Journal for Re Attach Therapy and Developmental Diversities
eISSN: 2589-7799
2023 April; 6 (4s): 08-14

Suicidal Tendencies among Teenagers Psychho Sociological Factors Impacting Upon the Psyche

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Received: 11- February -2023
Revised: 19- March -2023
Accepted:11-April-2023

Abstract

A suicide is an act of intentional self-injury that results in death (1). More than 800,000 individuals commit suicide every year throughout the world. About 1.5 million people will have taken their own lives by 2020. One person killed themselves every twenty seconds in 2015, at a rate of 10.7 per 100,000. According to the World Health Organisation, suicide is the fifteenth leading cause of death globally (2, 3). Suicide rates among males are much greater than those among women. The ratio of men to women is greater in more developed countries, ranging from four to one in Europe and the Americas to one and a half times as high in the East Mediterranean - Western Pacific region. It's possible that these projections of suicides are still too low to account for the true tally. The procedure of registering suicides is complicated and sometimes includes the legal system.. It is possible that suicide fatalities are either overlooked or incorrectly categorised. Due to the stigma that still surrounds suicide, it is not always reported or acknowledged (5). Estimates suggest that nonfatal suicidal behaviour, such as suicide attempts, are 10-20 times more common than suicide itself. Every year, over 3 out of every 1,000 individuals report having attempted suicide. Approximately 2.5% of the population will attempt suicide at some point (6,7).

Keywords: Children, Adolescents, Youth, Suicidality, Risk, Resilience, Psychosocial

Introduction

There is a notable disparity in suicide rates around the world. Low and middle-income nations account for over 80% of the world's suicides (8). In South-East Asia, the suicide death rate is 15.6 per 100,000 people, whereas in the Eastern Mediterranean area, it is 5.6 per 100,000. The suicide death rate in Europe is much higher than the world average (10.7 per 100,000) at 14.1. Azerbaijan has one of the lowest rates in Europe at roughly 3.3 per 100,000, whereas Lithuania has one of the highest at 32.7 per 100,000. The suicide mortality rate is generally greatest in the nations of Eastern and Central Europe, average in the countries of Western and Northern Europe, and lowest in the countries of the Mediterranean Basin (3).

Suicide is a problem for people of all ages, yet there is a definite global trend showing that suicide rates grow with age. The rates are greatest among those aged 80 and over (60.1 per 100,000 males and 27.8 per 100,000 women worldwide), followed by those aged 70-79 (42.2 and 18.7 respectively), and those aged 60-69 (28.2 and 12.4%).

Youth see a dramatic decline in these numbers, with rates of 15.3 to 11.2 per 100,000 males to females among the

ages of fifteen and twenty-nine and 0.9 to 1.0 per 100,000 for those between ages of five and fourteen. Rates in Europe follow a similar pattern, falling from 53.2% at 14.0% respectively among those aged 80 and to 19.9% and 4.2% among those aged 15-29 at 1.0 and 0.4% among those aged 5-14.

Among people aged 15 to 29, "suicide ranks as the second leading cause of death worldwide (8). While suicide rates among young people in Europe are declining, it remains the second leading cause of death among those aged 10 to 19. Even among women aged 15–19, it is the leading killer (6.15 per 100,000). About 24,000 European young adults (aged 15 to 29) lose their lives to suicide each year (10, 11). In contrast, suicide is outside of the top 10 leading causes of mortality among those 65 and older. This information, along with the realisation that these numbers have not tended to decrease clearly and gradually over the last several decades, has scientists and policymakers more alarmed. The general public is also becoming more aware of the terrible repercussions of juvenile suicidality, not only in the tragic loss of young lives but also in the divisive psychological and bad socioeconomic ramifications on a national scale."

Taking preventative actions against youth suicide is a top priority from the standpoint of public mental health. Therefore, it is crucial to learn as much as possible about the factors that put young people at risk for engaging in suicidal behaviour. What follows is a brief discussion of the most significant risks that have been identified via scientific study in this field.

Clinicians who work with children who are experiencing mental health issues are understandably concerned about suicidal thoughts and actions. The lack of consensus on how to define teenage suicidality has impeded research into this important topic. Intent to die may be shown in a variety of actions, not only suicidal ideation and intentions, but also in suicide attempts, stopped efforts, and aborted attempts. Self-harm is a necessary but insufficient condition for a conduct to be considered suicidal. Non-suicidal self-injury, on the other hand, refers to acts of self-harm committed for causes other than suicide. Intentional self-injury is included in the category of deliberate self-harm.

