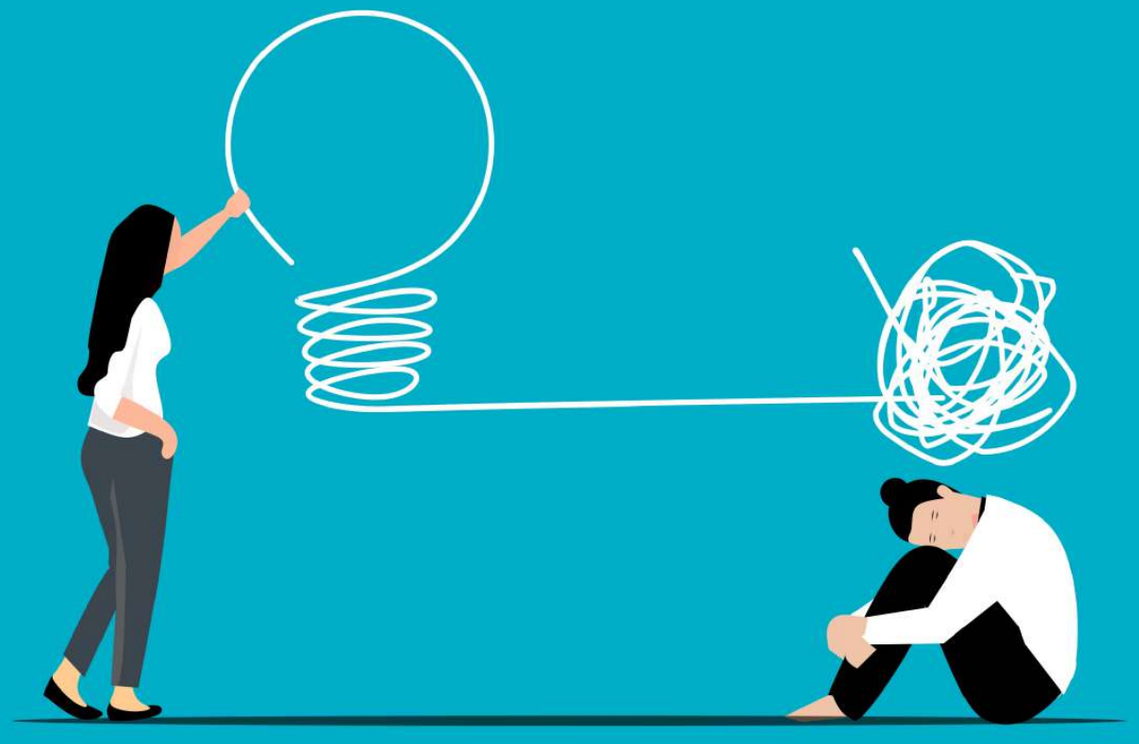

It’s okey not to feel okey

preventive management of presuicidal syndrome

Funded by the European Union

Instytut Wiedzy i Kompetencji

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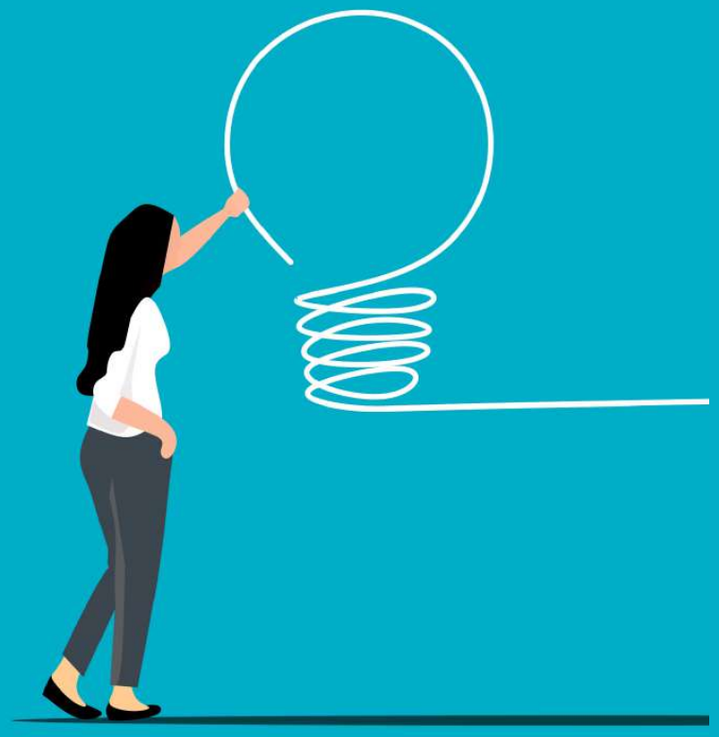

It’s okey not to feel okey
Handbook of good practice for preventive management of syndrome presuicidal.

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The presented publication is the intellectual result of the project **‘Strong Heads - Counteracting Youth Crises’** coordinated by the Knowledge and Competence Institute Foundation, co-financed by the Erasmus+ KA2 Programme of the Small Scale Cooperation Partnership, project number 2023-3-PL01-KA210-YOU-000173060.

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When a young person says “I can't do it anymore”, they are not always looking for attention. Sometimes he really can't. In a world that demands the maturity of adults and the enthusiasm of children, more and more teenagers are not finding the space to be themselves. More and more of them are becoming silent. And silence is not always a sign of peace - it can sometimes be a cry of despair.

This conviction gave rise to the “Strong Heads” project, initiated by the Knowledge and Competence Institute Foundation and the Turkish NGO UNA Gençlik Derneği / Danube Youth Association. Both organisations, which work with young people experiencing mental difficulties on a daily basis, recognised the growing, alarming problem of suicidal crises among young people in their respective countries. The project, funded by the Erasmus+ programme under Action KA210-YOU, aims to develop and implement prevention tools for professionals and educators working with young people - the people who are often the first to notice changes in the behaviour, emotions and attitudes of their charges.

The main outcome of the partnership effort is the publication you hold in your hands “It's okay not to feel okay - a good practice handbook for preventive management of presuicidal syndrome”. It is not just a body of knowledge - it is a call to action. To vigilance, empathy and courage in confronting one of the most complex and painful phenomena in the youth world today - suicidal thoughts and self-destructive behaviour.

In the project proposal, we can read that in Poland in 2022 there were more than two thousand suicide attempts and suicides among people under the age of 18 - an increase of 150% compared to 2020. According to the ‘Always Pomerania’ portal, in some regions, such as Pomerania, suicides already account for nearly half of all youth deaths.

Frightening? Yes.

True? Unfortunately, also.

Behind these statistics are the stories of children and teenagers who did not get help in time. Whose suffering went unnoticed, ignored or trivialised.

In Turkey, the situation is no better. Teenagers are facing massive social and economic problems - the effects of the war in Syria, the refugee crisis, high inflation, natural disasters (including earthquakes) and limited educational and career prospects. For many young people, everyday life is a constant struggle to survive in an unfavourable system. In this struggle, they sometimes lose. With themselves.

Both partner organisations work on behalf of excluded young people - those who are already facing the consequences of trauma, discrimination, stigmatisation or lack of life stability. In Poland, these are mainly foster care alumni, young refugees from Ukraine, and people with disabilities. In Turkey - young people with refugee experience, economically excluded, socially marginalised. The common denominator is one thing: the need for psycho-emotional support, which is growing faster than the availability of professional help.

A suicidal crisis is an emotional state in which an individual contemplates or plans to take their own life. It is often preceded by so-called “presuicidal syndromes” - sets of warning symptoms such as chronic feelings of emptiness, loss of meaning in life, shutting down, self-harming, abandoning plans, saying goodbye. These symptoms are sometimes subtle. They are sometimes misinterpreted as ‘typical teenage moodiness’ or ‘emotional blackmail’. And yet they are an alarm signal.

It is worth remembering that suicide is not an illness. It is an act of desperation resulting from a lack of resources to cope with mental suffering. It is a dramatic attempt to escape from pain - not from life as such. This is why it is so important to equip youth workers with the competences to recognise risks and respond before tragedy strikes.

- Why was the project developed?

The project partners, the Institute of Knowledge and Competence and UNA Gençlik Derneği, operate in a context where the availability of psychological and psychiatric help is insufficient. In Poland, there are only a few dozen suicidologists and only 20 certified resilience trainers. In Turkey, the situation is similar - resources are limited and the needs are constantly growing. Therefore, it has become important to create a tool that will enable youth coaches, educators, educators and volunteers to work effectively on suicide prevention.

The Strong Heads project was not born out of a need to theorise, but out of experience of everyday life - the difficult, non-obvious kind, where quick but thoughtful decisions need to be made. Together, the partners identified key challenges: the paucity of educational materials, the lack of procedures for dealing with crisis situations, the lack of knowledge of myths and facts about suicide, and the great fear of adults of “making a mistake” when dealing with a young person in crisis. Out of these challenges, the idea of creating a handbook that is not an academic elaboration but a tool for everyday practice was born.

- A youth perspective

Young people do not want pity. They want understanding. They want to know that their emotions are valid, even if they are difficult, uncomfortable or “out of step” with societal expectations. They want to be able to talk about what hurts them - without fear of being laughed at, rejected or judged. This calls for systemic change, but also - and perhaps most importantly - a change in adult attitudes

The “Strong Heads” project includes not only the production of this publication, but also workshops for 170 teenagers from Poland and Turkey. They are the ones who co-create the content, share their experiences and verify the beliefs of adults. Their voice is crucial, because only through it can the real needs of young people be understood. For many of them, participating in the project is the first time someone has listened to them and taken them seriously. It is the first step towards change.

- The importance of international cooperation

The joint activities of two organisations (from Poland and Turkey) allow us to look at the problem from a broader perspective. Both countries have different historical, cultural and social experiences, which influences different attitudes towards mental health and suicide. The exchange of knowledge and good practices allows for universal but also practical solutions. This gives the publication the potential to become an effective tool in different settings and educational systems.

- Purpose of the publication

The handbook, which was the result of a transnational collaboration, is intended to serve as a guide to the topic of prevention in the presuicidal syndrome. It includes not only definitions and descriptions of the phenomena, but also practical tips, intervention scenarios, suggestions for resilience-building exercises, ways to defuse myths about suicide, and elements of psychological first aid. It was created by practitioners - for practitioners. With young people in mind. With a view to those who can save someone's life before it's too late.

We invite you to read the results of our work - we believe that you will find many valuable tips here, which will make our work for children and young people in mental health crisis even more effective.

Authors

Let's Talk to the Experts

- **Małgorzata Zdrojewska** is a psychologist and psychotherapist with more than 20 years of experience in working with children, adolescents and families, specialising in cognitive behavioural therapy and therapy for adolescents struggling with anxiety, depression and autism spectrum disorders, including Asperger's Syndrome. She works both in public settings - including schools and community psychological support centres - and in her own therapeutic practice. As an expert psychologist at the Regional Court in Gdansk, she also has experience in forensic psychology and in addiction diagnosis. In her work, she combines empathy, active listening and professionalism with a strong commitment to improving the mental well-being of young people. She is also an experienced educator - she has delivered numerous trainings for teachers and parents, webinars for young people and psycho-educational workshops. She is currently pursuing postgraduate studies in cognitive behavioural psychotherapy at SWPS, being advanced in her certification. This is a conversation with a person who not only knows the mechanisms of the young person's psyche, but who can also talk about them with sensitivity and clarity - without simplification and with genuine understanding.

1. What are the signs that a teenager is experiencing depression rather than simply going through a more difficult adolescent period?

The symptoms of depression in teenagers can be different from those in adults - they are often mistaken for “rebellion” or a “difficult age”. And sometimes it can be the other way around - a teenager is going through a difficult adolescence and this can be mistaken for depression. Distinguishing depressive symptoms during this difficult period that is adolescence is not easy. It is worth being vigilant because depression is a serious illness that can lead to complications if ignored.

The predominant symptoms of depression in teenagers are sadness, depressed mood, emptiness, despondency, tearfulness, psychomotor inhibition. Irritability, anger, outbursts of aggression are also very common symptoms. The adolescent may be perceived by those around him as a rude, aggressive, uncultured person, but behind this façade may be a serious depressive disorder.

Other very common symptoms of young people experiencing depression are a lack of self-esteem and a constant sense of guilt. In this illness, young people tend to blame themselves for many things in life - from serious, relationship-related issues to minor things such as studying or tidying up. A common symptom during a depressive episode in adolescents is a sense of hopelessness-‘nothing makes sense’. This is a very worrying and dangerous symptom because the feeling of hopelessness can lead to thoughts or even plans of suicide or to self-harm, as a way of coping with emotional tension. Other symptoms, more physical than emotional, are sleep problems. People suffering from depression tend to be very sleepy during the day and have difficulty sleeping at night. Lack of energy, constant tiredness and rapid fatigue are another classic symptom of depression. Other symptoms of this illness are difficulty concentrating attention, lack of motivation to learn and, naturally, a drop in academic performance. Somatic pains and appetite disturbances may also occur. Behavioural symptoms, i.e. visible in our behaviour, are withdrawal from social life, avoidance of family and friends, lying in bed during the day and even, due to feelings of hopelessness and lack of energy, neglect of appearance and personal hygiene.

Depression is an illness in which resignation and suicidal thoughts are very common. If a teenager says he doesn't want to live, wants to disappear, feels like a burden - let's always take it seriously. Do not wait for him or her to ‘get over it’. Such a young person absolutely needs the help of a specialist.

The difference between depressive symptoms and the difficult period of adolescence, in which behaviours or feelings resembling depressive symptoms may be present, lies primarily in the number, severity and duration of the above-mentioned symptoms.

Depression is an illness and the symptoms that appear are permanent, regular, long-term. They must last for at least 2 weeks for most of the day and must cause suffering. In addition, in order to be diagnosed with depression, the sufferer must have a number of severe symptoms - not just one or even two. It is also important to remember that a diagnosis of depression must be preceded by the exclusion of general medical causes of the adolescent's malaise.

In summary, adolescence is a difficult time for both parents and teenagers themselves. The changes taking place in the brain not only cause unpleasant, depressing and difficult feelings, but also contribute to impulsive behaviour, often incomprehensible to the teenagers themselves, not to mention parents or teachers.

If we find a young person's behaviour worrying, it is worth observing him or her for a few consecutive days. If a young person is only depressed, sad or isolated from peers for a few days, these may be typical symptoms of adolescence related to the daily changes in the teenage brain. If the worrying symptoms last longer than two weeks, it is worth consulting a specialist.

2. What are the most common causes of depression in adolescents - is it more school pressure, peer relationships or maybe social media?

The model that best explains the causes of depression in children and adolescents is Reinecke's biopsychosocial model of depression, which states that the development of depression is primarily influenced by biological, psychological and social (environmental) factors. Biological factors include a genetic predisposition, hormonal disorders (pubertal hormonal storm), neurotransmitter disorders (serotonin, dopamine) or chronic physical illnesses (e.g. diabetes, thyroid problems) and high emotional sensitivity. Psychological factors may include distortions or deficits in information processing, low self-esteem, lack of self-confidence, perfectionism, strong pressure to achieve (e.g. in school, sport) and/or excessive self-criticism for mistakes. Important psychological factors also include difficulties in accepting oneself or one's gender identity. Transgender people are more likely to experience depression. However, this is not due to transgenderism per se, but mainly to external factors such as discrimination and violence, rejection by family or relatives, lack of social acceptance, problems with access to health care, including that related to transition.

Indeed, epidemiological studies show higher levels of depression, anxiety and suicide attempts among transgender people, especially those who lack social support. The social factors influencing the development of depression in children and adolescents largely include problems within the family - arguments, divorce, violence, emotional coldness of parents, lack of support from parents or peers. The situation most painful for adolescents is social isolation or being rejected by a group, as the need for peer acceptance is great at this age. Important social factors are also problems at school, i.e. bullying, harassment, appearance pressure, conflicts with teachers and also excessive stimuli, i.e. lack of time for mental rest. An important negative factor in recent times has been social media providing the opportunity to compare oneself with others causing overwhelming pressure to ‘look or live perfect’. Speaking of social media, it is essential to mention cyberbullying, which exists and is growing among children and adolescents, causing feelings of rejection and loneliness , which can prove to be the first step towards depressive disorders.

Other factors that may contribute to the development of depression are stressful or traumatic events, e.g. loss of a loved one (death, break-up), change of school, moving house, break-up of a friendship or romantic relationship, experience of violence or sexual abuse.

Depression in adolescents can result from a number of overlapping factors - biological, psychological, social and environmental. In sufferers, there are usually at least two or more such factors. One factor is genetic predisposition. We need to remember that we inherit a general predisposition to develop a mental illness or disorder.

However, these are only predispositions. If a person who has inherited the aforementioned predisposition does not have any negative experiences in life, he or she will not necessarily become ill with depression. Conversely. A person who has experienced difficulties in life, but is not genetically burdened, does not necessarily develop a depressive episode either. On the other hand, if genetic predisposition is complemented by other additional factors, such as psychological, social or traumatic, the likelihood of developing depression increases.

3. How can depression affect a young person's daily functioning e.g. at school, at home, in relationships with others?

Depression can have a huge impact on a young person's functioning - mentally, emotionally, socially and physically. The lowered mood and sadness that accompanies a young person for most of the day means that the young person may feel depressed, empty or indifferent. A young person with impaired self-esteem, which is a very common symptom of depression, often experiences feelings of guilt, hopelessness, a sense of low self-esteem and a lack of enjoyment of previously enjoyed activities are also characteristic.

The emotional components of depression discussed above result in the sufferer not wanting to meet peers, family, avoiding them, which contributes to the development of social isolation. Withdrawal from social life is a very negative phenomenon because, on the one hand, it takes away the chance for the person suffering from depression to maintain or build up social contacts, which is extremely important at the developmental age, and, on the other hand, it sustains and develops depressive disorders.

In social relationships, on the other hand, the person may exhibit outbursts of anger, irritability and difficulty in communicating, which very often results in a lack of understanding from those around them and their negative reaction, which secondarily contributes to the sick person avoiding social contact. It is also worth mentioning that depression is often misinterpreted as laziness or rebellion, which is often unfair. Depression has a huge impact on a young person's school functioning. One symptom is difficulty concentrating, which naturally causes problems remembering and concentrating on lessons. This influences a lack of motivation to learn, a reluctance to go to school and skipping classes, resulting in a drop in academic performance. The educational efforts of a teenager, and not only that, doomed to failure, very often result in negative thoughts - the conviction that ‘nothing makes sense’, which can be very dangerous as it can lead to suicidal thoughts or attempts.

Depression can result in a young person using self-aggression - self-harm as a way of coping with psychological pain. Another way to cope with difficult emotions is to abuse psychoactive substances - alcohol, drugs as an “escape” from problems. Spending time in front of the computer ‘surfing the Internet’ is also an escape from the illness. This is often the only enjoyable activity a teenager has the energy for. Unfortunately, this can lead to computer/Internet addiction.

Depression is usually primary, and addiction to the Internet or psychoactive drugs is a secondary process, undertaken as a strategy to cope with negative emotions.

In addition to the aforementioned psychological and social phenomena, depression has a huge impact on physical well-being. Sleep disorders, which are one of the symptoms of depression manifesting themselves in the form of insomnia or excessive sleepiness, affect energy, or rather the lack of it. It is also worth mentioning the frequently occurring somatic complaints, i.e. headaches, abdominal pain, fatigue for no apparent reason.

4. What does the process of treating depression in adolescents look like and is it different from adult therapy?

The treatment of depression in adolescents is a very important and complex process, as young adulthood is associated with intense emotional, social and physical development. Depression during this period can significantly affect a young person's functioning, relationships with peers, family and academic performance. Treatment of depression in adolescents usually involves several components and should be individually tailored. The most commonly recommended form of treatment, particularly in mild to moderate depression, is psychotherapy. There are many strands of psychotherapy but the most recommended and effective form is cognitive behavioural therapy (CBT). It teaches young people how to recognise and change negative thinking and behavioural patterns. It also teaches how to deal effectively with emotions. In addition, it develops assertive behaviour and shows how to deal with difficult situations in a constructive way. It has a well-documented effectiveness in the treatment of adolescent depression.

Family therapy is also very often recommended. It is particularly useful in situations where family problems are affecting the young person's wellbeing. It includes sessions with parents or carers.

As a main form of treatment, less commonly used, is psychodynamic therapy , but this can be useful for a deeper understanding of emotions and defence mechanisms. For more severe depression or when psychotherapy is unsuccessful, pharmacotherapy is used. In adolescents, antidepressants must be used with caution and always under the close supervision of a psychiatrist. The most commonly used are selective serotonin reuptake inhibitors (SSRIs), e.g. fluoxetine (as the only one approved by the FDA for adolescents). Of course, the support of the family and environment, especially peers, is very important and invaluable. It is also worth mentioning a healthy lifestyle, i.e. regular physical activity, a healthy diet, sleep hygiene and limiting screens (social media, games).

Focusing on the differences in the treatment of depression in adolescents and adults, it is important to mention that the therapy for adolescent depression differs significantly from that for adults and older people - both in terms of approach and therapeutic goals. These differences are primarily due to the developmental stage the young person is in.

Adolescents, adolescents are in a developmental period, i.e. they are just developing their identity, learning to regulate their emotions, building independence, shaping their personality. Therapy must therefore take these processes into account. Adults usually already have a more formed personality structure, better tools to verbalise their problems and cope with them. In adolescent therapy, the therapist spends more time on psychoeducation, often using more figurative language, metaphors, symbols, elements of play, or body work to get to the adolescent's emotions, thoughts or beliefs, which is sometimes extremely difficult.

In adolescents, the family plays a very important role in the therapeutic process - both as a source of support and sometimes as a stress factor, which is why family therapy, which has recently become very popular, is also very often recommended. In adult therapy, the family is not always involved as the patient usually functions more independently.

For adolescents, peer relationships and school pressures are huge sources of emotion - both positive and negative, so both need to be taken into account in child and adolescent therapy.

Adolescent therapy often focuses on social relationships, feeling accepted and dealing with rejection by peers, which happens quite often. Adults, on the other hand, face a different context: work, relationships, parenting, financial responsibility, which is also often a source of worry and stress.

A difference due to developmental age is that a young person may find it difficult to talk about feelings and does not always come forward of their own accord. It is often the parents who initiate contact.

The therapist's task at the beginning is to focus on building rapport and trust before moving on to deeper work. With adults, it is usually quicker to move on to specific problems.

When considering pharmacotherapy, adolescents are sometimes more sensitive to the side effects of medication. Medication is used less frequently and usually in combination with psychotherapy. In adults, pharmacotherapy tends to be used more often as the mainstay of treatment.

In summary, the treatment of adolescent depression is very demanding. It requires an individual approach, consideration of the developmental and family context and greater flexibility in the forms of work.

5. What can parents or teachers do if they suspect that a teenager is depressed, but he or she denies it and doesn't want to talk?

If parents suspect that their teenager may be depressed, the most important thing is not to ignore the symptoms and to act with care, but also decisively. The earlier the teenager gets help, the better the chance of a quick recovery and avoiding complications (such as isolation, addictions or suicidal thoughts).

Parents can observe their teenager - pay attention to changes in mood, sleep, appetite, isolation, giving up on passions, crying outbursts, anger or apathy. Communication with the child is also very important. The way a parent communicates with their teenager can be both therapeutic and can also lead to or reinforce symptoms.

Here are some tips:

- Ask gently what is going on, is something overwhelming the child?
- Try not to ask a lot of questions, just listen carefully, even if the teenager doesn't say much.
- Avoid lecturing, scaring and moralising. Don't say: “Get over yourself”, “Others have it worse”, “It's just that age”. Instead: ‘I see you've been sad and closed off lately’, ‘I'm worried about you’, ‘Can I help you somehow?’.
- Suggest seeing a child and adolescent psychologist or school counselor, without pressure but firmly. You can say, "You don't have to deal with this alone. There are people who have already helped many people your age. Come on, we'll go together."
- An important thing parents can, or rather should, do is to keep their child safe. Remove potentially dangerous things from the environment if you suspect suicidal thoughts.
- Limit excess chores, ensure a calm and stable home environment.

