

Suicide Among Young People: Risk Signs and Principles of Assistance

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Received date: February 02, 2026: Accepted date: February 12, 2026: Published date: February 23, 2026

Citation: Bon E. I, Maksimovich N.Ye, Sitsko A, Malenouskaya M, (2026), Suicide Among Young People: Risk Signs and Principles of Assistance, *Journal of Clinical Otorhinolaryngology*, 8(1); DOI:10.31579/2692-9562/155

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Abstract

Suicide represents one of the most significant and tragic problems in modern healthcare. According to WHO data, approximately 720,000 people die by suicide annually, with young people aged 15–29 being at particular risk. Each such case is not merely a statistic but a profound personal tragedy, a heavy loss for loved ones, and evidence of psychological suffering that was not identified in time [1].

The student environment, unfortunately, often becomes a backdrop for the development of suicidal thoughts and behavior. During this period, young people face a complex of stressors: high academic workload, social competition, re-evaluation of life goals, and sometimes separation from their usual support system [2, 3]. All of this can exacerbate emotional instability and contribute to the development of depression, which is one of the key factors in suicide risk

Keywords: suicide; youth suicide; risk factors; warning signs; depression; psychological aid; crisis intervention; students; mental health

Introduction

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The student environment, unfortunately, often becomes a backdrop for the development of suicidal thoughts and behavior. During this period, young people face a complex of stressors: high academic workload, social competition, re-evaluation of life goals, and sometimes separation from their usual support system [2, 3]. All of this can exacerbate emotional instability and contribute to the development of depression, which is one of the key factors in suicide risk [4].

The paradox lies in the fact that most people in a pre-suicidal state, in one way or another, signal their distress—through changes in behavior, emotional state, or direct statements [5].

However, those around them are not always able to recognize these signals in a timely manner or do not know how to respond to them appropriately. This is hindered not only by a lack of knowledge but also by entrenched myths, the stigma surrounding mental disorders, and the fear of making a mistake.

The purpose of this article is to systematize the signs of suicide risk among youth and describe the principles of first aid in such situations. For future healthcare workers, it is important to learn not only to see these signs but also to competently build communication with a person in crisis. It is

attentiveness, psychological literacy, and a willingness to help that can become decisive factors in redirecting a person from thoughts of suicide to seeking professional support [6, 7].

It is asserted that suicide is, in most cases, a preventable tragedy, and the common goal of the medical community is to implement all possible measures for its prevention, especially among young people.

Main Body

A key aspect of preventing suicidal behavior among young people is the timely recognition of signs of increased risk, which represents a complex diagnostic and communicative task. In clinical practice and everyday observation, special attention should be paid to any unexpected or dramatic changes in behavior that may serve as external indicators of deep internal distress. These include: loss of interest in usual activities, sudden decline in academic performance, unusual reduction in activity, inability to exert volitional effort, poor behavior at school, unexplained or frequent disappearances from home and truancy, increased consumption of tobacco, alcohol, or drugs, incidents involving law enforcement, and participation in riots [8, 9].

The appearance of such phenomena necessitates a thorough assessment of mental state, within which the possibility of developing depression must be considered. Symptoms of depression in young people often extend beyond classical frameworks and may manifest not only as sad mood, feelings of boredom and fatigue, and sleep disturbances, but also as somatic complaints without organic cause, psychomotor agitation, reduced concentration, as well as behavioral disorders—aggression, disobedience, withdrawal, and alcohol or drug abuse [10, 11]. The presence of these signs indicates a high

level of psychological distress and is a direct indication for referral to a specialist—a clinical psychologist or psychiatrist.

Assessing the level of suicide risk requires a comprehensive approach. One of the most significant risk factors is a history of suicide attempts. In stressful situations, young people are prone to resort to such actions again [12].

The second most significant serious risk factor is depression. Of course, a diagnosis of depression should be made by a physician specializing in psychiatry, but teachers, supervisors, educators, and other staff in educational institutions should be aware of the diverse symptoms of depression. In a normal state, manifestations such as reduced self-esteem, despondency, attention deficits, increased fatigue, and sleep disturbances are often observed. Similar symptoms are characteristic of depression, but they are not a cause for concern if they do not increase in severity and are short-lived. Depressive thoughts can occur in healthy young people; they reflect the normal process of development, especially if a young man or woman is engaged in solving existential questions. It is the intensity, depth, and duration of suicidal thoughts, the context in which they arise, and the inability to distract the young person from these thoughts that distinguish a young person in a state of suicidal crisis from a healthy peer [13, 14].

Another serious task is identifying the aforementioned external situations and negative life events that activate suicidal thoughts and increase the risk of suicide [15].

The effectiveness of early intervention directly depends on competence in establishing communicative contact and the ability to overcome common but dangerous myths. It is important to refute the key misconception that discussing suicidal thoughts can induce them [16].

