

INTRODUCTION

Adolescence is not only a "stage" of development, it is an experience. The experiences of adolescence take place within a specific historical time frame, cultural context, and subculture defined by gender, ethnicity or country region. This means we must be sensitive in the consideration of how adolescence is different from one generation to another due to the historical, economic, and technological times, from country to country as a result of broad cultural differences, for those of different ethnic groups, and from subcultures within the broader society. (Dusek, 1996)

All adolescents share certain common experiences, but they also have unique individual differences with characteristics that are important to the particular adolescent. Adolescents who grow up in poverty have a different adolescence than those who grow up in middle or upper class families, regardless of other individually different characteristics. For most adolescents, the transition to adulthood has strains and stresses. Adolescence is in fact a particularly stressful period of development. For some, chronic difficulties become the norm in their lives. They may show an inability to cope with common stresses. They may become delinquents, runaways, dropouts, or experience disorders of social functioning such as eating disorders, suicide and mental disturbances.

In this topic, the writer will focus on the suicidal risk, which is one type of serious difficulty that occurs during the adolescent years.

WHAT IS SUICIDE?

Suicide is a tragedy for the individual and for the family. In many cases, it leaves hurt, disgrace, rumors, and bitterness in its wake. Because of the stigma attached to suicide, family members often feel shame in addition to their grief. They feel that somehow they must be responsible for not having prevented one of their own from reaching such a point of isolation. They find it difficult, if not impossible, to collect the suicide insurance.

Suicide is related to a general sense of overwhelming hopelessness, although it also may result from the accumulation of adverse life events such as family conflicts; loss of a family member due to illness, death or divorce; breakups or problems in romantic relationships or friendships; school failure; being apprehended in a delinquent, forbidden, or embarrassing act of situation; or real or imagined mental or physical illness.

(Hetherington, et al 1993) Suicide victims range from the happy -go-lucky types, who give no clear clues before acting, to the classic loners, who scream silently for help.

Suicide is the taking of one's own life. One of the more difficult issues involved is identifying the possibility of suicide when no objective evidence of suicide is present.

Suicide is the second leading cause of death among adolescents, outranked only by deaths due to accidents. (Dusek, 1996)

Researchers have studied suicide ideation, which means suicide is not a syndrome but a symptom. Like other symptoms, it can be the manifestation of a number of underlying problems, not necessarily just depression. (Walker, et al 2001) The risk of suicide taking one's own life is a significant factor in all depressive states. Although it is

obvious that people also commit suicide for reasons other than depression, most who complete the act do so during or in the recovery phase of a depressive episode. (Carson, et al 2000)

Among all emotional problems, depression must be taken seriously, because it is depression that most frequently results in irreversible harm: death by suicide. The majority of adolescents who attempt suicide suffer from depression, are alienated from their parents, and suffer overwhelming feelings of loss, hopelessness, and isolation. (Moshman, et al 1999) Just as genetic factors are an issue in depression, they appear in suicide too; the closer the genetic relation to someone who has committed suicide the more likely the individual will commit suicide. (Santrock, 1995) We do not have the complete answers for detecting when an individual is considering suicide or how to prevent it. If severe depression is not something that parents should attempt to treat themselves; a mental health professional must be involved in the process. (Moshman, et al 1999). Social imitation, or "copycat" suicides, appear to occur particularly in adolescence when individuals are most vulnerable to the belief that the future is beyond their control or they are unlikely to meet their dreams. (Craig, et al 2002) Adolescent suicide attempts are often unplanned and impulsive, as many want to die rather than get help. (Turner, et al 1994) In general, adolescents who attempt suicide are not responding to a single upsetting event. Rather, suicide generally occurs within the context of longstanding personal or family problems.