Parents should be aware that treating their child's depression is a complex and long-term process - it can take weeks and often even months. It is not an illness that disappears after one visit to a specialist or after starting pharmacotherapy. Patience on the part of adults is crucial during this time - expecting immediate results may not only be unrealistic, but may even be counterproductive, as it creates pressure that a child in crisis cannot bear. The child needs to feel that his or her pace is accepted and that every - even the smallest - step towards improvement is noticed and appreciated.

It is very important that the child feels safe and accepted. He or she needs space to experience emotions, but at the same time the presence and closeness of caregivers. It is useful to talk to the child, to be there for them - not necessarily with ready-made solutions, but with an openness to listen. This sends a signal to the young person that he or she is not alone, that he or she has people around him or her who love and support him or her - no matter where he or she is at.

Parents do not have to cope alone - they can and should reach out for help. Support can be found in a variety of places, depending on the situation and the needs of the family:

- Mental health counselling centres for children and adolescents - operating within the framework of the National Health Service, offering free psychological, psychiatric and therapeutic help. Community support centres are also available in many places, offering care without the need for a prior referral from a doctor.

- School psychologist - is often the first person a child can talk to about their difficulties. Collaboration between parents and the school psychologist can help to create a coherent support system involving home and school.

- Private therapy clinics - this is an option for families who can afford this form of support. It often gives greater flexibility in the choice of specialist and appointments, and waiting times for the first appointment can be shorter.

The most important thing, however, is not to delay taking action.

Let's Talk to the Experts

- **Marta Łoboda** is an experienced educator and oligophrenopedagogue, specialising in child and adolescent mental health. She has a degree in child and adolescent psychology with a special focus on developmental support, which enables her to successfully combine psychological knowledge with pedagogical practice. Her professional interests focus on emotional and educational support for children with intellectual disabilities and young people experiencing mental health difficulties. In her work, she focuses on an individual approach to the child - with attention to their needs, abilities and potential. She believes that the key to effective support is to combine substantive preparation with warmth, consistency and genuine commitment. Her experience ranges from working in the school environment to a therapeutic approach working with families and a team of professionals. Thanks to her interdisciplinary perspective, she is able to accurately identify difficulties, support the development of children with deficits and help them build their self-esteem. This is a conversation with an expert who has a great understanding of the mechanisms of children in crisis and is able to talk about them clearly, empathetically and from the perspective of a practitioner - someone who accompanies young people every day on their journey to better wellbeing and greater independence.

1. What are the characteristics of the adolescent group in terms of suicidal behaviour? What characterises adolescents in this context?

Young people are a group particularly vulnerable to suicidal behaviour. Adolescence is a time of intense biological, emotional and social changes, which often cause internal disorganisation, a sense of chaos and instability. Teenagers experience extreme emotions and often lack developed mechanisms for coping with stress and failure. Impulsive decision-making and difficulty in predicting the long-term consequences of actions are characteristic of this age group, which can lead to violent reactions, including self-destructive behaviour.

Among young people, we observe a relatively high percentage of suicide attempts compared to adults, but a lower percentage of so-called ‘successful’ (fatal) attempts. This is often due to the choice of less effective methods or, in some cases, an ambivalent attitude towards the act of taking one's own life, which can be an expression of a cry for help rather than a clear intention to die. However, such attempts should not be interpreted as ‘frivolous’ – every suicide attempt should be treated as a sign of a serious crisis and a need for specialist intervention.

2. What are the main determinants of suicidal behaviour among young people?

Suicidal behaviour in young people is multifactorial in nature – it is never the result of a single cause, but rather the result of a complex interaction of biological, psychological and social factors. The main determinants are mental health disorders, including depression, anxiety disorders, mood disorders and personality disorders, especially borderline personality disorder. Often, more than one disorder co-exists, which exacerbates the crisis and leads to a loss of hope.

Experiences of violence, both domestic and peer violence, including cyberbullying, also play a significant role. Emotional, physical or sexual violence, whether chronic or a single traumatic event, can undermine a young person's sense of self-worth and security. Other important determinants include family situation – emotional instability at home, emotional coldness of parents, excessive criticism, divorce, mental illness or addiction in the immediate environment significantly increase the risk of suicide attempts.

Teenagers who experience difficulties at school, including educational failure, rejection by peers or pressure to achieve, may also be particularly vulnerable.

Socio-cultural factors such as marginalisation and lack of acceptance of gender identity or psychosexual orientation are also significant. Contemporary media – especially the internet and social media – can reinforce pressure, intensify social comparisons and perpetuate feelings of inadequacy, and in extreme cases promote or normalise self-destructive behaviour. These determinants reinforce each other and create a network of risk factors that can be overwhelming for young people without adequate support.

3. What personality factors in young people are associated with an increased risk of suicide?

Certain personality traits significantly increase young people's susceptibility to suicidal thoughts and suicidal behaviour. One of these is impulsivity – a trait that manifests itself particularly during adolescence in the form of violent emotional reactions, making decisions without considering their consequences, and difficulty in controlling behaviour. Combined with the emotional instability characteristic of adolescence, impulsiveness can cause a suicide attempt to become a sudden, dramatic reaction to a momentary crisis. Another important personality trait is a tendency towards low self-esteem and a chronic feeling of inadequacy. Young people who are unable to recognise their own worth often internalise failure and criticism as proof of their hopelessness. A pattern of negative thinking about oneself and the future, especially when it takes the form of dichotomous thinking (all or nothing), leads to the belief that the situation is hopeless. Perfectionism, although often seen as a positive trait, can actually increase the risk of suicide, especially when young people cannot tolerate failure and do not allow themselves to be weak.

Young people with a high level of interpersonal sensitivity, who experience relationships and rejection intensely, may be more prone to emotional crises resulting from peer conflicts or breakups.

In addition, people with difficulties in regulating their emotions and a lack of developed strategies for coping with stressful situations often resort to destructive behaviours as the only known form of relief. These characteristics are not a direct cause of suicide attempts, but they create a psychological background which, under certain external circumstances, can lead to a critical moment.

4. What are the main warning signs of suicidal behaviour among young people?

Warning signs preceding suicide attempts in young people can be subtle, spread out over time, or, conversely, sudden and dramatic. They often take the form of behavioural changes that those closest to the person may consider to be ‘typical rebellion’ or temporary difficulties of adolescence. However, loss of interest in everyday activities, withdrawal from social contact, deterioration in school performance, and increasing problems with sleep and appetite are potentially worrying symptoms. Young people may start making statements about death, transience or the meaninglessness of life, such as ‘no one will miss me’ or ‘I have nothing to live for’ – although they do not always say this explicitly.

Some may engage in self-harm – cutting, burning or other forms of self-aggression, which may be a mechanism for regulating emotions, but also a sign of a progressive crisis. It is worth paying attention to ritualistic tidying: giving away belongings, writing letters, organising one's space – all of these may indicate an intention to take one's own life. A surprising but very dangerous sign is a sudden improvement in mood after a long period of depression – this may mean that the decision to take one's own life has already been made and the person is experiencing temporary relief from the end of their internal struggle.

Careful observation and openness to conversation are crucial – do not ignore any worrying signs, even if they seem harmless at first glance. Any change in a young person's behaviour requires reflection and, if necessary, contact with a specialist.

5. What is presuicidal syndrome?

Presuicidal syndrome is a set of symptoms preceding a suicide attempt, constituting a kind of culmination of an internal emotional crisis. The concept was developed by Erwin Ringel, who described three main characteristics of this state: narrowing, inhibition of aggression and a growing fascination with death. A person experiencing this syndrome ceases to see alternatives – their thinking becomes extremely reduced, focused solely on the problem they cannot solve. They cease to see the future, relationships lose their meaning, and emotions centre around suffering, guilt and helplessness.

Aggression, which could be a natural defence mechanism against the world, is suppressed and directed inwards. Deep psychological self-aggression emerges: self-punishment, self-humiliation, feelings of being a burden. A person in this state not only loses touch with their own worth, but also begins to believe that leaving will bring relief not only to themselves, but also to those around them. At the same time, thoughts of death grow – initially as an escape, then as the only solution.

Presuicidal syndrome is an emergency condition that requires immediate response – specialised, attentive and multi-level. Early recognition can prevent a young person from taking the final step. That is why it is so important for people working with young people to be able to see not only what is said directly, but also what is hidden in behaviour, mood and everyday gestures.

Introduction

In April 2023, the UNAWEZA Foundation published a report entitled ‘YOUNG MINDS. An open discussion about mental health.’ The publication was based on an analysis of the results of a survey conducted on a sample of over 180,000 young people from Poland, including teenagers and children aged 10 to 19.

The conclusions catalogued in the summary report provide a clear answer: the mental health of children and young people in our country is at risk, and respondents have dramatically low levels of self-esteem and belief in their own abilities.

The results of the survey published on the UNAWEZA Foundation website (https://www.unaweza.org/aktualnosci/mlode-glowy-raport-z-badania/, accessed on 05.06.2023) show that over 60% of the students surveyed would like to have more self-respect, and everyday stress overwhelms over 80% of the respondents.

In addition, almost 40% of children and teenagers in Poland say they have no will to live, and one in ten children has attempted suicide.

Half of students have low self-esteem, on average one in six children self-harm, nearly half of Polish teenagers have eating disorders, over 50% of young people lack motivation to do anything, and nearly 40% declare ‘poorer mental well-being’...

Young people in Poland are lonely, full of fears about tomorrow, convinced of their own powerlessness. The survey paints a picture of a generation in mental crisis, exacerbated by the COVID-19 pandemic and the outbreak of armed conflict in Ukraine. Children and young people have no friends, are afraid of confronting everyday problems, and are convinced of failure – both at school and in their private lives.

The situation outlined above allows us to conclude that children and young people in Poland are increasingly facing depression and mental disorders caused by social pressure, fears about the future, and identity issues.

In the introduction, we will address the topic of mental health in children and adolescents, with a particular focus on the concept of depression. We will catalogue its symptoms and provide guidelines for early diagnosis of the disease. We will also present statistical data on the mental health crisis in this group. The main part of this section will be devoted to the treatment of depressive disorders in children and adolescents. In this section, we will focus on ways to support young people in a mental health crisis caused by depression. We will briefly discuss pharmacological and non-pharmacological therapies for treating depression in children and adolescents, which will be elaborated on later in the publication.

To summarise, we will present the results of our own research on the mental health of children and adolescents with refugee experience.

Depression

The concept of depression and its symptoms

The term depression is used in everyday language – it is common to refer to someone who is sad, stressed or depressed as a person with depression. Colloquially, we use the term depression to describe a natural reaction to a difficult experience.

In addition, expressions such as ‘I'm depressed on a rainy day’, ‘a depressing song’ or ‘a depressive mood’ give the misleading impression that depression is something trivial – temporary sadness or nostalgia.

However, depression is a serious, life-threatening illness when we consider it as a reason for attempting suicide.

It is a mental state characterised by deep feelings of sadness, lack of energy and loss of interest in life. Depression, or depressive disorder, is not only a set of symptoms related to mental health, but also a range of behavioural and physical disorders that have a significant impact on an individual's daily functioning.

From a medical point of view, depression is classified as an affective disorder, i.e. related to a so-called mood disorder.

In terms of symptom severity, we distinguish between:

- mild depressive episode,
- moderate depressive episode, and
- severe depressive episode.

Depressive symptoms also occur in complex disease syndromes, e.g. in the case of adjustment disorders or anxiety-depressive disorders.

It is important to understand that depression is a serious illness that requires specialist treatment, including the use of appropriate medication, which will be discussed later in this article.

Depression also occurs in children and adolescents – until recently, it was a condition diagnosed only in adults, but recent years have brought a breakthrough in the diagnosis of depression and treatment planning for young people, including children.

Children and teenagers also experience difficult situations and it is natural that they react to them with frustration, sadness and anxiety – however, these emotions are usually short-lived and the child is able to overcome them. Depression occurs when a young person is permanently sad, does not enjoy life and this state persists for a long time.

Depression in children and adolescents is often recurrent, which has an impact on later stages of development – teenagers with depression often have difficulty building social relationships, making friends and forming relationships. The illness means that they enter adulthood with a baggage of difficult experiences, educational deficiencies and low self-esteem.

The negative consequences of depression among young people include, among others:

- school problems,
- deterioration of social adjustment understood as the inability to function in a peer group,
- risk of suicide attempts,
- risk of recurrence of depressive episodes in the future and the anxiety associated with it.

The above-mentioned effects of the disease are so serious that they require comprehensive psychological and psychiatric care, long-term treatment and therapy to mitigate their destructive impact on the individual's future functioning.

What is the etymology of depression in children or adolescents?

There is no clear answer to this question – there are a number of factors that can contribute to the onset of a depressive episode in a teenager. These include:

- hereditary (genetic) factors, which are a common cause of depression; some sources say that it is a hereditary disease that develops in children of parents with depression;
- environmental factors (e.g. the family environment in which the child grows up), including in particular family ties, parenting style, and relationships with parents or guardians;
- personal factors related to the individual characteristics of each person, which include, for example, the ability to control anxiety, reaction to stress, and
- factors related to the individual's experience, such as school performance, relationships with peers, and trauma experienced in early childhood.

However, it may happen that the disease appears in a child or teenager who does not belong to the above-mentioned risk groups – it is worth remembering this and remaining vigilant when observing young patients, regardless of the presence of factors conducive to the disease.

Furthermore, depression is a disease that affects all children – it is diagnosed both in introverted children (quiet and modest) and in so-called ‘difficult children’ (with hyperactivity and concentration problems). There are no rules here, which is why thorough diagnosis and individual treatment of each case are so important in recognising the disease.

Making the right diagnosis is difficult because it is often unclear what is the consequence and what is the cause of the illness – whether cognitive disorders (e.g. low mood) contribute to the onset of a depressive episode or whether the depressive episode triggers them.

What are the symptoms of depression?

The symptoms of depression are psychosomatic in nature – they involve changes in the patient's behaviour, mood and physical symptoms.

The most common symptoms of depression include:

- psycho-emotional symptoms (‘mood changes’), including feelings of sadness, emptiness, hopelessness, excessive sensitivity, hypersensitivity;
- physical symptoms, including headaches, stomach aches, digestive problems, muscle aches, reduced pain tolerance, reduced resistance to infections;
- behavioural symptoms, including, among others, feelings of chronic fatigue, decreased or increased appetite, irregular sleep patterns (difficulty falling asleep, interrupted sleep or excessive sleepiness), difficulty concentrating, and impaired memory.

In addition, people with depression may also experience suicidal thoughts, in particular:

- suicidal thoughts – feeling that the world would be better off without us;
- suicide planning – planning how to take one's own life, imagining saying goodbye to loved ones, choosing a place to attempt suicide;
- suicide attempts;
- risky behaviour that may lead to ‘accidental’ danger, injury or, in extreme cases, loss of life.

In children and adolescents, the symptoms of depression are similar to those listed above for adults.

Young people suffering from depression:

- have difficulty concentrating, solving problems, and learning at school;
- give up their previous hobbies;
- have suicidal thoughts and behaviours;
- have disturbed sleep and eating patterns;
- see themselves in a very negative light – they do not accept their appearance, behaviour or ability to perform their tasks effectively.

Teenagers also experience tearfulness and frequent self-harm.

It is also worth noting that puberty is conducive to depressive disorders – hormonal changes affect mood swings and changes in physical appearance, which can be difficult to accept for young people who attach great importance to attractiveness (especially in times of body worship in social media and among peers).

There are certain symptoms of depression that are characteristic of adolescence. Firstly, depressive episodes in teenagers often coexist with feelings of anger and irritability, which are typical of this age group. Young people are also more likely to develop eating disorders (especially young girls) and abuse alcohol or other intoxicants as a means of escaping reality and anxiety. In addition, most young people suffering from depression have suicidal thoughts. However, it is comforting that in most cases these thoughts do not turn into action – a suicide attempt. We will devote more attention to this topic in the next part of the introduction – in the section 'Depression and suicide – suicidal crisis among children and adolescents'.

In summary, depression is a serious illness that can occur at the least expected moment and in virtually any child or teenager – whether they are secretive, hyperactive, cheerful, have friends or are loners. It is extremely difficult to determine what caused the illness and what was its consequence. In both cases, school failures, lack of passion and eating disorders can be mentioned.

- The scale of the problem among Polish teenagers – analysis of statistical data

This section presents the results of two nationwide studies on the mental health of children and young people in Poland. The first is a report commissioned by the Ombudsman for Children – 'Study on the quality of life of children and young people, the perspective of children (2021) and their parents (2022) Area – mental well-being' from 2023 (source: https://brpd.gov.pl/wp-content/uploads/2023/01/Raport-z-badania-jako%C5%9Bci-%C5%BCycia-dzieci-i-m%C5%82odzie%C5%BCy_obszar-samopoczucie-psychiczne.pdf, accessed on 06.06.2024) and the second is a UNICEF analysis from 2021 (source: https://niewidacpomnie.org/2023/02/20/depresja-dzieci-i-mlodziezy-statystyka-rodzaje-przyczyny-i-objawy-depresji-u-dzieci/, accessed on 06.06.2024).

The first source states that data collected by the Children's Helpline of the Ombudsman for Children shows that due to the coronavirus pandemic and the resulting restrictions, there has been an increase in the frequency of medication use, tension and loneliness among Polish teenagers. In turn, the report ‘Job in the network 2.0. Mental health of Polish teenagers in remote learning’, cited in the preamble to a study commissioned by the Ombudsman for Children's Rights, conducted at the beginning of the pandemic (2021) by the Foundation for Health Education and Psychotherapy, states that as many as 3 out of 4 Polish teenagers are worried about their future, over 60% have trouble sleeping, and 70% feel more nervous and irritable than before.

The same source shows that as many as 31% of children and young people in Poland indicate their own mental health and that of their peers as the main problem affecting their everyday life.

In turn, the analysis commissioned by the Children's Ombudsman General highlights findings related to the mental well-being of children and young people, which indicate that approximately 14% of students in Poland require significant intervention related to their mental functioning. Children and teenagers who are ‘below the norm’ are a group whose mental health is at risk.

Similar data can be found in the second source cited on the previous page – on the website of the Nie Widać Po Mnie Foundation, where we can read that according to a 2021 UNICEF analysis, over 10% of children aged 10-17 in Poland (10.8%) suffered from various forms of mental disorders. This amounted to a total of over 409,000 people, and the National Health Fund reports an even higher number of young people who required specialist psychiatric or psychological care in 2021 – over 630,000 teenagers.

The data cited on the previous page shows the scale of the mental health problem among children and young people in Poland. At the beginning of the pandemic, over 15% of Polish teenagers required specialist mental health care. According to non-governmental organisations working for the well-being of children and young people, this figure is still greatly underestimated – many young people do not seek help, trying to cope with everyday problems on their own.

Months of isolation followed by a new ‘war’ reality have caused anxiety and emotional and cognitive disorders among young people. Polish teenagers live under pressure to achieve at school (the so-called ‘double cohorts’, difficulties associated with remote learning and its consequences) and are afraid that they will not meet the expectations of their guardians. At the same time, they fear exclusion from their peer group and the outbreak of armed conflict.

At the end of this brief analysis, it is worth quoting one more conclusion from the Children's Ombudsman's Report: Polish children and teenagers feel lonely. A feeling of loneliness accompanies 12% of children in the second grade of primary school, 23% in the sixth grade of primary school and as many as 37% of teenagers in secondary schools. Only 17% of parents notice this problem in their children, which is extremely worrying, especially as the data clearly shows that with age (adolescence), teenagers' self-assessment of their mental health declines significantly, and this problem is not sufficiently observed by their parents.

Parents lack the time and skills to correctly assess their children's mental state. Therefore, the report's first recommendations include the development of support networks and educational programmes aimed specifically at parents, who, as the closest people to their children, should be the first source of support in a mental health crisis.

- The scale of the problem among Turkish teenagers – analysis of statistical data

The mental health of Turkish teenagers is shaped by a variety of socio-economic, religious and political factors.

High inflation and the financial difficulties associated with it have a significant impact on the mental health of Turkish teenagers. According to a 2021 OECD report, two-thirds of 18-29 year olds in Turkey expressed concerns about their household finances and overall socio-economic well-being. Furthermore, a study conducted by the Centre for International Studies indicates that inflation leads to stress, negatively affecting the mental health and quality of life of young citizens.

The political situation and social events have a significant impact on the mental health of young people in Turkey. A study conducted after the 2023 earthquake showed that socio-political factors, such as political uncertainty and social tensions, were associated with a deterioration in mental health not only among those affected by the disaster, but also among young people who were not directly affected (increased social anxiety). In addition, young people in Turkey express concern about their socio-economic situation, which leads to increased stress and mental health problems.

Research shows that young women in Turkey are more vulnerable to mental disorders than their male peers. This is particularly true for depression, anxiety disorders and eating disorders. In a traditionally conservative society, young women experience additional pressure from gender norms, social control, expectations of female roles, and limited access to sex education and autonomy in their lives. They often face double standards and a lack of space to express themselves.

Young women often struggle with the conflict between their own aspirations and the pressure of family and society. In many cases, this leads to social isolation, especially in rural areas where access to psychological support is limited. In large cities (e.g. Antalya, where the transnational partner operates), the situation is better, but there is still a lack of systemic solutions in the field of mental health prevention.

Depression and suicide – the suicide crisis among children and young people

We began our discussion by stating that depression is a deadly disease if we consider it one of the most common causes of suicide. According to police data, children and teenagers in Poland decide to take their own lives primarily because of bullying at school or by peers, problems in the family environment and mental disorders, which include depression.

Based on an analysis of statistics from the National Police Headquarters (source: https://demagog. org.pl/analizy_i_raporty/samobojstwa-w-2022-roku-przedstawiamy-dane-policji/, accessed on 06.06.2024), we can conclude that every year in our country there is an increase in the number of suicide attempts and deaths caused by suicide, which is particularly evident in the upward trend among children and young people. In 2022, according to police data, there were almost 15,000 reported suicide attempts in Poland – it is worth noting here that this number may be significantly higher, as some incidents are not recorded. In 2022, 5,108 people died by suicide, which indicates that almost one in three attempts was 'successful' (resulting in death). Also in 2022, there was a sharp increase in the number of suicides among children and young people – 2.5 times more than in 2020. In 2022, 2,093 people under the age of 18 took their own lives, with the highest number (over 2,000) of teenagers in the 13-18 age group. The only consoling fact is that only a small percentage of suicides among children and young people result in death – among the 150 cases mentioned above, only 15 were suicides resulting in death. Unfortunately, however, the number is increasing every year, which leads to the conclusion that young people in Poland are experiencing a suicidal crisis.

There are many reasons for this situation, and they are essentially the same as the causes of depression – from the pandemic and the resulting social isolation, through difficulties at school, lack of family support, to eating disorders.

What is more, according to the article 'Suicide crisis among children and young people' (source: https://www.vogue.pl/a/kryzys-suicydalny-wsrod-dzieci-i-mlodziezy-w-polsce, accessed on 06.06.2024) shows that as many as 75% of teenagers from the LQBT+ group have had suicidal thoughts. This huge percentage indicates that discrimination is still present in our country and its impact on the mental health of children and young people from disadvantaged groups.

Suicidal crises are equally common among teenagers who have been victims of abuse or other forms of sexual violence.

Children and adolescents under the age of 13 commit relatively few suicides. This number rises sharply in the 13-18 age group, which indicates that young people in our country do not receive adequate help in time, whether from their families, schools or mental health professionals. That is why it is so important to recognise a crisis, including depression, at an early stage and to respond to it skilfully.

