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Examining the Factors Leading to Suicide among Youth in Urban West Region Zanzibar

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Abstract: **Youth suicide is a major public health and psychosocial concern, particularly in settings where psychological distress, social pressures and economic difficulties interact. This study examined the psychological, social and economic factors leading to suicide among youth in the Urban West Region of Zanzibar. A mixed-methods approach was employed using a descriptive research design. Purposive sampling was used to select 50 participants, comprising 30 youth aged 15–30 years and 20 key informants, including psychologists, teachers, parents and social workers. Quantitative data were collected through questionnaires and analysed using frequencies and percentages in SPSS, while qualitative data from interviews were analysed thematically. The findings indicated that psychological experiences including perceived burdensomeness, difficulty coping with stress, emotional isolation and severe emotional distress were important areas of vulnerability. Social factors included family conflict, inadequate emotional support, social rejection or discrimination, loneliness and bullying. Economic findings highlighted the mental-health burden of unemployment and the restriction of life opportunities by limited financial resources, although financial stress was not experienced uniformly by all participants. Interview findings reinforced the quantitative results and showed that psychological, social and economic pressures often interact. The study provides context-specific evidence relevant to counselling, community support, youth development and suicide-prevention planning in Zanzibar.**

Keywords**: Economic Factors, Emotional Distress, Psychological Factors, Social Factors, Suicide Prevention, Suicidal Behaviour, Urban West Region, Youth, Zanzibar.**

1. INTRODUCTION

Suicide is the intentional act of causing one's own death and is understood as a complex phenomenon shaped by psychological, social, biological and environmental conditions. Suicidal behaviour may occur across a continuum that includes suicidal thoughts, planning, attempts and completed suicide (World Health Organization [WHO], 2024; Australian Institute of Health and Welfare, 2025). Among young people, suicide is a particularly important public health concern because adolescence and early adulthood involve major developmental, educational, interpersonal and economic transitions. These transitions may increase exposure to stress while coping resources and access to professional support remain limited.

International evidence indicates that depression, hopelessness, emotional distress, interpersonal difficulties and social isolation are consistently associated with suicidal thoughts and behaviour among young people. Hawton et al. (2022) emphasised that suicide among young people is rarely explained by a single circumstance; rather, psychological difficulties interact with family, social and environmental stressors. Turecki et al. (2019) similarly identified psychological pain, hopelessness and other forms of emotional suffering as important elements in suicide risk. Ribeiro et al. (2018) found that depression and hopelessness are important predictors of suicidal ideation, attempts and suicide death.

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The African context presents additional challenges because many countries face limited mental-health resources, socioeconomic inequalities and stigma surrounding mental illness. Lund et al. (2020) noted that social determinants such as poverty and economic insecurity are closely connected with common mental disorders, particularly in low- and middle-income settings. Patel et al. (2018) further argued that global mental-health responses need to consider social and economic conditions alongside clinical services. In East Africa, research has identified family difficulties, social pressures, psychological distress and socioeconomic challenges as important areas for suicide-prevention efforts (Khasakhala et al., 2013; Macharia & Wambua, 2022).

In Tanzania, suicide and suicidal behaviour remain important concerns among adolescents and young adults. The dissertation on which this article is based notes evidence of suicidal thoughts, planning and attempts among Tanzanian students and reports continuing concern about suicide in Zanzibar. The study also highlights the importance of understanding suicide within the cultural and religious environment of Zanzibar, where distress may be interpreted and disclosed differently from other settings. Zanzibar's Urban West Region, including Amani, Mwanakwerekwe, Magomeni and Malindi, provides an important setting for examining these issues because of its urban population, social diversity and concentration of young people.

Despite the existence of international and national literature, the dissertation identified limited context-specific evidence explaining how psychological, social and economic factors shape vulnerability to suicidal behaviour among youth in the Urban West Region. This evidence gap limits the ability of counsellors, families, schools, communities and policy actors to design interventions that respond to local realities. The present article therefore examines three areas: psychological factors, social factors and economic factors leading to suicide among youth in the Urban West Region of Zanzibar. The study was guided by two theories Cognitive Behaviour Theory and Interpersonal theory of suicide. The Cognitive Behavioural Theory, which provides a useful framework for understanding how stressful experiences can influence thoughts, emotions and behaviour (Beck, 2011; Beck et al., 2011). And The Interpersonal Theory of Suicide (ITS) was developed by Thomas Joiner in 2005 to explain the psychological and interpersonal factors that contribute to suicidal behaviour (Joiner, 2005). According to the theory, suicidal behaviour occurs when an individual simultaneously experiences perceived burdensomeness, thwarted belongingness and acquired capability for suicide (Van Orden et al., 2010).