Research data indicate the opposite: empathetic, non-judgmental discussion of these experiences reduces the level of emotional tension and gives a person a sense of relief, becoming the first step toward safety. Avoiding this topic, on the contrary, increases isolation and feelings of hopelessness. This principle is fundamental for first aid. Following risk assessment, the transition to the phase of direct assistance becomes critical, built on two fundamental principles: maintaining self-esteem and skillfully establishing communication. Positive self-esteem is a key psychological resource that protects young people from despondency and increases resilience to stress. Work on strengthening it includes several practical directions: it is important to systematically emphasize a person's real successes and achievements, even minor ones, recalling past victories to foster a sense of competence; it is necessary to avoid destructive pressure and excessive demands for constant perfection, which deplete emotional reserves; and it is essential to encourage activity in areas that promote personal development and independence—sports, building healthy peer relationships, forming meaningful life goals [17].

Tactful support in these endeavors creates a foundation for overcoming the crisis. However, the central and most pressing problem for a young person at suicide risk or after an attempt is an acute breakdown in communication—the inability to discuss their pain. Therefore, the first and most important step in preventing tragedy is establishing trusting contact, breaking the barrier of silence. It is extremely important to dispel the main myth that paralyzes help: the fear of provoking suicide by talking about it directly has no evidential basis. On the contrary, open, empathetic discussion of suicidal thoughts gives a person relief, reduces the feeling of isolation, and forms a bridge to obtaining help [5, 18]. At the same time, one should remember the increased sensitivity of a person in crisis not only to the content of words but also to nonverbal components of communication—intonation, facial expressions, open posture, "body language"—which often convey sincere care more convincingly than any rehearsed phrases.

Recommendations for Assisting Persons with Suicidal Tendencies:

1. You must remain yourself. Anything else is perceived as deception, even if unintentional, sounds false, and is not sincere for you or your interlocutor.

2. Your task is to establish a trusting relationship with the person so that they can tell you the truth about what is on their mind. They need to feel equal to you, as with a friend.

3. What exactly you say (or do not say) is not so important. What matters is HOW you say it. If you cannot find the right words but feel genuine concern, your voice and intonation will convey it.

4. Deal with the person, not the "Problem." Speak as an equal, not as a superior. If you try to act as a teacher or expert, or attempt to solve problems in a straightforward manner, it may push the person away.

5. Focus your attention. Listen for feelings, not just facts, and for what is left unsaid, along with what is said. Allow the person to pour out their soul without interruption.

6. Do not think you have to say something every time there is a pause. Silence gives each of you time to think.

7. Show genuine involvement and interest; do not conduct a cross-examination. Simple, direct questions ("What happened?", "What's going on?") will be less threatening to the interlocutor than complex, "investigative" questions.

8. Steer the conversation toward the emotional pain, not away from it.

9. Try to see and feel the situation through your interlocutor's eyes. Be on their side; do not take the side of people who may be hurting them or whom they may be hurting.

10. Give the person the opportunity to find their own answers, even if you think you know the obvious solution or way out.

11. In many cases, there simply is no solution, and your role is to provide friendly support, listen, and be with the person who is suffering. Providing time, attention, and care may seem insufficient. People in a state of grief, in a situation that seems hopeless, can make you feel helpless and foolish. Fortunately, you do not necessarily have to come up with a specific solution, immediately change a life, or even save it. Your interlocutor will save themselves and change their own life. Trust them.

12. And finally. When you don't know what to say, say nothing. But be present!

Unfortunately, public knowledge about suicide is insufficient. The minds of many people are filled with prejudices about suicide, which hinder positive action when identifying suicidal behavior and prevent taking necessary measures regarding a suicidal person [19]. Below are the most common misconceptions about suicide, the incorrect conclusions drawn from them (rationalizations), and the correct, true facts verified by years of observation and confirmed by special research.

- **Prejudice:** Most suicides are committed with little or no warning.

- o **Rationalization:** Since no one knows about the suicide in advance, it is impossible to do anything to prevent it.

- o **Fact:** Most people give warning signals about their reactions or feelings due to events pushing them toward suicide [5]. These signals (or cries for help) can be given by a person in the form of direct statements, physical (bodily) signs, emotional reactions, or behavioral manifestations. They communicate the possibility of choosing suicide as a means of relieving pain, reducing tension, maintaining control, or overcoming loss.

- **Prejudice:** One should not talk about suicide with a person you believe is at risk, as it might give them the idea to do it.

- o **Rationalization:** It is best to simply avoid the topic altogether.

- o **Fact:** Talking about suicide does not create or increase the risk of committing it. On the contrary, it reduces it [16, 18]. The best way to identify suicidal intentions is a direct question about them. An open conversation expressing sincere care and concern caused by the person having thoughts of suicide is a source of relief for them and often one of the key elements in

preventing immediate danger of suicide. Avoiding this topic in conversation can become an additional reason for suicide. The risk increases because, having tried to discuss this topic with one interlocutor and been refused, the person will feel even more alone and will subsequently show even less energy in searching for another person capable of helping them.

- Prejudice: If a person talks about suicide, they will not commit it.

o Rationalization: There is no need to deal with people who talk about suicide.

o Fact: People who take their own lives usually directly or indirectly let someone know about their intentions beforehand. Four out of five people intending to end their lives talk about this desire with another person in some form before death [5]. Refusing to take these conversations seriously and participate in them contributes to death by suicide.

