Indonesian Journal of Global Health Research
Volume 4 Number 2, May 2022
e-ISSN 2715-1972; p-ISSN 2714-9749
http://jurnal.globalhealthsciencegroup.com/index.php/IJGHR

PERCEPTIONS OF EARLY ADOLESCENTS, PARENTS, TEACHERS, AND HEALTH WORKERS ABOUT SUICIDE IN EARLY ADOLESCENTS

Atih Rahayuningsih[1]*, Achir Yani Syuhaemi Hamid[2], Budi Anna Keliat[2], Raden Irawati Ismail[3]
[1]Faculty of Nursing, Universitas Andalas, Limau Manis, Kec. Pauh, Kota Padang, Sumatera Barat 25175, Indonesia
[2]Faculty of Nursing Science, Universitas Indonesia, Jl. Prof. DR. Sudjono D. Pusponegoro, Kukusan, Kecamatan Beji, Kota Depok, Jawa Barat 16425, Indonesia
[3]Faculty of Medicine, Universitas Indonesia, Jl. Salemba Raya No.6, RW.5, Kenari, Kec. Senen, Kota Jakarta Pusat, Daerah Khusus Ibukota Jakarta 10430, Indonesia
*atihrahayuningsih@gmail.com

ABSTRACT
Suicide is a global problem. Every country has almost the same problems related to suicide, namely related to the statistical suicide rate which tends to increase, the increase in suicide as a cause of death, and the tendency to incidence of suicide at a younger age. This study purposes to explore the perceptions of early adolescents, parents, teachers, and health workers about suicide in early adolescents. The research method uses descriptive qualitative. The study obtained data from twenty-three participants. Determining participants by purposive sampling. Research sites for several junior high schools in Jakarta. Analyzing the interview transcript data using the Colaizzi method. Producing six themes covering perceptions of suicide risk, perceptions of causes of suicide risk, primary responses to stressors that cause suicide risk, assessment of coping sources in facing suicide risk, risk of suicide as a destructive coping mechanism, and strategies to prevent suicide risk in adolescents. early. The results of the study were recommended as variables in building a suicide prevention model in early adolescents.

Keywords: early adolescence; perception; suicide

First Received	Revised	Accepted
28 March 2022	12 April 2022	20 May 2022
Final Proof Received		**Published**
25 May 2022		30 May 2022

How to cite (in APA style)
Rahayuningsih, A., Hamid, A., Keliat, B., & Ismail, R. (2022). Perceptions of Early Adolescents, Parents, Teachers, and Health Workers about Suicide in Early Adolescents. *Indonesian Journal of Global Health Research*, *4*(2), 295-302. https://doi.org/10.37287/ijghr.v4i2.1007

INTRODUCTION

Suicide is a global problem. Every country has almost the same problems related to suicide, namely related to the statistical suicide rate which tends to increase, the increase in suicide as a cause of death, and the tendency to incidence of suicide at a younger age. Data in the United States of America's adolescent suicide from 1950 to 1990 increased by 300% (Holliday, 2012). Other data revealed that suicide among teenagers in the United States has increased in number, especially teenage girls aged ten to fourteen years, with the highest increase from 0.5 to 1.7 per 100,000 population (Curtin, 2016). The results of Brett's research from McGill University in Canada showed an increase in the number of emergency room patients diagnosed with suicide from 580 thousand in 2007 to 1.1 million in 2015 and 43% of the cases were aged five to ten years. Japanese Government data (2016) also shows that suicide among students is common, between 1972 and 2013 there were 18,048 people under the age of eighteen who committed suicide. The teen suicide rate may not be significantly higher than the suicide rate in older age groups, but suicide is the leading cause of death among younger ages in Australia (Cleary, et al, 2019). The immediate effect of suicide is death. The average

death rate from suicide was 1.4 per 100,000 population (WHO, 2018). Suicide is the second leading cause of death in the 10 to 14 year age group in the United States with 517 cases (CDC, 2017). The incidence rate is worrying due to the tendency for suicide to recur at an older age.