Risk Factors for Suicide in Teenagers And Youth

Putting a number on how old someone is considered young is arbitrary and changes over time and between countries (12).Children younger than five who commit suicide are unusual. The vast majority of research and reviews focusing on suicide among young people (7–12 years old) and teenagers (13–20 years old) focus on these age groups. These teenagers are more susceptible to mental health issues throughout adolescence (13). Movement, change, and transition from one state to another characterise this stage of life across many different dimensions. Adolescents have weighty, real-world choices including where to live, which schools to attend, which friends to keep, etc.

They face novel difficulties as they forge their own identities, grow in confidence and self-reliance, form new close connections, etc. Meanwhile, they are experiencing continuous, ever-evolving mental and bodily processes of their own. They have to deal with often unrealistically high standards set by close friends and family. Feelings of powerlessness, uncertainty, tension, and loss of control are common responses to precarious circumstances like these(14). Young people require significant strengthening resources such a secure place to live, close relationships, a robust support system, & financial stability to confront these obstacles and cope with these sentiments. The protective factors reinforce and preserve such assistance, or act as an insurance policy against, the risk variables that weaken or limit access to them.

Several based on populations psychological funerals of suicides, including interviews with important sources and examination of records, as well as follow-up studies of individuals who have attempted suicide, have been conducted in recent decades (15). It is generally acknowledged (16) that each suicide is the consequence of a unique and complex interaction of biological, psychological, and social factors. This research is very useful for suicide prevention efforts since it identifies several different sorts of characteristics that are clearly connected with an elevated risk of teenage suicide.

Suicidality in this group is significantly linked to depression, although it is not always present, suggesting that suicide conduct is the product of a complex interplay of circumstances. In addition, social and temperamental

variables, among others, have a role; not all depressive children and adolescents exhibit suicide thinking or behaviours. In order to develop effective measures for preventing and treating suicidality in children and adolescents, it is important to know which youth are more prone to relapse.

Factors Highlighting Tendencies Towards Suicide

Adolescents and younger children have their own unique risk profile due to a combination of psychological, social, and biological variables. This study, however, aims to examine the research done on the topic of psychosocial risk factors with teenage suicide.

Depression

Suicidality in teenagers has been linked to depression, which has been seen in both clinical or non-clinical samples. Suicide attempts were shown to be five times more common in those with major depressive illness compared to those without the disease, regardless of gender, age, ethnicity, or socioeconomic level. Depressive symptomatology (as judged by the Beck Depression Inventory) may also influence the connection between despair and suicide acts, according to the findings of a cross-sectional research by Spann et al.

Adolescents who may not suffer from depression may nonetheless have suicide ideas and/or behaviours.

Previous suicide attempt

Across clinical as well as non-clinical samples, previous suicide attempts have been shown to be a strong predictor of subsequent suicide attempts, tripling the risk over the course of follow-up. Other prospective studies have found similar associations between past suicidal behaviour and suicide plans, and between past non-suicidal self-injury and the likelihood of future non-suicidal self-injury.

Drug and alcohol misuse

Teenage alcohol abuse is a risk factor for self-harm in both clinical and non-clinical populations, according to cross-sectional and longitudinal investigations of teenage alcohol intake. In addition, suicide thoughts may be triggered by alcohol abuse even in the absence of major depressive symptoms.

Also, using tobacco products or abusing drugs (including cannabis) may raise the risk of suicidal behaviour; combining the two substances, which happens frequently, raises the risk even further.

Latent psychiatric Symptoms

Related psychiatric diseases that may contribute to suicidal ideation and behaviours in kids and teens include anxiety, eating, bipolar, psychotic, affective, sleep, and externalising disorders. Research into why some people with ASD take their own lives has gained momentum. There seems to be a linear relationship between the amount of comorbid conditions and the risk of suicidality. An further indication of future risk for suicide attempt is readmission to hospital, as shown in a follow-up research.

Various Risk Behaviours

Low instrumental or social competence, as well as having been in a fight with punches or kicks in the preceding year, may be linked to suicidality in this age group.

Adverse life events

Some suicides or suicide attempts have been linked to traumatic experiences that occurred shortly beforehand. Although these factors rarely act alone as a sufficient cause of suicide/attempts, they do play a significant role as precipitating factors in young people who are already at risk due to, for example, a psychiatric condition and/or other risk factors for self-harm as detailed below. In this respect, stress-diathesis models postulated that exposure to adversity combined with preexisting vulnerabilities would enhance the likelihood of suicide activity. But stressful events change with age. Family strife, school problems (such as bullying or test anxiety), traumatic experiences, and

other sources of distress often precede suicide thoughts and actions among young people.

Sustained Family Conflicts

Suicidal conduct has been linked to family conflict, even after accounting for demographic factors including age, gender, and the presence of mental problems. Teenagers who have attempted suicide are more likely to report parental stress, a lack of adult support outside the house, physical violence from a parent, expulsion from the family, and living without both parents than their control group counterparts. Parental suicide conduct, premature mortality, related mental illness, unemployment, poor income, neglect, divorce between parents, other parent loss, and domestic abuse are other risk factors for suicidality.

