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SUICIDE IN THE IVORIAN CONTEXT: BETWEEN THE CRISIS OF SOCIAL TIES AND THE FRAGILITY OF MENTAL HEALTH IN THE DISTRICT OF ABIDJAN (COTE D'IVOIRE)

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ABSTRACT: This study examines some of the social burdens of suicide in the Ivorian context. The study is essentially qualitative. Using a methodological approach based on documentary exploration and data collection from field surveys (interviews) conducted among a category of actors in the district of Abidjan, the following result was obtained: Socio-psychological and cultural burdens interact to lead an individual to suicidal behaviour.
Keywords: Crisis, Social ties, Suicide, Fragility, Mental health, Côte d'Ivoire

I. INTRODUCTION

Since the word suicide keeps coming up in conversation, one would think that the meaning is known to everyone and that it is superfluous to define it. In reality, however, the words of everyday language, like the concepts they express, are always ambiguous, and the scientist who would use them as he receives them from use and without further elaboration would expose himself to the most serious confusion. Not only is the understanding so unclear that it varies from case to case according to the needs of the discourse, but also, since the classification from which they are the product does not proceed from a methodical analysis, it merely reflects the confused impressions of the crowd. It happens again and again that very disparate categories of facts are indistinctly brought together under the same heading, or that realities of the same nature are called by different names (E. Durkheim, 1897, P1).

No doubt, vulgarly speaking, suicide is above all, the act of desperation of a man who no longer wants to live. But, in reality, because one is still attached to life at the moment of leaving it, one does not allow it to be abandoned; and, among all the acts by which a living being thus abandons that of all his possessions which passes for the most precious, there are common features which are obviously essential. On the contrary, the diversity of motives which may have dictated these resolutions can only give rise to secondary differences. When, therefore, devotion goes as far as the certain sacrifice of life, it is scientifically a suicide (E. Durhkeim, 1897, P.5).

What is common to all possible forms of this supreme renunciation is that the act which consecrates it is accomplished with full knowledge of the facts; it is that the victim, at the moment of acting, knows what must result from his conduct, whatever reason, moreover, may have led him to behave in this way. All acts of death which present this characteristic feature are clearly distinguishable from all others in which the patient is either the agent of his own death, or is merely the unconscious agent of it. They are distinguished by an easily recognizable character, for it is not an insoluble problem whether or not the individual knew in advance the natural consequences of his action. They therefore form a definite, homogeneous group, discernible from any other and which, therefore, must be designated by a special word. That of suicide suits him, and there is no need to create another; for the very great generality of the facts which are daily so called is one of them. Suicide is any case of death which results directly or indirectly from a positive or negative act, performed by the victim himself and which he knew should produce this result. The attempt is the act thus defined, but stopped before death has resulted (E. Durhkeim, idem).

Every suicide is a tragedy. It is estimated that over 800,000 people die by suicide and there are many attempted suicides for every death. The impact on families, friends and disasters is far-reaching, even long after loved ones have committed suicide. Unfortunately, suicide is too often not considered a major public health problem. Despite an increase in research and knowledge about suicide and its prevention, the taboo and stigma

surrounding suicide persist and often people cannot seek help or be left alone. And if they do seek help, many health systems and services do not provide timely and effective assistance. Yet suicides are preventable. This report encourages countries to continue the good work where it is already under way and to put suicide prevention at the top of the agenda, regardless of a country's current status in terms of suicide rates or suicide prevention activities. With effective evidence-based interventions, treatment and support, both suicides and suicide attempts can be prevented. The burden of suicide is not only on the health sector. It has multiple impacts on many sectors and on society as a whole. Thus, to initiate suicide prevention, countries should use a multisectoral approach that addresses suicide in a comprehensive manner, bringing together the different sectors and stakeholders most relevant to each context (Dr Margaret Chan Director-General in World Health Organization, 2014, P.2).

In the light of the above-mentioned findings, in May 2013, the Sixty-sixth World Health Assembly adopted the first-ever World Health Organization (WHO) Plan of Action for Mental Health. Suicide prevention is an integral part of this plan, with the aim of reducing the suicide rate by 10 per cent by 2020. There is no single explanation as to why people die by suicide. However, many suicides occur impulsively and, in such circumstances, there is easy access to a means of committing suicide such as pesticides or firearms that can make the difference between a person living or dying (World Health Organization, 2014, P.7).

