# "Hello Again, World!" Surviving Adolescent Self-Directed Violence

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"Please come now,
I think I'm falling;
I'm holding to all I think is safe
It seems I found the road to nowhere
And I'm trying to escape.
I yelled back when I heard thunder,
But I'm down to one last breath.
And with it let me say...
let me say:
Hold me now, I'm six feet
from the edge
And I'm thinking that maybe six feet
Ain't so far down..."

—from "One Last Breath" by Creed (2003)

If these lyrics from a song that is popular among our youth are any concrete indications of what they are thinking and feeling, then it is not farfetched to say that death by self-directed violence appears to be a fascinating way out of adolescent pathos. Yet there is no denying that underlying this desire to die is a deeper longing to be saved from self-destructive tendencies and to continue living.

## INTRODUCTION

More commonly known as suicide, self-directed violence is a voluntary act of harming oneself with the intention of usually ending one's life. The documented social reactions to suicide vary greatly from society to society and from period to period. In some societies, cultural traditions have elevated suicide to a socially acceptable and

sometimes mandatory practice (Tan 2000b, Hebding and Glick 1992, Morales 1979). In Japan, particularly during wartime, suicide was institutionalized in the *hara kiri* as a way out of disgrace and in defense of one's honor. Sometime in the mid-20th century, some of our Muslim brothers in Southern Mindanao incorporated it in their practice of *huramentado* to avenge an injustice against self and family. This days, diehard members of terrorist groups are using suicide to inflict the greatest public carnage and destruction as exemplified by the 11 September 2001 tragedy in New York City, while advocates of the right-to-die employ suicide as a dignified exit from an unbearable disease.

Contrary to these instances, however, most societies regard suicide as a form of deviance (WHO 2002, Macionis 1998, Hebding and Glick 1992). Particularly in western countries, suicide is being opposed, tabooed, stigmatized, condemned, or criminalized for religious or cultural reasons. The Jewish and Christian religions have traditionally strongly disapproved of suicide. In England, it was punishable as a crime (felony) until 1961 and viewed as a sin such that the suicide's body was denied burial in a Christian cemetery and the suicide's possessions were confiscated by the Crown. Similar penalties were reportedly enforced in the English colonies in America until the 1950s.

In western-influenced and Christianized countries like the Philippines, a social stigma is also attached to suicide (Sta. Cruz-Espina 2001, Tan 2000b, Morales 1979). For the predominantly Catholic Filipinos, taking one's life is sinful and shameful. The blame is placed alternately on the suicidal person or on his/her family. Society commonly labels the suicide victim or survivor as mentally unstable and social pressure is somehow brought to bear on the family who is implicated in or suspected to be contributory to the self-destruction of its member. Moreover, because there is an inherent drama in suicide stories, tabloids are quick to pick up and sensationalize them. It is not surprising then that suicide has become a tabooed subject. Families refuse to talk about deaths due to suicide and may go to great lengths to cover up such an incidence. Consequently, suicide attempts are not recognized as a cause of morbidity and suicide deaths often end up getting misreported as accidents.

## INCIDENCE AND DYNAMICS OF SELF-DIRECTED VIOLENCE ESPECIALLY AMONG THE YOUNG

The rate of dying by one's hand has increased by 60 percent worldwide in the last 45 years, according to the World Health Organization (WHO 2000). In 1996, approximately 390,000 deaths by suicide were reported to have occurred in the Western Pacific Region alone, where it has also been estimated that at least one million people attempt suicide each year (WHO 2002a:10). In 2000, the statistics led WHO to predict a global mortality rate of one death for every 40 seconds due to suicide, or 16 deaths per 100,000 population, or a total of about 815,000 deaths, making suicide the 13th leading cause of death worldwide (WHO 2002b:19). The highest rates were found

in Eastern European countries, while the lowest rates were reported in Latin America and in a few Asian countries.

The Philippines counts among those countries with the lowest suicide rates in the world. Even among the 10 countries in the Asia-Pacific Region for which the WHO had compiled statistics as of November 1999, the country showed the lowest incidence with 2.5 deaths per 100,000 males and 1.7 deaths per 100,000 females in 1993 (Table 1). Within the country, however, health statistics from the Department of Health (DOH) showed an increasing trend that was consistent with the global rise in suicide cases. Tan (2000a) found that the number of reported suicide cases in 1993 (851) was more than three times the reported figure (247) for the previous year, but he noted the absence of recent statistics for comparability. The lack of national statistics on suicide rates has encouraged individual researchers to be innovative in their search. For example, Sta. Cruz-Espina (2001) relied on a library compilation of news clippings on successful suicides and found that a total of 60 Filipinos (or approximately 5.45 cases per month) took their life from January to November 2000.

In general, suicide rates tended to increase with age and the highest rates traditionally belonged to the elderly. In 1995, for instance, the rates for the elderly aged over 75 years were approximately three times more than those of the youth aged 15–24 years. However, the absolute figures were observed to be generally highest in the 15–44 years group, making self-inflicted injuries the fourth leading cause of death and the sixth leading cause of ill-health and disability among people in this age group (WHO 2002b:19).