WARNING SIGNS

Why do adolescents attempt suicide? There is no single answer to this important question. It is helpful to think of suicide in terms of proximal and distal factors. Proximal or immediate factors can trigger a suicide attempt. Highly stressful circumstances such as loss of a boyfriend or girlfriend, failing a class at school, or an unwanted pregnancy can produce suicide attempts. But distal, or earlier, experiences often are involved in suicide attempt as well. A long-standing history of instability and unhappiness may be present. A lack of affection and emotional support, high control and a strong push for achievement by parents during early childhood are related to depression among adolescents, especially adolescent girls; a combination of these early childhood experiences can set the stage for poor coping when further stresses are encountered during adolescence. (Santrock, 1995)

Feldman mentions several warning signs which might indicate when a teenager's problem may be severe enough to warrant concern about the possibility of suicide attempt. They include: (1) School problems, such as missing classes, training, and a sudden change in grades; (2) Running away from home; (3) Frequent incidents of self-destructive behavior, such as careless accidents; (4) Loss of appetite or excessive eating; (5) Withdrawal from friends and peers; (6) Sleeping Problems; (7) Signs of depression, tearfulness or overt indication of psychological difficulties, such as hallucinations; (8) A preoccupation with death, and after life, or what would happen "if I died"; (9) Putting affairs in order, such as giving away prized possessions, making arrangements for the care of pet, and drawing up a will; (10) An explicit announcement that the person is thinking about suicide. (Feldman, 2002)

Several factors will be explained to understand the suicidal behavior, as warning signs, including suicidal ambivalence, clinical pictures, types, stages and risk factors.

Suicidal Ambivalence

The ambivalence that typically accompanies thoughts of suicide finds classic expression in Hamlet's famous soliloquy:

To be, or not to be; that is the question: Whether nobler in the mind to suffer the slings and arrows of outrageous fortune or to take arms against a sea of troubles, and by opposing end them? To die: to sleep; no more; and by a sleep to say we end the heartache and the thousand natural shocks. That flesh is heir to, 'tis a consummation. Devoutly to be wish'd - To die to sleep; To sleep: perchance to dream; Ay, there's the rub; For in that sleep of death what dreams may come When we have shuffled off this mortal coil, Must give us pause.

Hamlet classified suicidal behavior into three categories: To be, not to be and to be or not to be: (1) The "to be" group involves people who do not really wish to die, but instead want to communicate a dramatic message to others concerning their distress. Their suicide attempts involve non-lethal methods such as minimal drug ingestion or minor wrist-lashing; (2) The "not to be" group includes people who seemingly are intent to die or are dying. They give little or no warning of their intent, and they generally rely on the more violent means of suicide, such as shooting themselves or jumping from a high place; (3) The "to be or not to be" people are ambivalent about dying and tend to leave the question of death to fate. The methods used for the suicide attempts are often dangerous but moderately slow acting, such as drug ingestion. (Carson, et al 2000)

Adolescents who attempt suicide often feel they have no source of emotional support. They frequently are alienated from their families and may have had disruptions or losses of intimate relations and relations with peers that give them an increasing sense of isolation and helplessness. (Hetherington, et al 1993)

Clinical Picture

The clinical picture of suicidal adolescents varies; suicidal behavior is a symptom and is difficult to examine in terms of clinical features. There are a number of approaches to the understanding of suicide. The psychological approach, which identifies the commonalities of accomplished suicides despite their tendency to be individualized and idiosyncratic events. These commonalities are: (1) The common purpose of suicide is to seek a solution; (2) The common goal of suicide is the cessation of consciousness; (3) The common stimulus in suicide is intolerable psychological pain; (4) The common stressor in suicide is frustrated psychological needs; (5) The common emotion in suicide is hopelessness; (6) The common negative state in suicide is ambivalence; (7) The common perceptual state in suicide is constriction; (8) The common action in suicide is egression (to depart from the region of distress); (9) The common interpersonal act in suicide is communication of intention; (10) The common consistency in suicide is with lifelong coping patterns. (Walker, et al 2001)

