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Understanding and Preventing Child Suicide in the United Republic of Tanzania: Seligman's Theory of Well-Being and Logo-Therapy

Mabula Masalakulangwa
St. Paul's University

Abstract

Children in the world today are more abandoned, neglected and abused than any time in history. Tanzania as part of the world is not an island. Suicide remains the second leading cause of death globally. While rare in younger than 10 years, suicide death rates increase markedly between the ages of adolescence and young adulthood. In 2022, more than 3000 people including children killed themselves in Tanzania, placing the country 4th in Africa with the highest suicide rate. The prevalence of depression in the general population of Tanzania is 4.1%, while suicide has been reported in 2.3/100 000 of the general population. Although a child according to the varied definitions is any person from age 5 to 18, this study focuses on children ages (but not limited to) 7-17, and 17-27. It is, however, worth noting that Article 1 of the United Nations Convention on the Rights of the Child defines 'children' as persons up to the age of 18 (UNCRC). Child suicide indicates failure of social institution. The objectives of the study are: i) to explain child suicide ii) to elucidate the causes of child suicide, and iii) to offer preventive measures of child suicide in the United Republic of Tanzania. The study employs the WHO Non-Invasive Qualitative Violence Info Methodology which generates evidence to address this acute but neglected problem. The WHO Non-Invasive Violence Info Methodology is supplemented by the Inter-Generational Qualitative Method which recognizes and includes all ages as the problem is cross-cutting. The Seligman's PERMA theory of well-being and Logo-Therapy are applied in this study. The results indicate that the myths and facts of suicide have not been captured by social institutions. The study suggests humane treatment of all children. All children must be treated equally with dignity and sanctity. Family and parenting should be improved to be child-centered, and schooling should not only be inclusive but invitational as well. The study concludes that it is the Behavioral sciences approach which holds a promise in preventing suicide. According to Behavioral sciences, knowledge and information enhance management of any problem. Children who are dying of suicide have been suffering from unnoticed intra-psychic conflict for long time.

Key Words: *Child Suicide Ideations, Law, Psychology, Ethics, Policy, Counseling*

1.0 Introduction

Suicidal ideation and attempted suicide are a huge problem in the United Republic of Tanzania, especially in the rural areas. Previous research has emphasized the importance of the ability of medical professionals to identify young people who are at risk of committing suicide leaving out parents, guardians, care-givers, and teachers. All social institutions namely: i) the family, ii) religion, iii) education, iv) health, v) sports/entertainment, and vi) politics or the political economy need to know the warning signs of suicidal behavior. Psychotherapists need to be able to assess the type of information given to other children after a suicide of one of their mates,

and assessing their views and training needs on the prevention of suicidal behavior in children. Social institutions need to change, and for the first time intentionally be child-centric to address child suicide. Children with suicidal ideation, who make up one in 20 children worldwide, are particularly vulnerable to child suicide although good quality data are lacking on causes and means of prevention of child suicide. Key challenges exist in the measurement of suicidal ideations and violence, which in part explains the dearth in evidence.

2.0 Systematic Literature Review

Emile Durkheim's *Suicide* addresses the phenomenon of suicide and its social causes. Suicide primarily results from a lack of integration of the individual (child) into society. It is important to identify the impetus for suicide and its psychological impact on the victim, family, and society (Durkheim, 1897, 1952).

Suicide remains a significant social and public health problem in the United Republic of Tanzania, in Africa and in the World (Berlim *et al.*, 2007, pp. 100(1–3):233–9, Radbo *et al.*, 2008, pp. 46:729–37). In 1998, suicide constituted 1.8% of the total disease burden globally, and is estimated to rise to 2.4% by 2020 (Bertolote *et al.*, 2009, pp. 91-8).

Suicidal behavior is complex. The process ranges from suicidal ideation, that can be communicated through verbal or non-verbal means, to the planning of suicide, attempting suicide, and in the worst case, actual suicide (Van Orden *et al.*, 2011, pp. 117:574-600). Worldwide, suicide has been found to be one of the three leading causes of death among those in the most productive age group (15-44) and the second leading cause of death in the 15-19 years age group (IASP, 2012, pp. 1-3; Patton *et al.*, 2009, pp. 374:881-92).