An analysis of suicide statistics among the 15–19 year olds in the United States showed that the rates had doubled between 1968 and 1987 to 16.2 per 100,000 boys and 4.2 per 100,000 girls, leading suicide to rank second, after

**Table 1. WHO-compiled suicide rates (per 100,000) in the Asia-Pacific Region as of November 1999**

| Country | Year* | Males | Females |
|---|---|---|---|
| Sri Lanka | 1995 | 44.7 | 16.6 |
| Japan | 1996 | 24.3 | 11.5 |
| New Zealand | 1994 | 23.6 | 5.8 |
| Australia | 1995 | 19.0 | 5.1 |
| China (SAR Hong Kong) | 1996 | 15.9 | 9.1 |
| Republic of Korea | 1995 | 14.5 | 6.7 |
| China (mainland) | 1994 | 14.3 | 17.9 |
| Singapore | 1997 | 14.3 | 8.0 |
| Thailand | 1994 | 5.6 | 2.4 |
| Philippines | 1993 | 2.5 | 1.7 |

**Most recent year available.*

accidents, as a cause of death among American teenagers (O'Reilly, 1990 cited in Long, 1995:13). For children below 15 years old, a study involving 26 industrialized countries (including Japan, Hong Kong, Taiwan, and Singapore) revealed that childhood suicide rates quadrupled during 1950 to 1993 (CDC 1997). It also showed that suicide ranked sixth as a cause of death particularly among children aged 5–14 years, with death among boys happening 2.5 times more than that among girls. Moreover, the highest childhood suicide rate came from the United States, which was two times higher than those in the 25 other countries combined. The rates of suicide among the young have been increasing to such an extent that they are now considered by WHO (2000) to be the group at highest risk in a third of the developed and developing countries.

The phenomenon of violence against oneself has long attracted many researches particularly in industrialized, urbanized, and modernized societies where it was first noticed and where suicide rates have been escalating ever since. The "most famous" suicide study was done in the late nineteenth century by Emile Durkheim based on statistics in his native France (Danigelis, et al. 1987 cited in Fernquist and Cutright 1998). Durkheim's societal integration theory attributed the occurrence of suicide largely to a lack of social support, social integration, and social regulation (anomie) that altogether cause individuals to lose connections with society. He found that certain traits tended to be associated with suicide, namely: belief in a religion that stresses individuality in seeking salvation, being a male, unmarried, or divorced, coming from the educated or a higher social class, and experiencing economic crises (Durkheim 1951). Subsequent studies on suicide have built on and expanded Durkheim's theory or refuted some of his findings (see Fernquist and Cutright 1998, Taylor, et al. 1998).

To date, the results accumulated from many studies have shown that despite variations across and within countries, death by self-directed violence is still generally higher among men than among women (with a ratio of 3 males: 1 female; WHO 2002a) despite the fact that more women than men harbor suicidal thoughts and attempt self-annihilation (Wartik 1991). This disparity is often traced to the preferred suicide method: men's use of guns and other violent means and women's use of drugs and other ways that provide second chances. Such demographic characteristics as age, race or ethnicity and type of residence (urban or rural) are also important variables in suicide occurrence.

Furthermore, although self-directed violence is associated with many complex sociocultural factors, it tends to occur most likely during stressful periods brought on by individual and family crises. Distressing events such as the loss of a loved one, employment, or personal honor, failed marriage, breakup of a romantic relationship or family ties, bad school performance, inability to escape from poverty or to resolve a crisis, arguments with family or friends, and legal, health or work-related problems may be common human experiences, but they act as precipitating

factors that trigger suicide in certain people who are predisposed, at risk or vulnerable to self-destruction (WHO 2000 and 2002a, Wartik 1991, O'Reilly 1990).

The predisposing risk factors or so-called "triggers" to suicide include alcohol and drug abuse, a history of physical or sexual abuse in childhood, social isolation, painful or disabling illness, access to the means for killing oneself (typically guns, medicines or agricultural poisons), psychiatric problems caused by depression and other mood disorders, and a recent history of suicide attempt, i.e., an attempt within the previous six months has been found to be a powerful predictor of a subsequent fatal suicidal behavior (Verona, et al. 2001, WHO 2002a, Wartik 1991).

In the last decade, suicide has been linked to such variables as violence against women, sexual orientation, and bullying in school. World Bank and some cross-cultural studies provided mounting evidence showing that domestic or marital violence is a leading cause of suicide attempts by girls and women in the United States, Africa, South America and Melanesia, as well as a cause of mass suicide among rural women in China (Bunch, et al. 1995, Pearson 1995). Several studies also indicated that homosexual and bisexual youths in American society are two to three times more likely to kill themselves than heterosexual youths (see Savin-Williams 1994). Lesbian, gay male, and bisexual youths faced chronic stress created by the verbal and physical abuse and harassment they continuously received from peers and adults in a homophobic society. This situation not only threatened their mental health but placed them at great risk to engaging in risky behaviors (like substance abuse, running away from home, or prostitution) and eventually killing themselves to escape from chronic stress. In the early 1990s, there were reports about Japanese children resorting to suicide because they could no longer take the bullying suffered in school (Almario 1995).

Today suicide is widely regarded as a mental health issue of public significance. In more than 90 percent of all cases, suicidal behavior is associated with mental disorders particularly depression (WHO 2000). It is estimated that depression affects some 340 million people worldwide at any given time (WHO 1996). Even children are not spared from depression (or other forms of mental disorders) which is most likely to appear for the first time in the 15–19 year olds, according to the National Institute of Mental Health (cited in Wartik 1991). Depression is a type of mood or affective disorder that causes a person to have uncontrollable mood swings. Other characteristics of depression include unaccountable sadness, diminished pleasure in daily life, weight change, a disturbed sleeping pattern, fatigue, feelings of worthlessness and self-blame, diminished ability to concentrate, and indecisiveness. These symptoms persist for several years in a person suffering from chronic depression or dysthymia. Depression alone is said to account for at least 60 percent of the suicides (WHO 1996). Hence programs to improve mental health have been targeted to address suicide prevention.

The comparatively low rate of suicide among our Filipino youth may not be alarming, but the recurrence of news about the young attempting to take their life and sometimes succeeding have led some individuals to be concerned enough to write about or to investigate this phenomenon (Gallardo-Lagasca, et al. 2001, Victor 2001, Cruz-Espina 2001, Bueno 2001, Tan 2000a, Morales 1979). The writers or researchers are usually medical professionals, possibly because they have greater access to detailed information about suicidal cases and have played a significant role in helping suicidal individuals recover their mental and physical well-being. One child psychiatrist noted that her youngest patient who attempted suicide was an eight-year-old boy, though majority were 14 years or older (Bueno 2001).

