOSTI/P/24/36516). All research activities were conducted in full compliance with the approved ethical guidelines. Written informed consent was obtained from all participants after a clear explanation of the study objectives, procedures, and potential risks.

Participants were assured of their right to withdraw from the study at any point without any consequences. Anonymity and confidentiality were strictly maintained, with all data securely stored and accessible only to the research team. Participants identified during interviews as requiring immediate or further psychological support were referred to the hospital's Mental Health Clinic (MHC) for appropriate care.

RESULTS

Sociodemographic data

This study had a total of 16 participants who fully participated in the study to completion, with 56% being male and 44% females. Two interviews were carried out in Kipsigis, two in English and 12 in Kiswahili. Four interviews were carried at participants' homes while 12 were carried out at the hospital at the MHC in a private room. Below is a table outlining the sociodemographic characteristics of the participants.

Table 1:

Sociodemographic Characteristics of Study Participants

Variable		Frequency
Sex	Male	9 (56%)
	Female	7 (44%)
Age	20-30	6 (37.5%)
	31-40	2 (12.5%)
	41-50	1 (6.3%)
	51-60	5 (31.2%)
	>60	2 (12.5%)
Relationship with survivor	Sibling	5 (31%)
	Mother	5 (31%)
	Father	1 (6%)
	Spouse	1 (6%)
	Uncle	2 (13%)
	Cousin	2 (13%)
Marital status	Married	9 (56.2%)
	Single	5 (31.3%)
	Widowed	2 (12.5%)
Education level	No formal education	2 (12.5%)
	Primary school	3 (19%)
	High school	5 (31.3%)
	College	6 (37.5%)

Experiences of Household members

a). Narrative Sense-making

Participants attributed the experiences to life-stressors faced by the suicide attempt survivor ranging from mental health issues to financial difficulties and relationship strain. Despite attributing the attempt to the stressors mentioned above, some participants attempted to make sense of the incidents using cultural beliefs, with many expressing beliefs in curses and family sins as possible causes.

b). Emotional and Psychological Responses

Household members reported experiencing a range of negative emotions and psychological responses following these incidences ranging from shock immediately following the incident, emotional pain, sadness, guilt, shame, fear and anxiety. Others reported having confusion, disturbed and excessive thoughts. Expressing her emotional pain one participant narrates:

"It feels very bad for my heart to hear that my husband has attempted suicide three times. It really hurts because since that time we have never had peace. But before then, we were living very well, so these suicide attempts have caused me a lot of pain." (Participant 11, Wife, 29 years)

c). Social Dynamics

Relationship dynamics within households were diversely affected, with some experiencing weakening of bonds while others experiencing strengthening of bonds. Social isolation and stigma from the community, especially following repeat attempts or concomitant serious mental health illnesses were experienced by some households as expressed by the following participant:

"…some of our friends and some of our villagers have ended up avoiding us. They say that if your sister is mentally ill like that, it means even you can be mentally ill like that." (Participant 9, Sister, 20 years)

d.) Physical and Practical Impact

Participants experienced physical injuries while attempting to rescue their loved ones from harming themselves. They also experienced additional responsibilities related to caring for and providing financial needs of the attempt survivors. Many reported reduced work productivity due to the burden of providing care.

Existing Support Structures

a). Healthcare Provision

Most participants expressed receiving good support from the hospital through medical care and mental health services provided for their loved ones following the attempt. Many expressed being attended to promptly and appreciated the healthcare providers for assisting the survivor of the suicide attempt:

"And the family members, we were also well taken care of in hospital. We were encouraged not to shout at (name), not to be very offended because of her illness. We were encouraged to take care of her." (Participant 1, Brother, 42 years)

b). Practical Support

Participants expressed receiving different forms of practical support including rescuing of the survivor, financial support and transport to seek care. This kind of support was received from different people ranging from household members, other extended family members, friends and neighbours.

c). Spiritual and Moral Support

Religious leaders, in this study pastors, and church members were a great source of spiritual support. Many participants reported that they would be visited at the hospital by pastors and received prayers and encouragement from them. Church members also visited them at the hospital and at their homes and this support continued long after the incident. A participant whose husband had attempted suicide and experienced mental health problems mentioned:

"We always walk this journey with our pastor who prays with us. Even tomorrow, they are planning to pay us a visit at home with the other church members to fellowship and pray with us." (Participant 11, wife, 29 years)

Desired Support Structures

a). Mental Health and Professional Support

Participant desired that their affected loved ones would continue receiving mental health care as their well-being would greatly impact the well-being of the household. This continued care included offering medical treatment, identifying the root cause of the attempt, encouraging them and treating other concomitant mental health illnesses. Additionally, they acknowledged the mental effects of the attempts and desired psychological help through individual professional counselling and family therapy:

"I would want counselling also because this thing has really stressed me. It's really affecting me because he's my only brother. I would want to be counselled, but not by people at home because I am not ready to disclose all my secrets to them." (Participant 5, Brother, 24 years)

b). Need for information & Education on Suicide

There was a general lack of information regarding suicide during the hospital admission and afterwards as expressed by most of the participants, ranging from information about causes of suicide attempts, discussing progress of the survivor, to handling the individual and preventing recurrence. Participants reported that although they were asked the events surrounding the suicide attempt, they were not given much information as expressed by the following participant:

"We were not told how to prevent her from killing herself." (Participant 1, Brother, 42 years)

There was a need for education on how to handle the survivor including how to identify triggers and warning signs, immediate interventions following the incident and how to relate to a survivor of an attempt.

"...what we would wish to know is number one, what is this illness and what causes it? And number two is how do we handle somebody when he has such an issue? And number three, when it is beyond family, what can we do about it, especially when the situation is like (name's) situation, we feel like it's beyond us. What can be done next so that we can help (name)?" (Participant 2, Mother, 58 years)

Participants desired information to be disseminated during hospital visits, through community outreached by hospital staff, religious leaders and trained laymen.

c.) Community Support

Participants desired to have support groups in the community by people experiencing similar incidents for purposes of education and moral support. Additionally, the desired financial and material support, acknowledging the financial burden of care they faced.

c.) Community Leadership Intervention

Some participants expressed having approached community leaders for help during the crisis but received no help. They desired assistance from community leaders such as chiefs and village elders in resolving conflicts, addressing the triggers of the attempt and advocating for the needs of affected households.

"The Chiefs and the village elders also have to play a role in prevention of suicide attempts. They can be keen on those families which have needs and are not able to provide the needs for themselves and urge community members to help those families." (Participant 12, Mother, 59 years)

DISCUSSION

Household members in this study used cultural beliefs to explain the suicide attempts with the beliefs revolving around family and generational curses. Other studies done in Africa have elicited similar beliefs concerning suicide although from the perspective of community members and not those directly affected (Mugisha et al., 2013; Ongeri et al., 2022). These beliefs reflect the deep-rooted culture in African countries and its role in making sense of phenomena, especially those that may not be easily understood. Relationship difficulties, financial crises and mental illnesses were viewed as major causes for suicide attempts in this study. These were similarly the common causes of suicide attempts as identified in Sub-Saharan Africa (Akotia et al., 2019; Quarshie et al., 2020).

Emotional and psychological responses experienced in this study, ranging from immediate response of shock, to emotional pain and grief, anxiety and hyper-vigilance are similarly reported in several other studies (Asare-Doku et al., 2017; Krysinska et al., 2020; Vivekanandhan et al., 2024). Anxiety and hyper-vigilance were more common in those who had experienced repeated attempts. Viewing this in the lens of Bowen's Family Systems theory (Bowen, 1966) which views family as one emotional unit, a suicide attempt by one family member caused immense emotional disturbances on other family members with the member bearing most of the burden of care being the one most psychologically affected. The differences seen in findings in different households in this study can similarly be explained by this study's theoretical framework that postulates that the ability of a family to navigate a stressful event determines their bonds and showing how family dynamics may impact an experience of a suicide attempt (Bronfenbrenner, 1977). Thus, households in this study that successfully navigated the stress of a suicide attempt emerged as one strong emotional unit while those that failed experienced disunity. Studies have reported spousal strain following such attempts (Buus et al., 2014; Ferrey et al., 2016), while others have reported unity (Nygaard et al., 2019).

