

To the Editor:

Preventing Youth Suicide

This letter is in reference to Dr Ung's article published in the *Annals* which investigated youth suicide and parasuicide in Singapore.¹ The study of suicide has a very respectful tradition as many studies have led to the recognition of cultural and environmental risk factors. The efforts of local researchers who seek a deeper understanding of suicide do receive our appreciation and emphasise the many facets of this phenomenon.

We strongly believe that suicide prevention strategies do transcend cultural boundaries; and using different sources they can be developed into a common group of action strategies. Although we should always consider the cultural background of a suicide victim, there are some common basic characteristics that identify the suicidal individual. Starting from Shneidman's assumption² that any suicide relates specifically to unmet or frustrated needs of an individual who defines an issue for which the suicide is perceived as the best solution, we underline the fact that youth suicide today has become a major public health problem worldwide. The suicide rate of young male adults in western countries is almost at the same level as the rate of middle-aged men. In many countries in Asia, women's suicidal behaviour has higher rates compared to their western counterpart; and this is also the case of young female adult.

Alcohol abuse has been suggested as a possible cause for the increase in youth suicide rate.³ Socioenvironmental factors, such as school and work problems, are very important topics in the organisation of preventive measures. Ung¹ reported that there was a peak of parasuicide during the examination months. Indeed, difficulties in school and not entering college pose significant suicide risk.⁴ Among high school students in community samples, the reported frequency of suicide ideation ranged from 11% to 49% and the frequency of suicide attempts among this group ranged from 3.6% to 9%.⁵ The potential high school dropouts are youth at increased suicide risk who have a clear need for indicated preventive intervention.⁶ Studies have demonstrated the efficacy of school-based semester-long class⁷ that integrates social support and skill training elements.⁸

The prevention of youth suicide is in part dependent on the ability to identify populations at high risk and to offer prompt, effective interventions. Evidence showed that the suicidality of adolescents who completed suicide is rarely recognised by professionals and consequently these young people fail to receive the assistance that may prevent their death.⁹ General practitioners and secondary-school teachers are in a good position to detect youth at risk for suicide. They should be instructed to detect early warning signs in adolescents. Also, they should know the risk factors and

elements of prevention. Very often, both the general practitioners and teachers are confident about their knowledge of suicide prevention strategies. This assumption prevents them from understanding and applying new strategies for suicide prevention.

A family history of suicidal behaviour greatly increases the risk of completed suicide. Studies have also found high rates of parental psychopathology, particularly depression and substance abuse, to be associated with completed suicide in adolescents. Also, parental divorce and problematic parent-child relationships greatly increase the risk of suicide.⁴ Stressful life events have been reported in people who engaged in suicidal behaviour.

The role of mass media in suicide reporting is very important, as very often stories of suicide are sensationalised and have great impact on teenagers who may experience a contagion effect. It has been reported that suicide stories reported by the mass media are followed by a significant increase in the number of suicides.¹⁰

Both suicidal thoughts and feelings are usually reported as being related to the youth's sexual orientation. Suicide attempts often occur after their awareness of their sexual feelings and before the youths disclose their orientation to others, including parents.¹¹

Findings from various studies have shown that medically serious suicide attempts are significantly more likely to have mood disorders, substance abuse, conduct disorders, or antisocial personality disorders than are community controls.¹² Again, hopelessness, depressive disorders and alcohol abuse are very important risk factors in the medically serious suicide attempts. Also, a prior suicide attempt is an important predictor of death by suicide.^{13,14}

We emphasise the need to establish channels of communication between researchers in suicidology in various parts of the world and to compare experiences in this field for a deeper analysis of suicidal behaviour. Elaboration of new youth suicide prevention strategies should be the starting point of collaboration between countries worldwide.

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Dr Ung replies:

The author(s) of the letter have made very good and pertinent suggestions as to how our growing understanding of the factors in youth suicide can be put into use practically. Especially important is the final part that again reiterates the need for experience and communication sharing within various researchers, clinicians and health professionals in this area. Unfortunately as the author(s) point out, "the suicidality of adolescents who complete suicide is rarely recognised by professional". This belies the difficulties of accurate suicide prediction. One area of optimism is in the downward trend in adolescent suicides in the United States over the last few years. Gould et al¹ have suggested that this could be due to the increasing tendency to use antidepressant medications in depressed youth. Perhaps if this can be confirmed with the collaboration the author(s) has highlighted that we need urgent, then there is indeed a bright light at the end of the tunnel.

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