Two empirical studies done by medical specialists in psychiatry and adolescent medicine and focusing on a limited number of youth suicide cases in the Philippines indicate parallel findings in some foreign studies. In one study of 30 consummated adolescent suicides reported to two Metro Manila police districts within a five-year period (1972–1977), Morales (1979) discovered a ratio of 2.3 males: 1 female and the occurrence of more suicides in late adolescence (18–21 years). The fatal methods used were gunshot at the temple or chest (40% of the cases), hanging, poisoning with insecticide and formalin, jumping off a high place, and drowning. The use of a gun was common among males, while hanging and poisoning were common among females. In the majority of cases, the suicide act was committed while alone and inside their homes. Less than a third left suicide notes that bade goodbye and explained their action. One-sixth of the cases had a history of previous suicide attempts, drug abuse, or schizophrenia (and was under treatment when suicide was committed).

The precipitating factors in the 30 fatal suicides were emotionally destabilizing incidents like having a misunderstanding/quarrel with or separation from a sweetheart, growing despondent over studies, getting reprimanded by elders for some fault, feeling disappointed because a request to be married was refused by parents, possessing no money for the wedding after elopement, and having an alcoholic or jobless parents. The triggers were a history of one to six suicidal attempts prior to the fatal one, a psychiatric disorder (schizophrenia) that was under treatment, drug addiction, and periodic moodiness, restlessness, insomnia, and poor appetite.

The other study by Gallardo-Lagasca, et al. (2001) was about suicide survivors. It reviewed the patient charts of all 19 adolescent suicide attempters admitted to the Philippine Children's Medical Center during a 14-year stretch (January 1985-April 1999) and then conducted follow-up, in-depth interviews with six of them. The attempters were mostly females (12 of 19) and in mid-adolescence (14–16 years). The case informants were four females and two males. Almost all were first episode attempts and took an overdose of medicine or toxic substance (only one was a wrist-slashing case). Based on recorded information in the charts, the precipitating factors were predominantly

interpersonal problems with family, relatives or friends, including breakdown of romantic relationships. Other factors were related to school and financial problems, unwanted pregnancy, drug addiction, and sexual abuse. (The last two factors were considered precipitating rather than predisposing factors in this study.)

The six case studies revealed a common background tinged with abandonment and lack of affection from the family, which led the attempters to harbor ill feelings toward parents. Compounded by other problems encountered at school or with friends, rape experience, and loss of self-esteem, the adolescents underwent changes in behavior and outlook prior to attempting suicide. Sleeplessness, irritability, uneasiness, loss of appetite, home avoidance, disrespectfulness, and antisocial attitudes characterized these changes. After their suicide attempt, they underwent but did not complete the recommended number of psychotherapy/counseling sessions. Among the four female cases, recurrence of suicide attempt was prevalent before recovering from their problems. All have fully recovered at the time of the interview with the help of their family, prayers, and refocusing on studies.

Although suicide generates a large amount of public interest amongst us Filipinos, not much attention has been given to suicide research in our country. Victor (2001b:18) succinctly noted that "except for some small studies, most local information come from centers and small groups that cannot represent the general Philippine population." Tan (2000b) likewise noted that we do not have any ongoing major studies looking at causes and prevention of local suicides.

Having reviewed the suicide literature prior to my own study, I can attest to these observations about the paucity of research undertakings on local suicides. Interestingly, I also found that the available researches were focused more on youth suicide, both fatal and nonfatal, and generally sought to understand the suicidal profile, triggering factors and necessary intervention mechanisms. My own research interest lies in understanding our adolescents' perception of suicide and depression, their own suicidal thought or ideation, and what roles the major socialization agents play in triggering or preventing the consummation of this ideation. This interest was sparked when, in the course of one fieldwork, I came to live with a rural family in Nueva Ecija whose only daughter took her life right after her boyfriend took his in the fashion of Shakespeare's Romeo and Juliet.

## OBJECTIVES AND METHODOLOGY OF THE STUDY

In this paper, I shall present the findings of an exploratory study I conducted among purposively selected college male and female students in late 2002. The study's objectives were to understand the views and experiences on suicide and depression of these students, and to describe the family relationships, precipitating events, and post-suicide attempt experiences of some suicide attempters among them.

Through an initial survey of 30 students, I sought to understand their adolescent views on and experiences with suicide. The survey instrument used was a self-administered questionnaire. A trained adolescent female research assistant, herself a college student at the time of the study, helped me to locate the survey respondents. The first few respondents were her friends and schoolmates who in turn referred to us their acquaintances for inclusion in the survey. This referral method was utilized to obtain most survey respondents. Using a screening question asked before administering the questionnaire, only those respondents who had once thought of suicide as a way out of a problem and/or those who had friends or neighbors aged 13–20 years with this suicide ideation, were included in the survey.

The survey respondents hailed from five colleges and universities in and near Metro Manila. Most (60%) of them were males. Their average age was 18 years old, but they belonged within the age range of 16 and 21 years old. While they represented different year levels, many (43%) were freshmen. At the time of the study, they were enrolled in various courses belonging to the fields of business and economics, liberal arts, natural sciences, engineering, and education. Slightly more than half of them were residents of Metro Manila; the rest lived in the outskirts namely Bulacan, Cavite, and Laguna.

Out of the 30 survey respondents, I selected four cases of suicide attempters to conduct an in-depth analysis of their family relationships, the events that precipitated the suicide attempt, the manner of inflicting self-harm, and the events that immediately followed the suicide attempt. Apart from having attempted a suicide, the other main selection criteria were the informants' close familiarity with my adolescent research assistant and, by association, their acceptance of me as interviewer as well as their willingness to grant informed consent for the interview.

The role played by my research assistant was very crucial in putting my informants at ease with me and my interview method. While the self-administered questionnaire had revived the informants' memories of suicide, the subsequent individual talks between them and my research assistant preparatory to the case interview allowed the emotions that came with the memories to be dealt with at the level of trust between friends. By the time I did my interview, they seemed ready to share their memories of a once traumatic event and did not appear visibly unsettled by remembrances.

