Suicide and adolescent psychology

Life

AdolescentPsychologyis a difficult specialty within the field. Many of the normal phases of adolescent development look like pathologies, and perhaps would be classified as such if the patients were adults. Thus, it is difficult, even for a trained professional, to tell the difference between a true pathology, and a " normal" mood orpersonalitypattern associated with adolescent development.

An area where this deficiency can lead to grave circumstances is the realm of adolescentdepressionandsuicide. Although true suicidal tendencies can be difficult to spot in adolescent behavior, timely identification and proper treatment are importantgoalsof Adolescent psychologists. Although causal theories differ, the treatment of teen suicide attempts and depression is fairly consistent across adolescent theorists.

Typical symptomology of suicidal tendencies in adults has several features. (Symptoms...2007) The underlying psychological cause of such ideations is usually depression. (Symptoms...2007) Symptoms of depression include sleeping pattern disruptions, feelings of low self-worth, loss of interest in pleasurable activities and lack of energy.

(Symptoms...2007) One of the key indicators that a depressed adult is contemplating suicide is self-report. (Symptoms...2007) Often, adults are not treated for suicidal depression until after they had made an attempt on their own life. (Symptoms...2007) Treatment for long-term depression in adults typically consists of medication and extensive therapy. (Symptoms...2007)

They type and length of therapy is contingent on many factors. (Symptoms... 2007) These include the specialty of the therapist, the diagnosed underlying

condition, and the severity of the depressive state. Similarly, the medical regime for adults with suicidal depression varies as a function of the underlying psychological cause for the depression. (Symptoms...2007)

Typical depressive mood disorders are treated with anti-depressants, while personality or perception disorders, which can lead to a secondary depressive condition, are better treated with medication targeted to the underlying disorder. (Symptoms...2007)

As complicated as the diagnosis and treatment of suicidal depression is in adults, it is even more so in the adolescent population. (Teen Suicide...2005) Suicide is the third-most common cause of death among individuals between the ages of fifteen and twenty-four. (Teen Suicide...2005)

There are large gender differences in accounting for teen suicide, but they are explained more by the methods used, than any particular predilection toward the act. (Teen Suicide...2005) 83% of adolescent suicides are males, whereas females make more attempts at suicide.

(Teen Suicide...2005) The discrepancy can be explained by the fact that males are far more likely to use a gun in their attempts, while the method of choice for females is pills. (Teen Suicide...2005) Of the two, the chances for success are much higher among those who use a gun. (Teen Suicide...2005)

According to the National institute of Mentalhealth, successful suicides among adolescents number about 8 in 100, 000. (Teen Suicide...2005) Attempts at suicide are estimated to be much higher. (Teen Suicide...2005)

The National YouthViolencePrevention Resource center found that about one in five teens think about suicide, one in six have actually planned for it, and

one in twelve had attempted suicide in the past year(Teen Suicide...2005) . As is the case with adults, most (about 90%) of adolescent suicide victims have an underlying mental disorder. (Teen Suicide...2005)

One moder theory of suicide in adolescence is espoused by Dr. David Elkind. He posits that there is a gap between physical and psychological development, which causesstressin the adolescent. (Elkind, 1998) Dr. Elkind theorizes that teenagers, who are often treated as adults at home and in schools, are not as complete in their psychological development as they are in their physical development.

(Elkind, 1998) This results, opines Dr. Elkind in a stressful dissonance that can lead to suicidal ideation. (Elkind, 1998) Additionally, exposing an adolescent to adult-type stressors, such as deadlines, appointments and specific goal-driven activities can cause stress. (Elkind, 1998) This stress can lead to depression and suicide. (Elkind, 1998)

On the other side of the coin, Dr. Elkind believes that over scheduling a young child may leave him or her bored when the structure surrounding the child disappears in their teen years. (Elkind, 1998) This subsequent lack of direction can also lead to depression. (Elkind, 1998)