A recent review in *Communication of Suicidal Intent* revealed that more than 40 percent of those who committed suicide had communicated their suicidal intent in very clear and specific terms, and another 30 percent had communicated a wish to die or a reoccupation with death. These communications were usually made to several people and occurred within a few weeks or months before the suicide. Investigators have analyzed suicide notes in an effort to understand better the motives and feelings of people who take their own lives. The notes, usually coherent and legible, were either mailed or found on the person's body, or located near the suicide scene. In terms of emotional content,

suicide notes are categorized into positive, negative, neutral and mixed affect. (Carson, et al 2000)

Types

There are three types of suicides: egotic, dyadic, and ageneratic. (Walker,et all 2001)

Egotic suicides result from intra psychic conflict and struggle. This type produces a suicide that is seemingly independent of situational circumstances. That is, where the impact on others seems less important than a person's disturbed ideation, withdrawal, or impassivity. These suicides often appear "irrational", magical, or nihilistic. Dyadic suicides appear to be a result of an incomplete or problematic interpersonal relationship. It may be with peers, boyfriends, or girlfriends, parents, or significant others. An interpersonal event such as a rejection or breaking up of a relationship often precipitates this type of suicide or suicide attempt. Ageneratic suicides occur when adolescents experience a displacement in their place in the appropriate generation. They may be "promoted" prematurely to adult roles as a result of deaths of parents or change in the family structure, or they may be infantilized by family dynamics. They may very well feel, they have lost their place in the appropriate generation and feel lost, isolated, empty, or disengaged.

Stages

Based on case studies, it is believed that a suicidal adolescent progresses through a series of discrete periods that can be detected if looked for: (1) A history of problems. Such problems may exist throughout childhood or in the recent past. Examples of problems include parents or close friends who have committed suicide or attempt suicide, or one or both biological parents missing from the home. (2) The escalation of problems. The

problems may escalate as a result of developmental changes occurring within the outset adolescence. Such changes occur in the individual's social, psychological, and physiological development, but may also be a function in the changes, of perception and expectation that can produce behavior problems, mood changes, rebelliousness, withdrawal, and the like. (3) Failure of coping. Strategies to deal with the escalation of problems begin to fail. (4) Failures to cope lead directly to the fourth stage, loss of hope. Such loss of hope may be manifested by social withdrawal, loss of future orientation, dropping out of school, increase in substance abuse and/or high-risk behaviors, or loss of general motivation for any activities. This hopelessness is a hallmark of almost all suicidal behaviors. (5) When hope is lost, there occurs for the adolescent a justification. During this time the person moves from thought to action. The "justification" event may appear trivial (e.g. breaking up with a boyfriend, failing attest, social rejection), but because of withdrawal from peer relationships or supports, the person feels without options or support. Life is a chronic problem. There appears no way out. To end the chronic problem, death appears to be the only way left. (Walker,et all 2001)

Risk Factors

Three factors play a role in determining the occurrence of suicidal behavior, that is: *Historical and Development Factors*: (1) Medical or physiological problems. Chronic illness or certain biochemical imbalances. (2) Concepts of death may differ for adolescents, especially in the younger age ranges. They may view death as temporary or act without an understanding of consequences. (3) Family systems and dynamics. Problems in such families might include disorganization, discard, enmeshment, poor communication and problem solving skills. (4) Parental psychopathology may increase

the risk of suicide. (Walker, et al 2001) *Situational Factors*. Many situational factors are related to an increase in suicidal behavior. An adolescent may feel stress as a function of skill deficits, especially in the interpersonal area. Academic and school stress is also considered to be a risk factor. General life stress can be a risk factor as well. Changes in social and cultural dynamics, such as popular valuation of youth could be a risk factor. Increasing family disorganization also provides less stable environments to teach problem solving or to model effective behavior. Access to lethal drugs and firearms are often available to even the youngest children and adolescent. Finally the effect of the media can greatly increase suicidal behavior. *Psychological Factors* .Depression, personality disorders, especially borderline disorders and disorders related to impulsivity. Certain forms of psychosis, especially where high levels of distortion are present. Eating disorders, usually bulimia, are associated with self-destructive impulses and may increase suicide risk. So can sex and sexuality and gender identity. Adolescents frequently must deal with loss, whether it is the death of grandparents or the loss associated with changing schools, peer groups or boyfriends or girlfriends. Finally, one of the least understood risk factor is substance abuse and chemical dependency.