The suicide rate in Indonesia is 3.4 per 100,000 population, ranking 158 in the world suicide rate ranking (WHO, 2018). Data from the Central Statistics Agency (BPS) in 2015 recorded that there were 812 suicides throughout Indonesia. A mid-2012 report by the National Commission for the Protection of Indonesian Children found data on twenty suicides in children with the youngest age of thirteen years (Nasional Geograpi Indonesia, 2015). The results of a survey conducted by the Health Research and Development Agency of the Ministry of Health of 10,000 students sampled from all provinces in Indonesia showed that 650 (6.5%) junior high school (SMP) and senior high school (SMA) students had suicidal thoughts (Balitbangkes Ministry of Health, 2015).

Daerah Khusus Ibukota Jakarta as a metropolitan city ranks sixth in the number of suicides, namely 31 cases. A survey in Jakarta related to adolescent suicide, among others, by the Global School-Based Student Health Survey (GSHS) and the Ministry of Health in 2015 which was conducted on 10,837 respondents at junior and senior high school levels showed that 5.2% of respondents had suicidal ideation, 5,5 % had planned suicide, and 3.9% had attempted suicide. The purpose of this study was to determine the perception of early adolescents, parents, teachers, and health workers about suicide in early adolescents.

METHOD

Researchers in exploring the perceptions and experiences of early adolescents, families, teachers, and health care workers about suicide in early adolescents used a descriptive qualitative research design. Qualitative descriptive research is conducted in an intuitive, analytic, and explorative manner. Before the interview began, participants signed a consent form to participate in the study. Research sites for several junior high schools in Jakarta. Retrieval of data through in-depth interviews. Research time from May to July 2020. The number of participants was twenty three people. Determination of the participants involved by means of purposive sampling. Data processing obtained in a qualitative narrative. The data analysis process was carried out simultaneously with the data collection process using the Colaizzi method. This research has passed the ethical test of the Ethics Committee of the Faculty of Nursing, University of Indonesia and the Ethics Committee of the Soeharto Heerdjan Mental Hospital.

RESULTS

The research resulted in six themes covering perceptions of suicide risk, perceptions of causes of suicide risk, primary responses to stressors that cause suicide risk, assessment of coping sources facing suicide risk, suicide risk as a destructive coping mechanism, and strategies to prevent suicide risk in early teens. Themes are formed by categories. This study identified twenty-nine categories based on the key words expressed by the participants.

The theme of the perception of suicide risk identified in this study is based on four categories, namely the risk of suicide similar to the method of suicide, unconscious suicide ideation, risk of suicide in early adolescents, and negative family perceptions. Participants' phrases as key words included hanging themselves, cutting their wrists, wanting to die, feeling better about dying but not thinking about committing suicide, not knowing that there are stages of suicide,

early adolescents might commit suicide, there is wrist slitting, keep the act of suicide a secret so as not to be embarrassed, will hit a child if he says he is going to kill himself.

The theme of the perception of the causes of suicide risk is composed of two sub-themes, namely internal factors and external factors. Internal factors that cause suicide risk are supported by three categories, namely inability to solve problems, early adolescent personality, lack of religious education. External factors causing risk of suicide consist of the category of challenge, victims of bullying, the influence of a consumptive lifestyle. Key word phrases include depression, broken home, having problems with parents, friends, or boyfriends, unstable, often joining in, easily frustrated, afraid of bad grades, loss of faith, lack of character, joining internet challenges, often being ridiculed friends, scolded by parents, and ignored.

The theme of the primary response to stressors causing risk of suicide is supported by five categories, namely cognitive, affective, physiological, behavioral, and social responses. Key word phrases include thinking that it's better to die, can't focus or have trouble thinking differently, feeling scared, feeling helpless, complaining of pain in the stomach, often feeling dizzy, having trouble sleeping, having trouble getting up in the morning, acting suspicious, locking your wrists, drinking insect poison, trance, stay quiet when bullied, watch if anyone responds to social media status, feel alone in a crowd, and withdraw.

The theme of assessing the source of coping is facing the risk of suicide based on the categories of personal abilities, social support, lack of resources, lack of positive belief to get help, and support system responses. Key word phrases include confusion, frustration, feeling that no one can understand, thinking that there is no help, limited economic ability of parents, thinking how hard life is, fear of being scolded, don't dare to tell stories, never asked, want to help, don't know teenagers have thoughts want to kill theyself.