According to the World Health Organization report (WHO, 2019), suicide is the second leading cause of death among young people aged 15-29, after road traffic injuries. Among young people aged 15-19, suicide is the second leading cause of death among girls (after maternal conditions) and the third leading cause of death among boys (after traffic accidents and interpersonal violence). Suicide rates are highest in high-income countries. Suicide is the second leading cause of death among young people. The global age-standardized suicide rate for 2016[1] was 10.5 per 100,000 population. However, rates vary widely among countries, from 5 suicide deaths per 100,000 population to more than 30 per 100,000. While 79% of suicides worldwide occur in low- and middle-income countries, high-income countries have the highest rate at 11.5% per 100,000 population. Nearly three times as many men as women end their lives in high-income countries, while in low- and middle-income countries the differences between men and women are more tenuous (WHO, op cit).According to the Federal Office of Public Health, it is estimated that there are approximately 10

Suicide attempts per year for each recorded suicide. Behavioural differences exist between women and men. Women make two to three times as many suicide attempts as men, while nearly 75% of recorded suicides involve men. This difference can be explained in particular by the methods of suicide used by men and women. Men most often use radical methods such as hanging and firearms. Women prefer other methods of suicide, such as the use of drugs that allow for medical intervention. Another reason is that women find it easier to talk to others about their concerns and seek help from professionals, while men tend to keep their suffering to themselves until the last moment. However, this observed difference in behaviour between men and women is by no means intended to perpetuate gender stereotypes (STOP SUICIDE, 2000, P3).

As a result, the most common methods of suicide are hanging, self-poisoning with pesticides and firearms. Key interventions that have been shown to be effective in reducing the number of suicides include limiting access to the means of committing suicide; sensitizing the media to responsible media treatment of suicide; implementing programs for youth to build their capacity to cope with life's difficulties; and early identification and management and follow-up of those at risk (WHO, op cit).

In response, suicide prevention measures are being taken in some countries, but much more needs to be done in the five years since the publication of the first World Health Organization (WHO) global report on suicide, the number of countries with suicide prevention strategies has increased, as noted by WHO in preparing for World Suicide Prevention Day, to be held on 10 September 2019. However, the total number of countries with strategies, at 38, is still too low, and governments need to commit to developing such strategies (WHO, ibid.). "Despite progress, there is still one death by suicide every 40 seconds," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "Each of these deaths is a tragedy for family, friends and colleagues. Suicides are preventable. To this end, Dr Tedros Adhanom Ghebreyesus calls on all countries to integrate proven suicide prevention strategies into their national health and education programmes in a sustainable manner" (WHO, op cit).

In African society, and Ivorian society in particular, "talking about death" is a taboo subject and "killing oneself" is even more taboo. Although taboo, suicide is very present in Ivorian society. It is not a matter for whites or rich people, as some people like to think. And if we hear a lot about cases of suicide in recent years, it is mainly because with social networks, information is widely accessible to all (R. Klohi, 2019).

In April 2019, the suicide of a Catholic priest in Maféré, a commune in the south-east of Côte d'Ivoire (about 100 km from Abidjan) had shocked the country. The priest, accused of having sexually abused a girl, had

[1]Organisation mondiale de la santé (2018). Estimations de la santé mondiale en 2016 : Décès par cause, âge, sexe, par pays et par région, 2000-2016. Organisation mondiale de la Santé, Genève.

chosen to kill himself to escape justice. In a note written before he took action, he had implored forgiveness from all those he had "offended". Suicide, a global problem from which Africa is not exempt.

While the link between suicide and mental disorders (particularly depression and alcohol use disorders) is well established in high-income countries, many suicides occur impulsively in a time of crisis and failure to cope with life's stresses, such as financial problems, a break-up, illness or chronic pain," continues WHO in its 2019 report on the phenomenon of suicide (R. Klohi, idem).