This theory suggests a preventative viewpoint on teen suicide. (Elkind, 1998) Once an adolescent articulates a desire for suicide, or makes the attempt, Dr. Elkind recommends the standard psychological treatment, and medication, if warranted. (Elkind, 1998)

A more environmental viewpoint is espoused by Dr. Bronfenbrenner. (Paquette & Ryan, n. d.) He views human development as an interaction

between individuals and a system of bioecological systems. (Paquette & Ryan, n. d.) He views any psychopathology, including teen depression or suicide as a dysfunction whose development is engendered by deficiencies in the mesosystem (immediate social surroundings) of the individual.

(Paquette & Ryan, n. d.) This approach to development does not lend itself particularly well to the treatment phase of suicide in adolescents, rather, it offers a socially-constructed theory for the phenomenon. (Paquette & Ryan, n. d.)

Preventative " treatment" in this paradigm would consist of fostering a healthy, positive mesosystem around the individual, so that they might develop in a psychologically healthy manner. Again, one is forced to conclude that an already-depressed or suicidal teen would be best served by therapy and possible pharmaceutical remedies. (Paquette & Ryan, n. d.)

A more cognitive approach to adolescent behavior is espoused by Dr. Robert Selman. (Selman's...2002) His theories, which are derived from those of Piaget, rely on modeling and other cognitive methods to explain behavior. (Selman's...2002)

As such, he would explain the phenomenon of adolescent suicide as a response to a social context where such behavior is observed to have a positive outcome. (Selman's...2002) Rarely would the cues be direct, but cultural stimuli such asmusic, television, and movies could inadvertently (or blatantly) glamorize the practice of suicide, and compel an adolescent, especially one who already suffers from depression or some other psychological ailment to attempt suicide. (Selman's...2002)

Of these theories, the one whose suggested treatment appears to be most effective is Selman's. Cognitive therapy has been found to decrease repeated suicide attempts by 50%. (Asher, 2005) While this particular study focused on adults, there is little reason to think that the results would be demonstrably different with adolescents.

(Asher, 2005) Interestingly, the same cannot be said of pharmaceutical treatment options. (DeNoon, 2002) It has been shown that teens who take antidepressants actually have an increased rate of suicide than those who do not. (DeNoon, 2002) Recent evidence suggests, however, that the same studies prove that the conclusion drawn from the data was erroneous, as the scientists failed to control for other variables such as severity of the depression, and other factors.

(DeNoon, 2002) Despite these conflicting findings, or perhaps because of them, a therapist should be cautious about " throwing drugs at the problem" and dismissing a patient with a prescription. (DeNoon, 2002) In addition to the pitfalls of possible adverse effects of the drugs themselves, this kind of treatment is far more vulnerable to negative outcomes hinged on misdiagnosis.

(DeNoon, 2002) If a closely monitored patient is found to have another type of disorder, to which depression is merely a secondary characteristic, that therapist can make the appropriate pharmacological and therapeutic revisions. (DeNoon, 2002) If, on the other hand, an underlying condition is missed, and the patient dismissed with antidepressants, the results could be tragic. (DeNoon, 2002)

Owing to the nature of serotonin-stimulating drugs, which most antidepressants are, an effect of a non-depressed person taking this medication is the onset of severe depression. (DeNoon, 2002) This would result in the therapist causing the very symptoms he or she is attempting to relieve. (DeNoon, 2002)

The main commonality of all of these perspectives is the need to monitor closely the disposition of the patient. The only way to differentiate true depression from a phasic anomaly of normal adolescent development is to observe the behavior and responses over a long period of time.

For example, behavior that might be characterized as bipolar, buts of high energy and enthusiasm contrasted with lethargy and depression may be the normal reaction to hormone development in an adolescent. Without context, it is almost impossible to tell the difference Thus, the best preventative measure would be to treat any suicidal ideation as a serious symptom and have a therapist interact for a long period with the adolescent.

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