The theme of suicide risk as a destructive coping mechanism based on the category of suicide is considered as a way out of the problem and consideration of the influence of religion. Keyword phrases include annoyance, not being noticed, not knowing how to solve problems, fear of sin, religiously forbidden suicide, wanting to die or not being in the world but not wanting to commit suicide.

The theme of strategies for preventing suicide risk in early adolescents consists of three sub-themes, namely optimizing early adolescent support systems, increasing resilience and self-efficacy of early adolescents, and facilities that help prevent the risk of suicide in early adolescents. The first sub-theme was arranged according to the categories of increasing awareness, increasing open communication, increasing support, and increasing the family's ability to prevent the risk of suicide. Key word statements, among others, must be loved by the child, the child should not be ignored, hug the child if there is a problem, the family must care more, take time to chat, ask questions, help solve problems, provide religious understanding, follow up on the results of the SRQ examination, the family knows problems, making decisions, caring for family members, modifying the environment, utilizing health facilities.

The second sub-theme was formed from the categories of knowledge and skills to prevent the risk of suicide, as well as positive beliefs in the ability to prevent the risk of suicide. Key word statements include stages of suicide risk, signs and symptoms of suicide risk, increasing self-esteem, solving problems correctly, fighting thoughts of dying, and hope for the future.

The third sub-theme comes from the category of suicide risk prevention applications. Keyword statements include do not know, are willing to use if any, if there is something good, there is also need for such an application, the teacher must be notified.

DISCUSSION

First theme: Perceptions of suicide risk

The category of suicide risk is the same as that of suicide based on the majority of participants perceive the notion of suicide risk as a means or action to end life. Participants could not further describe the definition of suicide because what is understood about suicide is the methods used by individuals to end their life such as hanging themselves, drinking insect poison, cutting wrists, and jumping from tall buildings or bridges. Muhibin (2002) explains that a concept is formed because of a number of stimuli that demand a response, if done repeatedly it will form an attitude and behavior. The participants' knowledge about the risk of suicide is limited because the information obtained is only how the suicide was committed.

The category of unconscious suicide ideas is formed from data that originates from adolescent participants. Beck's hopelessness theory can explain how participants who consciously answered never wanted to commit suicide but actually thought that death could be a way out of the problem at hand. Hopelessness theory has a major contribution as a predictor of suicidal behavior. Individuals with hopelessness are 1.3 times more important to explain suicidal ideation than individuals who are depressed (Holliday, 2012). Research Results De Leo, et al. (2005), provide an overview of two possible plans for the development of suicidal thoughts and suicidal behavior over time. A total of 300 participants in only 20% of the suicide plans and attempted suicide reported that the progression of the suicide process increased in severity over a longer period of time. In contrast, 57.1% of participants stated that the suicide process was not continuous, but fluctuated irregularly before a suicide attempt or eventual suicide attempt. Only 0.8% of suicides who attempted suicide reported no previous suicidal ideation or suicide plans.

Both theory and reality explain that suicidal risk behavior is possible in early adolescence. This study also describes that early adolescents also have a risk of suicide, although the identification of suicide rates is higher in late adolescence (Sari et al, 2018). Erickson's theory of development reveals that teenage suicidal ideation begins during the "industrial vs. inferiority" phase and continues through the "intimacy vs isolation" phase. Early and late teens are shaping “identity vs role confusion” where the focus is “who am I?” and how people judge their appearance. The crisis during this period triggers suicidal ideation and makes it difficult to transition to unusual problems and is not a later stage of development (Holliday, 2012).

Most of the participants had a perception that the risk of suicide was within the scope of their family, as God forbid it seemed my child would not do that. The category of negative family perceptions about suicide supported by statements would keep the act of suicide secret so as not to be embarrassed, would hit the child if he said he was going to kill himself, made the family not open to discussing the risk of suicide as a health problem that might occur in family members. This is in line with Nova's (2017) study which revealed that families feel embarrassed when others find out that their family members have attempted suicide. Families tend to shut down and are reluctant to seek help. Other studies have shown that closing oneself is a response to stigma (Azizah, Daulima, Putri, 2015). Research by Mclaughlin et al., (2014) explained that most participants felt ashamed with neighbors, friends and extended family about what was on their mind regarding family members who had attempted suicide.