Compared internationally, Côte d'Ivoire has a relatively high suicide rate in Africa. The latest WHO estimates of the suicide rate by country and age-standardized age are for the year 2016. At that date, they were last updated on 17 July 2018. In 2016, 32 suicides per 100 000 men were recorded in Côte d'Ivoire compared to 13 suicides per 100 000 women. However, the figures for all genders combined show 23 suicides per 100,000 inhabitants. And under this look, Côte d'Ivoire has the second highest suicide rate in Africa, behind Lesotho (28.9/100,000). "In the Africa region, if we compare the rates for both sexes, Côte d'Ivoire is second only to Lesotho. If we take into account the male suicide rates in the African Region, Côte d'Ivoire has the highest rate in the region," said Collins Boakye-Agyemang, the Communication Officer of the WHO Regional Office for Africa contacted by Africa Check (Africa Check, 2019). In Côte d'Ivoire, as elsewhere in Africa, suicide remains taboo. In its report, WHO states that the age-standardized suicide rate in 2016 was 23 per 100,000 inhabitants. The number of suicides recorded in the same year was 3,446, including 2,475 men and 971 women (R. Klohi, 2019).

On the basis of the age-standardized suicide rate, the WHO report shows that Côte d'Ivoire ranks second in Africa, behind Lesotho (28.9) and ahead of Uganda (20). But in terms of the number of suicides, the country is in fifth place, behind Nigeria (17,710), South Africa (6,476), the Democratic Republic of Congo (4,453) and Uganda (4,105). However, these figures should be put into perspective. Indeed, of the 183 WHO States for which estimates have been established for the year 2016, only about 80 had good quality data on civil registration (R. Klohi, 2019). To this end, "modelling methods were required to generate estimates for the majority of the remaining countries, mainly low- and middle-income countries. Given that the majority of suicides occur in these countries, there is an urgent need for quality data on civil registration in this context", stated the WHO report (R. Klohi, idem).

Despite an increase in research and knowledge about suicide and its prevention, the taboo and stigma surrounding suicide persist and often people cannot seek help or be left alone. (Dr. Margaret Chan Director-General World Health Organization, op cit). This study examines some of the socio-psychological and cultural burdens that interact to lead an individual to suicidal behaviour. In concrete terms, the aim is to identify some of the factors that trigger suicide on the one hand and, on the other, to identify the different perceptions of the actors involved in suicide. Consequently, what are the socio-psychological and cultural factors that interact to lead an individual to suicidal behaviour? In other words, what are the different perceptions of the actors following the debates they provoke about suicidal behaviour? In short, what are the factors that trigger suicide in Côte d'Ivoire?

Drawing inspiration from the work of Pierre Bourdieu (1964), for whom the social field is a space for legitimising positions, proposes a model of structural homology in which social actors elaborate social representations in accordance with their positions in the social space. This trend, developed in Geneva by W. Doise's team (1986 cited by J.C. Vladimir, 2013, P.22), draws from Pierre Bourdieu's concepts of field structure and habitus to define social representations as: "principles that generate positions that are linked to specific insertions in a set of social relationships and organize the symbolic processes involved in these relationships" (P. 85). These generating principles reflect the idea that religion influences the regulation of individuals' cognitive systems. This pattern of thought is relevant to this study in that it explains, through the sociological characteristics of individuals, the variability of their positions on a controversial subject (W. Doise, 1986 / 1985, cited by J.C. Vladimir, idem).

L. Negura (2006) agrees with this when she argues that: "These sociological characteristics of individuals often hide identity dynamics that translate into social and symbolic relationships of power and other forms of power, which have a certain effect on the way social representation organizes the discourse around sexuality. These identity dynamics have an effect on the behaviour of individuals, which in turn has a symbolic charge" (P. 47). In relation to this study, the data that will be collected in this work will enrich the debate on the justification of the positions that individuals take with regard to suicidal behaviour. Above all, however, it will highlight the factors triggering suicide in the context of the emergence of suicide in Côte d'Ivoire. This observation makes it possible to question whether suicide is considered a major health problem by the WHO, but not necessarily the same for the Ivorian authorities in the context of the emergence in 2020. There is, in fact, to date no national suicide prevention strategy in Côte d'Ivoire.

We do not pretend to present a comprehensive picture of suicide triggers. Indeed, the preceding lines nevertheless illustrate the possibility of using various theoretical approaches or thought patterns to explain suicidal behaviour in the Ivorian context. The literature review reveals that few studies have attempted to

understand how, at the present time of the emergence of Côte d'Ivoire, individuals commit suicide (which is the subject of controversy) and what are the different ideologies of the actors in terms of suicidal behaviour? The results of this study are likely to contribute to further discussion on suicide.

