PREVENTION OF SUICIDAL BEHAVIOR IN ADOLESCENTS

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Relevance. According to numerous studies, for every completed suicide, there are 10 to 20 suicide attempts, highlighting a disturbing trend related to voluntary life termination. Adolescent suicide represents a particular concern. It is important to note that two-thirds

of those who attempted suicide did not actually intend to do so, often acting impulsively and without understanding the consequences of their actions [1, 2]. This underscores the need to search for reliable indicators of suicide probability. Identifying these indicators at the level of psychophysiological reactions can complement the psychological tools currently used for suicide diagnostics [3].

Objective. To assess the social and individual-psychological factors in adolescents aged 14 to 18 that are associated with both high and low risks of suicidal behavior.

Materials and Methods. To evaluate social and individual-psychological factors, the following tools were used: Suicide Risk Detection Method for Children (developed by A. A. Kucher and V. P. Kostyukevich) to identify factors contributing to the formation of suicidal intentions; Beck Depression Inventory (BDI) by A. Beck (1961, 1978); Method for Identifying Adolescent Suicidal Tendencies (SPSP) by M. V. Gorskaya (2008) to determine levels of anxiety, frustration, aggression, and rigidity; and Reasons for Living Inventory (RFL) by M. Linehan et al. (1983).

Results. Both groups demonstrated similar factors that could be classified as belonging to the "risk group." This group includes the following children and adolescents: those from families where suicides have occurred; children and adolescents from single-parent or socially disadvantaged families; individuals with a tendency toward perfectionism; those suffering from chronic diseases or mental/psychological disorders (depression, anxiety disorders); those who have experienced humiliation or tragic losses; highly self-critical children and adolescents frustrated by the discrepancy between expected success and real-life achievements; children and adolescents abandoned by their social environment; and those with disrupted interpersonal relationships.

Diagnosis must account for the stages of suicidal behavior, ranging from prolonged suicidal thoughts to concrete attempts. Suicidal intentions are often associated with emotional instability and affective states (anger, resentment), meaning adolescents rarely plan such actions carefully, though warning signs exist. These include feelings of helplessness, hopelessness, loss of interest, depression, sleep and appetite

disturbances, declining academic performance, isolation, persistent suicidal thoughts, ambivalence, and emotional withdrawal. A psychologist can help reduce emotional tension, develop compensatory mechanisms, and change the individual's attitude towards life and death, or in urgent cases, arrange for the adolescent's hospitalization.

Protective factors against the development of suicidal behavior include established positive life attitudes, a healthy mental disposition, and a set of personal factors such as a developed sense of duty and responsibility; emotional attachment to family and loved ones; concern for one's health and fear of causing oneself physical harm; psychological flexibility and adaptability; the ability to relieve psychological tension; interest in life; the presence of life plans and goals; the presence of current life values; religiosity; and fear of the sin of suicide.

As preventive measures to prevent suicidal behavior, the following actions can be highlighted: organizing joint efforts between family, school, and peers to provide social support (psychoeducation); isolating the child from destructive guardians if necessary ("Blue Card" system); conducting socio-psychological training; individual and group activities aimed at increasing self-esteem; teaching social skills for overcoming stress; and training in the practical application of active problem-solving strategies.

References:

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