Treatment of depressive disorders in children and adolescents

The previous pages briefly described the symptoms of depression and its prevalence among children and adolescents in Poland. In this section, we will focus on the treatment of depressive disorders among the youngest. First and foremost, it is essential to respond early to the first symptoms of the disease in a child or adolescent. Both parents and people who have direct contact with children (teachers, psychologists, educators) should be particularly sensitive to the signals they receive.

Be alert if:

- you notice sudden problems at school, such as reduced attendance, lower grades, problems with concentration,
- you notice changes in your child's behaviour in a group, e.g. alienation, avoidance of social contact,
- your child or teenager is gaining or losing weight,
- a young person is self-harming, is overly interested in suicide, or signals that they see no meaning in life.

All of the above symptoms, especially if they last for several weeks or months, may indicate depressive disorders – the sooner we notice them, the greater the likelihood that we will be able to help a young person in a mental health crisis in time.

Early diagnosis of depression is important because it can prevent serious health and social crises.

If you suspect depression in a child or teenager, it is best to consult a mental health professional - depression is treated by child psychiatrists and psychotherapists, as well as psychologists. A mental health professional will make a diagnosis and then begin treatment.

The treatment of depression consists of the following:

- pharmacological treatment,
- psychotherapy,
- educational work with the patient and their family.

The main goal of treating depression is to eliminate its symptoms, including somatic symptoms (depending on their occurrence - sleep disorders, appetite disorders, anxiety attacks, concentration problems and others). However, long-term non-pharmacological treatment is equally important, during which we shape the young person's sense of agency, responsibility for their own life and ability to cope with problems.

Non-pharmacological methods of treating depression

Non-pharmacological methods of treating depression include:

- psychotherapy and
- psychoeducation.
-

Psychoeducation, as the name suggests, encompasses activities related to mental health education. It involves providing children, adolescents and their families with knowledge about depression, its symptoms, causes and treatment methods. The main goal of psychoeducation is to increase the awareness of people suffering from depression about their mental state and, as a result, to build their coping skills.

The most important goals of psychoeducation include:

- understanding the illness (depression) – educating about what depression is, its symptoms and causes, understanding the symptoms
- recognising early symptoms – educating on how to recognise early symptoms of the illness in oneself or a loved one and how to respond effectively
- developing coping skills in the event of illness,
- supporting the family of the patient - psychoeducation can be extended to the parents or loved ones of a sick child/teenager to provide them with important information about mental health and to foster empathy and understanding, which are key to recovery,
- increasing motivation to seek treatment.

Psychotherapy, in turn, is one of the key approaches to treating depression, especially among children and adolescents. We can distinguish between:

- individual psychotherapy,
- group psychotherapy and
- family psychotherapy.

Group psychotherapy is particularly important in the therapeutic treatment of children or adolescents who have problems establishing peer contacts, building and maintaining relationships. Family psychotherapy is important because the loved ones of a child or teenager suffering from depression often need support and answers to their questions (how to support their loved one in crisis, how to protect their own mental health, how to support other family members).

Cognitive behavioural therapy (CBT) plays a special role in the treatment of children and adolescents struggling with depression. It is a therapeutic approach that focuses primarily on working with the young patient's thinking - it involves understanding and changing negative thoughts, feelings and behaviours that affect the mood and functioning of the child or adolescent.

This type of therapy is one of the most effective and well-documented therapeutic approaches used in the treatment of various mental disorders, including depression in young people.

The most important principles of cognitive behavioural therapy include:

- The concept of thinking: CBT assumes that thoughts influence a person's feelings and behaviours. Children and adolescents struggling with depression often experience self-deprecating thoughts that reinforce feelings of ‘hopelessness’ and sadness. The therapist helps to identify these negative thoughts and trigger positive ones.

- The concept of behaviour: CBT believes that our behaviour is the result of both our thoughts and what is known as social conditioning. Young people with depression may exhibit social withdrawal and avoid activities. The therapist helps them understand what behaviours may contribute to depression and how to make changes in their behaviour.

CBT is particularly useful for anxiety disorders, which often occur in young people with depression.

Examples of stages of CBT:

- Assessment and diagnosis: The therapist conducts a thorough assessment of the child's symptoms, including an analysis of factors contributing to the onset of depression.

- Therapy goal: The therapist and the child/teenager work together to set a therapeutic goal, i.e. what they want to achieve during therapy, e.g. reducing symptoms of depression, but also improving relationships with peers or overcoming stress and anxiety.

- Identifying thoughts and feelings: The therapist helps identify negative thoughts and feelings that affect mood and functioning.

- Developing new thoughts and behaviours: The therapist supports the young patient in developing more positive and realistic thoughts and behaviours.

- Exercises in everyday functioning: The therapist encourages the use of new skills and techniques in everyday life.

- Monitoring progress: The therapist regularly assesses the progress of the child or adolescent and adapts the therapy to their needs.

Features of CBT:

- Cognitive behavioural therapy is usually a short-term therapy, but the duration may vary depending on the individual needs of the patient.

- CBT therapists often involve parents in the therapeutic process.

- CBT combined with medication is one of the most effective forms of treatment for childhood and adolescent depression.

Pharmacological methods of treating depression in children and adolescents are used in moderate or severe cases (in cases of mild depression, therapy is recommended).

If a young patient does not respond to other forms of therapy (psychotherapy), the doctor decides to introduce pharmacological treatment. It is important to remember that the treatment of depression with medication should always be preceded by a consultation with a psychiatrist – the decision should be carefully considered, and pharmacological treatment in children and adolescents should be carried out with caution, as the young brain may react differently to medication than adult patients.

The topic of drugs in the pharmacological treatment of children and adolescents with depression is certainly so extensive that it could be the subject of a separate discussion, which is why only the most commonly used ‘classes’ of drugs are listed below.

1. Selective serotonin reuptake inhibitors – a group of drugs that increase the availability of the neurotransmitter serotonin in the brain, e.g. fluoxetine, sertraline, paroxetine. Selective serotonin reuptake inhibitors are usually the first choice in the pharmacological treatment of depression in children and adolescents.

2. Serotonin and noradrenaline reuptake inhibitors – a group of drugs that increase the availability of the neurotransmitter serotonin in the brain, while simultaneously increasing noradrenaline, which is responsible for the body's response to stress and situations requiring mobilisation and activation.

3. Tricyclic antidepressants – a group of drugs known as ‘older class’ drugs, which are less commonly used in children and adolescents due to their greater tendency to cause side effects.

Pharmacological treatment should always be combined with other forms of therapy, such as psychotherapy, and the decision to use pharmacotherapy should always be made on an individual basis for each patient based on an assessment of their health and therapeutic needs, especially in the case of young people whose nervous system is still developing.

It is worth remembering that there are many different ways to support a child or teenager with depression – psychotherapy and pharmacotherapy are key to overcoming the illness, but we can also:

- encourage regular physical activity – sport promotes the release of happiness hormones, but it is important to remember that a person suffering from depression may not have the strength to exercise, so it is worth starting with simple activities that do not require good physical condition (walking, swimming, walking and running),
- introduce art therapy – expressing feelings through art can be useful, especially when a child or teenager needs to vent negative emotions,
- focus on finding a passion,
- involve the patient's family in the fight against the disease.

Nowadays, we are certainly experiencing a mental health crisis, especially among children and young people. There are many factors contributing to this, including the Covid-19 pandemic, the war in Ukraine, but also rapid technological progress and the high pressure exerted by parents on children and teenagers. Double school years and problems with getting into secondary school, education reform, social pressure to look perfect, economic problems in Polish families caused by inflation... There can be many factors that trigger the disease. However, the most important thing is to react to its onset in time – when the symptoms are not yet severe and the young person has a chance to recover from the illness without significant consequences.

For this to happen, we adults need to be vigilant – first and foremost parents, but also teachers, educators, coaches and all those who come into contact with the younger generation on a daily basis. We need to look for the signs that children give us and then help them seek help.

Depression is an illness – a deadly one, and therefore dangerous and requiring treatment. It has nothing to do with laziness or passivity; these symptoms are the result of a serious illness and should not be underestimated – this is important to remember.

We invite you to read the script!

Part 1

The specificity of adolescence in the modern world (what adolescence is, adolescents as a social group - opportunities and threats, psychological needs of children and adolescents, developmental tasks)

Adolescence, or the period of growing up, is one of the most intense and multifaceted stages in human development. It is a time of transition between childhood and adulthood, during which an individual's identity, independence and way of functioning in the social world are formed. The modern world, full of dynamic social, technological and cultural changes, makes this stage even more demanding and ambiguous. Adolescents struggle not only with natural developmental processes, but also with new forms of pressure – media, educational, social and emotional.

In this part of the study, we will focus on discussing the basic aspects of adolescence from the perspective of developmental psychology. We will present what adolescence is and how it proceeds in the context of contemporary realities. Next, we will look at young people as a specific social group whose situation is full of both potential and threats. In the following subsections, we will describe the key psychological needs of children and young people, such as the need for belonging, autonomy and recognition, as well as the main developmental tasks that young people must face in order to enter adulthood with a sense of identity and agency.

Understanding the specific nature of adolescence is essential to effectively support young people, both in everyday relationships and in crisis situations, including in the context of mental health. The knowledge contained in this section provides a foundation for further consideration of the causes and mechanisms of emotional crises in young people, including suicidal syndrome.

What is growing up?

Growing up, also known as adolescence, is a pivotal stage in every person's life. It is a time of transition between childhood and adulthood, which is marked by intense physical, mental, emotional and social changes. This process does not happen at the same time for everyone – its onset and pace vary from person to person, but for most young people it is a period full of challenges, searching, uncertainty and discovery. Adolescence plays a key role in the formation of personal and social identity, laying the foundations for future adult life.

Growing up is a multidimensional process – it cannot be reduced to a single category of change. The body, mind and emotions of young people undergo dynamic transformation. At the same time, their relationships with other people, ways of thinking, experiencing the world and themselves change. Each of these areas influences the others, and their interaction creates a complex, individual map of development.

- Physical changes

In this section, we will focus on the first dimension of adolescence – physical changes, which are usually the first to appear and herald the beginning of a new stage of life.

Physical changes are one of the most visible and significant aspects of puberty. They are often the first sign that a child's body is beginning to transform into that of an adult. Under the influence of hormones, the body triggers a series of complex biological processes that result in rapid growth, sexual maturation and increased physical capabilities.

One of the most characteristic phenomena of adolescence is the so-called ‘growth spurt’, i.e. a sudden and intense increase in height, which usually begins between the ages of 10 and 14. The bones lengthen and the proportions of the body change – the limbs grow faster than the torso, which can lead to temporary clumsiness. In girls, this growth usually begins earlier than in boys, but boys catch up later with a greater final increase.

As you grow, your body weight increases, your muscles develop and the composition of your body fat changes. These changes are a natural part of development and may occur unevenly – some people grow quickly, others gradually. For many young people, this stage can be a source of frustration, anxiety or comparisons with their peers, which affects their self-esteem and body image.

The second fundamental aspect of growing up is puberty, a series of biological changes leading to sexual maturity. This process differs between girls and boys, but in both sexes it is related to the action of hormones: oestrogen and progesterone in girls and testosterone in boys. In girls, puberty usually begins with breast development, followed by pubic and underarm hair growth, changes in body shape – the body becomes more rounded, and the first menstruation (menarche) occurs, which is one of the most important biological signals of the end of the first stage of puberty. In boys, puberty manifests itself in the enlargement of the testicles and penis, the appearance of body hair, muscle development, deepening of the voice (mutation) and sometimes acne. This process tends to be more prolonged than in girls, but its effects are equally significant.

The third important element of physical changes is the development of overall physical fitness. During adolescence, muscle strength increases, motor coordination improves and the body's efficiency increases. Young people begin to have better control over their bodies, and many develop an interest in sports and take up regular physical activity. This is a good time to develop healthy exercise habits that can last a lifetime.

It is also important to note that physical changes affect not only the body but also the psyche of young people. The rapidity and unpredictability of these changes can cause stress, confusion and even identity crises. G. Stanley Hall, considered one of the fathers of developmental psychology, pointed out in his 1904 work that adolescence is a time of ‘storm and stress’ – intense emotions and groundbreaking changes that affect not only the body but also the soul.

In summary, physical changes are much more than just an external transformation. They are the foundation on which the rest of the ageing process is built – emotional, mental and social development. Understanding these changes, their dynamics and individual nature is crucial for supporting young people during this unique but difficult period of their lives.

- Mental and emotional changes. Social development.

Although adolescence is often associated mainly with biological changes, such as physical growth and sexual maturation, it is in fact a complex psychosocial process involving parallel emotional, social, cognitive and identity development. This period lays the foundation for the development of adult personality and, consequently, the individual's mental health in the future.

One of the most important theorists of human development who recognised the importance of adolescence as a stage of identity formation was Erik Erikson. In his classic theory of psychosocial development, he described adolescence as a time of particular conflict – a conflict of identity and role confusion. As he emphasised in 1968, ‘the main challenge of adolescence is to develop a sense of identity.’ This means that young people, while exploring the world and themselves, try to answer the questions: ‘Who am I?’, ‘What is important to me?’, ‘What is my role in society?’

Identity is not fixed once and for all – it is shaped by interactions with the environment, experiences of success and failure, comparisons with others, and emotional and social trials. Young people experiment with different roles, values and affiliations, trying to find themselves in the context of their peers, family and culture. This intense exploration, although natural and necessary for development, also carries the risk of confusion, uncertainty and even emotional crises.

Both changing relationships with parents, who often cease to be the sole authority figure, and the growing importance of peer groups – often acting as an emotional mirror – can affect the mental well-being of teenagers. Pressure to conform, fear of rejection, low self-esteem, and conflicts arising from the need for independence are just some of the challenges that affect young people's mental well-being.

Contemporary reality further complicates this process. Young people are growing up in a world of dynamic social change, in the age of digital media, in an atmosphere of uncertainty related to the climate, the political situation, the economy and their professional future. The number of young people experiencing mental health problems such as anxiety disorders, depression, eating disorders and adjustment difficulties is increasing. Therefore, understanding what mental health is, what factors influence it and how it can be supported is becoming not only a matter of knowledge, but also a real educational and social need.

Emotional changes

Adolescence is a time of intense emotional experiences. Mood swings, increased sensitivity, the need for independence and the search for one's own emotional identity are natural elements of this stage of life. The hormonal changes that accompany physical maturation affect not only the body but also the nervous system, especially the structures responsible for processing and regulating emotions, such as the amygdala and prefrontal cortex.

Adolescents experience emotions more strongly than children and often more intensely than adults. Joy, sadness, anger, feelings of injustice, euphoria and frustration can alternate and appear without any apparent cause. Lack of experience in recognising and expressing emotions, combined with social pressure and the expectations of those around them, can lead to internal conflicts, low mood and even risky behaviour.

Cognitive changes

Adolescence is a period of significant cognitive development. The young person's brain matures, which affects the way they think, learn and make decisions. A key change is the transition from concrete thinking (characteristic of children) to abstract and hypothetical thinking.

Adolescents begin to understand concepts such as justice, morality, the future, and the relativity of opinions and perspectives. Thinking becomes more reflective and multidimensional – young people are able to analyse situations, predict the consequences of their actions and consider different scenarios. However, this process is not harmonious – the development of the prefrontal cortex, responsible for planning and impulse control, is not complete until adulthood. Hence, impulsiveness and risky behaviour are not uncommon at this age.

Young people also gain an increasing ability to think critically – they begin to question authority, social norms and ideas passed on by adults. This is a natural and necessary stage, enabling them to build their own system of values and intellectual identity. The role of adults is not to silence rebellion, but to accompany young people on their journey of discovery – to create space for discussion, questions and joint reflection on answers.

Social changes

Adolescence also brings profound changes in the social sphere. Young people cease to see themselves solely as members of their family and begin to seek their place among their peers, social groups and society as a whole. Relationships with parents are transformed from hierarchical and dependent to more partnership-based and dialogue-oriented (albeit often turbulent). A need for autonomy and independence emerges, which can manifest itself in the form of rebellious behaviour or isolation.

Peer relationships are particularly important. The social group becomes the main point of reference – it is here that young people test social roles, learn cooperation, loyalty and conflict resolution, but also experience rejection, judgement, competition and pressure.

Peer acceptance often becomes more important than the opinion of adults, which can lead to conformity or behaviour that contradicts previous norms.

Contemporary adolescence also takes place in the context of social media, which intensifies social comparisons, influences self-image and can generate strong feelings of exclusion or inadequacy. Shaping social identity is a process that requires support and understanding – young people need space to explore different roles, experience failures and successes, and build a sense of belonging on that basis.

- Changes influenced by the environment – the role of culture, environment and social context

Adolescence does not take place in a vacuum. It is a process deeply rooted in cultural, social and environmental contexts, which not only modifies the course of development, but also determines how young people experience themselves and their place in the world. As early as 1928, in her classic work Coming of Age in Samoa, cultural anthropologist Margaret Mead pointed out that adolescence does not follow a uniform course in different cultures. As she wrote, ‘growing up differs in different societies and cultures,’ and what is considered normative, desirable or difficult in one context may look completely different in another.

From the perspective of contemporary developmental psychology, culture is recognised as playing a key role in shaping both the expectations placed on young people and the development scenarios available to them. In societies dominated by collectivism, individual identity is often built on belonging to a group – family, community, nation. Young people are encouraged to conform to the norms and values of the community, and their individual aspirations are often subordinated to the common good. In more individualistic cultures, on the other hand, the emphasis is on self-fulfilment, autonomy and discovering one's own path in life, which can result in greater freedom but also a greater sense of loneliness or pressure to make independent choices.

These differences translate into many aspects of growing up: from perceptions of gender roles, to attitudes towards education and work, to intergenerational relationships. In some cultures, growing up involves rites of passage that symbolically mark the transition to adulthood. In others, the boundary between childhood and adulthood is more blurred, which can lead to a longer period of dependence and delayed independence.

Just as important as culture in the broad sense is the immediate social and environmental context, i.e. the social environment in which an individual grows up. For example, young people living in rural areas may face different challenges than those in large cities, both in terms of access to education and culture, as well as opportunities for development and contact with diverse worldviews. Family environment, economic situation, parenting style and relationships within the local community are of great importance in shaping a sense of security, values and identity.

The family, as the basic social group, is the first filter of culture through which young people begin to perceive the world. The values it transmits, such as diligence, religiosity, empathy, hierarchy and independence, provide an interpretative framework within which adolescents build their identity and make choices. Family communication patterns, attachment styles and conflict resolution methods significantly influence young people's emotional and social adaptation in other relationships.

It is also worth emphasising that the influence of culture and environment on adolescence is dynamic and two-way. Young people are not merely passive recipients of cultural messages – through their choices, lifestyles, interests and actions, they also influence the world around them. Adolescence is therefore a process of negotiating identity in dialogue with culture, family, peers and oneself.

Understanding the role that cultural and environmental factors play in the process of growing up is essential to fully grasp the complexity of this stage of life. Margaret Mead showed that young people's experiences are not universal – on the contrary, they are deeply rooted in local norms, values and systems of meaning. Thus, every young person grows up not only as a biological individual, but also as a participant in a specific culture, society and history.

In summary, adolescence is a complex process that goes far beyond the framework of biological development. It is a time of intense reorganisation – not only of the body, but also of the way one experiences oneself, one's relationships with others and the world. Young people face numerous, often conflicting stimuli: they develop within their own family and cultural environment, but are also confronted with global messages from digital media. They must constantly adapt to changing social expectations and norms while trying to understand who they are and what they need.

At the same time, different dimensions of identity develop – physical, mental, emotional, cognitive and social – which do not always keep pace with each other, which can lead to tension, uncertainty and the need to redefine oneself. This is a stage in which every experience – both support and lack thereof – can have long-term consequences.

Understanding adolescence as a multi-layered process deeply rooted in context is the foundation for further reflection on young people's mental health. Only by recognising this complexity can we attempt to effectively support young people in their development, rather than demanding that they quickly ‘become adults’.

Young people as a social group – opportunities and threats

Contemporary young people live in a world of dynamic technological, cultural and social change. As the structure of societies changes and globalisation and digitalisation permeate almost every aspect of everyday life, the nature of adolescence is also undergoing transformation. Today's adolescence is, on the one hand, a time of intense challenges arising from uncertainty, information overload and social pressure, and on the other, a space full of potential, innovation and opportunities to actively shape reality.

Young people – usually defined as those aged 12 to 24 – are not a homogeneous group, but a diverse community that can take different forms and have different experiences in different cultural and social contexts. Regardless of local conditions, however, adolescence is a transitional period in which young people intensively build their identity, social relationships and resources that enable them to function in adult life.

Young people should be seen not only as an age group, but also as a specific segment of society – dynamic, changeable, susceptible to influence, but also capable of creative responses to the surrounding reality. The characteristic features of this group include:

- Internal diversity – young people are not homogeneous. Differences resulting from ethnic origin, socio-economic status, religious beliefs, gender identity or sexual orientation translate into different experiences of growing up.

- Identity exploration – adolescence is a time of intense searching for answers to questions such as: ‘Who am I?’, ‘What do I want to do?’, ‘Which group do I belong to?’. Young people test different social roles, group affiliations and value systems, often in confrontation with the expectations of those around them.

- Developing social relationships – peer relationships take on particular importance. They provide a reference point for self-esteem, teach cooperation, negotiation and conflict resolution, but can also become a source of pressure or exclusion.

- Civic engagement – young people are increasingly involved in social and political life, participating in climate movements, social campaigns, volunteering and local initiatives.

- Cultural and digital exposure – young people operate at the intersection of local and global culture, which shapes their values, lifestyle, consumer choices and communication methods. Social media is becoming a key channel for building image and identity.

Despite numerous challenges, young people have significant potential which, if properly supported, can be a driving force for social development. The most important opportunities include:

- Creativity and innovation – young people naturally seek new solutions, combine ideas and experiment, making them a valuable source of innovation in both the technological and social spheres.

- Access to knowledge and education – growing educational opportunities and widespread access to information enable young people to acquire the skills they need to live in a knowledge-based society.

- Social and political activity – involvement in public affairs is becoming a way of building civic responsibility. Young people are speaking out in debates on climate, human rights, inequality and exclusion.

- Adaptability – thanks to growing up in a changing environment, young people are flexible, quick learners and able to adapt to new conditions.

- Technological potential – digital natives easily assimilate new technologies and often navigate virtual environments better than adults, which creates space for development in many sectors of the economy.

In addition to the opportunities mentioned on the previous page, young people also face threats that can hinder their development and negatively affect their well-being. The key ones include:

- Mental health problems – increasing levels of anxiety, depression, mood disorders, self-harm and suicide attempts are alarming phenomena. The causes can be found, among other things, in the pressure to succeed, loneliness, peer violence and unrealistic role models promoted in the media.

- Addictions – substance abuse, but also addiction to screens, games, social media and the internet are becoming increasingly common. These can lead to social isolation, concentration disorders, deteriorating relationships and educational outcomes.

- Unemployment and job insecurity – difficulties in entering the labour market and lack of job stability reduce feelings of security and ability to plan for the future.

- Social exclusion – social inequalities, lack of access to education, marginalisation due to origin or identity result in a lack of participation in social life and a feeling of alienation.

- Social and cultural pressure – expectations regarding appearance, success, lifestyle or ‘being someone’ can place an excessive burden on young people's mental health. Popular and commercial cultural norms often promote superficiality at the expense of authenticity.