The study is important to counselling psychology because it demonstrates that suicide prevention cannot be reduced to identifying one risk factor. Instead, the findings indicate the need to recognise interactions among emotional distress, family relationships, social connectedness, economic opportunity and access to support. The findings are intended to contribute to locally relevant counselling services, community-based prevention, youth-support programmes and mental-health policy in Zanzibar.

2. RESEARCH METHODOLOGY

The study employed a mixed-methods approach within a descriptive research design. The mixed-methods approach was selected because the study required both quantitative evidence on the distribution of psychological, social and economic experiences and qualitative information explaining how these experiences were understood by professionals and other key informants. Mixed-methods research allows quantitative and qualitative evidence to complement one another and can provide a broader understanding of complex social and psychological problems (Creswell & Plano Clark, 2018).

The study was conducted in the Urban West Region of Zanzibar, focusing on Amani, Mwanakwerekwe, Magomeni and Malindi. The target population consisted of youth aged 15–30 years, while key informants were selected because of their professional or community knowledge relevant to youth mental health and suicidal behaviour. The final study sample comprised 50 participants: 30 youth and 20 key informants, including psychologists, teachers, parents and social workers. Purposive sampling was used to identify participants who could provide information relevant to the study objectives.

Primary data were collected using a structured questionnaire for youth and semi-structured interviews for key informants. The questionnaire used a five-point response scale ranging from strongly disagree to strongly agree and covered psychological, social and economic factors. Psychological indicators included hopelessness, persistent sadness, perceived burdensomeness, difficulty coping with stress, emotional isolation and severe emotional distress. Social indicators included family conflict, inadequate emotional support, social rejection or discrimination, loneliness and bullying. Economic indicators included financial stress, unemployment, financial responsibilities and restricted life opportunities.

Quantitative data were coded and analysed using Statistical Package for the Social Sciences (SPSS) version 26 and Microsoft Excel. Frequencies and percentages were used to summarise responses and identify patterns. Qualitative interview data were analysed using thematic analysis following familiarisation, coding, categorisation and development of themes (Nowell et al., 2017). Quantitative and qualitative findings were compared during interpretation so that interview evidence could provide contextual explanations for patterns observed in the questionnaire data.

Validity and reliability were supported through alignment between the study objectives, conceptual framework and research instruments, pre-testing of the questionnaire, clear questions and consistent data-collection procedures. Trustworthiness of the qualitative component was addressed through procedures including triangulation, member checking, peer debriefing, reflexivity, an audit trail and transparent linkage between data and themes. Ethical procedures included informed consent, confidentiality, voluntary participation and the right to withdraw. Because the topic involved sensitive questions about mental health and suicidal behaviour, participants were informed that they could decline to answer questions and that referral information for professional counselling support would be provided when emotional distress arose.

3. RESULTS AND DISCUSSION

The results are presented according to the three research objectives. The quantitative findings are first summarised using frequencies and percentages, followed by interpretation and discussion with the qualitative evidence and relevant literature. The article focuses on the 30 youth who completed the questionnaire for the quantitative findings, while the interview component provided perspectives from the 20 key informants.

Psychological factors leading to suicide among youth

TABLE: I. PSYCHOLOGICAL FACTORS

Psychological indicator	SD n (%)	D n (%)	N n (%)	A n (%)	SA n (%)
Hopeless about future	12 (40.0)	12 (40.0)	3 (10.0)	1 (3.3)	2 (6.7)
Persistent sadness/depressive feelings	8 (26.7)	11 (36.7)	7 (23.3)	2 (6.7)	2 (6.7)
Feel like a burden to others	6 (20.0)	7 (23.3)	5 (16.7)	11 (36.7)	1 (3.3)
Difficulty coping with daily stress	11 (36.7)	2 (6.7)	7 (23.3)	6 (20.0)	4 (13.3)
Emotionally isolated around others	9 (30.0)	7 (23.3)	9 (30.0)	4 (13.3)	1 (3.3)
Severe emotional distress in past year	7 (23.3)	5 (16.7)	4 (13.3)	7 (23.3)	7 (23.3)