II. METHODOLOGY

I.1 Survey site and participants

The study took place in the District of Abidjan from 1 February 2020 to 25 February 2020 inclusive among 60 people including 32 women and 28 men. We interviewed both males and females because perceptions of a fact differ depending on whether one is male or female. The sample was determined using the non-probability sampling technique. In this regard, Matthieu Wilhelm (2014, PP.7-8) teaches us that: "Non-probability sampling is characterized by an additional assumption about the target population: the homogeneity of the distribution of the observed character. Thus, the selection of individuals participating in the survey is not necessarily purely random. This is a very strong assumption, which only rarely holds true. The respondent-driven sampling (RDS) method belongs to the family of snowball methods. The main idea of snowball sampling is to increase the size of a sample by using the social networks of the people recruited. The RDS technique takes up this idea and adapts it to be applicable. However, the purpose of the RDS method is quite different since it is to estimate proportions of sub-populations within the sampled population". Furthermore, the eligibility criterion for our college of informants was their status as women and men. Above all, the fact that the resource persons interviewed belonged to families in which one of their parents committed or attempted suicide.

I.2 Data collection techniques and tools

This study was essentially qualitative. Several techniques were used in this research in order to obtain a body of data that was available, accessible and consistent with the subject of the study. We opted for two modes of collection: Documentary exploration and semi-structured interviews. Documentary exploration allowed us to take stock of the current situation with regard to our research topic. We consulted methodological works and specific works on suicide. The syntheses and criticisms of these documents helped us choose our topic and develop our problematic. The documents we consulted helped us understand the perceptions of the players in the suicide game. But also to understand the socio-cultural logics which justify the position of the actors with regard to the taboo built around suicide in Côte d'Ivoire on the one hand, and on the other hand, to identify the factors triggering suicide during the emergence period in Côte d'Ivoire. The semi-structured interviews consisted of an oral face-to-face meeting between us and the actors interviewed. This exchange enabled the actors to express their perceptions and interpretations of suicide in Côte d'Ivoire.

I.3 Method of data analysis and processing

The structuro-systemic approach allowed us to analyse the suicidal behaviour of Ivorians. In this study, the systemic approach enabled us to identify the social factors that trigger suicide and to make the link with the other systems that make up the enabling environment in which an individual constantly interacts with family members could lead to suicidal behaviour. According to Alpe et al. (2007), structural analysis is a fundamental theoretical current of systemic analysis. The structural approach explains social phenomena based on social networks. This makes it possible to decipher the relationships between actors, to understand the position of actors within the network and to study the general shape of the network. It is a question of studying the structure where the actor is studied by the links he builds with other actors. In short, network structural analysis makes it possible to evaluate the structure of a network and to provide explanatory elements regarding the suicidal behaviour of the actor. In this study, structural analysis enabled us to identify the rules and norms that codify and guide the suicidal behaviour of individuals. Indeed, the systemic approach also allowed us to identify the mechanisms of the parents' approaches to preventing one of them from committing suicide.

III. RESULTS

The results of this study can be broken down into three areas: the factors that trigger suicide, the perceptions of those who commit suicide, and the mechanisms of the parents' approaches to preventing one of their children from committing suicide.

II-1 Suicide Triggers

II-1-1-Ruptures in social ties

Emile Durkheim founded the holistic method against methodological individualism and thus intends to evacuate individual behaviour and yet cannot construct reasoning by making a perfect abstraction of individuals. Thus for the study of the social phenomenon of suicide. Indeed, Emile Durkheim considers the behaviour of individuals belonging to the society where suicide occurs (Social Phenomenon). Consequently, for Emile Durkheim, in periods of strong economic growth, individuals expect their situation to improve and