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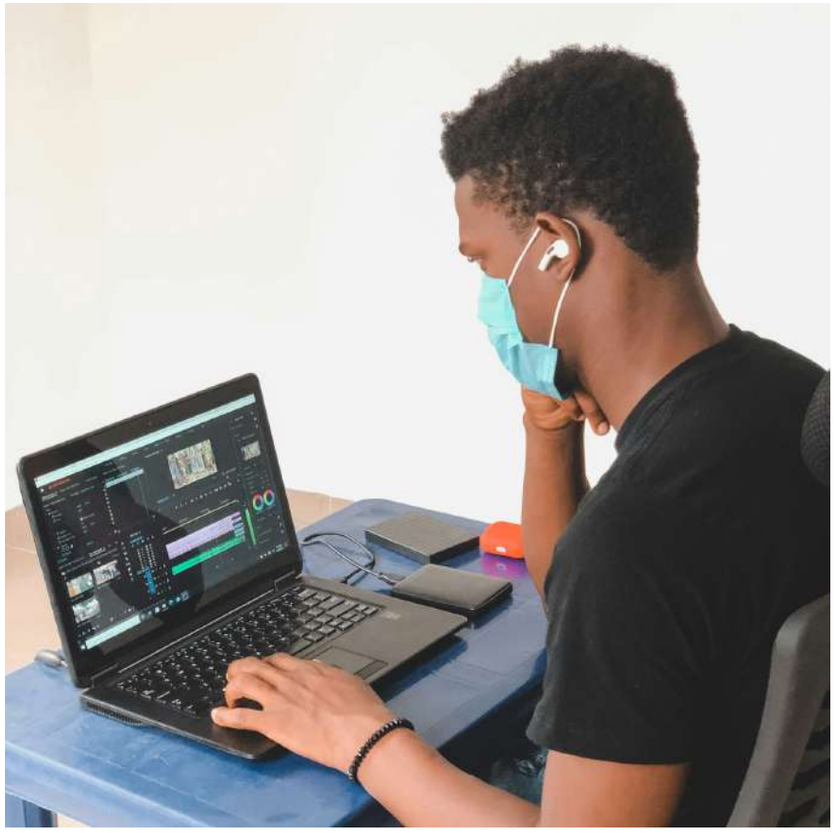


Young people are a social group with extremely high developmental, creative and social potential, but at the same time they are particularly sensitive to the changes taking place in the modern world. The period of adolescence, which is a time of identity formation, relationship building and making the first independent decisions, is becoming particularly challenging in the 21st century. Young people today live in a reality saturated with stimuli, information complexity and pressure to succeed – which, on the one hand, offers them unprecedented opportunities for development, but on the other hand, can exacerbate psychological tensions, feelings of instability and confusion.

The digital reality, the volatility of labour markets, growing social inequalities, climate challenges and the blurring of traditional social patterns mean that young people are increasingly finding it difficult to define their place in the world. Their socialisation and maturation process takes place in a space that does not provide clear answers, but requires them to adapt quickly and act in a multidimensional way.

That is why it is so important to create coherent, supportive environments for young people that enable them to explore themselves and the world safely. Family, school, local communities, non-governmental organisations, public institutions and the digital space – all these spheres should work together to build a support system based on understanding, dialogue and access to psychological, educational and social resources.

Only through such an integrated strategy is it possible to effectively strengthen young people's development opportunities while reducing risk factors. It is crucial not only to respond to threats, but above all to proactively create conditions that foster the well-being, autonomy, creativity and social responsibility of young people.

Investing in young people cannot be seen as an expense or an optional activity – it is a strategic decision about the shape of future society. It is young people who will determine the direction of cultural, technological, economic and political change in the coming decades. By supporting them today, we gain a strong, empathetic and conscious tomorrow.

The psychological needs of children and young people

The mental health of children and young people is not a static state, but a dynamic process shaped by interaction with the environment, life experiences and the individual's internal resources. One of the key conditions for proper psychological development is the systematic and adequate satisfaction of basic psychological needs. These needs form the foundation of a sense of security, well-being, motivation and identity. Their fulfilment determines the ability to adapt, build relationships, make decisions and cope with emotions. Failure to meet these needs can lead to developmental disorders and serious emotional and social difficulties.

- The need for security

Psychological and physical safety is a basic need for the stable functioning of an individual. Children and young people need a predictable, stable and supportive environment that protects them from violence, chaos, disorganisation and unjustified stress. A lack of security can result in increased anxiety, excessive emotional tension, difficulty concentrating and impaired learning ability. In the long term, this can lead to developmental problems, adjustment difficulties and psychosomatic disorders.

- The need for belonging and acceptance

Humans are social beings – the need to belong to a group and be accepted by others plays a fundamental role in psychological development. Children and young people look for places where they can feel noticed, understood and welcome. Lack of peer or family acceptance can lead to isolation, low self-esteem, social withdrawal and even symptoms of depression or anxiety. Supporting peer relationships, openness and empathetic communication are key to meeting this need.

- The need for autonomy and self-determination

During adolescence, the need for independence becomes extremely important, including the ability to make decisions, explore one's interests and experience agency. Restricting this need can lead to frustration, rebellion, loss of motivation and inhibition of identity development. Supporting young people in making choices – including wrong ones – promotes the development of responsibility and independence.

- The need for competence and effectiveness

Children and young people develop through learning and experiencing their own effectiveness. They need opportunities to develop their skills, take on challenges and achieve success. Strengthening competences – academic, social and practical – builds self-esteem and increases motivation to act. Ignoring this need can lead to a lack of self-confidence, withdrawal or compensatory behaviour.

- The need for identity and a coherent self-image

Adolescence is a time of intense searching for answers to the question ‘Who am I?’ Shaping identity – both individual and social – requires support, space to experiment and acceptance of diversity. Failure to meet this need can lead to identity crises, difficulties in making life decisions and problems in accepting responsible social roles.

- The need for recognition and respect

Children and young people need positive reinforcement, recognition of their efforts, skills and commitment. Receiving sincere recognition builds self-esteem and encourages further development. Excessive criticism, lack of emotional support and inadequate expectations can lead to low self-esteem, the development of perfectionism or complete withdrawal from activities.

- The need for understanding and empathy

In their relationships with adults, children and young people expect not only control and instructions, but also understanding and empathy towards their experiences. When their emotions are trivialised, ridiculed or ignored, it is more difficult for them to learn healthy ways of expressing their feelings and building relationships. A supportive environment that recognises their emotions and responds with care promotes the development of emotional maturity and interpersonal skills.

- The need for meaning and purpose

From an early age, children and young people ask themselves questions about the meaning of their actions and the direction they are heading in. The need for meaning and purpose in life includes aspirations, dreams and a sense that their lives matter. A lack of perspective, goals or hope can lead to a loss of motivation, apathy and even depression. It is the role of adults to support young people in discovering their passions, formulating plans and accompanying them in their implementation.

- The need for stable and supportive family relationships

Family relationships are the first and most important developmental context. Children and young people need closeness, care, predictability and acceptance within the family. Tension, conflict, lack of communication or emotional distance can lead to emotional development disorders and difficulties in building healthy relationships with other people.

- The need for rest, balance and self-care

Contemporary young people often function under pressure: educational, peer and social. That is why it is so important to provide them with space for rest, regeneration and contact with themselves. Lack of this balance can result in chronic stress, burnout, sleep disorders and weakened mental resilience.

Meeting the psychological needs of children and young people is not only a prerequisite for their proper development, but also the foundation for building a healthy, resilient society. Each of these needs – from safety and recognition to meaning – is part of a larger puzzle in which young people develop their identity, relationships and skills. Conscious responses to these needs by adults – parents, teachers, educators, psychologists – are an act of care, but also of social responsibility.

Understanding the inner needs of young people not only minimises the risk of mental disorders, but above all creates an environment in which young people can flourish, learn, make mistakes and mature with a sense of purpose and agency.
A society that supports young people in their mental health neds is investing in its future – a stable, conscious and sustainable one.

Developmental tasks of young people

Adolescence is a time of fundamental change, during which young people face numerous challenges resulting from rapid physical, mental and social changes. In order to go through this stage in a constructive way, individuals must accomplish a series of so-called developmental tasks – goals that are naturally inherent in a given period of life and whose achievement determines the harmonious development of personality.

Robert Havighurst, the creator of the classic theory of developmental tasks, defined them as normative challenges that individuals undertake at a specific moment in their lives. They stem from three main factors: biological changes (e.g. puberty), social expectations and personal aspirations. In the case of young people – usually between the ages of 12 and 24 – these tasks are particularly intense, often overlapping, and their proper completion has an impact on their future adult life.

At the same time, according to Erik Erikson, adolescence is associated with key psychosocial conflicts that individuals must resolve in order to achieve emotional and social maturity. In this chapter, we will take a detailed look at the developmental tasks of young people, their significance, the benefits of accomplishing them, and the potential consequences of neglecting them.

- Shaping personal and social identity

This is the most important and complex task of adolescence. Young people try to answer questions such as: 'Who am I?', 'What is the meaning of my life?', 'Which group do I belong to?' In this process, they explore various social roles, value systems, worldviews and lifestyles. The influence of peer groups, mass culture and social media significantly modifies this process.

- Benefits: a stronger sense of identity translates into emotional stability, better self-esteem, greater resilience to peer pressure and the ability to make informed life decisions.
- Risks: a lack of clear identity can lead to confusion, susceptibility to negative influences, difficulty in making commitments and an increased risk of depression and addiction.

- Gender and sexual identity development

Adolescence is also a time of exploration and formation of one's gender identity and sexual orientation. This requires not only self-knowledge, but also courage and openness in expressing oneself, especially in societies where sexuality is still stigmatised.

- Benefits: Acceptance of one's sexuality and gender identity allows for the development of a sense of authenticity, consistency and comfort in relationships.
- Risks: Lack of acceptance from those around them, marginalisation or internal identity conflict can lead to mental disorders, social isolation and symptoms of trauma.

- Development of social and interpersonal skills

Young people learn how to function in a group, communicate their needs, respond empathetically to others, and deal with conflict situations. Peers become the most important point of reference – a source of support, but also of pressure.

- Benefits: developed social skills are the foundation of healthy interpersonal relationships, promote social integration, and influence success in education and future work.

- Risks: a lack of interpersonal skills can lead to loneliness, exclusion, difficulties in relationships, and an increased risk of risky behaviour.

- Acquiring cognitive and creative skills

Adolescence is a time of intense brain development, especially in the structures responsible for abstract thinking, problem solving, planning and decision making. Young people shape their learning style, develop passions and build skills for the future.

- Benefits: the development of cognitive and creative abilities enables adaptation to a changing world, independent thinking, innovation and problem solving in various life contexts.

- Risks: deficits in this area can result in educational difficulties, limited professional development and a low sense of agency.

- Development of independence and responsibility

Young people gradually take control of their lives: they learn to manage their time, make decisions, plan for the future and take responsibility for their actions. This is the first step towards adulthood, which requires a supportive but not controlling environment.

- Benefits: a sense of autonomy supports the development of responsibility, initiative and emotional self-regulation.

- Risks: placing responsibilities too early or too late, as well as overprotection, can lead to helplessness, dependence or extreme rebellion.

- Preparation for professional and civic roles

During this period, young people make educational decisions, gain their first work experience and begin to understand their role as citizens – they become involved in volunteering, social activities and take an interest in politics. This is a time for laying the foundations for future social and professional activity.

- Benefits: shaping professional and social identity supports a sense of purpose, belonging and agency.

- Risks: lack of support and career guidance can lead to frustration, fear of the future and social exclusion.

- Forming close relationships and developing intimacy

According to Erikson's theory, the identity formation stage is followed by the intimacy stage. Young people learn to build deep relationships based on trust, respect and emotional closeness. This is also the time of first romantic relationships.

- Benefits: the ability to form lasting, satisfying relationships promotes mental and social well-being.

- Risks: an inability to build closeness can result in loneliness, emotional difficulties and problems in interpersonal relationships in adulthood.

The developmental tasks of young people are an integral part of shaping their identity, independence and emotional maturity. Their fulfilment influences the overall functioning of the individual, both personally and socially. Supporting young people in tackling these tasks requires conscious involvement on the part of adults: parents, teachers, psychologists, but also systemic structures – education, health care, youth policy.

Failure to achieve developmental tasks does not rule out the chances of a healthy life, but it can result in numerous difficulties: from mental disorders, through relationship problems, to professional limitations. It is therefore necessary to create environments that not only understand these processes but also actively support young people in going through them – without pressure, but with care, structure and access to developmental resources.

Growing up is one of the most dynamic and sensitive stages in a person's life. It cannot be reduced to biological maturation alone – it is a complex psychological, emotional and social process that takes place in the context of a changing world, rising expectations and constant tensions between the need to belong and the desire for independence. Young people, who are caught between childhood and adulthood, are trying not only to understand themselves, but also to find their place in a reality that often does not provide ready-made answers.

Contemporary youth function in an extremely complex context shaped by globalisation, digitalisation, pressure to succeed, changing social roles and intergenerational relations. As a social group, they bring with them enormous creative, civic and cultural potential, but at the same time they are exposed to numerous threats: from information overload and identity crises to mental health problems. Young people today face challenges that were completely marginal just a few years ago, such as the need to define themselves in a world dominated by social media or to build relationships in a hybrid space (online/offline).

In order to effectively support young people during this period, it is essential to understand their psychological needs – both fundamental ones, such as security and belonging, and more complex ones, such as the need for meaning, autonomy and identity. Satisfying these needs determines not only an individual's well-being, but also their ability to build relationships, learn, make decisions and enter adulthood in a healthy way.

A key category that organises the process of growing up is developmental tasks – challenges that an individual must undertake in order to reach the next stages of emotional and social maturity. Both Havighurst's theory and Erikson's psychosocial model show that adolescence is not a time of ‘waiting for adulthood,’ but a fully-fledged period of development governed by its own rules.

The fulfilment of these tasks – from shaping identity, through the development of social and cognitive skills, to building relationships and planning for the future – requires not only the commitment of young people themselves, but above all wise and adequate support from those around them.

Part 1 of the publication is an attempt to organise the key issues related to adolescence. It presents young people as a group with enormous potential and, at the same time, a high level of vulnerability. It describes the basic psychological needs of young people, indicating how their fulfilment affects mental health and overall development. Finally, it presents developmental tasks as signposts leading through a difficult but important stage of life.

Understanding all these elements allows us to build environments – family, educational, social and cultural – that not only ‘manage young people’ but also genuinely support their development. Only such a perspective creates the conditions for young people to grow up safely, learn, try things out, make mistakes and find themselves – and, as a result, become healthy, aware and engaged adults.

Part 2

Understanding suicide (about the causes of suicidal behaviour, the scale of the phenomenon, suicide stereotypes and myths)

Although adolescence is a period of development, exploration and identity formation, it can also be a time of intense emotional tension, internal conflict and feelings of misunderstanding. For some young people, these burdens become so overwhelming that they lead to self-destructive behaviour, including suicide attempts. Suicide, as an extreme phenomenon, often defies easy explanation. It requires a deep understanding of both the psychological reality of the person in crisis and the socio-cultural context that influences that reality.

The aim of this part of the publication is to provide a comprehensive overview of suicidal behaviour among young people. It will discuss the causes of such behaviour, its scale and dynamics, as well as the most common stereotypes that continue to hinder effective prevention and adequate support.

Suicidal behaviour is not the result of a single factor. It is always the result of a complex interaction between individual psychological predispositions, life experiences and social and cultural factors. Mental health problems, violence, isolation, family difficulties, mood disorders, addictions, peer bullying, identity crises or lack of access to help – all these factors can contribute in different ways to a growing sense of hopelessness. Importantly, suicide is rarely an impulse – it is much more often the final stage of gradually deepening mental suffering, which may remain invisible to those around the person for a long time.

One of the biggest obstacles to effective suicide prevention is the presence of harmful myths that have grown up around the subject. There is still a belief that ‘those who talk about suicide will not commit it’ or that suicide is a sign of weakness or a form of blackmail. Such simplifications not only deepen the stigma surrounding people in crisis, but also prevent those around them from offering support. Other common myths include the belief that asking someone about their suicidal thoughts may ‘inspire’ them to act on them – which contradicts research confirming that open, empathetic conversation can have a protective effect.

Understanding and debunking these stereotypes is essential to effective prevention, education and intervention.

Suicidal behaviour among young people is a complex phenomenon, delicate and deeply rooted in the psyche, but also in social narratives, education and health policy. To effectively counteract it, it is not enough to know that the problem exists – we need to understand why it occurs, how it manifests itself and what we can do as individuals and as a society. This part of the publication aims to do just that: to shed light on the complexity of the phenomenon, to give voice to facts rather than myths, and to indicate paths for responsible response.

About the causes of suicidal behaviour

Suicide is an extremely complex phenomenon – a dramatic act that ends a person's life and shocks not only those closest to the deceased, but also society as a whole. Understanding it requires moving away from simplifications and stereotypes. There is no single cause, no single pattern, no single course of events. Suicide is always the result of a combination of factors: psychological, social, environmental and, sometimes, biological. Only a careful analysis of these factors allows us to see how thin the line between crisis and tragedy can be. In the case of young people, the causes of suicidal behaviour are often rooted in the tension between the need to be accepted and the inability to meet the demands of their environment. Adolescents experience rapid emotional, physical and cognitive changes that often destabilise their existing sense of security. If this internal chaos is met with a lack of understanding, pressure to succeed, loneliness, violence or rejection, there is a risk of deepening mental suffering.

Mental health is undoubtedly one of the main causes of suicidal behaviour. Depression, anxiety disorders, personality disorders, emotional instability and self-harm are all factors that significantly increase the risk of suicidal thoughts and attempts. Depression among young people, although sometimes downplayed as ‘bad moods’ or ‘teenage angst’, is a serious disorder that can completely distort their perception of the world and themselves. A teenager may feel overwhelming guilt, worthlessness, and a lack of prospects – and be unable to seek help because they do not believe that anyone will understand them.

Another important area is experiences of violence – physical, emotional, sexual – both within the family and among peers. Young people who have experienced violence or neglect are much more likely to exhibit self-destructive behaviour. Traumatic experiences can weaken the ability to cope with emotions and build secure relationships. Peer violence – including cyberbullying – has a destructive effect on self-esteem and a sense of belonging, which are so important during adolescence.

Difficult family circumstances also play a role: conflict, divorce, illness or death of a loved one, addiction in the family or lack of a permanent caregiver. For many young people, home is not a safe haven but a source of chronic stress. In such circumstances, feelings of loneliness and the belief that no one can help them grow.

Addictions are also a significant risk factor – not only to psychoactive substances, but also to behaviours such as gambling, pornography or compulsive use of social media. Addictions can serve as maladaptive strategies for coping with psychological stress, but in the long term they deepen isolation, helplessness and suffering.

Today's young people are also heavily influenced by the digital world. While the internet can be a source of support and information, it can also be a space that exacerbates frustration and comparisons. Idealised images of life, popularity measured by the number of likes, cyberbullying and exposure to harmful content (e.g. promoting self-harm or suicide) can lead to inner turmoil and feelings of inadequacy.

Biological factors should also be taken into account, such as genetic predisposition, neurochemical disorders (e.g. low serotonin levels) and a family history of suicide. Although these factors do not in themselves determine suicidal behaviour, when combined with other stressors, they can increase susceptibility.

Social and cultural factors are a separate category – norms regarding masculinity and mental strength, taboos surrounding the expression of emotions, and the stigmatisation of mental disorders. A young person may come to the conclusion that they have no right to feel bad, that their suffering is a sign of weakness that must be hidden. In such cases, not only do they fail to seek help, but they also do not send clear signals to those around them.

The causes of suicide are never clear-cut. It is not a single incident, but an accumulation of experiences that, over time, create a sense of hopelessness. Many people function seemingly normally for a long time – masking their suffering, joking, attending school – until the psychological tension becomes unbearable.

That is why it is so important to recognise the so-called warning signs – changes in behaviour, withdrawal from social contact, loss of interest, disturbing statements or sudden decisions (e.g. giving away personal belongings). Not every sign means immediate risk, but each one should prompt us to stop and talk.

Understanding the causes of suicidal behaviour in young people requires empathy, knowledge and attentiveness. Only then is real prevention possible – based not on fear, but on a willingness to listen, talk and seek help together. In a crisis, it is not about looking for someone to blame, but about not missing the chance to save someone's life before tragedy strikes.

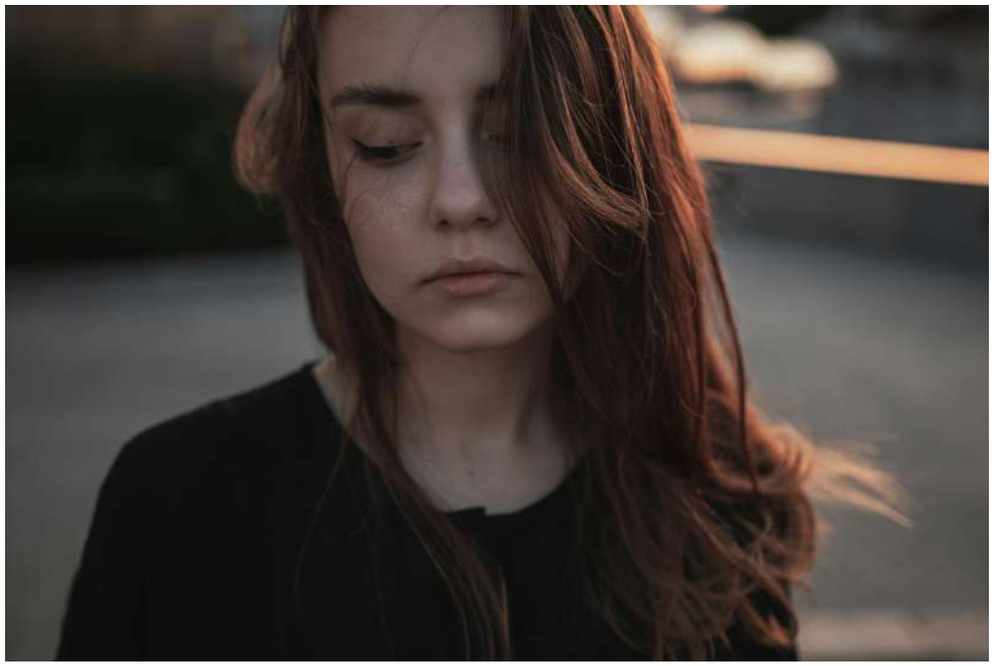
- Premises and warning signs

Suicidal behaviour does not appear suddenly and without warning. Although many people struggling with suicidal thoughts hide their emotional state from those around them, there are signs that, if recognised, can save lives. The ability to recognise these signs and respond appropriately is one of the most important elements of effective prevention.

A person considering taking their own life often sends signals – both directly and indirectly. Some of these may be easy to spot, such as direct statements about wanting to end their life, made in conversations, text messages or social media posts. Such statements are not a form of ‘emotional blackmail’, as some people mistakenly believe, but a dramatic expression of pain that has become unbearable. Any statement suggesting suicidal intent, regardless of context, should be treated as an alarm signal.

Hidden, subtle signs, often distorted by defence mechanisms or masked by seemingly neutral behaviour, are much more difficult to recognise. These include sudden mood swings – especially a transition from depression to unexpected ‘calmness’, which may result from a decision to commit suicide and the relief associated with it. Changes in daily habits are also worrying – loss of appetite, insomnia or, conversely, excessive sleepiness, neglect of appearance, giving up activities that were previously important to the person.

It is worth paying attention to social withdrawal – suddenly avoiding contact with family and peers, giving up activities, isolating oneself at home or in one's room. A person in crisis may express feelings of hopelessness, guilt, lack of purpose and meaning in life, either directly or indirectly. Sometimes statements such as ‘Everything would be better if I disappeared’, ‘No one would miss me’, ‘I can't do it anymore’ appear – these should not be ignored, even if they are said jokingly or under your breath.



There are also behavioural signs that may indicate suicidal intentions: suddenly tidying up personal affairs, giving away favourite possessions, writing farewell letters, searching for information about methods of suicide, or clearly ‘saying goodbye’ to those around them. A person may suddenly become extremely reflective, nostalgic or overly emotional, as if closing a certain chapter of their life.