I had lunch with the informants before every case interview. I found this to be a good occasion for getting to know them as persons, to allay any doubt or fear they could be harboring about the interview, to assure them of their right to privacy, confidentiality, and anonymity, to obtain their informed consent, and to surface questions they had about the purpose of my study. The interviews were leisurely afternoon chats that lasted for several hours with each informant so it helped that the informant was free from classes for the rest of the day.

## FINDINGS OF THE SURVEY

**Knowing others with suicide ideation.** It so happened that all 30 students contacted by the study were qualified to be respondents of the self-administered questionnaire survey because they possessed adolescent friends or neighbors aged 13–20 years who had thought or articulated the idea of suicide as a way out of a problem.

The respondents cited as many as five friends or neighbors who entertained suicidal thoughts or suicide ideation in medical parlance. Among the 30 respondents, 43 percent claimed they each knew three persons and a third knew only one person each with suicide ideation (Table 2). In all, the respondents knew a total of 74 friends or neighbors with suicidal thoughts. At the time the friends/neighbors harbored these thoughts, they were about 12 to 20 years old, with a median age of 17 years old. Most of them (53% of 74) were females.

However, while all 74 of them once thought of suicide, it is fortunate that only about half (49%) went ahead to attempt it and only one of the attempts was fatal (Table 1). The reasons for attempting to harm their life were varied, but the three most mentioned ones are: (1) family problems which include parental separation or extramarital affair, misunderstandings, lack of family care and attention, and family's dire financial straits; (2) love problems like experiencing a broken heart and quarrels with boy/girlfriend; and (3) personal problems such as inability to cope with problems in life, feeling unloved or unwanted, and thinking life is worthless.

**Having personal suicidal thoughts.** Among the 30 respondents, only 11 (37%) had thoughts of committing suicide and this happened when they were between 15 and 18 years old, or 16 years old on the average (Table 3).

Asked what triggered the suicidal thoughts, the most mentioned responses were: (1) the feeling that suicide was the easiest solution to end their problems or to attain peace, (2) family-related problems that included fear of the ire of displeased parents and inability to adapt to parental rules, and (3) love problems such as getting brokenhearted and difficulties in coping with a breakup.

What prevented the respondents who had suicidal thoughts from attempting to take their life? There were two most mentioned reasons, namely: (1) because they received help like advice and guidance from family members, relatives or friends, and (2) they had to talk themselves out of it and motivate themselves to go on living. One respondent said fear of God led to discounting suicide as a way out of problems; another explained that since death was not achieved with repeated attempts at suicide (*"hindi ako mamataymatay"*), it was better to start living (Table 2).

**Perceived principal causes of adolescent depression and possible assistance.** The respondents were almost unanimous (28 of 30) in the belief that depression triggers suicidal ideation and attempts in adolescents, and that the causes for their depression are varied. Out of the many causes given, the most mentioned responses could be classified into three principal types, as follows (Table 4).

**Table 2. Selected data on respondent's friends/neighbors with suicide ideation**

| Variable | (N = 30) Frequency | (%) |
|---|---|---|
| No. of friends/neighbors with suicide ideation | | |
| One | 10 | (33.3) |
| Two | 3 | (10.0) |
| Three | 13 | (43.3) |
| Four | 1 | (3.33) |
| Five | 3 | (10.0) |
| Total number of friends/neighbors | 74 | |
| Estimated age of friends/neighbors when they thought of suicide | | |
| Median age | 17 years old | |
| Age range | 12–20 years old | |
| Sex of friends/neighbors | | |
| Female | 39 | (53% of 74) |
| Male | 34 | (46) |
| Did not indicate | 1 | (1) |
| No. of friends/neighbors who attempted suicide | 36 | (49% of 74) |
| No. of successful attempts | 1 | (3% of 36) |
| Reasons for suicide attempt | | (Multiple response) |
| Family problems | | 25 |
| Love problems | | 15 |
| Personal problems | | 7 |
| School problems | | 6 |
| Peer problems | | 3 |
| No answer | | 18 |

The first principal type concerns family-related problems which include conflicts with parents or siblings, physical abuse experienced at home, and financial hardships encountered by the family. The second most mentioned type covers causes related to unsatisfactory love life, experiencing a broken heart from failed romance or unrequited love, and frequent squabbles with a sweetheart. Finally, the third principal type includes causes related to feelings of personal inadequacies, like looking ugly, feeling unloved or unwanted, self-hate, lack of motivation, or inability to cope with grief. There are other causes mentioned pertaining to different problems met in school, with interpersonal relationships, or drug use, among others.

Ninety percent of the respondents also believed that suicidal adolescents could be helped to deal with their depressive state. It is worth noting that they think this help could come first from friends or the peer group, then from the family, and finally from the school.

The ways friends could help include talking the suicidal person out of it or

**Table 3. Selected data on respondents' experience with suicide ideation**

| Variable | (N = 30) Frequency | (%) |
|---|---|---|
| Whether R ever thought of suicide | | |
| Yes (6 males; 5 females) | 11 | (37) |
| No | 19 | (63) |
| R's age at time of suicide ideation | | |
| Age range | 15–18 years old | |
| Average age | 16 years old | |
| R's reasons for suicidal thoughts | (Multiple response) | |
| Easy way out of problems | 5 | |
| Family problems | 3 | |
| Love problems | 2 | |
| School problems | 2 | |
| To know how it feels to die | 1 | |
| No. of Rs who attempted suicide | 1 (of 11) | |
| R's reasons for reconsidering life | (Multiple response) | |
| Family, relatives, friends helped | 3 | |
| Self-motivation | 3 | |
| Others: fear of God, repeated failure to kill self | 2 | |
| No answer | 3 | |

giving advice, simply being there or lending an ear, making the person feel loved, and helping the person to forget his/her problems. Among the kinds of help that the family could give to a suicidal member, the most mentioned is to show love, understanding, and support for this member. Other ways are to provide proper guidance to or inculcate proper values in the adolescent child and have open communication with this child. Lastly, the school could help address the occurrence of adolescent depression through its counseling programs (or having regular sessions with guidance counselors), school-sponsored activities that promote personality development and healthy lifestyle, coordination with parents of "bothered" youth, and helping students to deal with failing marks.