Social isolation in this study was experienced by a few participants, mostly those who had experienced multiple attempts, a family history or accompanying serious mental illness. This reflects ongoing stigma associated not only with suicide but also with mental illness reported in studies done both in African and Western studies (Ongeri et al., 2022; Scocco et al., 2017; Tawiah et al., 2015). In view of the SEM framework used in this study, societal factors such as cultural beliefs and the level of stigma in a community greatly impacted the experience of household members following a suicide attempt as some community members had judgmental views based on their cultural beliefs leading to isolation and propagating stigma towards affected households.

The financial burden and reduced productivity faced following suicide attempts have not been explored in Sub-Saharan Africa as studies on this topic are limited. However, a systematic review done in Sub-Saharan Africa including 7 studies explores the economic burden of caregiving for persons with mental illness and reported that up-to 50% of carers were unemployed owing to the burden of caregiving (Addo et al., 2018).

Healthcare provision was generally satisfactory in this study. Other studies have reported unsatisfactory care at the hospital, poor and fragmented follow up, and others experienced blame from healthcare providers (Krysinska et al.,

2020; Spillane et al., 2020). Some studies reported satisfactory follow up but relatives felt uninvolved in the care (McLaughlin et al., 2016). The high level of satisfaction with health care provision and follow up, coupled with hospitality reported in this study may reflect the role of faith-based institutions in offering compassionate and quality healthcare services. Patients have reported satisfaction in healthcare provision in faith-based hospitals compared to public institutions due to the respect to patient's dignity and empathy experienced in those institutions (Olivier et al., 2015). However, the findings of satisfactory healthcare may not be fully generalizable to other settings as this study was carried out only on household members of individuals admitted to a faith-based institution and thus the experience of healthcare provision may differ depending on the setting.

The support from community demonstrated in this study was not reported in a similar study done in Ghana (Asare-Doku et al., 2017). This could perhaps be due to higher levels of stigma on suicide in the setting of that study that pushed family members to secrecy with resultant isolation.
Despite the cultural beliefs about suicide held by communities in African setting (Mugisha et al., 2013; Ongeri et al., 2022), the ability of the communities, the church and religious leaders to support affected households and even the survivor perhaps against their beliefs signify that these groups can be a great resource to individuals affected by a suicide attempt and thus should be empowered to continue providing this support and aid in prevention strategies.

Providing mental health care and follow up to the survivor of the suicide attempt was greatly desired in this study. Caregiver burden can possibly be reduced through provision of proper healthcare to the survivor of a suicide attempt (Lavers et al., 2022; Maple et al., 2023). Additionally, counseling services were desirable both for the survivor and the entire household, not only at individual levels but also at family level as expressed in other studies (McLaughlin et al., 2016). Household members of an individual who attempts suicide are immensely affected psychologically and thus offering them counseling services will enable them cope with the stressful incident.

Other studies have reported desire for relatives to be included in the care of their loved ones following an attempt (McLaughlin et al., 2016; Wayland et al., 2021), however this was not reported in this study perhaps because many participants felt well involved in care at the hospital and follow up as shown by their satisfaction in the healthcare provision. Notably, the site where this study was undertaken has more mental health services and more investment in training than other peer hospitals in the same region and this may have contributed to this result. There is need to strengthen mental health services further in the facility and in the region as this is an important support structure to affected individuals.

There is a general shortage of mental health professionals in Kenya required to offer these services both to affected individuals and their families (Ministry of Health, 2015). The findings of this study underpin the need for more mental health human resourcing and the need to diversify ways of ensuring access to these services to affected households. In rural Kenya, where the shortage is even greater, Community Health Promoters (CHPs) may play a vital role in bridging this gap. The Kenya mental health policy acknowledges the need to train CHPs for mental health services, however the implementation and impact of this is unclear (Ministry of Health, 2015). Furthermore, their role in providing these services to households experiencing a suicide attempt is not included in this policy.