Risky and impulsive behaviour may also be worrying, such as driving dangerously, excessive use of psychoactive substances or self-harm. Although not all of these behaviours directly indicate suicidal intent, they should raise alarm when seen in the context of other symptoms.

However, it is important to remember that there is no universal set of warning signs. They can look different for everyone – they depend on personality, previous experiences, how someone copes with stress, and how they communicate with those around them. In the case of children and young people, these signs can be particularly difficult to detect, as many of them overlap with mood swings and generational conflicts typical of adolescence. This makes it all the more important to build attentive, empathetic relationships that allow even small changes in behaviour to be detected.

Not every crisis means an immediate threat to life. But every signal should be taken seriously. If you suspect a risk of suicide, do not ignore the problem, postpone conversations or ‘wait for it to pass’. The best response is empathetic presence – listening carefully, assuring the person that you are ready to help and, if necessary, referring them to a specialist. People struggling with suicidal thoughts rarely expect immediate solutions – most often they need to feel that they are not alone.

One of the biggest myths is the belief that talking about suicide can ‘encourage’ someone to commit it. However, research clearly shows that open, kind and non-judgmental conversations can have a protective effect – they reduce tension, provide space to name emotions and restore a sense of control. Young people need not so much ‘answers’ as genuine attention and the presence of adults who are not afraid of difficult topics.

Understanding the reasons behind suicide does not require one to be a psychologist. It requires sensitivity, a willingness to listen, and the courage not to look away from suffering. Any behaviour that deviates from the norm – especially when accompanied by a deterioration in mental well-being – should prompt us to reflect: ‘Does this person need my attention, help or presence right now?’ Many suicides can be prevented – if only someone notices the signs, reacts and offers hope when it is most needed.

- The effects of suicide

Suicide is an event with an exceptionally strong and long-lasting impact. It does not end with the death of the individual – on the contrary, it triggers a series of emotional, psychological and social processes that affect both the deceased's loved ones and the wider community. It is one of the most traumatic experiences that a family, school, peer group or local community can face. The effects of suicide are difficult to predict and even more difficult to alleviate – they leave behind pain, unanswered questions and a feeling that something was not noticed in time.

The emotional consequences for the family and loved ones are the most severe. Parents, siblings, friends and partners often experience intense grief mixed with guilt, anger, disbelief and loneliness. They are constantly asking themselves: ‘Could I have done something?’ Suicide causes a different kind of grief – more complex, marked by taboo and social silence. Those who have lost someone often struggle not only with their own pain, but also with the awkwardness of those around them, avoidance of the subject, and even stigmatisation. Lack of support can deepen suffering and make it difficult to go through the natural grieving process.

The effects of suicide are particularly strong in the school environment, especially when it involves a young person. Such an event can completely upset the emotional balance of students, teachers and school staff. Feelings of loss, confusion and often fear that similar situations may happen again arise. Among the peers of the deceased, suicide can arouse extreme emotions: from grief and anger to feelings of guilt for not noticing the signs or reacting in time. Some experience secondary trauma, especially those who witnessed the dramatic events, found the body or received a farewell message. One of the most disturbing phenomena that can occur after the suicide of a young person is the so-called Werther effect – the risk of further suicides in the same social group or environment. This phenomenon is particularly dangerous when the suicide is made public in a careless, sensational or glorifying manner. In such situations, there is a risk that other vulnerable individuals – especially those who have already had suicidal thoughts – will begin to identify with the deceased and perceive suicide as an acceptable or romantic form of escape. This is why responsible communication in the public sphere is so important, as is the rapid implementation of crisis measures in schools and institutions affected by the tragedy.

The effects of suicide also have a social and cultural dimension. Every suicide affects the collective consciousness – it undermines the sense of security, triggers a debate about mental health, but also reveals taboos and gaps in the support system. In many communities, the subject is still shrouded in silence or simplifications that place the blame on the deceased or their family. This way of thinking hinders open conversation and can lead to secondary victimisation of those who have suffered a loss, instead of offering them real help. The economic consequences, although less often considered, are also significant. Suicide entails costs – both direct, related to emergency services, hospitalisation and care for the bereaved, and indirect, resulting from the loss of socially and professionally active individuals. In the case of young people, these losses are particularly painful because they affect people who were just about to start their adult lives – their potential, creativity and commitment.

It is important to remember that the effects of suicide are not limited to a single moment. Many people carry the scars of loss for years, struggling with depression, PTSD, anxiety or relationship problems. Sometimes, one person's suicide triggers an avalanche – not only emotional, but also structural, revealing systemic neglect in prevention, psychological care and education.

Therefore, the response to suicide should not be limited to crisis intervention. Reflection and concrete action are needed: creating safe spaces to talk about emotions, strengthening the competence of teachers and educators, the presence of psychologists in schools, and the availability of help regardless of social status or place of residence. Effective prevention begins when we surround young people with a network of relationships that give them not only knowledge, but above all a sense of being seen, important and safe.

Suicide is never just a ‘private tragedy’. It is an event that leaves a lasting mark on the memory of the community. Understanding its effects not only allows us to better help those who are grieving, but above all, to create a society that is more attentive, resilient and ready to provide support before it is too late.

✅ Checklist: Warning signs of suicide risk in teenagers

Tick each item that you notice in a given person. The more positive answers, the greater the risk and the need for immediate action.

🗣️ Changes in speech and communication

☐ Talks about wanting to ‘disappear,’ ‘leave,’ or ‘end it all.’

☐ Expresses hopelessness, meaninglessness, or helplessness (’Nothing makes sense anymore,’ “No one cares about me”).

☐ Says goodbye to loved ones or says that ’everyone will be better off without me.’

☐ Mentions suicide or asks questions such as ‘What is it like to die?’

☐ Writes farewell messages, letters or strange posts on social media.

💬 Behavioural and mood changes

☐ Withdraws from relationships – friends, family, class.

☐ Loses interest in previous hobbies.

☐ Exhibits sudden mood swings – from depression to euphoria.

☐ Becomes irritable, impulsive or aggressive for no reason.

☐ Shows strong feelings of guilt, shame or self-hatred.

🧠 Emotional and cognitive symptoms

☐ Has difficulty concentrating, remembering things or making decisions.

☐ Often speaks negatively about themselves, puts themselves down (‘I'm hopeless’).

☐ Shows signs of depression: sadness, apathy, tearfulness.

☐ Openly talks about the meaninglessness of life or that it is not worth trying.

🔁 Changes in daily habits

☐ Neglects personal hygiene, dresses carelessly.

☐ Has trouble sleeping – insomnia or excessive sleepiness.

☐ Loses appetite or starts eating compulsively.

☐ Engages in risky behaviour (e.g. driving under the influence of emotions).

🩸 Self-destructive behaviour

☐ Self-harm (e.g. cutting, burning, scratching).

☐ Increased interest in death or suicide (e.g. on the internet).

☐ Collects items that could be used to take their own life.

☐ Has previously attempted suicide.

🔍 Life circumstances and stressors

☐ Has recently experienced trauma or loss (e.g. death of a loved one, parental divorce).

☐ Experiences violence in the family or from peers (including cyberbullying).

☐ Feels unaccepted because of their sexual orientation or gender identity.

☐ Feels lonely, has no one to talk to about their emotions.

If you have ticked several points, don't panic, but react. Talk to the person in a calm, empathetic and non-judgmental manner. Don't ask, ‘Why do you feel that way?’ but rather, ‘I can see that something is wrong. Would you like to talk about it?’

Don't be afraid to ask directly, ‘Are you having suicidal thoughts?’ You won't ‘suggest’ anything to them, but you can give them space to open up.

Always take these signals seriously. Contact a psychologist, counsellor or mental health clinic.

About the scale of the phenomenon

Suicide among young people is one of the most serious and underestimated challenges in modern mental health care. Epidemiological data clearly show that the scale of this phenomenon goes beyond individual tragedies – it has a global, systemic and social dimension. Although statistics cannot reflect the suffering behind each number, they do help us understand how serious and complex the problem is, including in the context of prevention and planning effective support strategies.

Every year, more than 720,000 people take their own lives worldwide, and suicide remains the third leading cause of death among people aged 15–29. In this age group, it is more common than many somatic diseases. It is estimated that approximately 200,000 young people aged 15–29 lose their lives to suicide each year – a dramatic figure that reveals the scale of emotional suffering in this population.

It is worth noting that nearly three-quarters of all suicides occur in low- and middle-income countries, highlighting global inequalities in access to healthcare and prevention. At the same time, worrying trends are also observed in highly developed countries – in the United States, the number of suicides among people aged 10–24 increased by 62% between 2007 and 2021. This indicates a clear link between civilisational changes, social and digital changes and the deteriorating mental health of the younger generation.

In 2021, there were 5,038 suicides among people aged 15–29 in the European Union, accounting for almost one in five deaths in this age group. Although the overall trend over the last decade shows a decline in youth suicide, there are significant differences between Member States. The highest rates were recorded in Slovenia (19.8/100,000), Lithuania (19.5/100,000) and Hungary (15.7/100,000).

Of particular concern is the strong gender gap, with young men committing suicide at a much higher rate than women. In some countries, the mortality rate for men in this age group is between 1.8 and almost 4 times higher than for their female peers. This shows how important it is to take gender into account in prevention and education programmes.

In Poland, youth suicide remains one of the most serious public health problems. Although data for 2024 indicate some optimism – the number of suicides among children and young people fell to 127 cases (a decrease of over 12% compared to the previous year) – the number of suicide attempts remains at a dramatically high level. Every day, at least six teenagers attempt to take their own lives.

Between 2010 and 2023, the number of suicide attempts among people under the age of 24 increased almost fivefold, from around 800 to over 3,900 cases per year. Poland remains one of the European Union countries with the highest number of youth suicides.

Experts point to a number of reasons for this: underfunding of child psychiatry, a lack of psychologists in schools, increasing educational pressure, cyberbullying, and the effects of prolonged isolation and stress caused by the COVID-19 pandemic.

Gender differences are also worrying: while most deaths involve boys, suicide attempts are much more common among girls, which may indicate differences in how they cope with suffering and express it.

In Turkey, the problem of youth suicide is also growing. In 2023, there were 4,061 suicides in the entire population, with a rate of 4.98 per 100,000 inhabitants. In the group of children and young people (under 20 years of age), nearly 9,000 suicides have been recorded in the last two decades, with boys accounting for more than half. In 2023, as many as 40% of all suicides involved people aged 20–34, indicating a particular risk in early adulthood.

An analysis of the causes shows that family conflicts are most often cited among girls, while chronic illness is most common among boys. External factors are also significant, including natural disasters such as earthquakes, which in some regions of the country exacerbate feelings of insecurity and instability. In Turkey, as in many other countries, 76% of all suicides are committed by men, confirming the global trend.

The scale of suicide among young people, although varying from region to region, clearly indicates that we are facing a mental health crisis among the younger generation. Although positive trends are observed in some countries, such as a decline in the number of deaths in Poland, the increase in the number of attempts and the persistently high level of risk are evidence of a deep systemic crisis.

Young people around the world face similar challenges: pressure to succeed, uncertainty about the future, lack of access to psychological support, stigmatisation and lack of space to talk openly about their emotions.

Coordinated action is therefore necessary: investment in psychiatric and psychological care, emotional education in schools, family support and effective suicide prevention programmes. The data, although painful, should be an impetus for change – so that young people in crisis are not left alone and their suffering is recognised and taken seriously.

‘The mean world syndrome’

The phenomenon we are currently observing is the increasingly frequent experience of children with the mean world syndrome, which puts them in a state of constant anxiety. Young people live with the permanent conviction that the world is only bad and full of threats.

In a world dominated by violence, disasters and tragedies, young people are losing their sense of security. Their main sources of information, such as television and social media, bombard them with disturbing news and stimuli that negatively affect their emotional state.

In this situation, interpersonal relationships play a key role. Both family and peer relationships have a huge impact on the emotional and mental development of young people.

Parents, struggling with their own problems, are not always aware of the changes taking place in their children's psyche. A lack of time and emotional resources often prevents them from responding appropriately to the needs and signals sent by young people. A multifaceted approach is important here, as research also shows that parental burnout is an increasingly common phenomenon. Unfortunately, Poland is the leader in this ranking in Europe. This phenomenon is exacerbated by working beyond one's physical and mental limits, insufficient financial resources, stress, chronic fatigue and a lack of external support.

The mean world syndrome does not have a single cause, but is the result of many factors that accumulate and lead to suicide attempts and other self-destructive behaviours. It is therefore necessary to take action on many levels, both socially and individually.

It should be emphasised that young people need support and understanding from adults. Daily conversations with parents or other caregivers can help children understand that the world is not only a place full of dangers, but also full of opportunities and goodness. It is important for parents to spend time with their children, trying to understand their emotions and the signals they send.

It is also extremely important to educate young people about mental health and the forms of support available to them. Awareness should be raised about the institutions and organisations that offer help to people in mental crisis, and the ability to use these resources should be promoted.

It should be remembered that suicide statistics are underestimated because not all suicide attempts are reported. Youth suicide is still a taboo subject. One consequence of this is that young people do not know that they can ask for help when they are in a crisis situation. They do not know where to turn. They believe that they are completely alone with this problem. In the context of the mean world syndrome, measures should be taken to raise public awareness of the mental health needs of young people and to improve the quality of interpersonal relationships, which have a significant impact on the emotional and mental development of young people.

The mean world syndrome phenomenon is not new. Researchers described it as early as the late 1960s and early 1970s. It concerns the influence of the media, mainly television, on our sense of security. It has been observed that regularly watching news about violence, natural disasters and tragedies leads to a drastic reduction in viewers' sense of security. Even if their own lives are relatively safe, they begin to feel fear, anxiety and stress. Today, with increasing access to the Internet, our children spend long hours online, exposing themselves to content that arouses fear and encourages comparison with others.

Social media, computer games and apps such as Instagram and TikTok are saturated with stimuli that deliberately play on our emotions. Of course, these are not always tragic events; often it is simply a constant bombardment of information about what is currently happening in the world, how many people have died and where. This information overload causes a lot of stress, especially in young people who do not yet have the tools to deal with their emotions.

That is why our children are increasingly experiencing the mean world syndrome, convinced that the world is dangerous and threatening, which results in escapism. Comparing today's reality with what we had a few decades ago, we can see a huge difference. In the past, life revolved around playing in the yard, adventures and joy, and children were not exposed to the dark side of life as they are now.

We must work together to find solutions, both at the systemic level and at home, through grassroots efforts. The most effective protection against dramatic situations is regular contact with your child, sensitivity and openness to provide them with space to talk openly about everything, both the difficult and positive aspects of life. It is important to show children that there is a way out of every situation, even the most difficult ones, and not to downplay their problems. Children do not realise that heartbreak or a friend's disloyalty does not mean the end of the world, so it is the job of adults, as parents, to reassure them that the world does not end with the difficulties they are currently experiencing. If young people are left alone with this belief, suicide attempt statistics will continue to rise.

Stereotypes and myths about suicide

Suicide is a topic that still evokes strong emotions – from fear and helplessness to misunderstanding and stigmatisation. Despite growing public awareness of mental health, there are still many myths and simplifications surrounding this phenomenon. These myths and simplifications make it difficult for people in crisis to get the support they need and for those around them to recognise the warning signs and respond appropriately.

The complex nature of suicide – encompassing psychological, social, biological and existential factors – makes it easy to fall into patterns of thinking that offer seemingly simple explanations: ‘It was an impulse’, ‘Anyone who really wants to die doesn't talk about it’, ‘He just wanted attention’. Such beliefs, although often repeated in good faith, can lead to downplaying the risk, judging people struggling with mental suffering, and ultimately to delaying intervention and deepening the loneliness of people in crisis.

Stereotypes about suicide can also be deeply rooted in culture and language. They influence how we perceive people who have attempted to take their own lives, how we talk about their experiences, and whether we consider their suffering to be ‘real’ or ‘valid.’ In some communities, suicide remains a taboo subject – it is silenced, denied, and even blamed or shamed. This social climate prevents many people struggling with suicidal thoughts from disclosing their condition for fear of judgement or rejection.

Meanwhile, effective suicide prevention starts with understanding. To be able to support, you need to be able to listen – without judgement and without prejudice. Therefore, one of the key tasks of mental health education is to deconstruct the myths and stereotypes that distort our perception of people in crisis. Only through accurate presentation of facts, empathetic narration and open conversation can we change society's attitude towards suicide and effectively help those who are suffering.

The aim of this section is therefore not only to debunk popular myths about suicide, but also to show how harmful they are – and why it is necessary to critically rethink them. By dismantling false beliefs, we create space for understanding, acceptance and professional help. Because suicide needs to be talked about – wisely, openly and responsibly.

Myth 1: ‘A person who talks about suicide won't actually do it. They're just crying out for attention.’

- Why this belief is harmful:

This myth downplays serious warning signs that may indicate a real mental health crisis. It assumes that talking about suicide is a form of emotional manipulation or exaggeration, rather than a genuine expression of suffering. As a result, people who communicate their suicidal thoughts are often not taken seriously, which significantly increases the risk that they will not receive help in time.

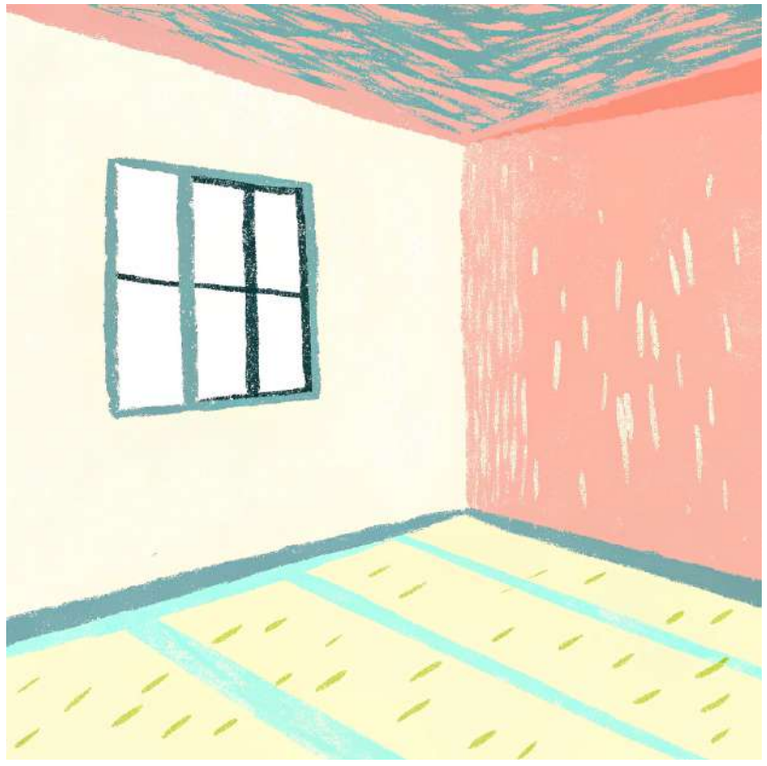
- What the research says:

According to numerous epidemiological studies, approximately 80% of people who commit suicide have previously signalled their intentions, either directly or indirectly, through words, behaviour, social media posts, withdrawal from relationships or putting their personal affairs in order (CDC, 2022; WHO, 2021). Talking about wanting to take one's own life, even if it sounds vague or dramatic, is a clear sign of risk and should be taken very seriously.

Research has shown that people who share suicidal thoughts are often seeking relief, understanding and support, not necessarily death itself – they want to stop suffering. This is not ‘emotional blackmail’ but an expression of desperation and a loss of resources to cope.

- What clinical practice says:

In psychiatry and psychotherapy, talking about suicidal thoughts is always treated as a serious signal – regardless of the tone of the statement or its frequency. The rule is: treat every declaration of suicidal thoughts as a real threat to life. There is no such thing as safe ‘talking about suicide’ – if someone talks about it, they need support and space to talk, not judgement.



Myth 2: ‘Anyone who really wants to commit suicide will just do it – they won't talk about it.’

- Why is this belief harmful:

This belief perpetuates a false image of suicide as a sudden act, committed in silence and without warning. It undermines the importance of statements and behaviours of a person in crisis, assuming that only silence means a real threat. This view leads to passivity on the part of those around the person: ‘if they are talking about it, it can't be that bad’. However, verbalising suicidal intentions is often the last warning sign before an attempt is made.

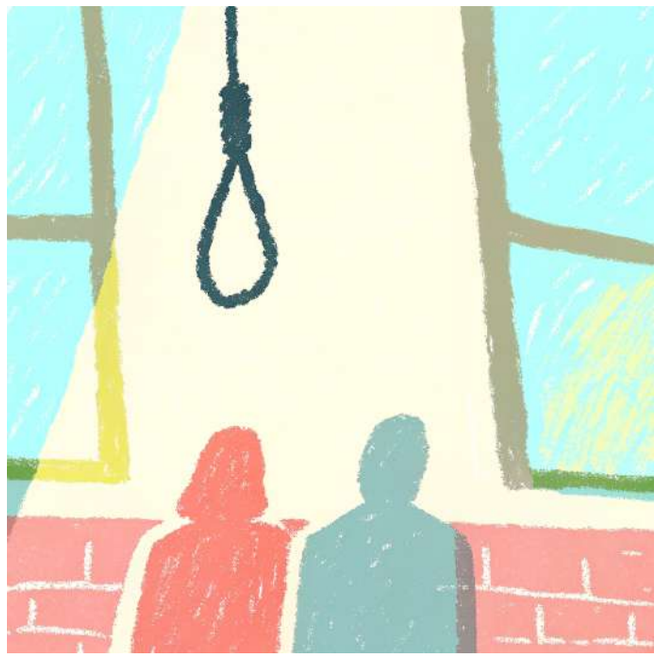
- What the facts say:

Contrary to myth, the vast majority of people who take their own lives have previously given clear or subtle signals to those around them. Data from the American National Institute of Mental Health show that as many as 4 out of 5 people who committed suicide had previously spoken about their intentions verbally or non-verbally. This can include, for example, talking about the meaninglessness of life, withdrawing from social life, giving away valuable possessions or posting farewell messages on social media.

The World Health Organisation (WHO, 2021) also points out that communicating suicidal intent, directly or indirectly, should be treated as one of the most serious risk factors. Most people in a mental crisis internally waver between the desire to live and the desire for relief from suffering. Talking about suicide can be an attempt to escape this ambivalence by contacting another person.

- What clinical practice says:

Psychiatrists and therapists emphasise that people who plan suicide are often in internal conflict – they do not want to die, but see no other way out of their mental pain. They often communicate their intention in the hope that someone will notice their suffering and respond. Silence does not mean that there is no danger, but expressing suicidal thoughts – especially repeatedly – does not mean that the threat should not be taken seriously.



Myth 3: ‘Suicide is always the result of a single dramatic situation – it is a decision made on impulse.’

- Why this belief is harmful:

This myth simplifies the complexity of suicide, reducing it to a single sudden decision made under the influence of strong emotions. As a result, it leads to the belief that all you need to do is ‘get through the difficult moment’ for the danger to pass. On the one hand, this can cause warning signs to be ignored, and on the other, it can create a false sense of guilt in those around the person who died: ‘If only I had stopped them...’

- What the facts say:

Suicide is rarely an impulsive act. In the vast majority of cases, it is the result of a long period of mental suffering, often lasting weeks, months or even years. Data from the WHO and studies conducted by, among others, the Harvard School of Public Health show that even if the act itself looks like a sudden decision, it is almost always preceded by chronic stress, depression, mental disorders, earlier warning signs and planning. Impulsiveness may be present, especially in young people or those under the influence of psychoactive substances, but it rarely occurs in isolation from a deeper crisis. What is more, for some people, planning suicide takes a long time and can be very deliberate, from choosing the means, to writing farewell letters, to choosing a moment when no one will be around.