## FINDINGS OF THE CASE STUDIES

### The Case of Jelo

Jelo, now 20, is a second year male college student taking up Business Management. Born to an upper middle class family residing in Quezon City, he is the youngest of three children. His eldest sibling is a 24-year old Medical Proper student; the middle sibling is a 22-year old special child. Jelo's parents are college graduates; his father is a businessman while his mother works in the telecommunications industry.

**Table 4. Respondents' opinions about adolescent depression, suicide, and how to help**

| Variable | N = 30<br>Frequency (%) |
|---|---|
| Principal causes of adolescent depression | (Multiple response) |
| Family-related problems, domestic violence, financial hardships encountered by family | 22 |
| Unsatisfactory love life, brokenhearted, unrequited love | 16 |
| Personal inadequacies: feeling unloved, ugliness, hates self, lacks motivation, no direction, no self-confidence, lonely, cannot cope with death of loved one, personal failures | 15 |
| Failing grades, academic pressure/frustration | 12 |
| Interpersonal problems: peer discrimination/pressure, betrayal of friendship, no social life | 7 |
| Doing drugs | 3 |
| Others: early pregnancy, work frustration | 2 |
| Whether depression can trigger suicide | |
| Yes | 28 |
| No | 2 |
| Whether suicidal adolescent can be helped | |
| Yes | 27 |
| No | 3 |
| Ways the friend can help | (Multiple response) |
| Talk the friend out of it, give right advice, enlighten the friend | 13 |
| Being there for/listening to the friend | 10 |
| Make the friend feel loved and important | 5 |
| Help the friend forget his problems | 2 |
| Be a good friend | 2 |
| Ways the family can help | (Multiple response) |
| Show love, understanding and support for the child | 19 |
| Provide proper guidance/supervision and advice, Teach good values | 5 |
| Have an open communication in the family | 4 |
| Focus on solving the child's problem | 2 |
| Ways the school can help | (Multiple response) |
| Through counseling/guidance counselors | 7 |
| Through engaging school activities/programs promoting self-esteem | 5 |
| Others: teach fear of God, coordinate with parents, give flunking students a chance | 4 |

**Family relationships.** Jelo describes his childhood as "colorful." He was born, according to his father's accounts, when father and grandfather were at odds with one another but were reunited on his baptismal day. His Lolo so loved Jelo at first sight that he refused to let him go, so the baby ended up staying with him for six years. It took a simple argument between his Dad and his Lolo to break up this arrangement and to have Jelo returned immediately to his parents. Jelo remembers a life of abundance and pleasant experiences of going places with his Lolo until he was six.

Life with his parents in the next 10 years was a contrast to the one lived with Lolo. "When I got home," Jelo reminisces, "Dad's business was down and we were hard up. I was a spoiled brat, accustomed to a spoon-fed life with Lolo so I had difficulty adjusting in my parents' home." His parents asked him to bear with their hardship but he was unable to do so. Looking back, Jelo assesses: "As I grew up with my family, I became somewhat selfish. I did not want to be asked to do household chores or to be reprimanded. I became rebellious and this caused my grades in school to suffer. It was worse when Dad said—why did I ever get you back from your Lolo?!"

The father-son relationship when Jelo was between six and 16 years old was marked with some ups and many downs. Although admitting there were times he was "cool" with his Dad, Jelo described the latter as often having a superior air about him and expecting the son to do his bidding immediately. The father was perceived to be quick to display anger at Jelo's slightest or simplest mistakes; he easily distrusted Jelo, harbored ill-feelings, and often scolded the son. The father was also prone to belittle Jelo's capabilities and to crushing his self-esteem with such barbed remarks as: "Where are your brains? I do not know where your brains go!"

Jelo's relationship with his mother was better and closer. Mom was his protector, shielding him from the father's ire when he erred. Jelo could tell his Mom about failed marks or other problems and they would discuss how to break the bad news to the father or what solutions were possible to solve his problems. Jelo was also very close to his older brother with whom he shared mutual interests in sports, computers, clothes, and "gimmicks."

**Precipitating events.** Jelo's attempt at self-directed violence occurred four years ago, when he was 16 years old and in third year high school. It so happened that when he started this level in high school, his brother also began medical internship in the province and came home rarely. At home, he felt his world cave in with the frequent reprimands he got from his Dad. With his brother and best buddy away and his father breathing down his neck, Jelo became more rebellious and delinquent in his studies. He accumulated failed grades in Math and Science in the third quarter of the school term and became disinterested to continue schooling.

Having skipped classes for three days, he brooded at home, contemplated his misfortunes in life, and entertained suicidal thoughts. Asked why he had such thoughts, Jelo recalls that he very much feared his Dad's reactions to his failures

in school. He did not want to worsen the situation he was already in nor did he want to add to his parents' own problems. When the brother came home on Jelo's fourth straight day (a Saturday) at home and they talked about his failed marks, his Mom advised that they should wait till the father was cool-headed before breaking the bad news. His brother, on the other hand, unexpectedly put on a "Daddy-attitude" saying how disappointed he was and even scolding Jelo. Feeling he had lost his only buddy at home, Jelo kept to his room and sank further into depression.

That evening, he went down to get a rope to execute his suicide plan not knowing his brother was watchful. Back in the room, he tied one end of the rope on the highest window grill and the other around his neck. As he was getting strangled, his brother broke through his locked door, punched him in the face to render him limp and unresisting. Immediately informed of the suicide attempt, the parents were shocked. Jelo's brief explanation said it all: *"Ako lang kasi ang nakikita ninyo dito!"* (Because I am the only one you see around here!)

