SUICIDE IDEATION AMONG YOUTH

IDEAȚIA SUICIDALĂ ÎN RÎNDUL TINERILOR

Nagah DAHAMSHE,
PhD student,
Tiraspol State University, Chisinau

Rezumat: *Suicidul este a treia cauză a morții printre tinerii de 14-24 ani. Motivele care-i determină pe tineri să recurgă la acest gest disperat sunt multiple. În calitate de părinți și profesori avem obligația morală de a descoperi aceste motive și de a susține tinerii în vederea excluderii unor situații fatale.*

Cuvinte-cheie: *ideație suicidală, tineri, comportament, factori de risc, educație.*

Suicide is an emotionally charged issue and the process of coping with it is rather complex. It is particularly difficult for us to face suicide of young people who have decided to take their own lives.This phenomena is scary, which determines us to avoid approaching, thinking or touch it. It often paralyzes us in "advance".

This is one of the main reasons that suicide is considered to be taboo in different cultures. This taboo "enhances the" conspiracy of silence on the subject and leads to the formation of prejudices, myths, and distortions of thinking and perception learning disabilities with regard to this phenomenon [7]. This problematic behaviour patterns prevent detection of distress and assisting on time and according to the needs. However, studies show that teens think about suicide, aware of the phenomenon and we know that some are even threatening, and even trying to perform. As a result, education and care, working with adolescents and children in school, cannot help but see the phenomenon in its various aspects that, often, are not treated at all, because of lack of knowledge and fear to touch it. This situation creates a sealed barrier relation to suffering and prevention of providing assistance in real time. The existence of these myths prevents us from correctly understand the emotional pain of those who are threatening to commit suicide.

It is very important to crack these myths by providing facts on the nature of the phenomenon. This is an opportunity not only to give correct information, but also to empower teachers, parents and counsellors by giving them the tools to recognize the complication of their students so that they can be a meaningful, attentive and helpful figure.

Most definitions of suicide share the notion by which suicide constitutes an act of intentionally putting an end to one's own life, while fully understanding the nature of the act and its objective requires greater preventively comprehensive researches and extended investigations [6], [9]. In Israel, suicide rates are 7.4 per 100,000, with 11.7 for males and 3.3 for females. For adolescents aged 15-24, rates are 5.4 (8.9 for males and 1.8 for females), and these peak at 22-24. In this age group, suicide is the second most

common cause of death for males and third for females, and it holds the highest attempt rates. Similar to other countries over the world, Israeli males complete suicide more frequently than females while females attempt to kill themselves more frequently.

Out of above 7.6 million citizens in Israel, nearly 1.2 million are between ages 15-24, just over 5.8 million (76.3%) are Jewish, about 1.5 million (19.7%) are Arab, and of those approximately 1.3 million (17%) are Muslim. There are 153,100 Christians residing in Israel, 127,600 Druze and 288,400 which are not classified by religion [3]. Although suicide rates for 15-24 year old Arabs are highest compared to other ages in this demographic, Arab adolescents living in Israel kill themselves 1.3 times less frequently than do Jewish adolescents (Israeli Ministry of Health, 2011). Nonetheless, the problem of suicidal behaviour in Arab youth is one which requires special attention. Concerning information shows that while there has been a gradual decrease in suicide rates for Jewish Israelis aged 15-24 since the mid-2000s, suicide rates in Arab youth have stayed more or less static. With 38% of all Arab Israeli suicides committed under the age of 25, compared to 16% of Jewish suicides, it seems that although the risk is generally lower in the Arab population, young age is especially strong as a risk factor in this group [9].

It was found that Muslim Arabs had the lowest suicide rate as compared to Jews, Druze, and Christian Arabs. However, among teenagers Christian Arabs had a lower rate of completed suicide than Muslim Arabs, although both groups had lower rates than Jews.