- What clinical practice tells us:

Psychologists and psychiatrists warn against trivialising suicide as a ‘momentary breakdown’. Such a narrative makes it difficult to notice the signs of an impending crisis and also contributes to the stigmatisation of people who are struggling with suicidal thoughts. Suicide is not a ‘weakness’ or the result of a single incident, but often the final stage of growing, untreated mental suffering that has remained invisible or misunderstood.

It is important to understand that even if the decision to take one's own life can be made in a short period of time, the process leading up to that decision is usually long-term. Therefore, it is crucial to support young people in building mental resilience and accessing help before a crisis arises.

Myth 4: ‘Anyone who has attempted suicide is just seeking attention – they won't really do it.’

- Why this belief is harmful:

This myth downplays the dramatic and potentially deadly experience of attempting suicide. Accusing someone of ‘seeking attention’ not only diminishes their suffering, but also discourages them from seeking help and openness. Such reactions from those around them can deepen feelings of shame, loneliness and worthlessness – emotions that are particularly dangerous in the context of subsequent attempts.

- What the facts say:

According to the WHO and the Centres for Disease Control and Prevention (CDC), people who have attempted suicide are among those at highest risk of repeating their attempt and dying. Data shows that approximately 25-30% of people who have attempted suicide will make another attempt, and within 12 months of the first attempt, the risk of recurrence increases several times. This means that every attempt, regardless of its ‘intensity’, is a real threat to life and always requires psychological or psychiatric intervention.

Importantly, many people do not end their lives on their first attempt, not because they did not want to, but because of chance, inadequate means, intervention by others or an impulsive plan. This does not invalidate the seriousness of the situation – on the contrary, it points to an urgent need for support before another, perhaps more successful, attempt is made.

- What clinical practice tells us:

Psychiatrists, psychotherapists and emergency medical personnel are unequivocal: every suicide attempt is an act of despair, not a cry for attention. It should be treated as an alarm signal of the highest order. A young person who has attempted to take their own life often returns to functioning in a seemingly ‘normal’ way, but internally they continue to struggle with the same difficulties that led them to the crisis. Ignoring this fact is a direct path to a repeat tragedy.

A suicide attempt is not only a sign of suffering, but also the last, dramatic form of communication in which a person says, ‘I cannot express in any other way that I cannot cope anymore.’ It is not ‘manipulation,’ but the result of a lack of other ways to deal with mental pain.

Myth 5: ‘Talking about suicide with a teenager may provoke them to attempt it.’

- Why is this belief harmful:

This belief stems from the mistaken assumption that talking about suicide can ‘put the idea in someone's head’ or ‘infect’ them with thoughts of taking their own life. As a result, many adults – parents, teachers, carers – avoid bringing up the subject, even when they see worrying signs. They are afraid that talking about it will ‘awaken the demon’. This leads to silence, which deepens the emotional isolation of the person in crisis.

- What the facts say:

Research conducted over the past two decades – including by the Suicide Prevention Resource Centre, the WHO and the American Psychological Association – clearly debunks this myth. Talking about suicide does not increase the likelihood of a suicide attempt. On the contrary, it reduces the risk by allowing the person in crisis to express their emotions, receive empathy and start the process of seeking help.

For example, a meta-analysis published in Psychological Medicine (2014), covering 13 studies involving over 3,000 people, showed that asking about suicidal thoughts not only does not increase the risk of suicide, but can also have a protective effect by signalling that the topic is not taboo and that someone is really listening.

- What clinical practice says:

From a therapeutic perspective, talking about suicide is a key tool for prevention. It allows us to recognise the level of risk, name difficult emotions and establish contact with a person in crisis. Young people often do not have the words to describe their suffering – if we do not ask them directly, they may never be able to confide in us. A simple question such as ‘Do you ever think about killing yourself?’ is not dangerous – it can be a lifesaver.

Silence about suicide, treating it as a taboo subject, builds a wall of shame and fear that prevents effective support from being provided.

Myth 6: ‘People who plan suicide don't give any signs – they do it without warning.’

- Why this belief is harmful:

This belief creates a false sense of security: if no one noticed anything, then the tragedy could not have been predicted or prevented. This way of thinking can justify social silence and inaction, and shift responsibility away from those around us. More importantly, this myth contradicts the facts: in reality, most people struggling with suicidal thoughts send out warning signs, although not always in obvious ways.

- What the facts say:

According to data from the World Health Organisation, the Centers for Disease Control and Prevention, and the National Alliance on Mental Illness, as many as 70–80% of people who commit suicide have previously signalled their intentions. These included both verbal statements and subtle behavioural changes: withdrawal from relationships, loss of interest, putting personal affairs in order, giving away possessions, saying goodbye to loved ones, or sudden calm after a long period of depression.

Although not everyone in crisis will speak directly about their desire to take their own life, there is almost always a change – in mood, lifestyle or behaviour. Ignoring these signs can lead to a failure to take life-saving measures.

- What does clinical practice say?

Psychologists and crisis interventionists emphasise that people at risk of suicide are often in a state of ambivalence: they are torn between conflicting emotions – the desire for relief and the need to be noticed. Their behaviour is often a symbolic cry for help, although they are unable or do not have the strength to openly ask for help.

From a prevention perspective, it is crucial to teach the public to recognise warning signs, including those that are not immediately obvious: sudden mood swings, persistent talk of meaninglessness, increased interest in death, isolation, giving away important possessions. Most suicides could be prevented if these signs were properly interpreted and taken seriously.

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Myth 7: ‘If someone has had a better day and seems calm, it means that the crisis is over.’

- Why this belief is harmful:

This myth can lull those around you – especially family, friends and teachers – into a false sense of security and lead to a tragic mistake: failing to provide support when it is most needed. Often, it is precisely this apparent improvement in mood that is a harbinger of the deepest despair – people in crisis feel relief because they have made a final decision that, in their eyes, ends their suffering.

- What the facts say:

Experts in crisis psychology and suicidology (including the Mayo Clinic and the American Foundation for Suicide Prevention) repeatedly emphasise that a sudden, unexpected improvement in mood in a person who has previously struggled with depression or suicidal thoughts can be a warning sign, not a sign of recovery. It often results from ‘pre-death relief’ – a feeling of peace that comes after deciding to take one's own life. The person feels that they have found a ‘solution’, even if it is tragic.

Research shows that in some people who committed suicide, their loved ones noticed a sudden ‘improvement’ in behaviour, which discouraged them from further discussing their problems or seeking professional help.

- What clinical practice says:

Experienced psychotherapists and psychiatrists agree: not every improvement in mood means that a person is coming out of a crisis. When assessing the mental state of a person who is depressed or in a suicidal crisis, it is important to consider the entire context and dynamics of the changes, not just a momentary impression of ‘feeling better.’

Myth 8: ‘People who really want to die cannot be stopped.’

- Why is this belief harmful:

This fatalistic statement suggests that nothing can be done to prevent suicide because the decision to die is irreversible and unquestionable. This approach undermines the meaning of help, support and prevention, and ultimately leads to inaction: ‘If they're going to kill themselves anyway, why bother talking to them?’ Meanwhile, most people with suicidal thoughts do not want to die – they want to stop suffering.

- What the facts say:

Psychological and psychiatric research clearly indicates that suicidal thoughts are usually ambivalent – the person does not so much want to stop living as they no longer see any other way of coping with their mental pain. The desire to die often coexists with the hope that someone will notice the suffering and offer a helping hand. Only a small percentage of people are completely convinced that they need to end their lives – and even they can change their minds if they receive support. Data from the WHO and the American Psychological Association show that most people who survive a suicide attempt later say they are grateful that someone helped them. In many cases, intervention – even seemingly minor – changed their decision. Research conducted on the Golden Gate Bridge has shown that over 90% of people who were prevented from jumping never attempted suicide again.

- What clinical practice says:

Psychotherapists and crisis interventionists emphasise that every conversation, every gesture, every reaching out matters. Even people who are determined to commit suicide can change their minds – often as a result of experiencing empathy, interest and understanding.

At the root of suicide lies a feeling of helplessness, loneliness and a lack of alternatives – which means that by changing the perception of the situation, offering real support and showing that there are other ways out, it is possible to effectively reverse the course of events. Suicide is not inevitable – it is a dramatic solution to a crisis that in most cases can be prevented.

Myth 9: ‘Suicide is a sign of weakness or selfishness.’

- Why this belief is harmful:

This myth has particularly destructive effects. It suggests that a person who attempts to take their own life is acting out of character, escaping from problems or thinking only of themselves. In reality, this approach reinforces the stigma surrounding people in mental crisis, prevents open discussion about suffering and discourages people from seeking help for fear of judgement.

- What the facts say:

All available data from the fields of psychiatry, clinical psychology and suicidology confirm that suicide is neither a selfish choice nor a sign of weakness of character. It is a sign of deep mental suffering, often accompanied by serious disorders such as depression, anxiety disorders, trauma, PTSD, personality disorders or psychosis.

According to research by Harvard Medical School and the World Health Organisation, people who attempt suicide are most often in a state of complete mental exhaustion, losing their sense of meaning, perspective and ability to cope with life. In their perception, suicide is not an act of harm towards others, but the last possible ‘solution’ to their suffering. This is very often accompanied by the mistaken belief that their departure will be a ‘relief’ for their loved ones – which is in fact a symptom of disorder, not selfishness.

- What clinical practice says:

Experts point out that people in a suicidal crisis do not act with cold calculation, but from a place of emotional desperation and extreme mental stress. Telling them that they are ‘weak’ or ‘selfish’ is exactly what they fear and often think about themselves. Reinforcing this narrative deepens their feelings of guilt, isolation and belief that no one understands their pain.

Instead of judging, create a space for conversation based on trust, empathy and understanding, not judgement. Suicide is not a choice – it is often a cry for help in the face of helplessness. By helping, we are not reinforcing weakness – we are giving strength to survive.

Myth 10: ‘Children and teenagers are too young to really think about suicide.’

- Why is this belief harmful:

This belief downplays the reality and seriousness of mental health issues in children and young people, perpetuating the false notion that ‘young people are exaggerating,’ ‘they'll grow out of it,’ or ‘they're not yet capable of making such a serious decision.’ Meanwhile, suicide is currently one of the leading causes of death among young people, and ignoring warning signs can lead to tragic consequences.

- What the facts say:

WHO and UNICEF statistics are alarming: suicide is the third leading cause of death among 15-19 year olds worldwide. However, this problem is also increasingly affecting younger children – in some countries, including Poland, there is a growing number of suicide attempts among children aged 10-13. In Poland in 2024, at least six teenagers attempted suicide every day, and 127 children and young people under the age of 18 died by suicide – despite a slight decrease compared to the previous year, these figures are still dramatically high. This is a clear signal that children and young people not only can, but do experience suicidal thoughts and crises.

- What clinical practice tells us:

Child psychiatrists and psychotherapists emphasise that the adolescent brain is particularly sensitive to strong emotions, stress, anxiety, social failure and rejection. At this stage of life, young people have not yet developed coping mechanisms and may experience enormous psychological suffering – often misunderstood or invisible to adults.

Children and teenagers can feel emotions just as intensely as adults, but they are not yet able to name, express or constructively process them. For this reason, they are more prone to impulsivity, especially in situations of severe stress or lack of support. There is no ‘lower age limit’ for suffering – and any disregard for it can end in tragedy.

Myth 11: ‘People who really want to kill themselves don't ask for help.’

- Why this belief is harmful:

This belief creates an image of someone planning suicide as completely closed off, silent, and determined—someone who can no longer be saved. In reality, many people struggling with suicidal thoughts try to communicate their suffering in subtle or direct ways, looking for even the slightest sign of concern or interest. This myth discourages those around them from responding and weakens their vigilance to warning signs.

- What the facts say:

Research conducted by the American Foundation for Suicide Prevention and the WHO shows that over 80% of people who commit suicide have previously signalled their intentions in some way – through changes in behaviour, verbal statements, notes, social media posts, sudden tidying up, giving away personal belongings or social withdrawal.

Many people say outright that they ‘see no point in living’ or that ‘everyone would be happier without them’ – but those around them often ignore these signals, dismissing them as ‘exaggeration’ or ‘emotional manipulation.’ Meanwhile, these statements may be a last-ditch attempt to express pain and see if anyone else cares.

- What clinical practice says:

Psychotherapists and crisis interventionists know that people in deep suicidal crisis are often unable to clearly say, ‘I want to kill myself. Help me.’ Instead, they may say, ‘I can't cope anymore,’ ‘Nothing makes sense,’ ‘I wish I could disappear,’ or ‘I'm a burden to everyone.’ These statements are cries for help — often the last ones.

Many patients who have been rescued from suicide attempts say that they ‘didn't really want to die, but didn't know how to ask for help anymore.’ That is why it is so important that we take every expression of suffering, every change in behaviour, every departure from routine seriously, and not just literal messages.

Silence does not necessarily mean there is no problem, but a request for help – even a veiled one – should be treated as an alarm signal, not a sign of a lack of real intention.

Myth 12: ‘If someone has already had therapy or is taking medication, it means they are no longer at risk of suicide.’

- Why this belief is harmful:

This myth creates a false belief that starting treatment automatically and immediately means getting out of a crisis. As a result, those around the person may stop paying close attention to changes in their well-being, and the person themselves may feel misunderstood when they do not experience immediate relief. This belief can lead to premature termination of treatment or downplaying of signs of relapse.

- What the facts say:

Psychological therapy and pharmacotherapy are key tools in the treatment of mental disorders – but they do not guarantee immediate improvement on their own. The process of mental recovery is complex, long-term and often requires trial and error and adjustment of treatment.

What is more, the first weeks after starting pharmacological treatment, especially with antidepressants, can be a period of increased suicide risk, especially in young people. These individuals may experience a slight increase in energy and motivation before their mood and thinking improve, which paradoxically increases their ability to act, including to carry out suicidal thoughts.

Even the end of therapy, even if successful, does not rule out the recurrence of symptoms of depression or anxiety, which can lead to the return of suicidal thoughts.

- What clinical practice says:

Psychotherapists and psychiatrists clearly indicate that treatment is a process, not a magic solution. People who are in therapy or taking medication may continue to struggle with strong emotions, feelings of hopelessness or low self-esteem. What's more, people who have been in treatment for a long time often stop sharing their difficulties with those around them for fear of being judged (‘you're still not over it?’).

Myth 13: ‘People who attempt suicide do so to manipulate others – they want to force them to do something.’

- Why this belief is harmful:

This myth brutally undermines the authenticity of a suicide survivor's suffering, reducing their actions to emotional blackmail. This interpretation deepens stigma, discourages people from offering help, and can lead to those who really need support being rejected, isolated, and even more vulnerable to further attempts. As a result, this myth increases the risk of death.

- What the facts say:

According to WHO data and clinical studies (including Dr. David Jobes, an expert in suicidology at the Catholic University of America), suicide attempts are most often the result of intense and prolonged mental suffering, not a ‘control mechanism.’ Many people who attempt suicide are in a state of extreme helplessness – their actions are a cry for help, not a calculated strategy.

It is true that some people in crisis may exhibit impulsive or dramatic behaviour – but this does not mean that their actions are any less real or less dangerous. It is impossible to effectively distinguish between a ‘real’ and a ‘fake’ suicide attempt – each requires a response, empathy and professional help.

Importantly, people who have been accused of manipulation are often afraid to talk about their suffering later, fearing that no one will believe them. This can lead to tragic consequences.

- What clinical practice says:

Psychotherapists point out that even if the behaviour of a person in crisis seems contradictory, incomprehensible or impulsive, it should not be downplayed or judged through the prism of ‘manipulation’. Very often, such behaviour stems from a lack of ability to express emotions constructively, a lack of prior support and deep psychological chaos.

Regardless of the motives, any attempt to take one's own life is an alarm signal that the person is no longer able to cope with their suffering and needs immediate help. Judgement and suspicion will not save a life – mindfulness, empathy and response can.

Myth 14: ‘If someone has friends, family and a good life, they will certainly not take their own life.’

- Why this belief is harmful:

This myth is based on the assumption that suicide is the result of external, visible difficulties — such as loneliness, poverty or lack of support. However, mental disorders and emotional crises can affect anyone, regardless of their life situation, financial status or the number of people around them. Thinking that ‘someone had everything’ can lead to ignoring the real signs of mental suffering, which are not always visible from the outside.

- What the facts say:

Suicidal research and clinical data (e.g. from Harvard Medical School, CDC and WHO) show that many people who committed suicide appeared to lead ‘normal’ or even successful lives. Good grades, a satisfying job, a large number of friends — none of these factors fully protect against depression, suicidal thoughts or an existential crisis. Mental suffering can be deeply hidden, and people in crisis may not show it to those around them — not because they are fine, but because they do not want to be a burden or do not know how to express their emotions.

Young people in particular are adept at masking their suffering, functioning on social media, in peer groups or even within their families as smiling, ‘go-getter’ individuals. In reality, they may be experiencing emptiness, feelings of inadequacy, anxiety or chronic depression.

- What clinical practice tells us:

Psychotherapists warn that the absence of visible ‘reasons’ for suicide does not mean that there is no suffering. Many patients who come to therapy after a suicide attempt have stable relationships, good grades or jobs, yet they feel deep inner pain. The causes can be hidden: chronic mental overload, undiagnosed depression, childhood trauma, suppressed identity or an internalised sense of not fitting in.

This is why it is so important to pay attention to emotions, not just appearances. A ‘good life’ does not always mean ‘a life without suffering.’ Instead of assuming that someone is ‘fine,’ it is better to ask, ‘How are you feeling today — really?’

Myth 15: ‘Myth: Suicide is linked to heredity.’

- Why is this belief harmful?

This belief has some biological basis, but it is very often misunderstood and exaggerated. The belief that ‘suicide is in the genes’ leads to the stigmatisation of entire families, encourages unjustified fatalism (‘it will happen to me anyway’) and can discourage people from seeking treatment or support because everything is supposedly ‘already predetermined’.

- What the facts say:

Genetic studies (including Brent, Melhem, Mann) indicate that there is a certain hereditary biological predisposition to mental disorders such as depression, bipolar disorder, impulsivity and anxiety disorders. These factors may increase the risk of suicidal behaviour, but they do not mean that suicide is ‘passed on in the genes’ like eye colour or blood type.

Important: most people who have a family history of suicide will never attempt suicide. Genetics may increase susceptibility, but environmental, social, emotional and psychological factors are crucial — including access to support, the quality of relationships, coping styles and life experiences.

- What clinical practice says:

Psychiatrists and psychologists caution against a deterministic approach to heredity. Families with a history of suicide may indeed be at higher risk, but not because of a ‘gene,’ but because of the way stress is passed down, the taboo around talking about emotions, hidden trauma, lack of access to treatment, or inability to seek help.

It is also worth adding that people who have lost a loved one to suicide are themselves at increased risk — not because of genetics, but because of the trauma they have experienced, grief, guilt and often unresolved emotions. That is why it is so important that people who have suffered a loss also receive specialist support.

- ‘If someone is planning to commit suicide, there is no way to stop them.’
- ‘Self-harm is just an attempt to get attention, not a real threat.’
- ‘If someone has survived a suicide attempt, they are over it.’
- ‘Only people with serious problems resort to suicide.’
- ‘Someone who smiles can't be depressed or planning suicide.’
- ‘Religious or spiritual people don't commit suicide.’
- ‘Children don't understand death, so they can't want to die.’
- ‘When someone says they want to kill themselves, it's just emotional blackmail.’
- ‘After therapy, a person is cured and there is no need to worry.’
- ‘Spoiled children and teenagers invent suicide out of boredom.’
- ‘It doesn't happen in good families.’
- ‘Suicide is a sign of cowardice or weakness.’
- ‘Positive thinking is enough to stop suicidal thoughts.’
- ‘If someone is really suffering, nothing will help them anyway.’
- ‘People who help others a lot don't have mental health problems.’
- ‘Suicide is always an impulsive act, without a plan.’
- ‘You can't talk about suicide in front of children – it will encourage them.’
- ‘Those who have goals and dreams are not at risk.’
- ‘Taking psychotropic drugs increases the desire to commit suicide.’
- ‘Love and support from loved ones is enough to save anyone.’
- ...

- Stigmatisation

Stigmatisation of suicidal people is a process in which individuals who have attempted suicide or died by suicide are stigmatised or negatively judged by society.

This phenomenon can lead to marginalisation and discrimination against people struggling with mental health issues and their loved ones. Stigmatisation of suicidal individuals can make it difficult for them to obtain support and help and discourage them from openly discussing mental health and suicidal thoughts.

Measures to reduce the stigmatisation of suicidal people include educating the public, promoting empathy and understanding for people affected by mental health issues, and raising awareness of the effects of stigmatisation on mental health and social well-being.

Stigmatisation of suicide can take many forms, ranging from stereotypical and simplistic views about the causes of suicide to exclusion and avoidance of those affected. This can lead to social isolation, thereby hindering the recovery and rehabilitation process.

People who are suicidal or have attempted suicide often experience prejudice, which may stem from ignorance, fear or a lack of understanding.

The stigmatisation of suicidal individuals can be particularly severe in cultures where suicide is taboo or considered contagious. In such communities, open discussion about suicide is rare, and people struggling with suicidal thoughts may feel even more isolated and helpless.

It is therefore important for society to be aware of the effects of stigmatising suicide and to promote openness, empathy and understanding towards people affected by mental health issues. Education about mental health, awareness of one's own prejudices and a willingness to support people in crisis can help reduce stigma and create a more supportive environment for everyone.

The stigmatisation of suicidal behaviour does not come out of nowhere – it is perpetuated by specific social relationships and systemic neglect, which can effectively discourage people from revealing their suffering and seeking help. Research shows that this stigma has many sources and can be reinforced in various areas of a young person's life.

In the family environment, emotional relationships, the way mental health issues are discussed and the system of responding to emotional difficulties are of great importance. In some cases, it is loved ones who, out of fear, ignorance or frustration, begin to belittle, shame or blame the person in crisis. Teenagers who have encountered misunderstanding or aggression from their families describe this as an experience of deep hurt and rejection. Many young people have experienced stigmatisation from those closest to them, often in the form of unwanted assumptions, judgements and a lack of empathy.

School, which should be a place of support and safety, often becomes a space where stigmatisation intensifies. Teachers, often unprepared to recognise and respond to signs of mental crisis, may – consciously or unconsciously – show fear, distance or belittlement towards their students. Almost half of teenagers admit to having experienced stigmatising behaviour from teaching staff.

However, the most painful experience is rejection by peers. For a person struggling with suicidal thoughts, such reactions can exacerbate feelings of hopelessness and the belief that there is no room for a return to balance.

The stigma associated with suicide can significantly affect the course of treatment and therapeutic outcomes. An internal sense of shame and a belief that one is ‘weak,’ ‘problematic,’ or ‘strange’ often leads to discontinuation of therapy, discontinuation of medication, or failure to disclose suicidal thoughts to a professional. This, in turn, dramatically increases the risk of relapse or escalation of the crisis.

What is more, people with a history of depression or schizophrenia are often perceived as unpredictable, ‘threatening’ or ‘incapable of normal life’, which negatively affects their professional and social situation. Discrimination in the labour market, difficulties in establishing relationships or exclusion from public life are real effects of stigmatisation, which further perpetuate marginalisation.