Source: Field Data (2026)

The findings show that psychological vulnerability was not uniform across the youth respondents. Most respondents rejected the statement that they were hopeless about their future, with 80.0% strongly disagreeing or disagreeing. Nevertheless, perceived burdensomeness was more concerning: 40.0% agreed or strongly agreed that they sometimes felt like a burden to others. Difficulty coping with daily stress was also reported by 33.3% who agreed or strongly agreed. Emotional isolation was acknowledged by 16.6%, while 46.6% agreed or strongly agreed that they had experienced severe emotional distress during the previous year.

These findings suggest that resilience and vulnerability can coexist. Many youth may maintain optimism and adequate coping while a substantial minority experiences emotional difficulties that may increase vulnerability to suicidal behaviour. Perceived burdensomeness is particularly important because it reflects negative self-evaluation and reduced perceived social value. This finding is consistent with the Interpersonal Theory of Suicide, which identifies perceived burdensomeness and social disconnection as important psychological-interpersonal conditions associated with suicidal thinking (Van Orden et al., 2010).

The finding is also consistent with Ribeiro et al. (2018), who found that depression and hopelessness are important longitudinal risk factors for suicidal ideation, attempts and death. Turecki et al. (2019) similarly identified hopelessness, psychological pain and emotional dysregulation as central elements of suicide risk. Glenn et al. (2020) emphasised the importance of emotional regulation and effective coping in reducing self-injurious thoughts and behaviours among young people. The current results therefore reinforce the need for counselling interventions that strengthen coping skills, emotional regulation, self-worth and realistic future orientation.

The qualitative findings provided further explanation. Psychologists, counsellors and social workers described hopelessness, depression, emotional pain, low self-esteem, anxiety and poor coping as recurring challenges among vulnerable youth. They also reported that young people may conceal emotional difficulties because of stigma or limited awareness of available services. Some professionals described withdrawal, persistent sadness, changes in behaviour and substance use as warning signs that should receive early attention. These findings indicate that psychological distress may develop gradually and become more dangerous when support is unavailable.

The results can be interpreted through Cognitive Behavioural Theory. Stressful experiences do not automatically produce suicidal behaviour; rather, the way young people interpret those experiences may influence emotional responses and coping. Economic failure, family conflict or rejection may become especially harmful when interpreted as evidence of personal worthlessness, permanent failure or an absence of future possibilities. Counselling can therefore target negative automatic thoughts, strengthen coping strategies and help young people develop more balanced interpretations of stressful life events (Beck, 2011; Beck et al., 2011).

Social factors leading to suicide among youth

TABLE: II. SOCIAL FACTORS

Social indicator	SD n (%)	D n (%)	N n (%)	A n (%)	SA n (%)
Family conflict	6 (20.0)	7 (23.3)	5 (16.7)	7 (23.3)	5 (16.7)
Inadequate family emotional support	11 (36.7)	9 (30.0)	4 (13.3)	3 (10.0)	3 (10.0)
Social rejection/discrimination	14 (46.7)	3 (10.0)	2 (6.7)	7 (23.3)	4 (13.3)
Loneliness	10 (33.3)	8 (26.7)	3 (10.0)	7 (23.3)	2 (6.7)
Bullying, online/offline	14 (46.7)	8 (26.7)	1 (3.3)	5 (16.7)	2 (6.7)
Severe emotional distress	7 (23.3)	5 (16.7)	4 (13.3)	7 (23.3)	7 (23.3)

Source: Field Data (2026)

Family conflict emerged as an important social concern. Forty percent of youth agreed or strongly agreed that they frequently experienced conflict within their families. Although 66.7% disagreed or strongly disagreed that they lacked adequate emotional support, 20.0% agreed or strongly agreed that they did not receive adequate support. This indicates that supportive family relationships exist for many youth, but a meaningful minority experiences gaps in emotional care.