Intervention Strategies

Prevention

The prevention of suicide is extremely difficult. One complicating factor is that most people who are depressed and contemplating suicide do not realize that their thinking is restricted, irrational and that they are in need of assistance. (Carson, et al 2000) . As we have seen, most people who attempt suicide do not really want to die and give prior warning of their intentions. If a person's cry for help can be heard in time, it is often possible to intervene successfully. In recent analysis of the problem of suicide prevention, Shaffer suggests three elements that seem to be involved in suicides: (1) Some triggering stressful event. This triggering event is often a disciplinary crisis with the parents or some rejection or humiliation, such as breaking up with a girlfriend or boyfriend, or failure in some valued activity. (2) Some altered mental state, which might be attitude of hopelessness, or reduced inhibitions from alcohol consumption, or rage. (3) There must be an opportunity - a loaded gun available in the house, a bottle of sleeping pills in the parent's medicine cabinet, or the like. (Bee, 2001)

Other prevention efforts have focused on education such as providing information to all high school students about risk factors in the hope that students might recognize a problem in a friend. Special training in coping abilities has also been offered, so that teenagers might be able to find some non-lethal solutions to their problems. The discouraging results are not likely to change until we know a great deal more about the developmental pathways that lead to this particular psychopathology. What makes one teenager particularly vulnerable and another able to resist the temptation? What combination of stressful circumstances is most likely to trigger a suicide attempt, and

how do those stressful circumstances interact with the teenager's personal resources?

Only when we can answer questions of these kinds will we be on the road to understanding teenage suicide. (Bee, 2001) There are multi-front prevention programs for teenage suicide, such as: (1) Professional education for educators, health, and mental health care; (2) Restricting access to firearms by passing strict gun control laws; (3) suicide education of the media to ensure correct information and appropriate reporting; (4) Identification and treatment of at risk youth. (Craig , et all 2002)

Crisis Intervention

The primary objective of crisis intervention is to help a person cope with an immediate life crisis. If a serious suicide attempt has been made, the first step involves emergency medical treatment, usually in the emergency room of a general hospital or clinic. Most people who attempt suicide after initial treatment, are referred to inpatient or outpatient mental health facilities. When people contemplating suicide are willing to discuss their problems with someone at a suicide prevention center, it is often possible to avert an actual suicide attempt. The primary objective is to help them regain their ability to cope with their immediate problems and to do so as quickly as possible.

The emphasis is usually placed on: (1) Maintaining contact with a person over a short period of time - usually one to six contacts. (2) Helping the person realize that acute distress is impairing his or her ability to assess the situation accurately and to choose among possible alternatives. (3) Helping the person see that other ways of dealing with the problem are available and preferable to suicide. (4) Taking a highly directive and supportive role - for example, fostering a dependent's relationship and giving specific suggestions to the person about what to do and what not to do. (5) Helping the person see

that the present distress and turmoil will not be endless. When feasible, counselors may elicit the understanding and emotional support of family members or friends, and, of course, they may make frequent use of relevant community agencies. (Carson, et al 2000) And threats of suicide should be listened to and taken seriously, and if necessary, concrete action to prevent it must be taken. (Hetherington, et al 1993) The idea that: All suicide attempts should be taken seriously; Developing a relationship with the client is essential; Enriched communication is necessary between all parties; Continual monitoring and support is needed; Acknowledgement of the client's pain and existence is very important; Provisions must be made for the person's returning to his or her previous environment. (Walker, et al 2001).

