Alarm bells in suicide risk

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Summary. The factors leading to suicidal behavior are multiple and prevention is certainly complex and never fully realized. It is still important to engage in an early recognition of mental disorders. In this evaluation two components must be present in the therapist's approach: a clinical assessment from an epidemiological, psychopathological point of views and an assessment based on the emotional experience (knowledge of the counter-transference).

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Received: 08.12.2014 - Revision: 07.02.2015 – Accepted:13.02.2015

In front of adolescent's suicide common immediate reactions are to attribute the letal act to a comprehensible cause or to a raptus. In newspapers, a cause, a stressful event, a guilter (a parent, a teacher, a boy or girl friend) are almost always indicated in order to underline that nobody could expect it, reinforcing the widespread view that suicide is unpredictable.

Alternatively, it is stated that the act was determined by madness, that is charachterized by an absolute nonsense.

Maybe to find explanations or responsabilities in the environment or in a raptus could be a way to tranquilize: so you can avoid the big questions about death and life.

The adults think that young people are always happy, joyful and they do not remember that adolescence is a difficult period with strong emotional distress and pains. Instead we must believe that suicide comprises multiple levels of comprehension and communication , often linked and that it still remains in part enigmatic (Pavan L, 2009).

We suggest some hypothesis of meaning that could represent adolescents' state of mood:

- as a protest against a society, a political system, a generation;
- to manipulate: to ask and obtain changes in the others, in a partner, in the family, in the environment;
- sometimes the social aspect prevails as a ritual, to belong to a group, as a sacrifice, to expire, from a philosophical point of view
- as a cry for help, to have someone that could support and take care of them;
- participation in a game: in order to test their courage, to face the fate, in various ways such as: race motorcycles, cars crushed against a wall, the rule to stop the race as late as possible, Russian roulette and other games where dying is attended;
- imitation: since Goethe published "The Sorrows of Young Werther" it is known that this possibility is particularly relevant, especially nowadays, given the importance assumed by the media;
- to try to replace the mental stress with the physical pain, closer to self-harm;
- to adjust the dysphoric adolescent's mood characterized by anxiety, anger, unesiness, even those closer to self-harm;
- because of shame: in the current society of appearance, mass media have greatly encouraged this component;
- the mystical suicide, committed from a religious vision, to reach afterlife.
- internet: there is a relatively new method that promotes motivation of "'appearance", of becoming "famous". There are also sites that encourage and suggest "how to do" it;
- blame: throw the burden of your body on the shoulders of someone else (teacher, parent, boyfriend / girlfriend, etc.);
- self-affirmation: "I'll show you what I'm worth, or how much I suffer," and be a hero;
- the desire to get out of the knowledge, looking for a break;
- the homosexual panic that could be present in communities such as schools, sport groups;
- the desire to expiate guilt, to achieve a self-punishment, more frequent in severe depression.

What are the signs that we can explore in order to understand the risk?

First, we must have in mind the cultural and generational difficulties and be well aware that almost always suicide is an act well thought, long prepared and finally realized; sometimes it is affected by a "silence", by an absolute lack of signals, or at least so it seems; more often there are signs that may be behavioural, such as acting out, escapes, vandalism, substance abuse. Other signals can be the onset of sudden failure at school, interpersonal conflicts with family or peers, or an exaggerated concern for health, especially of masculinity, the size of the penis, the body.

A third of the cases sends signals more direct, spoken or written, just in the 2-3 weeks preceding the gesture. The subjects may communicate thoughts, feelings, words, often written, phrases, poems, text messages. Sometimes they confide the suicidal intent to a friend, as a secret (which should not be respected) and often the person who receives this confidence underestimates, denies ("thai is nonsense,"it can not be true") and gives improper advice ("you should have a holiday","you have to do sport", etc.). It is important to dispel the belief that "he who says it will never be able to do". This is a frequent blunder that needs to be avoided.

The most important signal is a "suicide attempt": a conduct that does not result in death, sometimes because the means used were not lethal, other times because the fatal outcome was prevented by external causes, the so-called "missed suicide " (the string breaks, the pistol shot that deflects or help that is provided).

We called parasuicide all the self-harming behaviours from the more dangerous to the less serious, until to arrive at a "self-harm" that is culturally approved and accepted, such as the piercing, the cutting, the tattoo exasperated, and the self-destructive behaviors in an artistic context, when the body is injured, cut, flogged, pricked, burned, in the various expressions of Body Art. However, the "suicide attempt" should always be taken into serious consideration. It is the most important predictor of suicide, in particular within few months.

Another fundamental element to keep in mind is the presence of mental disorders: suicide is not a disease, not a symptom, but it is highly related to mental disorders, for which early recognition of a mental disorder and care it is equivalent to suicide prevention. Depression in particular, schizophrenia especially early on, addiction to alcohol and substance abuse, some personality disorders, emotional crisis, as well as somatic painful and disabling diseases. Besides the recognition of a disorder, such as depression, it is very important to learn to grasp the psychopathological expressions, such as agitated depression that is much more dangerous than

common depression, maybe more clinically severe, but where inhibition and stupor prevail.

According to most authors (Ladame, 1995; Jeammet,1995) three groups of adolescents at risk are recognized:

- subjects with an apparently good attitude that are perfectionist, inhibited, with rigid models of reference, who can not stand the failure and failures;
- impulsive subjects, often hostile with alcohol and substance abuse, with stories of anger, aggression, with unstable relationships, sometimes marginalized;
- atypically depressed subjects, who complain of pains, headaches, fatigue, insomnia, often with hypochondriacal concerns regarding in particular virility.

However, a specific, defined, shareable profile of subject at risk does not exist. Thus it could be important to define a "suicidal syndrome", characterized by:

- suffering and severe mental pain
- rigid cognitive attitude (cognitive tunnel) in which a sense of helplessness, of lack of exit ways prevails
- an exalted "impulsivity" which tends to prevail and to overcome any resistance.

These features have to be considered in any psychological assessment and we must also have in mind that the subject at risk presents a fundamental ambivalence toward life and death (Condini, 1999) and this is the premise for a professional intervention help. We have to avoid an intrusive attitude, but also the omission has to be excluded.

The purpose of early intervention should be directed to alleviate the despair and pain, to help and think of alternative solutions, and to control impulsivity, even with the use of psychotropic drugs. Clinicians should have a good awareness of their personal affective reactions and have to know how to control them. In other words, the counter-transference is very challenging.

So we must recognize the exasperating and destructive aspects of the person in question, avoiding defensive responses (only cold approaches, detachment, indifference, morality etc.). We have to avoid omnipotent answers, avoid feeling as the "savior" or the only person who can save the patient. It could be important to put some limits (time, space, for example) in that particular setting. We have to avoid the "rational"

challenge that is sometimes sought by "philosophical" thoughts about living and dying.

Finally, the clinician, who tries to help someone in a situation of risk, has to know his or her amount of depressive feelings and current attitude towards life.

Note

Paper presented at the CIRF Conference"Adolescenza sospesa : fine di una vita, inizio di una vita?" [Suspended adolescence: end of a life, beginning of a life?], Padua, October 18th 2014.

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