**Events after the suicide attempt.** Fortunately for Jelo, his attempt at self violence bore positive changes in their family relationships. They have agreed to be more attentive, communicative, and sensitive towards each other. Since then, Jelo's relationship with his Dad has markedly improved. The father now makes an effort to avoid throwing barbed comments at him, to listen to the son's problems before reacting, and to be generally more helpful. He has allowed Jelo more space to be himself, especially to spend unrestrained time once a week with his friends. They have agreed to a home-school-home routine from Monday to Thursday, home-school-friends' night out on Friday, rest at home on Saturday, and family day on Sunday. Jelo and his brother are back to their old camaraderie.

Today, Jelo regards the suicide attempt as the "most stupid thing" he has ever done. Although he does not talk about it to anyone, he believes in sharing the lessons he learned out of the experience with close friends. One lesson stands out: *"Di kamatayan ang sagot sa problema"* (death is not the solution to a problem). But he empathizes with a person who is driven to suicide because of unbearable pressures and lack of direction in life.

**The Twin Cases of Sally and Maya**

Sally and Maya are sisters. At present, Sally is 20 years old and Maya is 18. They represent the firstborn and the middle child, respectively, in a brood of three children born to a middle-income family. Their parents are college educated; but while the father runs a personal business, the mother has opted to be a full-time housewife. Their youngest sibling is a 15-year old only brother.

Among the three siblings, Sally is the highest achiever in school. She is now a third year Pre-Medicine student who excels in her studies and is a constant deans' lister. Compared to her only sister, Maya earns mediocre grades. In fact, on her first term as a first year college student of A.B. Psychology, she flunked Algebra.

At the time of interview, Maya was on leave-of-absence for one term from her studies as a sophomore college student because of financial difficulties.

**Family relationships.** The differential academic achievements of these two sisters reportedly affected their father's perception and treatment of his daughters. The father was more trusting of Sally who had proven her trustworthiness by producing excellent marks in school. Thus she was not strictly bound to comply with expected normative behavior. For instance, on the eve before school examination day, Sally would still be allowed to go out "gimmicking," or could get her father's permission for a night out even on short notice.

Maya, on the other hand, often got compared to Sally by their father. She noted with sadness and a little anger that he was not treating them fairly. "He was stricter with me...he did not allow me to leave the house...My behavior was always under constant scrutiny...everything I did was instantly compared to my big sister's actions especially when it came to school work!" Maya wanted her father's approval but had difficulty getting it.

Both sisters had a "good enough" relationship with their Mom, although this relationship did not appear sufficient for them to confide to her their deepest emotions and anxieties about love. Maya said she once attempted to unburden her problems with the Dad to her mother, but the latter merely advised her to "prove herself through good grades."

Despite the differences they experience in paternal treatment, the sisters enjoy a close, intimate relationship. Sally and Maya are very good friends who talk openly about their romantic life. Sally acknowledges the unequal treatment they get from their father and feels sorry for Maya.

**Precipitating events in Sally's case.** Two years ago when she was 18 years old, Sally had a boyfriend named Jun whom she loved so much, but with whom she had an on-and-off relationship. After one very big fight, they broke off. This proved to be so traumatic a breakup that agonized Sally. She could not and did not know how to stop feeling the heartaches so the idea of suicide crept into her mind. She kept the pain to herself and did not unburden it to her friends or her sister.

Past midnight of one evening, her mind muddled up by pain, Sally took a knife to the bathroom and started to slash her wrist. Feeling the strong pain of a bloody cut on her wrist, she awakened from a seemingly shocked state. Crying and bleeding, she woke up Maya who was sleeping in the bed next to hers.

Only 16 years old at that time, Maya was so aghast at what she saw but immediately took charge of the situation. She brought Sally back to the bathroom, washed and treated the wound, stemmed the blood flow as best as she could, and bandaged her sister's wrist. Throughout the process, Sally was crying due more to the physical pain so Maya lightly scolded her sister for her foolishness. Later, Maya cuddled Sally in bed as the latter poured her heartaches out. She kept close watch over her sister, fearing that the latter might be tempted to repeat the act.

**Precipitating events in Maya's case.** About a year after the suicide attempt of her older sister Sally, Maya committed the same wrist-slashing act. She was 17 years old then and a college freshman.

Maya's first year in college was memorable because she met and fell in love with Tony, another newcomer to the school. Tony was suave, dashing, and a good singer. Maya found him so endearing except for one thing—he was stingy when it came to spending for her. "Whenever I had money," explained Maya, "I would treat him and pay for our food. But not Tony! He always told me he had no money. Yet when I peeked into his wallet, I would find money there." Maya regarded this as an unfair exchange in their relationship and this became a frequent cause of disappointment and an irritant for her.

One time, Maya felt she had enough of Tony's stinginess and this brought on a "big fight over the phone over money." Maya brought up the numerous times he received free treats from her and this caused a painful exchange of words to ensue. Tony was embarrassed and mad at her accusation that he banged the phone. He also refused to pick up her subsequent calls and snubbed her attempts to talk to him. This made Maya so unhappy and depressed until finally her Mom intervened. The mother called up Tony and requested him to talk to her daughter. Tony was unable to refuse.

While talking to Tony over the phone, Maya toyed with her Swiss knife and suddenly got the idea of using it to threaten him to submission. She told him that she would use the knife to harm herself if he continued to disregard her and refused reconciliation. She began cutting her wrist when Tony continued to ignore her threat to inflict self-harm. She also described to him what she was doing. Perhaps sensing her persistence, Tony eventually asked her to stop her action and they patched up their differences. By the time she stopped, however, she had already drawn some blood from a superficial cut on her wrist. She treated her wound and later recounted the experience to Sally who was quite upset and angry at Maya's "silliness." "How can you do that when you yourself had stopped me from making the same attempt?" Sally fumed.