Social rejection and discrimination were also reported by 36.6% of respondents who agreed or strongly agreed that they had experienced such experiences. Nearly 30% reported feeling lonely, while 23.4% reported bullying either online or offline. Although most respondents did not report bullying, the minority who experienced it remain important because bullying can have substantial psychological effects even when its prevalence is lower than other social stressors.

The findings are consistent with Loades et al. (2020), who reported that social isolation and loneliness are associated with poorer mental health among children and adolescents. Qualter et al. (2021) likewise highlighted the negative psychological consequences of loneliness, including reduced self-esteem and increased hopelessness. Holt et al. (2018), through a meta-analysis, found a significant relationship between bullying and suicidal ideation and behaviour among young people. These findings support the present evidence that social connectedness is a potentially important protective resource.

The qualitative interviews strengthened the questionnaire findings. Counsellors and other professionals described family conflict, separation, peer pressure, stigma and weak social support as recurring challenges. Family disputes were reported to create emotional insecurity, while peer pressure could push young people towards risky behaviours in attempts to gain acceptance. Mental-health stigma was also described as a barrier to help-seeking because some youth fear being judged, labelled or misunderstood. Consequently, distress may remain hidden until it becomes severe.

The social findings are also compatible with the Interpersonal Theory of Suicide, particularly the importance of belonging and perceived social value (Van Orden et al., 2010). When young people experience rejection, loneliness, bullying or inadequate emotional support, they may perceive themselves as disconnected from others. Such experiences may interact with psychological distress and economic pressure, increasing vulnerability. Suicide prevention in Zanzibar therefore requires interventions that strengthen family communication, supportive peer relationships, school safety and community belonging.

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Economic factors leading to suicide among youth

TABLE: III. ECONOMIC FACTORS

Economic indicator	SD n (%)	D n (%)	N n (%)	A n (%)	SA n (%)
Financial difficulties cause significant stress	10 (33.3)	8 (26.7)	5 (16.7)	1 (3.3)	6 (20.0)
Unemployment negatively affects mental health	4 (13.3)	4 (13.3)	3 (10.0)	14 (46.7)	5 (16.7)
Limited financial resources restrict life opportunities	7 (23.3)	4 (13.3)	4 (13.3)	12 (40.0)	3 (10.0)

Source: Field Data (2026)

The economic findings demonstrate that financial experiences differed across participants. For financial difficulties as a source of significant stress, 23.3% agreed or strongly agreed, while 60.0% disagreed or strongly disagreed. In contrast, unemployment was perceived more strongly as a mental-health concern: 63.4% agreed or strongly agreed that unemployment negatively affected mental health. Similarly, 50.0% agreed or strongly agreed that limited financial resources had restricted their life opportunities.

These results suggest that unemployment and restricted opportunities may be more salient than financial stress alone. A young person may not currently experience severe financial hardship but may still experience frustration because unemployment or limited opportunities reduce expectations about education, employment, independence and future development. This interpretation is supported by Lund et al. (2020), who linked socioeconomic conditions to mental-health outcomes, and by Milner et al. (2018), who found an important relationship between long-term unemployment and suicide.

The qualitative evidence provided further depth. Counsellors, psychologists and social workers identified unemployment, poverty and financial hardship as important stressors. They explained that prolonged unemployment may create purposelessness and social exclusion, while financial hardship can restrict access to education, healthcare and other essential opportunities. Economic pressure may also make some young people feel that they are burdens to their families. Such perceptions can connect economic difficulties with psychological distress and social disconnection.

The findings should not be interpreted to mean that financial hardship inevitably produces suicidal behaviour. Rather, economic stress may operate through psychological and social pathways. Cognitive Behavioural Theory helps explain this process because the emotional effect of economic circumstances depends partly on how individuals interpret those circumstances. If unemployment or financial difficulty is interpreted as permanent failure or personal inadequacy, negative thinking and hopelessness may intensify. Conversely, supportive families, coping skills, education and community resources may buffer these effects.

The results therefore support an integrated approach to suicide prevention. Youth employment initiatives, vocational training, entrepreneurship, financial literacy and educational opportunities should be linked with counselling and psychosocial support. Addressing economic hardship without addressing emotional wellbeing may leave important mechanisms of vulnerability unresolved. Likewise, counselling alone may have limited impact when young people continue to face severe and persistent structural barriers to education, employment and social participation.

