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Mini Review Article

Risk of Suicidal Behavior in Adolescence

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Abstract

The term adolescence comes from the Latin term adolesce which means to suffer, for a long time adolescence was considered only a transit between childhood and adulthood, but today there are sufficient reasons to consider it within the development of the human being, and exclusive of our species.

Keywords : suicidal behavior; mental health disorders; depression

Introduction

The term adolescence comes from the Latin term adolesce which means to suffer, for a long time adolescence was considered only a transit between childhood and adulthood, but today there are sufficient reasons to consider it within the development of the human being, and exclusive of our species.

The World Health Organization (WHO) defines adolescence as the stage that takes place between 10 and 19 years. They usually divide it into two phases; early adolescence from 12 to 14 years and late adolescence from 15 to 19 years. In each of these stages, physiological changes (stimulation and functioning of the organs by hormones, female and male), structural (anatomical), psychological (integration of personality and identity) and adaptation to cultural and / or social changes are presented.

In adolescence, the burden of individual pressures or responsibilities increases, which together with inexperience and immaturity generate setbacks that can translate into moments of anguish, loneliness and frustration, which lead to risk factors for committing a suicidal act or behavior.

Suicidal behavior in adolescents is becoming more frequent; There is research that reports that family dysfunction, depression, alcohol and drug use, *bullying* and the use of technologies, without adult supervision, increase the risk of this behavior in this group. [2-3]

At this stage of life, it is considered as a critical period in which biological and psychological conflicts are lived. Social pressure, acceptance by the group, academic challenge among others and the response will be determined by the personality in formation of the individual, who at this stage faces problems to solve that constitute transcendental psychological tasks.

Factors that may be associated with suicidal behavior.

Individual: When there are health problems (chronic diseases), ñserious illnesses with hospitalization, chronic pain, communicable diseases for example (acquired immunodeficiency syndrome), presence of mental health disorders: depression, previous suicide attempt, misuse of alcohol and other drugs, learning problems, school failure, not linked to study and / or work, impulsivity, disabling diseases, vulnerability to humiliating events, involuntary internment, alteration of sexual identity, neglect and abuse of minors, isolation, separation, divorce, hopelessness, death of the partner, and adverse socioeconomic factors. [2-3]

Relatives: Family conflicts or disorganization; history of suicidal behavior in the family and families with severe and persistent mental disorders; domestic violence, sexual abuse, death or separation from family members, absence of parents, both psychological and physical; low educational level of the family group; social isolation or antisocial behavior; family communication problems; ease of means to facilitate suicidal behavior, poverty, family neglect. [4-5]

Community: Socioeconomic deterioration of the community, lack of access to health and education related services, limited opportunities to study, work or engage in extracurricular activities (cultural and recreational) unsafe neighborhood; exposure to aggression, violence; wars, disasters, belonging to a discriminated minority, high incidence of alcoholism and other addictions and accepted suicidal behavior.

Institutional: Systematic violations of the fundamental rights of patients in treatment centers for addictions to alcohol and other drugs; disorganized prisons and schools with a marked climate of violence. [2-3]

Dr. Sergio Pérez [4], a prominent connoisseur of the subject of suicidal behavior in adolescents, highlighted and enunciated among others some myths and gave his scientific answer in this regard that provides us with important elements for its prevention in this population group. The myths which, although highly relevant and culturally accepted, are enthroned in the population do not reflect scientific veracity because they are erroneous value judgments regarding suicide, suicides and those who attempt suicide, which must be eliminated.[5] With each myth, they try to justify certain attitudes of

those who sustain them, which become a brake on the prevention of this cause of death. [4]

It stands out and enunciates among others some myths and exposes their scientific answers such as: ***he who wants to kill does not say it***. Wrong criterion because it leads to not paying attention to people who manifest their suicidal ideas or threaten to commit suicide. Scientific criteria: of every ten people who commit suicide, nine of them clearly stated their intentions and the other hinted at their intentions to end their lives. ***He who says it does not.*** Wrong criterion since it leads to minimize suicidal threats which can be mistakenly considered as blackmail, manipulation, boasts. Scientific criteria: everyone who commits suicide expressed with words, threats, gestures or changes in behavior what would happen. ***Those who attempt suicide don't want to die, they just show off***. Wrong criterion because it conditions an attitude of rejection to those who try against their lives, which hinders the help that these individuals need. Scientific criterion: although not all those who attempt suicide want to die, it is a mistake to call them boastful, because they are people who have failed their useful mechanisms of adaptation and find no alternatives, except to try against their lives. If he really wanted to kill himself, he would have thrown himself in front of a train. Wrong criterion that reflects the aggressiveness generated by these individuals in those who are not trained to address them. Scientific criterion: every suicidal person is in an ambivalent situation; That is, of those who use it, and providing another of greater lethality is qualified as a crime of assistance to the suicide (help him to commit it), penalized in the current Penal Code.

The individual who recovers from a suicidal crisis is not in any danger of relapse. Wrong criterion that leads to reduce the measures of strict observation of the subject and the systematized evolution of the risk of suicide. Scientific criteria: almost half of those who went through a suicidal crisis and consummated suicide, carried it out during the first three months after the emotional crisis, when everyone believed that the danger had passed. It happens that when the person improves, his movements become more agile, he is able to carry out the suicidal ideas that still persist, and before, due to the inactivity and inability of agile movements, he could not do it. ***Talking about suicide with a person at this risk may prompt them to do so***. Wrong criterion that instills fear to address the issue of suicide in those who are at risk of committing it. Scientific criterion: it is proven that talking about suicide with a person at such risk instead of inciting, provoking or introducing that idea into his head, reduces the danger of committing it and may be the only possibility offered by the subject for the analysis of his self-destructive purposes.

Disseminating the warning signs of a suicidal crisis are also preventive measures such as: inconsolable crying, tendency to isolation, suicidal threats, desire to die, hopelessness, sudden changes in behavior, affections and habits, isolation, unusual behaviors, excessive consumption of alcohol or drugs, make farewell notes, as well as guide where to go in these cases and thus give tools so that the population has a greater resource to face Individuals at risk [6]

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