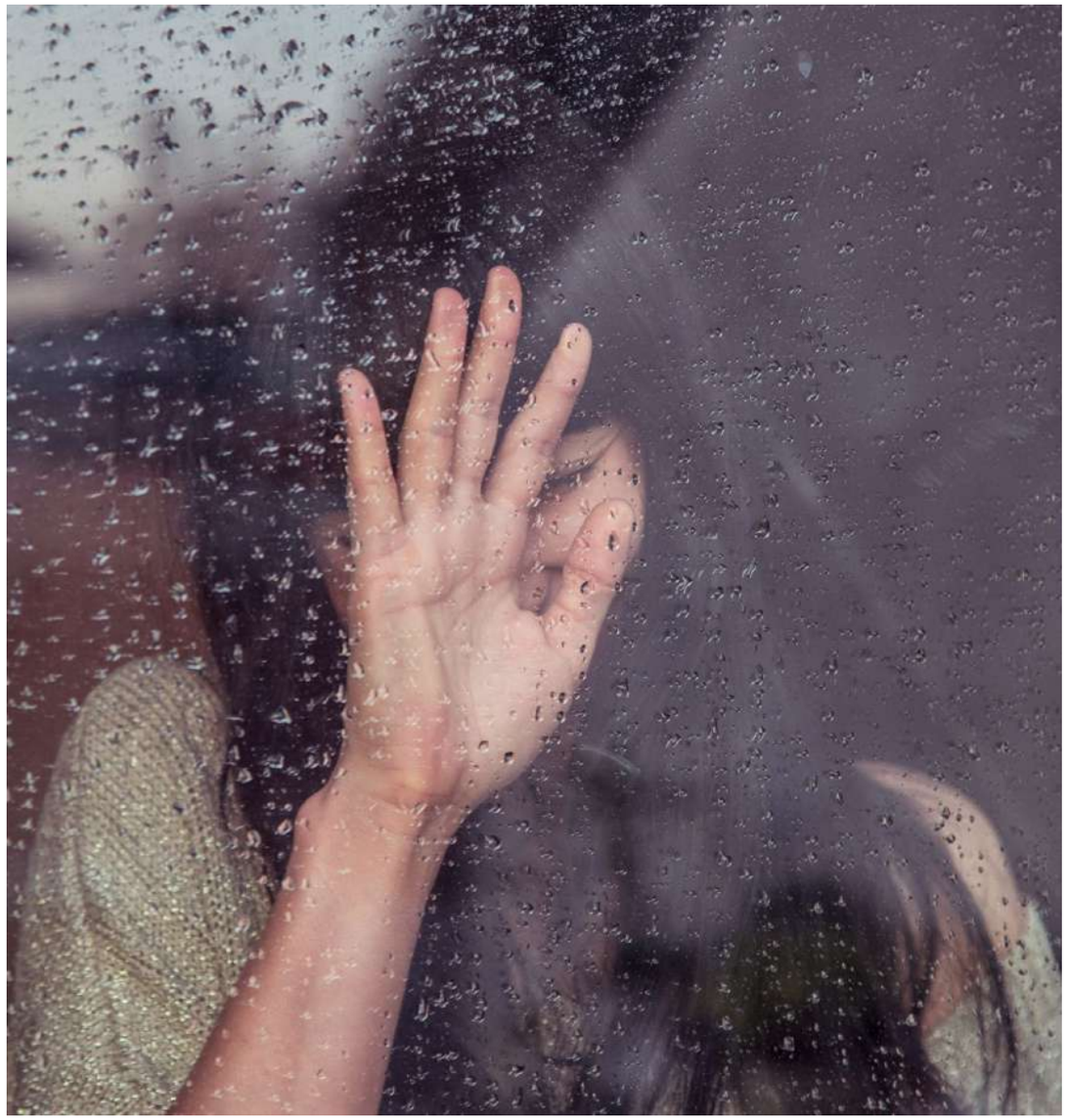
Combating stigmatisation requires comprehensive, multi-level measures – both in the social and institutional spheres.

One of the most important tools is education – both for young people and adults. Social campaigns, workshops and classes in schools should not only provide knowledge about mental health, but also teach empathy, communication and how to respond to crisis situations. An open, factual discussion about suicide does not promote this phenomenon – on the contrary, it creates a space to break the silence and seek help.

Responsible media coverage is also essential. Instead of sensationalising suicide, the media should focus on education, promoting stories of recovery from crisis and destigmatising treatment. Avoiding detailed descriptions of methods and providing information on where to find help (e.g. crisis hotlines) are examples of good practice in reporting on suicide.

It is equally important to create and support systemic forms of help – increasing access to therapy, psychological counselling, crisis intervention and support for families. Institutions should not only take action when a crisis arises, but also work preventively – teaching people how to recognise the signs of risk and how to respond without judgement.

It is also worth paying attention to the situation of people who have survived a suicide attempt or lost loved ones to suicide. They too often experience stigmatisation, shame, silence and isolation. They need support groups, specialist help and space to grieve without fear of judgement.



Part 3

Trauma and bereavement as an inherent process of death (understanding bereavement, trauma, post-traumatic stress disorder)

Death, especially sudden and incomprehensible death such as suicide, leaves behind not only emptiness but also deep psychological wounds. The accompanying experiences of grief and trauma become one of the most difficult stages of life for many people, both those close to the deceased and witnesses to the event. These are experiences that can disrupt the existing emotional order, question the meaning of existence and, in extreme cases, lead to secondary mental disorders such as post-traumatic stress disorder (PTSD).

It is still too rarely acknowledged that mourning after suicide differs from mourning after other forms of loss — it is often accompanied by feelings of guilt, shame, social isolation, fear of judgement, or difficulty expressing emotions in an environment that does not understand the specific nature of this form of suffering. At the same time, people affected by trauma as a result of suicide — whether as family members, witnesses, or even rescuers and educators — may experience chronic psychological effects that, without specialised support, deepen and become entrenched.

The third part of the publication aims to shed light on the phenomena of grief and trauma in the context of suicide, showing both their psychological mechanisms and possible effects, including the development of post-traumatic stress disorder. A key element will be understanding that both grief and trauma are not pathological states in themselves, but a natural, albeit extremely demanding, psychological response to loss, shock and emotional disruption.

In this section, we will look at:

– how grief after suicide differs from other forms of loss,

– how trauma affects the nervous system and emotions of people affected by the suicide of a loved one,

– what PTSD is in the context of suicide and how to recognise its symptoms,

– how to support people experiencing trauma and grief, both as professionals and loved ones.

Understanding these phenomena is not only a step towards better support for those affected by crisis, but also part of building a more aware, sensitive and ready society to accompany others in their pain — without judgement, with empathy and understanding.

Understanding grief – responding to loss after suicide

Grief is one of the most fundamental aspects of human experience. It is a feeling that accompanies us in the face of loss, passing and irreversible change. It is an emotional response to loss, which can be caused by the death of a loved one, separation, loss of health, job, or other life events. Although grief can be painful and difficult, it also opens us up to a deeper understanding of life, human relationships, and our own nature.

The first aspect worth noting is that grief is universal and inherent to humanity. Different cultures and communities have different mourning rituals and customs, but the feeling of loss and pain itself is universal. It is an expression of our sensitivity to change and the inevitable fact of life's transience. Grief is therefore an integral part of the human experience and can lead to reflection on the meaning of life and death.

Another aspect is that the grieving process is individual and can take different forms and stages. There is no single universal way of coping with grief, as each person is different, just as each situation of loss is different. Some people may need time to grieve alone, while others seek support in relationships with loved ones or support groups. It is important to allow yourself to experience the emotions associated with loss and to find healthy ways of coping with grief.

Grief is also a process that can bring with it a variety of emotions. From sadness and pain, through anger and guilt, to feelings of emptiness and confusion. Each of these emotions has its own meaning and can be part of the journey towards accepting the loss and finding new meaning in life. It is important to allow yourself to experience these emotions and seek support when needed.

However, although mourning can be a difficult and painful process, it can also lead to personal and spiritual growth. Experiencing loss can change us and prompt us to reflect on the values of life, interpersonal relationships and our own place in the world. It can teach us empathy, gratitude for life and appreciation for the present moment.

Ultimately, grief can lead to hope and the discovery of new meaning in life. Despite loss, life goes on, and we can find the strength to continue our journey. It can be a time of transformation, where we learn to cope with adversity and build a better tomorrow.

- The specificity of mourning after suicide

The loss of a person as a result of suicide is often associated with more intense and complex grief. The family, friends and peers of the deceased struggle not only with the pain of loss, but also with a range of secondary emotions such as shame, guilt, anger, fear of judgement and even a sense of shared responsibility. Those close to the deceased may obsessively search for answers: 'Why?', "Could we have done something?", "Did we miss the warning signs?" There is also a strong tension between grief and anger, sometimes directed at the deceased themselves.

This type of grief is often socially invisible – people in mourning are often met with awkward silence, avoidance or stigmatisation from those around them. Some fear that saying the word 'suicide' will cause them to be judged or blamed. This can cause the grieving process to be experienced in isolation and loneliness, without the social support that is taken for granted in other forms of loss.

People mourning the suicide of a loved one are more vulnerable to developing mental health problems such as depression, anxiety disorders, chronic grief or post-traumatic stress disorder. The risk of suicidal thoughts also increases, especially among those who feel responsible for the death of a loved one. That is why it is so important that the grieving process is not left solely to individual survival mechanisms, but is accompanied by appropriate emotional, social and therapeutic support.

The social perception of grief as a linear, 'closed' process, after which one must 'return to normal', does not correspond to the reality of those who have experienced a suicide loss. Mourning does not always end in acceptance – sometimes it becomes a permanent part of life that requires integration rather than forgetting. It is not about 'stopping feeling', but about learning to live despite the pain – with memories that do not weigh you down, but allow you to find meaning.

- Trauma after loss – the psychological effects of experiencing suicide

Experiencing or witnessing the suicide of a loved one is one of the most traumatic experiences a person can go through. In addition to natural grief, those affected often experience psychological trauma – an intense, overwhelming emotional and physiological reaction to the sudden, painful severing of bonds and sense of security. This trauma can be long-lasting, complex and often difficult to diagnose unequivocally, especially when it overlaps with the grieving process.

What is trauma?

Trauma is a psychological reaction to an event or series of events that exceed an individual's adaptive capacity. It can occur in response to a direct threat to life (one's own or another's) or to a situation that is subjectively perceived as extremely overwhelming. The key feature of trauma is not the event itself, but the body's and mind's reaction to its emotional significance – feelings of helplessness, terror, loss of control and internal disorganisation.

In the context of suicide, trauma may affect:

- direct witnesses of death (parents, siblings, partners, friends, emergency personnel),
- people who discovered the body of the deceased,
- loved ones who accompanied the person in crisis for a long time and were unable to help them,
- teachers, educators and peers who experience the effects of suicide in a school environment.

Complex trauma – long-term consequences

Unlike classic, one-off traumas, trauma after suicide is often complex in nature – it combines elements of acute trauma (shock and disorganisation), relational trauma (related to the loss of a bond) and existential trauma (related to questions about meaning, guilt and responsibility). It can lead to symptoms such as:

- persistent flashbacks or images related to the moment of death or its discovery,
- sleep disturbances, nightmares, excessive vigilance (emotional hyperventilation),
- avoidance of places, people or topics reminiscent of the loss,
- feelings of emotional numbness or, conversely, emotional hyperreactivity,

- difficulty concentrating, anxiety or panic attacks,
- feelings of guilt, feeling ‘different’ or separated from the world.

These symptoms can persist for many months or even years, especially if the trauma has not been identified or processed.

In children and adolescents, somatic symptoms, behavioural problems, aggression, developmental regression or educational problems may also occur.

Secondary and hidden trauma

It is important to note that trauma after suicide does not only affect the immediate family. Contemporary psychology draws attention to so-called secondary trauma, which is experienced by support persons such as therapists, teachers, educators and friends. Their suffering may be marginalised, and they often feel that they have no right to experience such deep emotions. The lack of social acceptance for expressing trauma encourages it to be hidden, which hinders the natural healing process.

The road to recovery

Trauma does not have to mean permanent psychological damage. Under favourable conditions, with appropriate support and space to express emotions, many people are able to go through the process of processing trauma in a constructive way.

The following are key:

- trauma therapy (e.g. cognitive-behavioural approach, EMDR, mindfulness-based approaches),
- group support and the opportunity to share experiences with other people who have experienced loss,
- a safe environment – free from judgement, silence and pressure to ‘come to terms with the situation quickly’.

- Grief, trauma, post-traumatic stress

Understanding grief, trauma and post-traumatic stress is a key psychological aspect in the context of human experiences that bring suffering and challenges. These three phenomena are closely related, but differ in their causes, symptoms and ways of coping.

Grief is a natural reaction to loss, which can be the death of a loved one, a breakup, the loss of a job or another significant part of life. It is an emotional process that involves a variety of feelings, such as sadness, anger, emptiness and confusion. During grief, people go through different stages, which may include shock, denial, anger, bargaining and acceptance. It is an individual process that requires time and allowing oneself to experience all the emotions associated with the loss.

Trauma, on the other hand, is an experience that causes deep psychological or emotional injury. It can be the result of traumatic events such as accidents, violence, abuse or war. Traumatic events can lead to the development of trauma-related disorders, such as PTSD (Post-Traumatic Stress Disorder), which manifest themselves in, among other things, recurring memories of the traumatic event, nightmares, excessive tension or avoidance of stimuli associated with the trauma.

Post-traumatic stress is a reaction to a traumatic event or series of events that threaten the life or safety of oneself or others. People with PTSD often have difficulty coping with everyday life, and their functioning may be significantly impaired by worsening symptoms such as anxiety, hyperactivity, avoidance of stimuli associated with the traumatic event, or difficulties in interpersonal relationships.

A common element of grief, trauma and PTSD is that they are experiences that can have a long-lasting impact on an individual's psyche and behaviour. They can lead to a deterioration in quality of life, health problems and relationship difficulties. However, despite the difficulties, it is possible to treat and cope with these experiences.

What is PTSD in the context of suicide and how can its symptoms be recognised?

Post-traumatic stress disorder is a serious mental disorder that can develop after experiencing or witnessing an event that exceeds the limits of normal human psychological endurance — one that involves a threat to life, extreme suffering or sudden loss. The suicide of a loved one, especially when it is unexpected, drastic, and the person is a direct witness or discovers the body, is one of the strong risk factors for developing PTSD.

Post-traumatic stress disorder is not a one-time emotional reaction. It is a persistent disorder of emotion regulation and mental functioning that can develop within weeks, months, or even years after the event. In diagnostic classifications, PTSD is diagnosed based on characteristic symptoms lasting at least one month, including:

- Intrusive memories and flashbacks – unwanted images reminiscent of the trauma that can appear suddenly.
- Avoidance of stimuli reminiscent of the event – e.g. avoiding places, conversations, people, thoughts or emotions associated with the trauma.
- Excessive arousal and psychophysical tension – difficulty sleeping, irritability, outbursts of anger, difficulty concentrating, excessive alertness.
- Negative changes in thinking and mood – chronic feelings of guilt, shame, depression, feelings of detachment from reality, loss of meaning in life.

In the case of PTSD resulting from a suicide experience, these symptoms often overlap with the grieving process. This makes diagnosis and psychological support particularly difficult – many symptoms may be mistakenly considered ‘normal grief’ or ‘a temporary reaction to loss.’

Post-traumatic stress disorder can occur in:

- people who were direct witnesses to a suicide (e.g. children, partners, siblings),
- people who discovered the body or provided assistance,
- people who spoke to the deceased immediately before their death or feel that their actions could have prevented the tragedy,
- family members and friends who have been with the person in crisis for a long time but were unable to help them,
- teachers, educators and counsellors after the suicide of a student,
- paramedics, police officers, firefighters – exposed to repeated exposure to dramatic events.

It is worth noting that PTSD does not always manifest itself immediately – it can develop slowly, over months or years, leading to a gradual deterioration in mental, professional and social functioning.

In children and adolescents, PTSD can have an atypical course – instead of classic symptoms, the following may occur:

- regression in behaviour (e.g. bedwetting, separation anxiety),
- problems with concentration and learning,
- outbursts of anger, impulsiveness,
- psychosomatic symptoms (stomach aches, headaches),
- withdrawal, emotional indifference or excessive agitation.

It is therefore particularly important to recognise the symptoms early and ensure that children have access to specialist support before the disorder becomes more severe.

How do young people cope with trauma? Adaptive mechanisms and survival strategies

Children and adolescents who experience trauma – especially that associated with the sudden, tragic death of a loved one, such as suicide – face an enormous challenge in adapting. Their nervous system, personality and emotional capacities are still developing, which means that the process of processing a traumatic event can be completely different from that of adults. Coping mechanisms, i.e. the strategies that young people use to deal with pain, internal disorganisation, anxiety and loss of security, are of key importance here.

Adolescence is a time of intense biological, cognitive and emotional changes. The adolescent brain, especially the areas responsible for regulating emotions (the limbic system) and impulse control (the prefrontal cortex), is still developing. This makes young people more prone to intense emotional reactions, impulsivity and difficulties in self-regulation after expe-riencing trauma. They also often lack access to emotional language that would allow them to express what they feel directly.

In addition, teenagers function in a strong social context — relationships with peers, the need to belong and avoid stigmatisation are just as important to them as support from their family. All of this influences how they process trauma and what coping strategies they use.

Typical mechanisms for coping with trauma

- Denial and avoidance

Many young people are not ready to confront the reality of a traumatic event. Suppressing emotions, avoiding talking about loss, and distancing themselves from memories, places or people associated with the tragedy are common defensive reactions. Although they may protect against an emotional overload in the short term, in the long run they hinder the trauma processing process and can lead to somatic symptoms, depression or anxiety.

- Regression

Some teenagers regress in their development — for example, they become more dependent on adults, avoid making independent decisions, and revert to childish behaviour (bedwetting, thumb sucking, separation anxiety). This is a natural mechanism for seeking security in the face of loss.

- Aggression and rebellion

Loss can trigger anger in young people — both towards themselves and their environment. Unexpressed grief can manifest itself as verbal aggression, oppositional and rebellious behaviour, risky activities (e.g. experimenting with substances, self-harm, conflicts with the law). This is not only a way of coping with tension, but also a form of communication: ‘something is wrong’.

- Overresponsibility and control

Some young people react in the opposite way – they become overly mature, take on adult responsibilities and give up their own needs in order to ‘keep everything together’. Although such behaviour is often praised by those around them, it is a hidden way of coping with the fear of further loss and an attempt to regain control over the world.

- Searching for meaning

Young people, especially in late adolescence, may respond to trauma reflectively – they ask existential questions and seek meaning in religion, philosophy, art or social activism. While this can be constructive, it can also be burdensome when questions remain unanswered.

- Turning to peers or social withdrawal

Some teenagers seek support in their peer group, trying to find understanding and comfort in relationships. Others, on the contrary, isolate themselves, feeling different, misunderstood or ashamed. Both strategies are a reaction to emotional chaos and the need to protect oneself from further suffering.

Effective support for traumatised young people requires:

- attentiveness to emotional and behavioural signals, even those that are hidden,
- acceptance and patience – young people need space to talk about difficult emotions without judgement or pressure to ‘cope’,
- building a sense of security – predictability, presence and emotional stability on the part of adults are key,
- ensuring professional support when symptoms persist or worsen – in the form of individual therapy, family therapy or support groups.

In addition, the role of emotional education and psychoeducation in schools cannot be overestimated – teaching young people to recognise emotions, regulate tension and seek help.

How to support people experiencing trauma and grief?

The role of loved ones and professionals

Supporting people who have experienced trauma and are in mourning — especially after the suicide of a loved one — requires more than just good intentions. It is a delicate, often lengthy process in which presence, empathy, attentiveness and appropriate action have a real impact on whether a person in crisis finds a path to recovery. Help provided in a conscious, wise and non-intrusive manner can be a key factor in preventing the development of serious mental disorders such as depression, post-traumatic stress disorder or chronic grief.

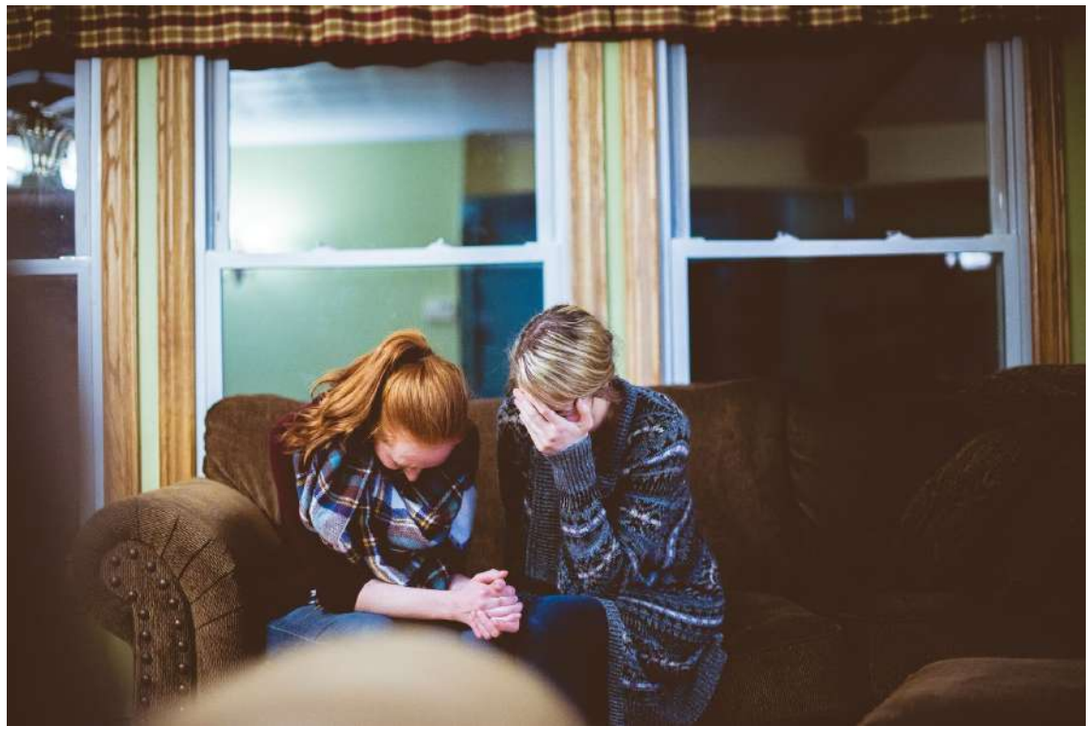
- Support from loved ones — how to be present without causing harm?

Don't look for the perfect words — just be there.

People who are grieving often need presence more than words. They don't expect ready-made solutions, but rather someone to accompany them without judging or trying to ‘fix’ them. Silent compassion, holding a hand, asking ‘would you like me to sit with you in silence?’ can be a stronger gesture than hundreds of words of comfort.

Avoid clichés and ‘good advice’

Phrases such as ‘time heals all wounds’, ‘you have to be strong’, ‘at least they're not suffering anymore’ – although often said with good intentions – can increase suffering and loneliness. Instead, it is better to say: ‘I can see how difficult this is for you,’ ‘I am here for you if you need anything,’ ‘you have the right to feel what you are feeling.’



Don't be afraid to talk about the deceased

Many loved ones avoid mentioning the deceased for fear that it will ‘remind’ the bereaved of their loss. However, it is the memory of the deceased that lives on in them — avoiding conversation can only deepen their grief. Gentle questions (‘Would you like to tell me about him/her?’, ‘What do you remember most?’) can help a person in mourning to sort through their emotions and regain a sense of continuity.

Respect the individual rhythm of grief and trauma

Everyone experiences loss in their own way and at their own pace. For some, mourning will last a few months, for others — years. For some, silence and withdrawal will be a natural reaction, for others — a need for action, talking and symbolic gestures. Do not rush the process. Do not compare. Do not measure by the standards of others.

Be present, not just ‘at the beginning’

Support is often intense immediately after a loss, but disappears after a few weeks or months. However, the pain of grief does not end after the funeral. Remind them of yourself, suggest a walk, breakfast together, ask, ‘Would you like us to go and light a candle together?’ Memory and presence over time are just as important as the first gestures.

- Professional support – how to act as a therapist, teacher, educator, doctor?

Build a relationship based on safety and trust

Professionals should first and foremost ensure a safe space where a person experiencing trauma or grief can speak without fear of judgement. Active listening, calmness, regular contact and clear rules for meetings all build the foundation for the healing process to begin.