For the period 1976-1985, male Muslim Arabs and Christians had lower age-standardized suicide rates than Jews and Druzes, but female Muslim Arabs and Druzes had lower age-standardized suicide rates that Jews and Christians. Muslim Arabs of both sexes, therefore, had the lower suicide rates. In order to estimate suicide attempts, studies examined the incidence and outcome of intentional injuries requiring emergency room care among children and adolescents. One study was performed in 1994 with the population of 0-17 year olds who presented to 23 out of a possible 28 emergency rooms all over the country during that one year period. A 6% to 9% random sample of days was selected at each hospital, and for each selected day the relevant records were reviewed for cause, nature, and outcome of injuries and socio demographic information. The annual incidence for intentional injuries resulting in emergency room visits was 19.6 in 10,000 children and adolescents aged 0-17 years of age (95% confidence interval (CI) 17.4-21.8 in 10,000). Fights/assaults constituted 54.1% of the presentations, abuse and rape 10.3% and self-inflicted injuries 10.8%. The rates were higher among boys than girls for fights/assaults and abuse, whereas attempted suicide and rape were three times higher among girls than boys. Nearly twice as many Jewish children and adolescents presented to the emergency room for intentional injuries than Arab children and adolescents, with the ratio becoming even greater for attempted suicide. Of all the intentionally injured, 21.7% were hospitalized. The mortality rate was 1.1 in 100,000 (95% CI =.7-1.7/100,00) with no significant

gender difference observed. No cases of suicide were reported for the Arab population, but there were 30 suicide attempts (rate of 0.6 per 10,000).

When examining risk factors among and within-cultural groups, it is important to look at these factors from three levels: 1) culturally non-specific risk factors which are common across cultural groups; 2) culture-specific risk factors which are unique to each cultural group; and 3) within-cultural group risk factors that help explain the variance in suicidal behaviour within each cultural group [4]. These same three tiers (gender non-specific risk factors, gender-specific risk factors, and within gender risk factors) can also be used to create a framework for examining gender differences in suicidal behaviour among adolescents in the Arab sector in Israel.

1. Non-Specific Factors. Many culturally non-specific risk factors have been associated with both female adolescent suicidal behaviour. These include the following: a family history of suicide, a family history of child maltreatment, previous suicide attempt(s), a history of mental illness (especially depression), a history of alcohol and substance abuse, feelings of hopelessness, impulsive or aggressive tendencies, local epidemics of suicide, social isolation, loss (relational, social, work, or financial), physical illness, easy access to lethal methods, unwillingness to seek help because of the stigma associated with mental health, substance abuse disorders, or suicidal thoughts, barriers to accessing mental health treatment, and cultural and religious beliefs [3].

2. Age is an important predictive factor for suicidal behaviour. In older adolescents suicide rates are higher than for younger adolescents and children. Brent, Baugher, Bridge, Chen, Chiappettam found higher suicide rates for older adolescents than for younger adolescents [2]. This may be due to the differences in the prevalence of psychopathology among age groups, the elevated risk of substance abuse, the cognitively capability of planning and executing a suicide attempt, or greater intent compared to younger suicide victims [1].

3. Gender differences. Researchers have debated the extent, nature, and interpretation of the suicide rate differences between male and female adolescents in the many countries, and also in Israel. In most studies it has been documented that females have more suicide attempts rather than males. Nevertheless, males complete suicide in higher rates in comparison with females [4], [8].

Many explanations have been offered for the gender paradox. The most common one is that girls and boys choose different methods to attempt suicide. Specifically, males are more likely to use firearms when attempting suicide than are females, and firearms are a particularly lethal attempt method. In contrast, females are more likely than males to attempt suicide via overdose. This suicide method has a more unpredictable outcome and there is a longer time period for someone to intervene with potential success [5]. Another possibility that has been offered is that adolescent females are more body aware and body image conscious than are adolescent males. As a consequence, female adolescents may be more likely to choose a suicide method that is non-disfiguring than are men. Fe-

male adolescents may also be more socialized to be relationship oriented and empathetic to family and friends than are male adolescents. They may then worry more about who will find them and how disturbing the scene will be to the discoverer than might males. This worry may lead females to choose less violent (and conesquently less lethal) suicide attempt methods. Finally, there may also be significant gender differences in access to and familiarity with suicide attempt methods, such that adolescent males may find it easier to obtain a handgun or rifle and may be more comfortable handling a gun or rifle than are adolescent females [ibidem]. Each of these potential explanations for the gender paradox warrants additional research and each of these explanations can be considered within a cultural framework.

"Suicidal behaviour" is a complex behaviour, caused by with different factors, inducing a disturbed mental strength that, if not treated on time, can develop into a real danger. The very existence of this phenolmenon among adolescents forces us to approach this problem more seriously, so that we could prevent it. In light of this, it is especially important to raise the awareness of the nature of this phenomenon in all its complexity. Thus, adults are those who can help adolescents to cope with those situations that may be perceived by them as having no way out and, as such, make life pointless and meaningless.

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