Lack of information on suicide by healthcare professionals was reported in this study and was consistent across different ages and educational levels. Even with repeated attempts there was still a lack of information on what to do and how to assist the survivors and safeguard them. Other studies done in Western countries have reported similar findings where parents would wish to support their children following an attempt but lacked knowledge on how to do so (Buus et al., 2014; Spillane et al., 2020). Need for information on how to navigate an attempt has been reported by both the survivors of an attempt and the families caring for them (McGill et al., 2019). Offering education on what to do following a suicide attempt is important as it has been associated with reduced caregiver burden, and has been reported to be valuable in boosting the sense of skill in ensuring safety following an attempt (Branjerdporn et al., 2023; Maple et al., 2023).

The desired methods of information dissemination in this study differed from a study done in Ireland where online sources of information and crises lines were preferred, and another study done in Australia where a need for specialized training for those caring for survivors aimed towards ensuring safety was desired (French et al., 2023; Wayland et al., 2021). The literacy levels in the setting of the study compared to other studies may have informed the difference in desired dissemination of information. A study done in the Coastal region of Kenya exploring strategies of suicide prevention from the perspective of community members highlighted

the crucial role of community leaders in emancipation of the community about suicide through community forums organized by chiefs and at religious gatherings, similar to suggestions made in this study (Ongeri et al., 2023). This reflects the crucial role of the clergy and other community leaders in suicide education showing that this responsibility is not only held by healthcare providers, hence need for collaboration with all stakeholders.

The desire for financial and material support from the community reported in this study may reflect economic difficulties faced and existing challenges in affordability of healthcare in these settings. Poverty rates in LMIC remain high and economic hurdles have been linked to increased suicidality (Bantjes et al., 2016). Hence, these households who are already at risk of suicide with their family history, are even more at risk with the financial challenges that increase due to additional care. According to the Kenya National Bureau of Statistics (2022), the poverty rate in Kenya is 38.6%, and only 22% of Kenyans have health insurance cover . This causes a heavy reliance on community help to raise finances for health care. These findings may reflect poor access and unaffordability of mental health services hampering universal health coverage. Similar studies in Western countries, although reporting reduced work productivity have not captured financial support for healthcare services as a need, perhaps due to better access to healthcare and health insurance. The new Social Health Insurance Fund (SHIF) in Kenya shall cover only 7 outpatient mental health visits per year (Ministry of Health, 2024). This is far less than what the average survivor of a suicide attempt needs and thus is likely to put further financial strain on their already struggling household members to meet their medical needs through out-of-pocket payments. Hence, there is need to relook and increase funding for mental health services in the SHIF to reduce the financial burden of care on these households.

Community leadership intervention was desired in addressing triggers of suicide attempts and to advocate for the needs of affected households. Community leaders are an integral part to improving health in the Kenyan context. The Kenya Suicide Prevention Strategy acknowledges the role of community leaders including religious leaders and administrative leaders, in suicide prevention through suicide education but does not capture their role in supporting affected household as desired by those with these experiences (Ministry of Health, 2022). This may be due to lack of studies in Kenya reflecting how these households desire to be supported by the leaders. Thus, beyond education on suicide, there is need for more exploration on how affected families desire to be supported by community leaders in a Kenyan context and inclusion of this into the strategic plan with clearly outlined roles.

This study had several limitations. Being qualitative in design, the results cannot be generalizable. Furthermore, it was conducted in a Faith-based organization and thus some results may not be similar in a different setting. There was a risk of researcher bias, however this was mitigated by having the transcripts, codes and themes reviewed by an independent reviewer in addition to personal reflexivity by the researcher and extensive discussions with the supervisors. Language barrier was a challenge for the principal researcher; however, this was mitigated by having a research assistant conversant with English, Kiswahili and Kipsigis which was the local language.

Conclusion

Household members are adversely affected following a suicide attempt. Many have pre-existing family problems which worsen further after an attempt. While some households experience strengthening of bonds, these incidents generally have a negative impact on their mental health, social dynamics and increasing burden of care both physically and financially.

Community support and support from religious groups and leaders are vital in helping these households to cope. Even though healthcare provision to the affected individual may be satisfactory, there is need to offer counseling services to these households to reduce the stress associated with the care. Education on suicide and support for affected households is important as household members are vital in suicide prevention and this mandate should not be limited to healthcare providers only but should include the clergy, community leaders and community at large.