- Prejudice: Suicide attempts that do not lead to death are merely a form of attention-seeking behavior.

o Rationalization: Such behavior deserves to be ignored or punished.

o Fact: Suicidal forms of behavior or "demonstrative" actions by some people represent a call or request for help sent to others. If no one responds, it is very easy to transition from a desperate cry for help to the conclusion that no one will ever help—and accordingly, from a lack of serious intent to die to a clear desire to end one's life. Punishment for suicidal behavior and its evaluation as an "unworthy" way of calling for help can lead to extremely dangerous consequences. Punishment often produces the opposite of the desired effect. Providing assistance in resolving problems and establishing contact is an effective method of preventing suicidal forms of behavior.

- Prejudice: A suicidal person definitely wants to die.

o Rationalization: There is no point in helping; they will make repeated attempts until they commit suicide.

o Fact: The intentions of most suicidal people remain ambivalent right up to the moment of death. Very few maintain certainty in their desire or a unambiguous decision to end their life. Most people are open to help from others, even if it is imposed on them against their will. The vast majority of individuals who have exhibited suicidal tendencies at some point in their lives find a way to continue living [20].

- Prejudice: Those who commit suicide are mentally ill.

o Rationalization: I am afraid of the mentally ill; they cannot be helped.

o Fact: Indeed, the presence of a mental illness is a high-risk factor for suicide [4]. However, many, very many people who commit suicide do not suffer from any mental illness. For them, it is merely a temporary situation from which they see no other way out.

- Prejudice: If a person makes one suicide attempt, they will not repeat it.

o Rationalization: Now I have no need to worry; the attempt itself prevents the possibility of further suicidal actions.

o Fact: Although most individuals who make a suicide attempt usually do not proceed to suicide, many of them repeat these attempts. The frequency of suicide among individuals who have previously made suicide attempts is 40 times higher than in the general population [12].

- Prejudice: Alcohol and drug abuse have no relation to suicide.

o Rationalization: When I drink, I by no means want to die, quite the opposite. Alcohol and drugs help forget problems.

o Fact: Dependence on alcohol and drugs is a risk factor for suicidal behavior [8]. Drinking and drug use, especially during withdrawal, can significantly contribute to suicide.

- Prejudice: Suicide is an extremely complex phenomenon; only professionals can help suicidal people.

o Rationalization: These people need help that I cannot give; only a specialist can help them; getting involved in such a dangerous undertaking is not my business.

o Fact: There are as many causes of suicidal behavior as there are people exhibiting it. Indeed, searching for general patterns applicable to all people shows that suicide is an extremely complex phenomenon. However, understanding and responding to suicidal behavior in a specific individual does not require deep knowledge in psychology or medicine. It only requires paying attention to what the person says, **TAKING IT SERIOUSLY**, offering support, and seeking appropriate help. Many people die by suicide precisely because emergency first aid and support were not offered or were inaccessible [7, 19].

- Prejudice: If a person has a tendency toward suicide, it will remain with them forever.

o Rationalization: There is no way to eradicate suicidal feelings, and one should not hope that a person will return to their daily duties after a suicidal episode.

o Fact: Most suicidal crises are transient and can be resolved with appropriate help. However, if emotional stress continues, relief does not come, and help is not provided, the risk of suicidal behavior persists. After receiving professional help, a person is most often able to resume their usual life and activities.

- Prejudice: Suicide is an inherited phenomenon.

o Rationalization: This means it is fatal, and nothing can help.

o Fact: This is a complex question. Indeed, scientists have recently been intensively searching for genes that may be related to the formation of suicidal behavior. However, the presence of some genetic basis does not mean that real help cannot be provided to a person, as we are talking about human behavior, which is important to notice and then bring to the attention of doctors or psychologists.

- Prejudice: If no note is left, the incident cannot be considered a suicide.

o Rationalization: There is no need to take any action.

o Fact: Only one-fourth of all individuals who commit suicide leave notes.

Conclusion

Suicide among young people, especially students, is a complex but largely preventable problem. Its solution lies in the timely identification of risks and competent crisis intervention. The key conclusion of the article is that most people in a state of pre-suicidal crisis give recognizable signals to those around them—through changes in behavior, emotional state, or direct statements [5].

The effectiveness of assistance depends on two fundamental conditions. First, it is necessary to overcome stigma and dangerous myths, the main one being the belief that talking about suicide can provoke it. Research and practice confirm the opposite: an open, empathetic dialogue reduces tension and gives a person a sense of relief [16, 18]. Second, the decisive role is played not so much by medical expertise but by the skill of trust-based communication. The ability to listen attentively, show genuine care, and support a person's self-esteem is often more important than the immediate search for solutions to all their problems.

Thus, a prevention strategy should combine education and practical action. It is important to train all those working with young people not only to recognize warning signs (from symptoms of depression to behavioral changes) but also to confidently engage in difficult conversations, following simple yet vital principles of first psychological aid [7, 10, 19]. Investment in such psychological literacy is a direct contribution to saving lives, turning a potential tragedy into a story of receiving timely support.

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DOI:10.31579/2692-9562/155

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