Other studies that support these results also reveal that families feel uncomfortable sharing stories with others because they feel ashamed and believe that suicide attempts only occur in sick families. The family accepts moral stigma from the behavior of family members that endangers themselves, especially the moral stigma felt by parents of children who have attempted suicide (Buus et al., 2013).

Second theme: Perceptions of causes for suicide risk

The causes of specific suicide risk in the adolescent population according to Stuart (2013, Keliat, Pasaribu, 2016) consist of risk factors related to psychological factors, family and genetic factors, environmental factors, biological factors, previous suicidal behavior factors, and sexual orientation factors. . In addition to these factors, several demographic factors are identified related to suicidal behavior, clinical factors, and social factors (Rager, Lepczynska, Sibilski, 2015) and spiritual (Lasrado et al, 2016). The results of the study identified the causes of suicide risk, including depression, broken home, having problems with parents, friends, or boyfriends, unstable, often joining in, easily frustrated, afraid of bad grades, loss of faith, lack of character, taking part in challenges. the internet, often teased by friends, scolded by parents, and ignored. Family and genetic factors are associated with a family history of committing suicide, parents who experience depression and the presence of family conflict or dysfunction (Suart, 2013, Keliat, Pasaribu, 2016). This is in line with research by Keliat et al., (2015) which revealed that 70% of junior high school students in Depok experience depression. Depression is a major risk factor for adolescents to commit suicide. Unlike in adulthood, depression in adolescents is more related to psychological problems.

Most of the study participants were female, so the risk of suicide was also greater. This is in line with the results of studies which reveal that female gender and reaching puberty increases adolescents' risk of suicide attempts and the risk of becoming depressed (Burt and Stein, 2002; Crowe et al., 2006; Holliday, 2012). Although there are many studies on risk factors, not all suicides can be linearly linked, many factors influence it.

Third theme: Primary responses to stressors causing risk of suicide

Assessment of stressors involves determining the meaning and understanding of the impact of a stressful situation (Stuart, 2013, Keliat, Pasaribu, 2016). The primary response expressed is thinking that it is better if you die, can't focus or have difficulty thinking otherwise, feel afraid, feel helpless, complain of pain in the stomach, often feel dizzy, have trouble sleeping, have trouble waking up in the morning, act suspicious, lock your wrists, drink poison insects, trance, stay quiet when bullied, watch if anyone responds to social media status, feel alone in a crowd, and withdraw. Phrases describing the need for action in dealing with suicidal risk behavior develop into successful suicidal actions.

Fourth theme: Assessment of sources of coping with risk of suicide

The source of coping is a protective factor. Coping sources are options or strategies that can help determine the actions taken and the risks of the decisions chosen. Coping sources can be reinforcement and help make effective decisions (Stuart, 2013, Keliat, Pasaribu, 2016). Expressions of confusion, frustration, feeling that no one can understand, thinking that there is no help, limited economic ability of parents, thinking how difficult life is, fear of being scolded, do not dare to tell stories, never asked, want to help, and do not know teenagers have thoughts of wanting to kill self indicates the need for action for education. The available coping resources have not been fully utilized.

Fifth theme: risk of suicide as a destructive coping mechanism

Suicide is not the end. Suicide is a call for help that must be responded to immediately (Stuart, 2013, Keliat, Pasaribu, 2016). Strong and negative environmental stressors will affect the ability of adolescents to avoid suicidal coping mechanisms. This explains how the risk of suicide can occur because of being upset, not knowing how to solve the problem.

Sixth theme: Strategies to prevent the risk of suicide in early adolescents.

Participants with a health education background provided a lot of input on the theme of strategies for preventing suicide risk. Health workers play a major role in the prevention, education and assessment of suicide (Aflaque and Ferszt, 2010, Stuart, 2013, Keliat, Pasaribu, 2016). Stuart (2013) concluded that suicide prevention strategies include control and reduction of lethal weapons, limiting the sale and availability of alcohol and drugs, increasing awareness of depression and suicide, lack of attention and strengthening suicidal behavior in the media, establishment of crisis intervention clinics. community based, campaigns to reduce stigma, and increase insurance benefits. The results provide an overview of prevention strategies, including optimizing early adolescent support systems, improving early adolescent resilience and self-efficacy, and facilities that help prevent the risk of suicide in early adolescents.