Recommendations

Recommendations for Policy

- Healthcare institutions should institute well structured counseling services for households experiencing a suicide attempt.
- Training offered to Community Health Promoters on mental health should include training on how to support households experiencing a suicide attempt within their community units.
- Support groups for affected households should be formed and conducted both at institution level and at the community level.

- Clearly outlined roles for stakeholders including community leaders and the clergy in supporting households affected by suicide attempts should be included in the Kenya Mental Health Policy.
- The funding and number of visits covered for mental health services in the Social Health Insurance Fund in Kenya should be relooked and increased to alleviate the financial burden of care.
- Access to mental health services at community level should be emphasized in line with WHO recommendations to deinstitutionalize mental health services

Recommendations for Research

- Larger quantitative studies should be done to measure the level of support for affected households and improve generalizability of the findings
- A survey on whether public education as outlined in the Kenya Mental Health Policy has translated into improved knowledge among households experiencing a suicide attempt in rural Kenya should be conducted.
- Interventional or feasibility studies on culturally adaptable educational support for households experiencing a suicide attempt should be conducted

Conflict of Interest

All authors declare no conflict of interest.

Funding

This study did not receive any external funding

REFERENCES

Addo, R., Agyemang, S. A., Tozan, Y., & Nonvignon, J. (2018). Economic burden of caregiving for persons with severe mental illness in sub-Saharan Africa: A systematic review. *PloS One*, 13(8), e0199830. https://doi.org/10.1371/journal.pone.0199830

Akotia, C. S., Knizek, B. L., Hjelmeland, H., Kinyanda, E., & Osafo, J. (2019). Reasons for attempting suicide: An exploratory study in Ghana. *Transcultural Psychiatry*, 56(1), 233–249. https://doi.org/10.1177/1363461518802966

Asare-Doku, W., Osafo, J., & Akotia, C. S. (2017). The experiences of attempt survivor families and how they cope after a suicide attempt in Ghana: A qualitative study. *BMC Psychiatry*, 17(1), 178. https://doi.org/10.1186/s12888-017-1336-9

Bantjes, J., Iemmi, V., Coast, E., Channer, K., Leone, T., McDaid, D., Palfreyman, A., Stephens, B., & Lund, C. (2016). Poverty and suicide research in low- and middle-income countries: Systematic mapping of literature published in English and a proposed research agenda. Global Mental Health (Cambridge, England), 3, e32. https://doi.org/10.1017/gmh.2016.27

Bengoechea-Fortes, S. de la P., Ramírez-Expósito, M. J., & Martínez-Martos, J. M. (2023). Suicide, neuroinflammation and other physiological alterations. European Archives of Psychiatry and Clinical Neuroscience, 1–13. https://doi.org/10.1007/s00406-023-01584-z

Bowen, M. (1966). The use of family theory in clinical practice. Comprehensive Psychiatry, 7(5), 345–374. https://doi.org/10.1016/S0010-440X(66)80065-2

Branjerdporn, G., Erlich, F., Ponraj, K., McCosker, L. K., & Woerwag-Mehta, S. (2023). What Is Helpful and What Is Challenging for the Caregivers of Young People Receiving Interventions to Prevent Suicide? Caregivers' Perspectives-A Rapid Scoping Review. Children (Basel, Switzerland), 10(11), 1801. https://doi.org/10.3390/children10111801

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American Psychologist, 32(7), 513–531. https://doi.org/10.1037/0003-066X.32.7.513

Buus, N., Caspersen, J., Hansen, R., Stenager, E., & Fleischer, E. (2014). Experiences of parents whose sons or daughters have (had) attempted suicide. Journal of Advanced Nursing, 70(4), 823–832. https://doi.org/10.1111/jan.12243

Carballo, J. J., Llorente, C., Kehrmann, L., Flamarique, I., Zuddas, A., Purper-Ouakil, D., Hoekstra, P. J., Coghill, D., Schulze, U. M. E., Dittmann, R. W., Buitelaar, J. K., Castro-Fornieles, J., Lievesley, K., Santosh, P., Arango, C., & STOP Consortium. (2020). Psychosocial risk factors for suicidality in children and adolescents. European Child & Adolescent Psychiatry, 29(6), 759–776. https://doi.org/10.1007/s00787-018-01270-9