therefore commit suicide more easily if their expectation does not materialize. This statement illustrates Emile Durkheim's argument: "I have already attempted suicide because I thought that my fiancé, after receiving his salary reminder, would give me money to do my business and become financially independent. Unfortunately, my project did not come to fruition" (D.P., 1 February 2020 in Yopougon-Abidjan at 10 am). It is therefore obvious that proponents of the holistic or Durkheimian approach could say that it is the phenomenon of economic growth that causes suicide rates to rise, by dismissing the ways in which individuals react to growth, but one must consider the individual in his or her reaction to a social phenomenon in order to establish a causal relationship with another phenomenon. In this vein, we see that: "Individuals commit suicide when they are still waiting to receive from others without mobilizing their own resources to carry out their projects. This is the case of my nephew who committed suicide leaving a letter in which he wrote that he thought his uncle would help him to migrate to Europe. Yet his uncle entrusted him with the management of his oil palm plantation and he refused this offer" (K.O, 5 February 2020, Songon-Abidjan at 3 p.m.). We cannot therefore rule out the hypothesis that suicide is a phenomenon determined exclusively by the structure in which individuals evolve. Thus, individuals react rationally to social phenomena. Consequently, the Durkheimian approach considers that individual suicidal behaviour is totally determined by social structures and therefore that there is no reality of freedom of determination of individuals. This Durkheimian analysis of suicide has epistemological limitations because, although it affects the freedom of individuals, it does not completely determine their actions.

In the light of this observation, suicide appears to be a voluntary individual social action. From then on, the phenomenon must be explained, certainly with a view to understanding the motivations of individuals taken individually, taking into account the perception that individuals give to their actions, as demonstrated by Max Weber. It is rightly stated: "One commits suicide voluntarily" (F.M., 13 February 2020, Abobo-Abidjan at 9 a.m.). To this end, for the Wébériens, suicide is a free act. It is not the social structure in which the individual builds his relationships that influences his desire to commit suicide. Moreover, the individual cannot be influenced in any way by the whole to consent to the act of suicide. It is therefore individual suicidal behaviours that can give meaning to the suicide rate in a society. Respect for the individual's position to commit suicide calls for psychosocial values. Consequently, any influence at all on the individual to commit suicide would be a form of deprivation of the individual's freedom.

II-1-2-From the fragility of mental health to the legitimization of suicidal behaviour

Starting from the principle that alienists see in every voluntary death a vesanic manifestation (E. Durkheim, 1897, 20 cited by L. Mucchielli & M. Renneville, 1998, PP5-6), the authors L. Mucchielli & M. Renneville show that Durkheim infers that this angle of approach reduces the etiology of suicide to an individual condition. The authors also showed the limits of both Emile Durhkeim's findings and his deduction. For these authors, the sociologist argues that the theory of alienation from suicide has been formulated in two forms. The first tends to consider suicide as a necessary and sufficient symptom to forge a nosological category, the second sees suicide as the manifestation of various mental disorders (L. Mucchielli & M. Renneville, idem). This statement illustrates: "My brother was depressed according to the clinical result and sometime later, he gave himself up to death by hanging" (A.K., February 18, 2020, Yopougon at 6 p.m.). Analysis of this statement by the respondent shows that suicidal behaviour is the manifestation of mental disorders (here, we follow the logic of L. Mucchielli & M. Renneville, idem).

According to authors L. Mucchielli & M. Renneville, Durkheim objects to the latter hypothesis that it cannot be proven because it is impossible to assess the influence of insanity on all cases of suicide and, even if examples to the contrary were not alleged, there would always be possibilities. This was based here on a radical critique of inductivism. Strangely enough, however, for the authors, Durkheim does not follow the same reasoning for the specific insanity thesis. Suicide monomania would be the most representative of this approach. However, the authors argue that Durkheim immediately recognizes that this clinical theory is universally abandoned and he infers from this rejection that suicide is not a separate madness.

For the authors (idem), Durkheim is left with a formal discussion of the second hypothesis that he attributes to the alienists, that of suicide caused by non-specific bladder manifestations. In order to analyse the interest of this causal relationship, he considers that it is first necessary to classify the suicides of the insane according to the morbid manifestations to which they refer, and then to see whether these forms make it possible to account for all cases of suicide. According to the authors, Durkheim then distinguishes between manic, melancholic, obsessive and impulsive or automatic suicides. For the authors (idem), these types do not seem to him to explain all suicides because they share the characteristic of being committed without motive or under the influence of a delusional reasoning that has no basis in reality.

However, unlike the insane, the normal depressed man always kills himself, according to Durkheim, for an objective cause that is not unrelated to external circumstances. Thus, the lunatics could only have maintained this second explanatory theory, tending to see every suicidal person as a lunatic, by excluding from the field of suicide all suicidal behaviour legitimised by society.