**Events after the sisters' separate suicide attempts.** Neither one of the sisters ever told their parents about their suicide attempts. However, their mother inquired about their bandaged wrists on separate occasions. In response, each daughter gave some flimsy excuse that prompted the mother to make an oblique reference to suicide. She also counseled her daughters not to do anything rash due to problems with their boyfriends.

Both sisters now carry the scar of their attempt at self-harm over love problems. Sally has never made up with Jun since the suicide try. Maya maintains her relationship with Tony who ignores the scar and becomes irritated whenever she brings it up. Both sisters have also learned a lesson from their shared experience on near-suicide: that suicide is a painful thing to commit against oneself. Asked whether Maya would have continued to cut herself if Tony had refused to make up with her, she

says that she would have probably stopped it once the pain became unbearable.

Although they would not wish to repeat the attempt, they nevertheless think that suicide is an option open to the young who feel they can no longer bear certain insurmountable problems. Sally and Maya tell of a common friend who had attempted to kill herself four times when she was young because of such problems. "*Hindi lang siya mamatay-matay* (she just doesn't die)." What ultimately saved this friend from self-destruction was a renewed spirituality; she has since then made her life a testimony to God's goodness.

**The Case of Mayumi**

Mayumi is a 20-year old mestiza; her mother is a Filipina while her father is Japanese. She is the eldest of three girls in the family; her other siblings are Mina and Mutya who are 17 and 15 years old, respectively. Mayumi was born and raised in the Philippines like her two sisters.

**Family relationships.** Mayumi had an unhappy family life largely because she was not in the good graces of her family, particularly her father. A domineering Japanese male, her father frequently compared her to Mina, the middle child who is the most intelligent among his daughters. Her mother tended to agree with the father in this regard. Thus Mayumi emerged as rebellious and headstrong, disappointed in her parents and always clashing with them. Her "wayward ways" also alienated her from her sisters.

In addition, Mayumi suffered from a social disorientation brought about by the frequent changes in her school milieu. Every few years, she would get transferred to a different school because of bad academic performance in the previous one. This was an aspect of her life that pushed her to start rebelling openly against her parents. "*Palipat-lipat ako kaya di ako nakaka-fit in*" (I kept on transferring so I couldn't fit in). As a new transferee in Grade 5, she recalled being teased and bullied by her classmates because she was perceived to be different. "*Mabilis nila akong nauuto kasi gustong-gusto kong maka fit-in* (They could easily con me because of my deep longing to fit in the group)." She turned out to be a delinquent student who cared less about school.

Her parents were also quick to blame her delinquency on her school friends. One friend they objected to was Lydia, another transferee Mayumi met in one high school. The parents believed Lydia was a bad influence for their daughter so the girls had to keep their friendship under wraps.

On many occasions, Mayumi faulted God for her unhappy life. She lamented about God's unfairness: "*Madaya ang Diyos kasi yung ibang tao may mga magulang na nagmamahal sa kanila tapos ako wala* (God is unfair for He gave other people loving parents but not to me)."

**Precipitating events.** Mayumi attempted to kill herself four years ago when she was 16 years old and in third year high school. "I would have done it earlier if I had the chance," she reminisced. She had a low self-esteem, no emotional outlet in the family, had few caring friends, and plenty of disgruntled feelings. She mulled

over the idea of suicide for some years before she finally tried it.

There did not seem to be a single precipitating event that triggered the suicide attempt. But Mayumi's access to sleeping pills without her parents' knowledge and the keys of her uncle's unoccupied house had helped to push her plan. She had her uncle's permission to use his house anytime she wanted to "retreat" from her difficult home life.

Mayumi had been feeling depressed for quite a while and could not sleep so she was taking some sleeping pills for her insomnia. For undisclosed reasons, she was able to buy the pills by the bottle from a local drugstore without a doctor's prescription. One August afternoon, her depression deepening, she recalled having just snapped and wanting to get out of this world and her problems. Bringing with her a recently-purchased bottle of sleeping pills, she went to her uncle's house. Normally, upon entering she would immediately switch on the radio. But this time, she headed straight for the bedroom and took as many pills as she could before passing out.

A little while later, her friend Lydia came by. Lydia was the only one who knew that Mayumi was going to be sleeping at her uncle's house that evening. She immediately became suspicious and worried when she came upon a quiet house. After finding Mayumi in the bedroom beside an almost empty bottle of sleeping pills, she phoned a nearby hospital to seek help. Mayumi was taken unconscious to the hospital in an ambulance but Lydia, trusting that she was in good hands, did not accompany her. Lydia was afraid of a possible confrontation with Mayumi's parents who disliked her association with their daughter.

"*Tanga ka na nga, nagpakatanga-tanga ka pa* (You are already stupid, but you made yourself more stupid)," were the derisive words Mayumi heard from her angry parents after she gained consciousness. Thus she resolved that the only way to live was to leave her family and home.

**Events after the suicide attempt.** Mayumi's attempt at self-directed violence did not improve her relationships in the family. She spoke of the experience with a few intimate buddies and relatives, and derived some therapeutic effect from the discussions. The sessions with her friends strengthened her resolve to leave their house right after high school graduation.

Since departing from home, Mayumi has taken odd jobs to enable her to live on her own. She has recently resumed her studies by taking some evening courses in college. Looking back, she believes the experience had awakened her to the realization that she needed to love herself in the absence of parental love. She feels better and happier living alone.

## SUMMARY AND IMPLICATIONS OF FINDINGS

My study is unlike the researches consulted on Philippine youth suicide, owing to its emphasis on adolescents' perceptions and experiences concerning suicide and depression. While other researchers gleaned information from suicide deaths and survivors among young people, I sought data from ordinary

college students in the city whose thoughts and experiences about suicide and depression revealed several major insights. Mostly borne by other research findings, these insights and their implications are as follows.