Suicide impacts on the most vulnerable of the world's population and places a large burden on low- and middle-income countries that are often ill-equipped to meet the general and mental health needs of their populations. Services are scarce in these countries as they have low budgetary allocations for health in general and for mental health in particular. As a result, there are few sustained efforts and activities that focus on suicide prevention on a scale necessary to reduce the number of lives lost to suicide (WHO, 2012, pp. 1-26).

Studies of personal and environmental factors related to suicide ideation and attempt among young people have been conducted in South Africa. One of these studies focused on the predictors of suicidal behavior (Peltzer *et al.*, 2008, pp. 36:493-502). Another study on environmental factors and adolescent suicidal behaviors, conducted in Limpopo Province, found that family conflict was a significant correlate for suicidal behaviors (Madu *et al.*, 204:32-(4)341-54). A qualitative study of adolescents concluded that a lack of knowledge of the availability of counselors, conflict in interpersonal relationships, perceived accusations of negative behavior, inadequate social support, past family and peer suicide attempts, as well as poor living circumstances were associated with attempted suicide (Shilubane *et al.*, 2012, pp. 14(2):177-89). A subsequent quantitative study among the same population demonstrated that suicide ideation is prevalent among these adolescents. Perceived lack of social support and negative feelings about the family and behavioral factors such as forced sexual intercourse and physical violence of partners were positively correlated with the risk of suicidal ideation (Shilubane *et al.*, 2014, 45(2):153-62, Berman *et al.*, 2006) and (Fisher, 2005, 48(5):364-73) also found that adolescents who attempted or completed suicide demonstrated warning signs in advance. They tended to talk about suicide, have sleeping and eating problems, withdraw from friends, give away prized possessions, lose interest in their personal appearance, use alcohol or

drugs, and take unnecessary risks. Furthermore, some studies have demonstrated that drug use is commonly associated with suicide (Borges *et al.*, 2010, 23(3):191--204). When the correlates of suicide risk among secondary school students are examined, one may find anger-related control problems, low self-esteem, perceived stress and unmet school goals as factors for suicide.

Addressing problems related to child suicide, child suicide prevention and psychotherapy treatment should be seen as a multi-professional issue. Those who do self-harm might seek help from parents, psychotherapists, or be referred to a variety of professionals in the community such as teachers, social workers, community mental health nurses, general practitioners, and psychiatrists. This suggests that there is a need to explore the level of knowledge and understanding that staff members of schools have of adolescent self-harm behavior. There is also a need to gauge parents, teachers' and doctors' ability to identify impending acts of child self-harm, prevent family and school conditions that might lead to child self-harm, and cope with uncertainties and emotions of students after a suicidal incident in the family, class or school (Timson *et al.*, 2012, pp. 35:1307-14). In response to the problem of child suicide, many families and schools acknowledge that suicide issues are often unavoidable and family or school professionals are increasingly accepting the role of "gatekeeper" in dealing with suicidal children. As children disclose information about themselves in their daily interactions through conversations with peers, their writing, and general behavior towards parents, guardians, care givers, or school staff, they provide a gateway for detection of warning signs of suicidal behavior and to offer psycho-social support or refer them for professional help (Van Orden *et al.*, 2011, pp. 1-3).

It seems as if suicide prevention programs and interventions or initiatives might reduce the incidents of child suicide in the family and at schools. However, before an effective intervention program and interventions or initiatives can be developed and implemented in families and or in school settings, the knowledge and skills base of parents, guardians, caregivers, teachers, and doctors needs to be assessed. Some of the available literature emphasizes the importance of the ability of school professionals or medical professionals to identify young people who are developing suicide risk behaviors (Walter *et al.,* 2006, pp. 45(1):61-8), but unfortunately parents, guardians, teachers and doctors are often neglected in the discussion of child and adolescent suicide. Parents, guardians, care givers, teachers and doctors should possess accurate knowledge of child and adolescent suicide and be capable of referring a child to relevant services (Crawford *et al.*, 2009, pp. 34(2):28-39; Schepp *et al.*, 1991, pp. 2:57-63).