Individuals who have demonstrated relatively stable adjustments but have been overwhelmed by some acute stresses are about 35 -40 percent of people coming to the attention of hospitals and suicide prevention center. For this group, crisis intervention is usually sufficient to help them cope with the immediate stress and regain their equilibrium. Individuals who have been tenuously adjusted for sometime and in whom the current suicidal crisis represents an intensification of ongoing problem are about 60 - 65 percent of suicidal case. For this group, crisis intervention may also be sufficient to help them deal with the present problem, but with their lifestyles of "staggering from one crisis to another," they are likely to require more comprehensive therapy. (Carson, et al 2000) The importance of the establishment of the therapeutic relationship, the stimulation of emotional growth, and the dissemination of the dependent aspects of the relationship are key steps in the therapeutic process. (Walker, et al 2001)

There are a number of reasons that adolescents commit suicide. One persistent theme is depression, where teens have a pervasive feeling of worthlessness, apprehension, and hopelessness. Other reasons include the loss of a love object and stress that sometimes occurs in family life. Many suicide victims are rejected youths who receive little affection or attention. Most are alienated persons who feel socially isolated from the rest of the world. The increase of teenage suicide in recent years has prompted many segments of society to take preventive measures. The detection and identification of conflict and stress are vital and require the collaboration of parents, teachers, counselors, and other concerned adult. Crisis intervention programs are important for prevention and follow up, the latter helping the victim cope with reality. Improving the conditions that may decrease suicidal tendencies, such as human relations or educational and employment atmospheres is important, too. The establishment of community resources, such as halfway houses, shelters, hotlines and adolescent clinics, are necessary steps in prevention.

Clinical Action

Assessment. Assessment of suicidality is often accomplished in an interview with a teacher, parent, school counselor or family physician. The goals of assessment take into account a number of key factors: sex and age, history of attempts, other self-destructive behavior, substance abuse, status of adaptive strategies, chronic of problems, experience of loss, support system, relation with parents and others, state of mind openness to communication, perturbation, and attitude toward death.

Postvention. Postvention is the process of dealing with the aftermath of a suicide or a suicide attempt. Sometimes it involves working with the person who attempted suicide in

recovery; sometimes it means helping a system or family deal with and adapt to the loss of an adolescent. The key to postvention is the establishment of a network of personnel to facilitate the expression of grief and loss of those directly affected by the suicide or attempt and also to identify and support all others related to this event. Threats of suicide should be listened to and taken seriously, and if necessary, concrete action to prevent it must be taken. (Hetherington, et al 1993)

CONCLUSION

There are a number of reasons that adolescent commit suicide. One persistent theme is depression, where teens may have a pervasive feeling of worthlessness, apprehension, and hopelessness. Other probable reasons could include loss of love objects and stress that sometimes occurs in family life. These are those rejected, who receive little affection or attention is also a factor. Most are alienated persons who feel socially isolated from the rest of the world.

If an adolescent shows indication that suicide is a possibility, it is unreasonable to ignore him or her, and it is wise to urge the person to seek a professional help. Because suicidal people feel such a profound sense of hopelessness and believe that they cannot be helped, assertive action may be needed, such as enlisting assistance of family members or friends. Talk of suicide is a signal for help, not a confidence to be kept. As yet, no sure way of predicting the likelihood of suicide exists, thus it is better to be safe than sorry. The increase of teenage suicide in recent years has prompted many segments of society to take preventive measure. The detection and identification of conflict and stress are vital

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Postvention is the process of dealing with the aftermath of suicide or a suicide attempt. Sometimes it involves working in recovery with the adolescent who attempted suicide; sometimes it means helping a system or family deal with and adapt to the loss of an adolescent. The key to postvention is the establishment of a network or personnel to facilitate the expression of grief and loss of those directly affected by the suicide or attempt and also to identify and support all others for whom this event has reactivated the unresolved state.

Crisis intervention programs are important in postvention and follow up, the latter helping the victim cope with reality. Improving the conditions that may decrease suicidal tendencies, such as human relations or educational and employment atmosphere is important, too. The establishment of community resources, such as halfway houses, shelters, and hotlines clinics, are necessary.