In view of the above-mentioned observations, the authors feel that there is a methodological point here that Durkheim cannot accept because this attitude amounts to defining suicide according to the nature of the motives that guide it. If one rejects this preliminary selection, it seems obvious to him that there are suicides committed in the name of a philosophy, a religion or a patriotic cause, in which there is no character of insanity: the motives are not fictitious and the suicide victim deliberately chose to commit his act. It remains for Durkheim, to conclude this criticism, to examine what he considers to be an intermediate state between insanity and perfect mental equilibrium: neurasthenia. Durkheim asserts that neurasthenia predisposes to suicide and he considers this psychological type to be the one most commonly found in suicidal people (1897, 35). It should not, however, be recognized as a determining factor in the act. To prove this, Durkheim posits that the number of neurasthenics varies with that of insane people. It is therefore sufficient for him to show that the rate of insanity does not vary concomitantly with that of suicides to rule out the hypothesis of a causal relationship between neurasthenia and suicide (L. Mucchielli & M. Renneville, 1998, PP5-6).

From the foregoing, it could be said that the effects of social addictions and the questioning of the difficulties experienced highlight the perceptions of those involved in suicide, i.e., between scholarly perceptions and popular perceptions of suicidal behaviour.

IV. DISCUSSION OF RESULTS

The background to this study is an analysis of some of the factors that legitimize the positions taken by actors with regard to suicidal behaviour in the Ivorian context. The study showed how the actors' perceptions and their lived experiences of suicidal practices are articulated and interpenetrate to legitimize individuals' willingness to commit suicide. It could be argued that the crisis in social ties and the fragility of mental health linked to social addictions allow individuals to engage in suicidal gambling. This attitude on the part of individuals is at the root of the dislocation of the family relationship, but above all of certain mental affective manifestations on the other hand. Nonetheless, the consolidation of social ties makes it possible to reduce suicidal behaviour.

It emerges that the main factor triggering suicide is the crisis of social ties on the one hand. On this basis, the present study does not come close to the results of the conclusion of research conducted by E. Durkeim (1897) on suicide that makes it possible to decipher the relationships between individuals, understand the position of the actors within society and study the general form of suicidal behaviour. The aim is to study the environment in which the individual continues and completes his socialization through the ties he builds with other members of his family.

Analysis shows that individuals who commit suicide often develop behaviours that are conducive to a crisis in social ties on the one hand and to fragile mental health on the other. From this angle, the results of this study confirm the findings of the study by L. Mucchielli & M. Renneville (1998, PP5-6), the authors L. Mucchielli & M. Renneville show that the sociologist suggests that the theory of suicidal alienation has been formulated in two forms. The first tends to consider suicide as a necessary and sufficient symptom to forge a nosological category; the second sees suicide as the manifestation of various mental disorders (L. Mucchielli & M. Renneville, idem).

Moreover, the present results of this study have shown some sociological burdens of suicide. These sociological burdens included the crisis of social ties on the one hand and the fragility of mental health on the other. Moreover, in the context of the dynamics of the object of the sociology of health, one could not be guided by a unilateral logic of the actors' interpretation of suicidal practices. Indeed, the barriers that distinguish each of the popular and scientific perceptions of suicidal behaviours and their internal homogeneity are being re-exercised. The focus of reflection on suicidal behaviour is now placed at the centre of the analysis of the plurality of social science disciplines - all this for the mental and reproductive health of individuals. In the light of the above-mentioned findings, it is worth mentioning that sociological burdens are directly associated with suicidal practices. Similarly, taking mental health into account is therefore an important issue that is a prerequisite for reducing suicidal behaviour in the Ivorian context.

V. CONCLUSION

This study is a contribution to the sociology of health and reproduction. It analyzes some social factors legitimizing suicidal behaviours in the Ivorian context. It was essentially qualitative, using appropriate survey tools. This enabled us to arrive at the results according to which the perceptions and knowledge of the actors interpenetrate and legitimise suicidal behaviour. Finally, it should be noted that the crisis of social ties is the primary indissociable or indisputable authority in terms of morality and suicidal behaviour of the actors. Let us remember that failure to respect the nature of social relationships and the preservation of social virtues such as respect for social positions enables individuals to develop suicidal behaviour. This attitude on the part of individuals is at the root of the lack of self-confidence to develop the conditions for individual self-fulfilment.

However, the curiosity of individuals to commit suicide appears to be an ideology of finding peace and stability after death.

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