Edwards, T. M., Patterson, J. E., & Griffith, J. L. (2021). Suicide prevention: The role of families and carers. Asia-Pacific Psychiatry, 13(3). https://doi.org/10.1111/appy.12453

Ferrey, A. E., Hughes, N. D., Simkin, S., Locock, L., Stewart, A., Kapur, N., Gunnell, D., & Hawton, K. (2016). The impact of self-harm by young people on parents and families: A qualitative study. BMJ Open, 6(1), e009631. https://doi.org/10.1136/bmjopen-2015-009631

French, Á., Gaynor, K., Nearchou, F., Raftery, S., O'Dwyer, B., & Hennessy, E. (2023). Parents' Information Needs in Relation to Adolescent Self-Harm: Perspectives of Parents and Professionals. Archives of Suicide Research: Official Journal of the International Academy for Suicide Research, 1–16. https://doi.org/10.1080/13811118.2023.2279524

Greenfield, B., Jolicoeur-Martineau, A., Brown, M., Kandiyoti, A., Henry, M., Sasson, T., Ahmadi, S., Vivani, T., Harnden, B., de Castro, F., Tran, B., Boodaghians, L., Weiss, M., Atsaidis, Z., & Wazana, A. (2021). Frequent follow-up of suicidal youth assessed in the emergency room: Long-term trajectory and predictors of suicidality. Preventive Medicine,152,106737. https://doi.org/10.1016/j.ypmed.2021.106737

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. Field Methods,18(1),59–82. https://doi.org/10.1177/1525822X05279903

Juel, A., Berring, L. L., Hybholt, L., Erlangsen, A., Larsen, E. R., & Buus, N. (2021). Relatives' experiences of providing care for individuals with suicidal behaviour conceptualized as a moral career: A meta-ethnographic study. International Journal of Nursing Studies, 113, 103793. https://doi.org/10.1016/j.ijnurstu.2020.103793

Kenya National Bureau of Statistics. (2022). Kenya Demographics and Health Survey 2022: Key Indicators Report. https://www.knbs.or.ke/reports/kdhs-2022/

Krysinska, K., Curtis, S., Lamblin, M., Stefanac, N., Gibson, K., Byrne, S., Thorn, P., Rice, S. M., McRoberts, A., Ferrey, A., Perry, Y., Lin, A., Hetrick, S., Hawton, K., & Robinson, J. (2020). Parents' Experience and Psychoeducation Needs When Supporting a Young Person Who Self-Harms. International Journal of Environmental Research and Public Health, 17(10), 3662. https://doi.org/10.3390/ijerph17103662

Lavers, G., Andriessen, K., & Krysinska, K. (2022). A Systematic Review of the Experiences and Support Needs of Informal Caregivers for People Who Have Attempted Suicide or Experienced Suicidal Ideation. International Journal of Environmental Research and Public Health, 19(9), 5181. https://doi.org/10.3390/ijerph19095181

Maple, M., Wayland, S., Sanford, R. L., & Bhullar, N. (2023). Predictors of Caregiver Burden Among Carers of Suicide Attempt Survivors. Crisis, 44(1), 41–48. https://doi.org/10.1027/0227-5910/a000836

McGill, K., Hackney, S., & Skehan, J. (2019). Information needs of people after a suicide attempt: A thematic analysis. Patient Education and Counseling, 102(6), 1119–1124. https://doi.org/10.1016/j.pec.2019.01.003

McLaughlin, C., McGowan, I., Kernohan, G., & O'Neill, S. (2016). The unmet support needs of family members caring for a suicidal person. Journal of Mental Health (Abingdon, England), 25(3), 212–216. https://doi.org/10.3109/09638237.2015.1101421

Ministry of Health. (2015). Kenya Mental Health Policy 2015-2030: Towards Attaining the Highest Standard of Mental Health. http://www.health.go.ke

Ministry of Health. (2022). Suicide Prevention Strategy 2021-2026. http://www.health.go.ke

Ministry of Health. (2024). Tarrifs to the Benefit Package Under Social Health Insurance Act No. 16 of 2023. https://health.go.ke