**Some demographics of adolescent suicide attempts.** Survey data show that a greater proportion of teenagers entertain suicidal ideation, but the majority does not act on it. In this study, the absolute numbers that attempt self-harm are indeed in the minority. Only one (or one-tenth) of the 11 respondents who claimed to have suicidal thoughts eventually tried to commit suicide and survived. Of the 74 people that all 30 respondents knew to have harbored suicidal thoughts, 36 (49%) made an attempt with one fatality. However, seen against population-based figures (per 100,000), the statistics for both attempts and death may be considered high even if they represent the minority. The data also indicate that young people in their mid-teens (16-17 years old), particularly the girls, are at risk for suicide. This is a finding common to other studies.

**Suicide as a consequence of depression.** There is little doubt in the minds of respondents that depression precedes suicidal ideation and attempts in adolescents. The four identified principal causes of adolescent depression are:

1. Family-related problems including domestic violence, financial hardship, parental separation or extramarital affair, misunderstandings, alienation from family love, care, and attention, inability to adapt to strict parental rules, and fear of incurring parental ire.
2. Romantic heart problems including brokenheartedness, unsatisfactory love life, quarrel with sweetheart, unrequited love, and difficulty in coping with a break up.
3. Feelings of personal inadequacies due to being unloved, unwanted, ugliness, self-hatred, lack of motivation, direction, or self-confidence, loneliness, and other personal failings.
4. Academic troubles like failing grades, school pressures and frustrations.

The other causes of depression are interpersonal problems (caused by peer pressure and discrimination, betrayal of friendship, and social isolation), drug dependence, early pregnancy, and work frustration.

The sources of all these reasons for the teenagers' depressive state are their significant social milieus: family, peers, and school. As shown in the case studies, depression is induced by the presence of long-standing problems between the adolescent and any one or more of these social milieus. It is marked by the adolescent's progressive inability to cope with deep-seated feelings of personal inadequacies that make life seemingly difficult and worthless.

Interestingly, the study's adolescent subjects see that the solution to their depression lies in the very sources of this depression. They think the family can dispel this mental state mainly by showing love, understanding and support for children; the friends can be valuable for

their advice, encouragement, and steadfastness; whereas the school can help through its counseling programs and activities promoting self-esteem.

None of the adolescents in the study has connected depression with mental or psychological disorder. This is probably reflective of the way their family and most of the Filipino society view depression—as a state people normally experience when facing problems, hence needing no serious medical intervention. This markedly contrasts with many findings linking suicidal episodes to depressive disorders that, when spotted and treated in time, may save the lives of our young. It is thus important to begin recognizing that depression is a medical problem and that even children can be ill with it. It is likewise important to educate the general public especially parents, child caregivers, and school authorities, to identify the disabling signs and consequences of depression in the young and to know how and where to seek the necessary help.

**Roles of socialization agents in molding child resiliency.** The study points to domestic trouble or problem within the family as not only the main depressant in an adolescent's life, but also the primary precipitating factor of adolescent suicidal ideation and/or attempt. A bad academic performance may be a strong indicator of domestic problem. Two of the four cases had linked attempted suicide to pressures from one or both demanding parents and breakdown of communication between parents and child, and the school grades suffered in both cases. This is an oft-repeated finding in practically all youth suicide researches which should have provided enough evidence to underscore how closely interlinked the children's lifelines and will to live are with their family.

Other insights from the cases show that suicidal adolescents do not have to come from objectively dysfunctional families, where parents have separated or one parent has abandoned the family. They may belong to "whole" families, but their perception of family ties as dysfunctional can push them to make an attempt on their life. The case of the two sisters who tried wrist-slashing because of romantic troubles echoes so many similar cases in the literature. One of them did it only to bring her boyfriend around to patch up with her.

These cases raise several questions. Of what value is one's life to an adolescent? How big or small should a problem be for a teenager to sink in depression and readily trade his/her life for a way out? What implications do these issues have on the ways major socialization agents like the family and the school develop the personality, character, and emotions of children today? To design suicide prevention measures for our adolescents, it appears imperative to know how effectively these social institutions are able to prepare children for the intensifying pressures and heartbreaks that are likely to escalate as they grow older, or for the impersonality of the world outside their family and peers. Nevertheless, findings suggest that a healthy family life with parents or elders attentive to children's

personal and social needs is still the best preventive action for suicide among our young.

**Suggested research agenda.** To address the increasing incidence of self-directed violence among our young people, we have to engage in the following studies:

- Documentation of changing statistics and trends on suicidal ideation, attempts, and completion across gender, age, and geographic categories.
- Investigations involving larger samples to ensure that the findings can be generalized to a broader population.
- Studies that draw from a holistic perspective, which treat suicide as an interplay of different personal/psychological, social, economic, and geographical factors.
- Researches that challenge existing western assumptions about youth suicide (e.g., linking it to substance abuse) and that ask bolder research questions like, "Are suicidal thoughts becoming a regular part of growing up in a modernizing society and a globalizing world?"

## CONCLUSION

The kind of world in which our children find themselves today places them at a most vulnerable position as they comprise a sector that is least able to modify what they deem undesirable in their life. As more societies like the Philippines embrace the complexities and accompanying turmoil of a modernizing and globalizing world, the statistics on self-directed violence among them are likely to continue increasing and may show no let up. Many studies have indicated that suicide is evidently a growing response of the young to the social consequences of a fast-changing environment. Having little or no control over these consequences, they may get pushed to the edge where death becomes the solution to all of life's problems.

To view suicide among the young and old alike as a mental or public health phenomenon may unwittingly place the burden of addressing this problem on the health professionals when in fact the challenge, as studies have revealed, should be confronted by us all. The challenge for many of us, especially to major socialization agents like the family, the peers, and the school, is how to provide them with a viable option to suicide—that is, the option to live and possibly attain a ful-filling life. According to the young, many times all it takes is to be more sensitive to the intangible need of people for caring relationships as a buffer against an impersonal world.

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