Academic Stressors

Students who have a negative outlook on their academic achievement are more likely to disclose suicide ideas, intentions, threats, and attempts, as well as cases of intentional self-injury. Adult samples have shown that perfectionism as a personality trait may be linked to suicidality. The association between perfectionist tendencies and suicidality may be mediated by adverse life circumstances (being bullied) or other psychological features (such as learned helplessness), according to the findings of a groundbreaking study evaluating the Perfection Social Disconnection Model in children and adolescents.

Trauma and Other Adverse Life Events

Early horrific events and other unpleasant life events have been linked to suicide behaviour, in addition to family disputes and academic performance issues. Suicide attempts between the ages of 4 and 12 are connected with a history of sexual abuse by a factor of 10.9, and between the ages of 13 and 19 by a factor of 6.1. Some bully victims may be especially susceptible to suicidal ideation due to psychological disorders in their parents and feelings of rejection at home, which contributes to the already elevated rates of suicidal behaviour and ideation among bully victims. The loss of a stable support system and the unfamiliarity of a new location are both stressors that might raise the likelihood of suicidal thoughts or actions. In addition to being exposed to suicide or suicide attempts, victims of human trafficking may also have experienced peer strife, legal issues, physical abuse, fears about sexual orientation, romantic breakups, and exposure to physical and/or sexual assault.

Temperament and Character

Certain character flaws have been linked to an increased risk of suicidal ideation. Adolescent suicidality has been linked to characteristics including neuroticism, perfectionism, interpersonal dependence, novelty seeking, pessimism, poor self-esteem, a view of being in a worse position than peers, and self-criticism. Risk factors for both depression and suicide thoughts include the use of unhealthy coping mechanisms.

Half of all teenagers who self-harm do it on the spur of the moment, highlighting the importance of impulsivity in the context of suicidality.

Contagion-Imitation

Younger individuals are more susceptible to social influence and imitation than older persons. Rather than "contagion," other scholars advocate for the use of the word "imitation." The word "contagion" makes people think of catching a sickness that leaves them helpless and unable to make decisions on their own. Learning through modelling, or imitation, is the process of picking up new behavioural patterns by seeing how a role model acts. Youth suicidal behaviour imitation may be prompted on a broad scale (by news coverage in the media, for example) or on a more micro level (by interactions with peers, friends, and teachers). Learn More. To begin, it's crucial to consider the model's specific attributes. Similarities between the young person and the model (in age, gender, emotional state, or background scenario), a close link between the two, or the model being someone they really like (such as a celebrity) all contribute to greater mimicking effects. Second, how and whether the model's behaviour is rewarded is crucial. More young people will mimic this behaviour if it is normalised and seen as good, comprehensible, and even commendable and courageous. Thirdly, the frequency and way of display of the model's

behaviour, such as the size and quantity of headlines, the amount of repeats, and the reality or fiction of the tale, are significant. The studies proved the dose-effect link. Suicide clusters occur when there is a series of real suicides, most often among teens, within a defined geographical region and time frame.

Availability of Means

Suicide ideators often feel conflicted about taking their own lives. In many cases, particularly among young individuals, the move from suicidal thinking to actual suicide is an abrupt response to intense psychosocial pressures. A person's capacity to make the shift depends on a number of factors, one of which is the availability of methods of committing suicide, and the method selected may also impact the lethality of the deed. There may be connections to suicide technique trends across countries. In keeping with this, most youth suicides are carried out through hanging, leaping from a great height or dashing into oncoming traffic, or poisoning with accumulated prescription medicines. Teenagers use a wider range of strategies, including the use of firearms and poison by young males in particular. Reducing people's access to lethal methods has been shown to be an effective suicide prevention strategy by a few studies (2,37). In the suicidal process leading up to suicide, cognitive availability, such as sensationalised media reporting or thorough online knowledge regarding means and ways of committing suicide, may play a significant role.

Aspects Determing Suicidal Tendencies

Significant mental difficulties, mostly depressive disorders and drug abuse disorders, were present in young persons whose conduct exhibited suicide tendencies. Suicide attempts are more likely when serious depressive illness is present.

It is vital to distinguish between depressed teenagers who have had suicidal impulses but have never tried suicide and those who have. Mood disorders fail to clarify all suicidal inclinations and acts. The research strongly suggests a combination of variables leading to suicidal conduct, highlighting the complexity of suicidality. A population at risk may be identified by factors such as a history of suicide attempts or the co-occurrence of many diseases.