Research in Africa and particularly in the United Republic of Tanzania has neglected the involvement of parents, guardians, care givers, teachers, and doctors in studies on child and adolescent suicide. Knowledge of suicidal behavior is important in preventing child and adolescent suicide as well as in providing support to peers and the wider family and school environment following a suicide attempt. The purpose of the study was to assess the knowledge, skills and training needs of parents, guardians, care givers, teachers and doctors concerning child and adolescent suicidal behavior. Although Wyman *et al.* (2008, pp. 76(1):104-15) demonstrated that many vulnerable children and youth will not confide to adults their distress even if they are suicidal, the suicide rate of children and adolescents might be reduced if parents, guardians, care givers, doctors, and teachers were educated about child and adolescent's suicide behavior and taught skills through well designed evidence- and theory-based intervention programs, as has been shown by previous suicide prevention strategies for physicians (Mann *et al.*, 2005, pp. 294(16):2064-74). In addition, parents' guardians', care givers', teachers' and doctors' knowledge of warning signs of child and adolescent suicidal behavior could assist in

the identification and referral of children at risk to available counselors or psychologists. It should be noted that counseling services are not sufficiently available at the family, school, or health institutions.

Suicidal ideation in the United Republic of Tanzania is an understudied risk factor for suicidal intent. There is need to investigate the patterns and risk factors for suicidal ideation among children (Dunlavy *et al.*, 2014).

Health risk behaviors among adolescents need to be studied as they have negative health effect and impose huge economic and social burdens on society. Among the various health risk behaviors that could be intervened, the consequences of attempted suicide were extremely serious and deserved special attention (Zhou et al., 2020).

3.0 Methodology and Methods

The study employs the WHO Non-Invasive Qualitative Violence Info Methodology which generates evidence to address this acute but neglected problem. The WHO Non-Invasive Violence Info Methodology is supplemented by the Inter-Generational Qualitative Method which recognizes and includes all ages as the problem is cross-cutting. Three focus group discussions were conducted, with 10 parents, 10 teachers and 10 Doctors in Mwanza Region, of the United Republic of Tanzania. Three focus group discussions were conducted with 6 parents, 6 Teaches, and 8 Doctors in Unguja and the surrounding islands, Zanzibar Central/South (capital: Koani), Zanzibar North (capital: Mkokotoni), Zanzibar Urban/West (capital: Zanzibar City). All focus group discussions were audio-taped, transcribed verbatim, and then analyzed using an inductive approach. The study uses Seligman's PERMA theory of well-being and Logo-Therapy as ways to mitigate child suicide.

4.0 Results, Findings and Discussion

The results demonstrate that Parents, Teachers and Doctors lack knowledge of the warning signs of suicidal behavior among children. They also report that they do not know how to support children in the event of attempted or completed suicide of another child. The school medical curriculums are perceived as lacking information on suicide and suicidal behavior.

Parents (Guardians, and or Care-Givers), Teachers, and Doctors in Mwanza Region need to be trained to identify children at risk, and to respond to situations by referring children at risk to appropriate mental health professionals and psychotherapists. School-based suicide prevention programs that are based on theory and evidence should be developed. These programs should include Training and Health Education to help Parents, Teachers and Doctors to identify symptoms of psychosocial problems that might lead to suicide, develop their skills in handling such problems, and help children to cope with their emotions after a suicide incident in the family, in the class or at school. The same was the case for teachers in Unguja and the surrounding islands, Zanzibar Central/South (capital: Koani), Zanzibar North (capital: Mkokotoni), Zanzibar Urban/West (capital: Zanzibar City). For Mwanza and Zanzibar, there is also a need to offer Health Education, Health Promotions and Personal Health Education and Health Promotion to children. The children of the study are those aged (but not limited to) 7-17, and 17-27. The first step in mitigating child suicide was identified as elucidating the causes of child suicide. Having elucidated the causes of child suicide, the next step was identified as delving into the myths and facts about suicide, which ultimately leads to revising the SDGs.