CONCLUSION

The study resulted in six themes covering perceptions of suicide risk, perceptions of causes of suicide risk, primary responses to stressors that cause suicide risk, assessment of coping sources facing suicide risk, suicide risk as a destructive coping mechanism, and strategies to prevent suicide risk in early teens.

REFERENCES

Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan Republik Indonesia. (2015). Survey Perilaku dan Persoalan yang Dihadapi Anak di Sekolah. http://dinkes.bulelengkab.go.id/artikel/pertemuan-evaluasi-uks-terungkap-650-siswa-punya-keinginan-bunuh-diri-69 diperoleh tanggal 5 April 2017

Badan Pusat Statistik. (2016). Jumlah Kasus Bunuh Diri menurut Provinsi 2015. https://databoks.katadata.co.id/datapublish/2016/12/22/jawa-tengah-provinsi-dengan-kasus-bunuh-diri-terbanyak-di-indonesia diperoleh 24 Nopember 2019

Centers for Diseases Control. (2017). *Suicide*. https://www.nimh.nih.gov/health/statistics/suicide.shtml diperoleh 24 Nopember 2019

Cleary M, Visenton DC, Neil A.L., West S, Kornhaber R, Large M. (2019). *Complexity of Youth Suicide and Implication for Health Services.* J Adv Nurs. 2019;75:2056-2058. https://doi.org/10.1111/jan.14095 diperoleh 6 September 2019

Curtin. (2016). *Suicide Rates Climb In U.S., Especially Among Adolescent Girls* https://www.npr.org/sections/health-shots/2016/04/22/474888854/suicide-rates-climb-in-u-s-especially-among-adolescent-girls diperoleh 22 April 2016

De Leo et al. (2005). *Lifetime Risk of Suicide Ideation and Attemps in An Australian Community : Prevalence, Suicidal Process, and Help-Seeking Behavior.* Journal of Affective Disorders vol.86 issues2-3 June 2005 215-224 http://doi.org/10.1016/j.jad.205.02.001 diperoleh 23 April 2016

Holliday C.E.B. (2012). *Teen Suicide : Experiences in the Emergency Department Following a Suicide Attempt.* Washington State University

Institute for Health Metrics. (2017). Tingkat Kematian Bunuh Diri Berdasarkan Umur di Indonesia 2007-2017. https://databoks.katadata.co.id/datapublish/2019/09/11/berapa-angka-bunuh-diri-di-indonesia diperoleh 24 Nopember 2019

Keliat et al, 2015, *The influence of the training of coping skills for stress on self-control and intensity of depression among adolescents with suicide risk,* https://www.sciencepubco.com/index.php/IJANS/article/view/4928/1975 : tanggal 30 Juni 2017

Kementerian Kesehatan Jepang. (2016). Jepang Catat Rekor Bunuh Diri Tertinggi di Dunia, Simak Datanya. http://internasional.kompas.com/read/2017/03/24/08332631/jepang.catat.rekor.bunuh.diri.tertinggi.di.dunia.simak.datanya. diperoleh 24 Maret 2017

Lasrado, R.A., Chantler, K., Jasani, R., Young, A. (2016). *Structuring Roles and Gender Identities within Families Explaining Suicidal Behavior in South India*. The Journal of Crisis Intervention and Suicide Prevention. 37(3) 205-211 http://doi.org/10.1027/0227.5910/a000379 diperoleh tanggal 24 Maret 2017

Stuart. (2013). *Principles and Practice of Psychiatric Nursing*. (10th ed). St. Louise : Mosby-Elsevier. Keliat, Pasaribu. (2016). Prinsip dan Praktik Keperawatan Kesehatan Jiwa Stuart. Singapura : Elsevier

Suicide Prevention Resource Center, Rodgers. (2011). Understanding risk and protective factors for suicide : A primer for preventing suicide. Newton, MA : Education Development Center, Inc.

Suicide Prevention Resource Center. (2017). *Suicide among Children and Early Adolescents*. https://www.sprc.org/news/suicide-among-children-early-adolescents diperoleh 24 Nopember 2017

WHO. (2018). *Suicide Rates 2018*. http://worldpopulationreview.com>countries>suicide-rate-by-country diperoleh 24 November 2019