Integration of quantitative and qualitative findings

The mixed-methods findings demonstrate that psychological, social and economic factors are interconnected rather than isolated. Quantitative responses showed that a substantial minority experienced perceived burdensomeness, difficulty coping with stress, severe emotional distress, family conflict, rejection, loneliness, bullying, unemployment-related concerns and restricted life opportunities. The qualitative interviews explained how these experiences may combine. For example, unemployment may create feelings of failure or burden; family conflict may reduce emotional support; and stigma may prevent the young person from seeking counselling. These interacting processes may intensify psychological pain and reduce resilience.

This integration is important because a purely psychological explanation would overlook the social and economic conditions in which distress occurs, while a purely economic explanation would overlook the cognitive and emotional processes through which hardship becomes psychologically harmful. The study therefore supports a multidimensional counselling perspective in which prevention addresses individual coping, family relationships, social inclusion, economic opportunity and access to professional services simultaneously.

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4. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The study concludes that youth vulnerability to suicidal behaviour in the Urban West Region of Zanzibar is shaped by interacting psychological, social and economic conditions. Psychological factors were particularly evident in perceived burdensomeness, difficulty coping with stress, emotional isolation and severe emotional distress. Although many respondents demonstrated resilience and did not report persistent hopelessness or depressive feelings, a substantial minority experienced psychological difficulties that require early identification and professional support.

Social factors were also important. Family conflict, inadequate emotional support, rejection or discrimination, loneliness and bullying affected a meaningful minority of respondents. The findings demonstrate that being physically surrounded by family or peers does not necessarily guarantee emotional connectedness. Supportive relationships, belonging and safe environments are therefore important protective resources. The qualitative findings further indicated that stigma can prevent young people from disclosing distress and seeking professional assistance.

Economic factors showed a more differentiated pattern. Financial hardship was not perceived as a major source of stress by all youth, but unemployment was widely perceived as harmful to mental health and half of respondents agreed or strongly agreed that limited financial resources had restricted their life opportunities. The qualitative findings suggested that economic pressure may contribute indirectly to suicidal vulnerability through hopelessness, perceived burdensomeness, social exclusion and reduced confidence about the future.

Overall, the study concludes that suicide prevention among youth in Zanzibar requires a comprehensive approach rather than a single intervention. Psychological counselling, family and community support, safe school and peer environments, economic empowerment and accessible professional mental-health services should be considered interconnected components of prevention. Religious and cultural institutions can also contribute by promoting hope, social support, moral guidance and appropriate referral to professional services.

Recommendations

Schools and communities should establish or strengthen confidential, accessible and youth-friendly counselling services. Qualified counsellors, psychologists and social workers should be available to identify emotional distress early, provide brief interventions and make appropriate referrals. Counselling should address perceived burdensomeness, hopelessness, emotional pain, coping difficulties and self-esteem.

Families, teachers and community leaders should strengthen supportive communication with young people. Parents and guardians should be encouraged to create environments where youth can discuss emotional difficulties without fear of punishment, shame or rejection. Schools should strengthen anti-bullying measures and promote peer-support systems that increase belonging and reduce social isolation.

Government and other stakeholders should strengthen youth economic empowerment through vocational skills, entrepreneurship, employment opportunities and financial-literacy programmes. These interventions should be integrated with psychosocial support because economic difficulties can influence mental health through frustration, hopelessness and reduced perceived opportunities.

Religious and cultural institutions should be actively involved in suicide-prevention initiatives in culturally appropriate ways. Religious and community leaders can help reduce stigma, encourage supportive relationships and promote timely referral to qualified mental-health professionals. Their role should complement rather than replace professional psychological and psychiatric care.

Health institutions should increase access to professional mental-health services. The study's youth respondents strongly supported counselling and mental-health support centres in schools and communities, while the qualitative findings emphasised the importance of accessible, confidential and affordable services. Awareness activities should accompany service expansion so that young people know where and how to seek help.

Finally, future research should use larger samples and designs that directly measure suicidal ideation, planning and attempts, and should examine how psychological, social and economic factors interact over time. Such research would strengthen the evidence base for suicide prevention among youth in Zanzibar and improve the precision of interventions.

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