Mugisha, J., Hjelmeland, H., Kinyanda, E., & Knizek, B. L. (2013). Religious views on suicide among the Baganda, Uganda: A qualitative study. Death Studies, 37(4), 343–361. https://doi.org/10.1080/07481187.2011.641136

Nygaard, L., Fleischer, E., & Buus, N. (2019). Sense of Solidarity Among Parents of Sons or Daughters Who Have Attempted Suicide: An In-depth Interview Study. Issues in Mental Health Nursing, 40(2), 133–139. https://doi.org/10.1080/01612840.2018.1519620

Olivier, J., Tsimpo, C., Gemignani, R., Shojo, M., Coulombe, H., Dimmock, F., Nguyen, M. C., Hines, H., Mills, E. J., Dieleman, J. L., Haakenstad, A., & Wodon, Q. (2015). Understanding the roles of faith-based health-care providers in Africa: Review of the evidence with a focus on magnitude, reach, cost, and satisfaction. Lancet (London,

England), 386(10005), 1765–1775. https://doi.org/10.1016/S0140-6736(15)60251-3

Ongeri, L., Nyawira, M., Kariuki, S. M., Bitta, M., Schubart, C., Penninx, B. W. J. H., Newton, C. R. J. C., & Tijdink, J. K. (2023). Perspectives on reasons for suicidal behaviour and recommendations for suicide prevention in Kenya: Qualitative study. BJPsych Open, 9(2), e38. https://doi.org/10.1192/bjo.2023.7

Ongeri, L., Nyawira, M., Kariuki, S. M., Theuri, C., Bitta, M., Penninx, B., Newton, C. R., & Tijdink, J. (2022). Sociocultural perspectives on suicidal behaviour at the Coast Region of Kenya: An exploratory qualitative study. BMJ Open, 12(4), e056640. https://doi.org/10.1136/bmjopen-2021-056640

Quarshie, E. N.-B., Waterman, M. G., & House, A. O. (2020). Self-harm with suicidal and non-suicidal intent in young people in sub-Saharan Africa: A systematic review. BMC Psychiatry, 20(1), 234. https://doi.org/10.1186/s12888-020-02587-z

Renjith, V., Yesodharan, R., Noronha, J. A., Ladd, E., & George, A. (2021). Qualitative Methods in Health Care Research. International Journal of Preventive Medicine, 12, 20. https://doi.org/10.4103/ijpvm.IJPVM_321_19

Scocco, P., Preti, A., Totaro, S., Ferrari, A., & Toffol, E. (2017). Stigma and psychological distress in suicide survivors. Journal of Psychosomatic Research, 94, 39–46. https://doi.org/10.1016/j.jpsychores.2016.12.016

Spillane, A., Matvienko-Sikar, K., Larkin, C., & Arensman, E. (2020). How do people experience a family member's high-risk self-harm? An interpretative phenomenological analysis. Archives of Suicide Research: Official Journal of the International Academy for Suicide Research, 24(sup1), 280–302. https://doi.org/10.1080/13811118.2019.1574248

Tawiah, P. E., Adongo, P. B., & Aikins, M. (2015). Mental Health-Related Stigma and Discrimination in Ghana: Experience of Patients and Their Caregivers. Ghana Medical Journal, 49(1), 30–36. https://doi.org/10.4314/gmj.v49i1.6

Vivekanandhan, S., Ramasamy, D., Cherian, A. V., & Hugh-Jones, S. (2024). Lived Experience of Caregivers of Suicide Attempt Survivors: A Qualitative Study with Indian Adults. Indian Journal of Psychological Medicine, 02537176241250162. https://doi.org/10.1177/02537176241250162

Wayland, S., Coker, S., & Maple, M. (2021). The human approach to supportive interventions: The lived experience of people who care for others who suicide attempt. International Journal of Mental Health Nursing, 30(3), 667–682. https://doi.org/10.1111/inm.12829

World Health Organization. (2014). Preventing suicide: A global imperative. World Health Organization. https://apps.who.int/iris/handle/10665/131056

World Health Organization. (2021). Suicide Worldwide In 2019: Global Health Estimates (1st ed). World Health Organization. https://www.who.int/publications/i/item/9789240026643