However, more work needs to be done in the area of determining which young people are likely to recur with their suicidal behaviour. Children and teenagers have an incompletely defined natural history of suicidal behaviours. There is a clear need for additional data to help build preventative measures for suicidality in children and adolescents and to better understand the complicated interaction between risk factors for suicidality.

Abuse of drugs and/or alcohol may also raise the probability of attempting suicide. Acute intoxication may increase impulsivity, heighten depressed thoughts and suicide ideation, impair cognitive functioning and the capacity to recognise alternative coping mechanisms, and lower barriers to self-inflicted injury, all of which can make susceptible people more likely to take their own lives. Furthermore, substance abuse may mediate or moderate the effect of other risk factors on suicidality, serving as both a proximal and distal risk factor for suicidality. In addition, a greater serotonergic loss has been described in "depression, impulsivity, and drug and/or alcohol use disorders, which may help explain their frequent co-association and also their relationship with suicidal behaviour, a violent behaviour associated with disturbances in the serotonergic system."

Personality characteristics like neuroticism and impulsivity may also play a role in making people more susceptible to engaging in suicidal activity. It is important to investigate the occurrence of affective regulation sensitivity among children and adolescents who are at risk for suicidality because of the correlation between poor emotional regulation techniques and behavioural impulsivity and suicidal behaviour.

Suicidal thoughts and actions may be triggered by traumatic experiences. Some teenagers may not be able to handle the stresses of their environment, such as family issues or peer disputes. Some research, however, suggests that a number of stressful life events, rather than any single stressful event, appear to be related to suicidal ideation and behaviour later in life. Some writers argue that suicidality is not only a rational reaction to high stress, which leads to the stress diathesis model of suicidal conduct. However, this is not the case for all children subjected to stressful life experiences. Therefore, from the perspective of preventing suicidal behaviour, more research is needed to clarify

the connection between traumatic life events as well as suicidality in the youth population.

Interventions for Treatment

A wide variety of treatments were used, such as antidepressants, mood stabilisers, antipsychotics, omega-3 fatty acid supplements, cognitive behavioural therapy, dialectical behavioural therapy, and more. Postcard interventions, youth support teams, and proactive community therapy were among the methods used for follow-up and referral. Due to methodological flaws, the data provided by these intervention studies is often weak and inadequate for making firm judgements on the efficacy of specific therapeutic treatments and subsequent follow-up or referral procedures. None of the interventions jumped out as really helpful. Due to its narrow focus, this evaluation did not collect information on possible risks and adverse events other than suicidal self-directed violence.

It is challenging to examine risk and protective variables for suicide outside of Veteran and military groups due to the diversity of suicide attempts and methods. For instance, we were unable to locate any randomised controlled trials (RCTs) that looked at the efficacy of therapies for reducing self-directed violence in persons with PTSD or TBI, two conditions that are surprisingly prevalent among Veterans and service personnel. The duties performed in the line of duty, the potential time spent away from family and other support systems, and the protective factors related to being a part of an organisation like the military may all lead to a very different set of life stressors for this population of interest.

Conclusion

The newest studies on the emotional and social factors that put adolescents at risk for suicide attempts have been summarised in this overview. It suggests that many characteristics and components, such as impulsiveness, mood illness, drug abuse, a history of self-harm, and familial and/or peer disputes, may impact a young person's danger/development of suicidality or suicidal conduct. Paediatric patients at elevated danger for self-harm and characteristics of resilience may be identified and targeted for preventative interventions.

Teen suicide is a major public mental health crisis. Adolescents, in particular, are more likely to have mental health problems than adults. Although suicide is relatively rare among children and teenagers, it becomes a serious issue during this developmental period. Youth suicide is a prominent cause of mortality globally, accounting for a big number of preventable fatalities and a considerable lot of senseless suffering and social loss, notwithstanding a recent downward trend in Europe.

The fact that each suicide results from a complex fluid and unique interplay between numerous contributing components means that isolated efforts to predict or prevent suicide are typically doomed to failure. However, our awareness of potential risks is rapidly growing. Mental illness, past attempts at suicide, certain personality traits, genetic loading, and family dynamics, as well as precipitating psychosocial pressures, exposure to inspiring models, and easy availability to means of suicide, are all significant risk factors in juvenile suicide. The only way to move forward is to provide methods that are population-based (which include promoting mental health, awareness-raising, education through initiatives on resilience to mental illness, careful coverage in the press, and limited access to ways to prevent suicide) as well as those that concentrate on those at greatest risk (such as veterans, young adults, and people with substance abuse problems).Policy goals and dedication are crucial in preventing adolescent suicide, but there must also be substantial, ongoing efforts to scientifically underpin and (re)evaluate existing and new suicide prevention strategies.

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