The most serious question among many is: What are the causes of suicide? Suicide is caused by many factors including: i) interrupted or broken childhood (Morley *et al.*, 2024), ii) childhood trauma, and the PTSD (Rankle, 2024, Tucci et al., 2024), iii) Domestic and family violence (Meyer *et al.*, 2019), iv) school violence including bullying (Winslade *et al.*, 2011; Allely, 2020), v) unhappiness and emotional problems, vi) uninvolved parenting, vii) child neglect, abandonment and abuse (Hill, 2024), viii) poverty, ix) lack of household livelihood security (Leivang *et al.*, 2024), x) stress from social media activities, including being a victim of cyber-bullying, xi) changes in friendships, and xii) changes in the families such as divorce, siblings moving out, or moving to a new town, and xiii) loses, or grief: suicide among children often happens after a stressful life event, such as problems at school, a breakup with a boyfriend or girlfriend, the death of a loved one (Montgomery, 2015; Green, 2022, Camerona *et al.*, 2022). Cyber bullying is also a cause of suicide:

> In the modern time, where anything can be accessed with a single click, social media has become more and more important in today's environment. The Internet has had a significant influence on everyone's life, and it goes without saying that young people make up the majority of internet users. The youth of the present time are living a digital life with the internet technology. It provides various comforts to its users. No doubt, internet technology has provided us lots of benefits; however, it also operates as a breeding environment for certain undesirable behaviors, one example of such undesirable behavior is cyber-bullying. Cyber-bullying is the misuse of technology with the intention to harass and harm others due to the fact that it is a common problem among youngsters and has more harmful effects than expected. It has many negative consequences on its victims such as stress, anxiety, social dissatisfaction, negative school attitude and in some cases, substances abuse, depression, physical harm, mental strain and in extreme cases, suicide also. That is the reason why it is treated as a disease in the 21st century. The tragic events and increased incidence of this new kind of bullying have therefore made researchers, educators, government officials, and parents aware of its severe ramifications. The main aim of this paper is to highlight cyber-bullying and its expected consequences on the youngsters in the present digital age (Mohinder, Singh, 2023).

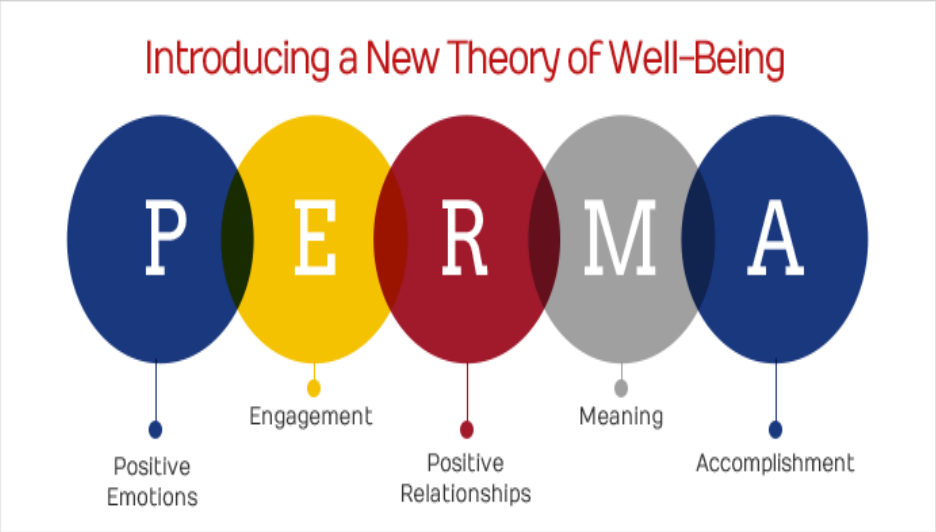
Structural determinants of mental ill-health such as extreme poverty, lack of access to empowerment opportunities and discrimination increase the likelihood of children committing suicide. Intra-psychic conflict is the central cause of suicide. Intra-psychic in psychoanalytic theory is the clash of opposing forces within the psyche, such as conflicting drives, wishes, or agencies. Also called inner conflict; internal conflict; intrapersonal conflict; psychic conflict. Intra-psychic conflict occurs within the psyche, mind, being or occurring within the psyche, mind, or personality. *Suicidal ideations* (SI), often called *suicidal thoughts* or ideas, is a broad term used to describe a range of contemplations, and or wishes for suicide. What comes next are the Myths and Facts about suicide:

Myths and Facts about Suicide		
	Myths	**Facts**
1	Depression and self-destructive behavior are rare in young people	Both forms of behavior are common in adolescents. Depression may manifest itself in ways which are different from its manifestation in adults but it is prevalent in children and adolescents. Self-destructive behavior is most likely to be shown for the first time in adolescence and its incidence is on the rise.
2	All young people with thoughts of suicide are depressed.	While depression is a contributory factor in most suicides, it need not be present for a person to attempt or die by suicide.
3	Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.	The opposite may be true. In the three months following an attempt, a young person is at most risk of dying by suicide. The apparent lifting of the problems could mean the person has made a firm decision to die by suicide and feels better because of this decision.
4	Once a young person thinks about suicide, they will forever think about suicide.	Most young people who are considering suicide will only be that way for a limited period of their lives. Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns.
5	Young persons thinking about suicide cannot help themselves.	While contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain full self-direction and self-management in their lives.
6	The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.	All people who interact with adolescents in crisis can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family, and friends providing a network of support.
7	Most young people thinking about suicide never seek or ask for help with their problems.	Evidence shows that they often tell their school peers of their thoughts and plans. Most adults with thoughts of suicide visit a medical doctor during the three months prior to killing themselves. Adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others.

8	Young people thinking about suicide are always angry when someone intervenes and they will resent that person afterwards.	While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.
9	Young people thinking about suicide are insane or mentally ill.	Although adolescents thinking about suicide are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most are not legally insane. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.
10	Suicide is much more common in young people from higher (or lower) socioeconomic status (SES) areas.	The causes of suicidal behavior cut across SES boundaries. While the literature in the area is incomplete, there is no definitive link between SES and suicide. This does not preclude localized tendencies nor trends in a population during a certain period of time.

Child suicide counts against the SDGs. SDG4, calls for access to inclusive and equitable quality education and lifelong learning opportunities for all by 2030.

The PERMA Model represents the five core elements of happiness and well-being. PERMA basically stands for **Positive Emotion, Engagement, Relationships, Meaning, and Accomplishments**. American psychologist and educator Martin Seligman designed the PERMA Model (Seligman, 2004, 2006, 2007, 2012, 2018, Gabriella and Seligman, 2023). PERMA model has to be in the company of Logo-Therapy. Logo Therapy is a form of psychotherapy that is focused on the future and on our ability to endure hardship and suffering through a search for purpose. Psychiatrist and psychotherapist Viktor Frankl developed Logo-Therapy prior to his deportation to a concentration camp at age 37 (Frankl, 2006). Three philosophical and psychological concepts make up Frankl's Logo-Therapy are: i) freedom of will, ii) will to meaning, and iii) meaning of life (Batthyany, 2009). Freedom of will asserts that humans [children] are free to decide and can take a stance toward both internal and external conditions.



Graph 3 Adopted from Seligman & Martin (2007, 2012)

Logo-therapy as developed by neurologist and psychiatrist, Viktor Frankl, is based on the premise that the primary motivational force of an individual is to find a meaning in life. Frankl describes it as 'the Third Viennese School of Psychotherapy' along with Freud's psychoanalysis (Freud, 1955, 1960, 1990, 1995, 2011, and 2017) and Adler's individual psychology (Adler, 1908, 1917, 1924, 1927, 1030, 1930, 1930, 1938, 1955, 1964, and 1979).

5.0 Conclusion

Emile Durkheim (1897, 1952) was right when he wrote that suicide primarily results from a lack of integration of the individual (child) into society. All social institutions namely: the family, religion, education, health, sports/entertainment, and the political economy or politics are failing but they need to be considerate to the child and offer authentic care. There is need to apply the PERMA Model and Logo-Therapy.

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