Avoid psychologising until trust has been established

Over-analysing, interpreting and ‘exposing the problem’ can be burdensome, especially in the early stages of trauma. It is more important to be a present, stable and attentive companion, especially in the case of children and young people.

Respond to physical and emotional symptoms

Trauma and grief often manifest themselves in physical symptoms such as insomnia, headaches, stomach problems and appetite disorders. Emotions such as anxiety, anger or apathy should also be treated as signals rather than disturbances.

Offer specific forms of help, but do not impose them

A professional may suggest individual or group therapy, bereavement workshops or relaxation techniques. However, it is important that the suggestion is not compulsory, but rather opens up space for the person experiencing the loss to make their own decision. In the case of children, art therapy, fairy tale therapy and drama can also be helpful.

Take a systemic approach – don't just work one-on-one

In the case of children and young people, it is essential to work with the wider community: family, school, peer group. If the trauma or suicide affects an entire class or school, crisis intervention should involve more than just the individual.

Helping with grief and trauma does not require extraordinary skills – it requires humanity, empathy, patience and silence that does not hurt. The most effective support is often not 'therapy', but being with another person in their pain, without trying to explain, judge or minimise it.

What heals is not 'curing the pain,' but the presence of someone who says, 'I don't know what you're feeling, but I want to be there for you.'

- The long-term effects of trauma and grief and ways of coping with loss

Both trauma and grief can have long-term consequences for a person's mental, emotional and physical functioning. These are not conditions that 'go away on their own' — they require attention, support and an appropriate process of working through the pain and loss. The more intense, sudden and unprocessed the experience — as in the case of suicide — the greater the risk of chronic symptoms.

People who have experienced trauma or the loss of a loved one may develop symptoms of post-traumatic stress disorder, such as intrusive memories, avoidance of situations reminiscent of the trauma, strong emotional reactions, heightened alertness or difficulty sleeping. Some people also develop depression, characterised by a decrease in energy, loss of joy in life and a feeling of emptiness.

Trauma and unresolved grief can make it difficult to build and maintain close relationships. Distrust, withdrawal, fear of rejection and sometimes excessive dependence on others may develop. This is often accompanied by low self-esteem and an inability to ask for support.

Chronic emotional stress can lead to health problems such as insomnia, headaches, digestive problems, high blood pressure and weakened immunity. The body reacts to mental overload, which is why taking care of your physical health becomes so important.

People who are grieving may have difficulty concentrating, making decisions, and performing school, work or household duties. Motivation declines, mental fatigue sets in, and even interests that were previously enjoyable may disappear.

Unresolved grief or trauma can lead to the use of psychoactive substances (alcohol, sedatives, drugs) as a form of emotional ‘anaesthesia’. Compulsive behaviours such as self-harm, eating disorders and internet addiction are equally dangerous.

Trauma and grief are not pathological conditions — they are a natural, albeit difficult, part of human life. However, they also provide an opportunity to deepen our relationship with ourselves, with others and with what is truly important to us. What seems like the end can become the beginning of a new understanding of ourselves and the world — if we receive the right support and allow ourselves to experience loss without shame, haste or the compulsion to ‘be strong’.

Interesting facts

So different, yet so similar – mourning in different cultures …

Mourning is an integral part of human life, and cultural differences determine different ways of experiencing it.
In some societies, mourning can be very ceremonial and lengthy, involving the organisation of solemn funerals and public ceremonies in memory of the deceased. In other cultures, the mourning process can be more private and focused on the personal experience of loss by the family and loved ones. There are also societies where mourning can be more joyful, providing an opportunity to celebrate the life of the deceased and the memories associated with them.
Regardless of its form, mourning is an important emotional process that allows individuals to adapt to loss, process their emotions and find a sense of peace and acceptance.
Countries where mourning customs differ from those in Poland.

India
In Hinduism, after the death of a loved one, the family organises a funeral ceremony during which the body of the deceased is cremated on a funeral pyre. The family and relatives usually mourn for a period of 13 days, called ‘anty esti’, during which various rituals and prayers take place. After this period, a ceremony known as ‘sraddha’ is held to mark the end of mourning, during which the deceased is officially bid farewell.
Japan
In Japanese culture, mourning is observed in a very solemn and ceremonial manner. After the death of a loved one, the family organises a funeral ceremony that includes many traditional rituals and rites. Many people also wear black clothing as a sign of respect and mourning. After the funeral, a ceremony is often held 49 days after the death, as well as on the anniversary of the death, during which prayers and offerings are made.

Nigeria

In Nigeria, funeral customs vary depending on the region and culture. In some communities, especially among the Igbo and Yoruba peoples, funerals are sometimes an occasion for large celebrations, during which songs are sung, traditional dances are performed, and the community shares a meal. Funerals can last several days or even weeks before the deceased is buried.

Thailand

In Thailand, solemn funeral ceremonies are held, which are an important part of culture and tradition. They often take place in the open air, with colourful decorations and flowers. The family of the deceased also organises many rituals and prayers to honour the memory of the deceased and ensure a smooth passage to the afterlife. After the funeral ceremony, communal meals are often organised, during which family and friends can come together to celebrate the memory of the deceased.

Mexico

In Mexico, the Day of the Dead (Día de los Muertos) is celebrated, during which the community focuses on remembering and honouring their deceased loved ones. On this day, offerings are prepared in the form of colourful displays called ‘ofrendas’, which contain the favourite foods and items of the deceased. The community also visits cemeteries to clean graves and place flowers and candles in memory of the deceased.

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Part 4

Support in mental health crisis

The mental health crisis among young people is a phenomenon that has taken on a new and alarming dimension in recent years. Statistical data, reports from international organisations and the experiences of people working with young people leave no room for doubt — more and more children and teenagers are struggling with depression, anxiety, self-harm, emotional burnout and suicidal thoughts. Although public awareness of mental health is growing, practice shows that young people in crisis still too often remain without adequate support — unnoticed, misunderstood, marginalised.

It is this stage — the mental crisis — that can be a decisive moment. It can lead to destructive behaviour, but it can also be a turning point towards recovery — provided that the young person is met with understanding, an appropriate response and properly planned help. That is why it is so important that teachers, educators, parents, youth workers and those around them are able to recognise the warning signs, know how to respond and have access to tools, procedures and support systems.

In this section of the publication, we will focus on answering the following questions:

– How can we support a young person experiencing a mental health crisis, especially a suicidal crisis?

– What are the forms and levels of help available?

– Why must systemic, community and institutional support go hand in hand with individual empathy and competence?

– What procedures can (and should) be implemented by those working with young people to respond appropriately in emergency situations?

This is not about adults ‘saving’ young people from a position of power, but about accompanying them in a wise, attentive and respectful manner. It is about moving away from thinking in terms of blame and punishment towards understanding, empathy and action. Helping a young person in crisis is one of the most difficult but also most responsible tasks that adults can face. In this section, we look at how this can be done effectively and ethically.

Types of support for young people in mental crisis

Helping a young person in mental crisis cannot be a one-off gesture or a superficial intervention. To be effective, it must be based on comprehensive and multi-level support that takes into account both the mental and emotional needs of the individual and their social, school and family situation. It is crucial to distinguish between different forms of support — from the daily presence of loved ones, through peer support, to professional therapeutic intervention and systemic institutional solutions.

- Informal support

This is a form of help provided by people from the immediate environment: family, friends, teachers, neighbours, coaches, clergy. It is often the first and most important line of support when mental health difficulties arise.

Why is it so important?

Young people do not usually seek professional help right away. Before they decide to contact a psychologist or psychiatrist, they need a trusted adult or peer who will listen to them and not dismiss the warning signs. The right response can stop the spiral of loneliness, shame and withdrawal.

Forms of informal support:

– talking and listening attentively without judging,
– providing a sense of security and acceptance,
– accompanying them in everyday activities,
– encouraging them to seek help,
– building bridges with the wider support system (e.g. helping them find a specialist).

- Peer support

Peers play a unique role in the life of a teenager — they are often the first people to whom secrets are entrusted, including those concerning mental suffering. This is why activities based on peer education and the development of so-called ‘mental health leaders’ have enormous preventive potential.

Why is it worth investing in them?

– young people talk to each other honestly, without fear of judgement,
– peers may notice changes in a friend's behaviour earlier,
– educated peers can refer a person in crisis to an adult or specialist.

Examples of peer initiatives:
– youth support groups,
– training in ‘psychological first aid’,
– school education campaigns created by young people,
– self-help youth chat rooms.

- Professional support

When difficulties exceed the resources of the person in crisis and their environment, specialist support is necessary. This may take the form of emergency crisis intervention or long-term therapy. It is important that the system is easily accessible, fast and understandable to young people.

Main forms of professional support:
– help from a psychologist, psychotherapist, child and adolescent psychiatrist,
– crisis intervention (e.g. at a counselling centre, mental health centre, hospital),
– therapeutic groups, therapeutic programmes for people in suicidal crisis,
– family therapy (if the crisis also affects family relationships),
– telephone or online help (e.g. crisis chats, intervention helplines).

- Institutional and systemic support

The effectiveness of assistance is also influenced by how the system works — schools, healthcare, non-governmental organisations, local governments. Institutional support consists of creating structural conditions in which psychological assistance becomes accessible and integrated.

Elements of systemic support:
– the presence of a psychologist in every school,
– school procedures for responding to crisis situations,
– implementation of emotional and psychological education,
– information campaigns at the municipal/county level,
– reimbursement and availability of therapy,
– interdisciplinary cooperation between specialists (school – counselling centre – health centre – NGO).

Effective support for young people in mental crisis requires the involvement of many people and levels of assistance: from the sensitivity of loved ones, through the attentiveness of peers, to the competence of specialists and good institutional practices. A mental health crisis does not end with a single conversation or consultation — it is a process that requires support, patience and openness. The most important message that should reach young people is: **‘You are not alone.’**

Why must systemic, environmental and institutional support go hand in hand with individual empathy and competence?

The contemporary approach to youth mental health is increasingly based on the so-called integrated model, which assumes close cooperation between different levels and forms of support. This means that even the best-designed systems – whether in schools, healthcare or social services – will not be effective if they are not implemented by people who demonstrate empathy, attentiveness and genuine commitment. The system can provide a framework, but it is people — teachers, educators, psychologists, parents, school nurses — who determine its quality in practice. Therefore, institutional and structural support must always coexist with a personal willingness to engage with others in crisis.

Systems and procedures do not work on their own — people do

Even the best procedure for responding to a suicide crisis at school will not work if the person responsible for implementing it fails to notice the warning signs or downplays the problem. A psychologist who shows no empathy and merely ticks off formal tasks may discourage a young person from seeking further help. On the other hand, a teacher who is able to listen carefully and treat students with respect can become a key source of support even when the system fails.

Institutions are extremely important – they provide access to help, tools and a legal framework. However, it is the personal approach of individuals that determines whether a young person feels heard, understood and safe.

Empathy as a prerequisite for effective support

In the case of young people in crisis, the mere presence of a specialist is not enough. Empathy — understood as deep and unobtrusive compassion — is the foundation of therapeutic and educational relationships, but also of any interpersonal relationship in which suffering is present. Empathy allows us to:

- break down barriers of shame and fear,
- create a safe space for conversation,
- build trust,
- stop a person in crisis at the moment of greatest danger.

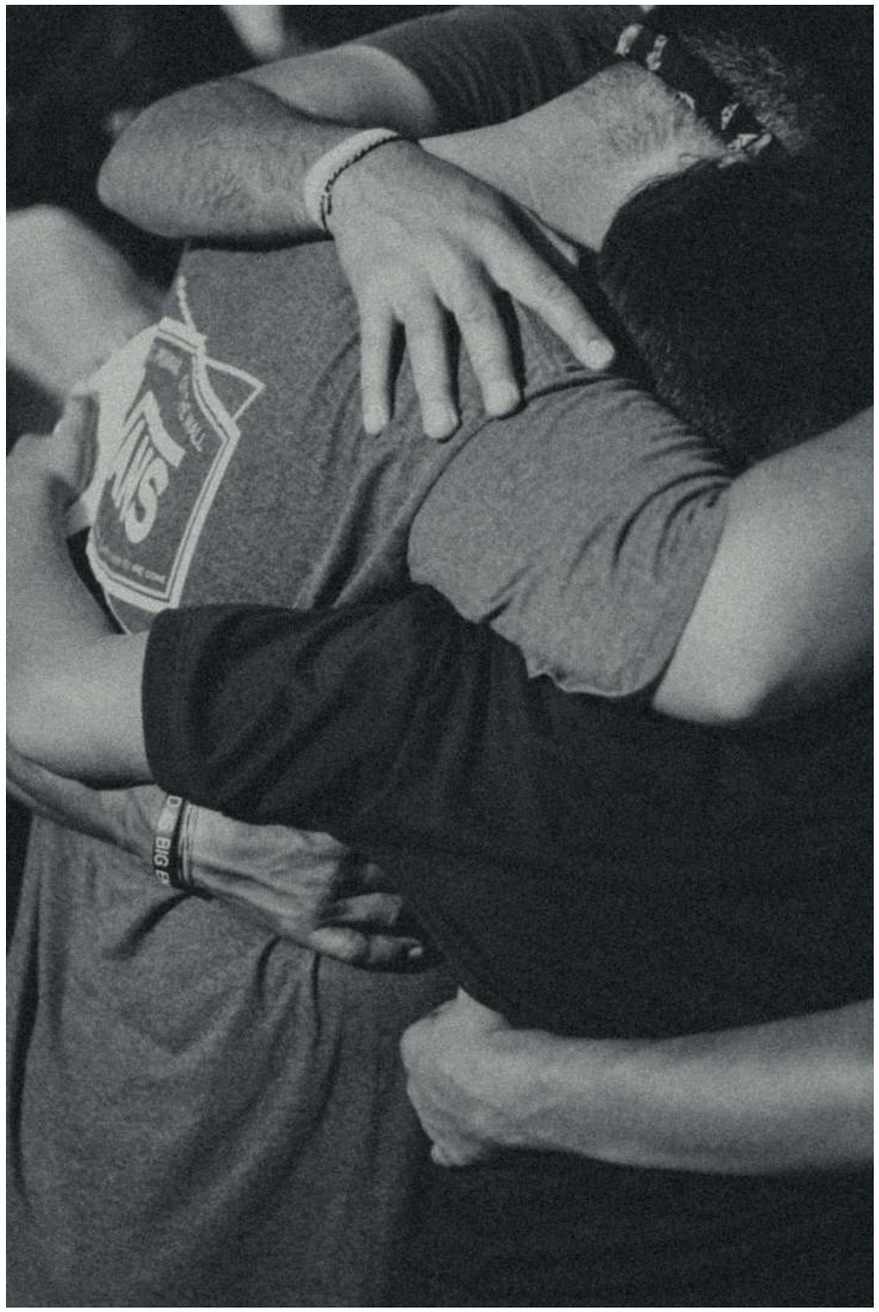
Without empathy, the system becomes cold, bureaucratic and blind. Without a system, empathy can prove helpless in the face of the scale of the difficulties.

Empathy without knowledge and skills can lead to excessive emotional stress or inappropriate responses. Competence, on the other hand, understood not only as theoretical knowledge but also as practical skills for responding to difficult situations, allows one to act responsibly, effectively and with respect for boundaries.

Therefore, every adult working with young people should receive regular training in mental health, recognising the symptoms of a crisis, responding to life-threatening situations and the basic principles of communicating with a person in crisis. Only a combination of empathy and professional training allows real help to be provided – without excessive emotion, but with full commitment.

Family, school, peer group, local community – all these environments have a huge impact on how a young person functions mentally. Environmental support, i.e. normalising help in an everyday context, helps prevent crises from escalating. But again, the environment only works when its members are attentive and ready to act.

It is not the school building that supports the student – it is the people who work there. It is not the counselling centre's website that helps in a crisis – it is the person on the other end of the phone or chat who responds with attention and understanding.



Procedure for dealing with situations threatening the mental health and life of a student

Purpose of the procedure

To ensure an immediate, effective and safe response from teaching staff in situations where there is a suspicion that a student is experiencing:

– suicidal thoughts or attempts,

– serious symptoms of depression, anxiety, self-harm,

– self-destructive behaviour,

– emotional or psychiatric crisis.

Scope of application

The procedure applies to all school employees (teachers, educators, psychologists, management, administrative and support staff).

Stage 1: Assessment of the situation

A person who notices:

a student's confession of wanting to harm themselves or take their own life,

signs of self-harm,

significant changes in behaviour (apathy, irritability, isolation, aggression, tearfulness),

disturbing content in the student's notebooks, statements or social media,

should:

✅ provide the student with a safe, quiet place,

✅ not judge or ignore the student's statements,

✅ remain with the student and immediately inform the school psychologist/educational psychologist or headteacher.

Stage 2: Assessing the risk and securing the student

The school psychologist/educational psychologist or headteacher:

✅ assesses the seriousness of the situation (including the possible risk of suicide or self-harm),

✅ does not leave the student alone – care must be continuous,

✅ calls the emergency services (112) if necessary,

✅ documents the course of events and the actions taken,

✅ informs the parents/legal guardians, unless this jeopardises the student's safety.

Stage 3: Notification of external services (if required)
In the event of an immediate threat to life or mental health, the school is required to:

✅ call the Emergency Medical Services (tel. 112),

✅ notify the family court, probation officer or social services if there is a suspicion of violence or neglect,

✅ contact the Mental Health Clinic to ensure further care.

Stage 4: Further support measures
Once the crisis situation has been resolved, the school:

✅ implements an individual support plan for the student,

✅ organises a support team (form teacher, psychologist, head teacher, parent),

✅ refers the student (with parental consent) to a psychological and pedagogical counselling centre,

✅ monitors the student's functioning,

✅ takes educational measures in the classroom/peer environment if the situation was known.

Stage 5: Documentation
In every case of suspicion or occurrence of a crisis situation, the following steps should be taken:

✅ make a memo (including a description of the situation, actions taken, people involved, dates and times),

✅ attach copies of any letters to parents or institutions,

✅ keep the documentation in line with personal data protection procedures (GDPR).

– Don't promise discretion when a student's life or health might be at risk.
– Do not leave a student alone in a crisis situation.
– Always refer the matter to the appropriate persons (psychologist, headteacher, services).
– React immediately – any delay could cost a life.
– Report any suspicions – it is better to take excessive action than to overlook a real threat.

In view of the growing number of emotional problems and mental health crises among children and young people, schools cannot be solely places of learning — they must also become spaces for early identification of problems, rapid response and adequate support. It is the school, as the environment where young people spend a significant part of their lives, that has a unique opportunity to notice the first warning signs.

We do not expect teachers and educators to become psychotherapists or doctors. But we do expect them — and we should prepare them for this — to be attentive adults who know what to do when a student begins to suffer. Their presence, a word, taking action is enough.

Every school should operate on the principle:

‘In this community, you are not alone. I see you. Help is available. Help is close by.’

Creating a culture of care, responsibility and empathetic response is not an add-on to education — it is its foundation. Whether a student feels safe determines not only their learning, but often their life.

The role of non-formal education in supporting young people in crisis

Non-formal education plays an increasingly important role in supporting the mental health of young people, especially in the context of traumatic experiences, loss, emotional crises and adjustment disorders. Unlike the formal system, which focuses on the transfer of academic knowledge, non-formal education emphasises personal development, social, emotional and relational competences, as well as the formation of attitudes conducive to building mental resilience.

Young people experiencing mental health difficulties often feel misunderstood, excluded or unheard in traditional institutional structures. Meanwhile, non-formal education spaces — such as youth organisations, peer support groups, thematic workshops, artistic activities and volunteering — allow them to express themselves authentically and safely, without the pressure of judgement or formal requirements. It is there that many young people experience for the first time that their emotions, needs and history have value.

Non-formal education can become an invaluable tool in mental health prevention and support.

The following are key elements of non-formal activities:

- partnership between adults and young people based on trust, openness and mutual respect
- activating and participatory methods that engage emotionally and intellectually (drama, storytelling, simulation games, participatory photography),
- working in a peer group, which gives a sense of belonging and alleviates loneliness,
- the presence of mentors and facilitators who are able to accompany rather than judge.

Non-formal education will not solve all the problems of young people, but it can play a fundamental role in building a sense of agency, value and competence in seeking help. It provides space to explore emotions, name difficult experiences and find new coping strategies. It can also serve as a bridge to professional support — those who run the classes are often the first adults to whom young people talk about their suffering.

Contemporary mental health crisis prevention cannot rely solely on specialist intervention. It must be systemic, but also everyday — spread across different areas of young people's lives.

Part 5

Crises in young people with refugee experience

The events of recent years — in the context of the project, especially the war in Syria and the Russian invasion of Ukraine — have caused one of the largest waves of migration in modern Europe and the world. Hundreds of thousands of families have been forced to leave their homes, leaving behind the lives they knew and heading into the unknown. Among them are young people — children and teenagers — who have become victims of dramatic circumstances through no fault of their own. Instead of being a time of security, development and exploration of identity, their childhood or youth is marked by fear, loss, instability and the need to adapt to a completely new reality.

Children and young people with refugee experience find themselves in a situation of multiple crises: separation, disorientation, alienation, trauma and exclusion. They have often survived bombings, the loss of loved ones, violence, fleeing their country, living in camps or temporary shelters, and then facing the hardships of adapting to a new country. Their mental and emotional functioning is burdened by both primary trauma (resulting from war experiences) and secondary trauma (related to migration, assimilation, social isolation or discrimination).

The specific nature of mental health crises in this group of young people differs significantly from those experienced by their peers growing up in a stable environment. Refugee youth often struggle with feelings of uprootedness, loss of cultural identity, lack of agency, and language difficulties, which exacerbate isolation and hinder relationship building. Many of them do not have access to systemic psychological support for administrative, linguistic, legal or culturally competent staff reasons.

The determinants of suicidal behaviour among young refugees are also different in nature: they are dominated by long-term deprivation of psychological needs, a sense of hopelessness, deep loneliness, experiences of prejudice and symbolic violence, as well as the trauma of unresolved loss. For some young migrants, the experience of being a refugee does not end when they cross the border — on the contrary, in their new place, another equally painful stage of identity crisis, adaptation and hidden suffering begins.

Understanding these mechanisms is crucial not only for professionals working with refugee youth, but also for educational and social institutions, the healthcare system, and integration policy. Only a comprehensive approach based on empathy, intercultural competence and adequate emotional support can contribute to the effective prevention of mental health crises and self-destructive behaviour in this particularly vulnerable group of young people.

Data and trends: mental health of refugee youth in Europe and Poland

In recent years, Europe has experienced a significant influx of refugees, including children and young people, mainly due to armed conflicts in Syria and Ukraine. According to UNICEF data, in 2023, European countries recorded 1,085,165 new asylum applications, of which approximately 268,150 (25%) involved children, representing an increase of 16% compared to 2022. In Poland, according to an IRC report, 956,633 refugees were registered at the beginning of 2024, of whom over 44% were children.

Research indicates a high prevalence of mental health problems among refugee youth. In Germany, among 131 young refugees, 42% showed symptoms of post-traumatic stress disorder (PTSD), 29% showed symptoms of depression, and 21% showed symptoms of anxiety PMC. In Poland, a study conducted after the start of the war in Ukraine found that among school-aged children, 29% met the criteria for depression, 36.5% for anxiety, and 57.2% for PTSD. Despite the high demand for psychological support, many refugee families face barriers to accessing mental health services, such as:

- Lack of information about available services
- Language barriers
- Lack of trust in institutions
- Limited number of professionals trained to work with young people who have experienced trauma and migration.

According to a UNICEF report, 20% of refugee families in Poland reported a need for psychological and psychosocial support. The data highlights the urgent need to develop systemic support for refugee youth, including:

- Increasing the availability of mental health services

Training specialists in working with youth with trauma experience

- Creating integration programmes in schools

Only through coordinated action at the local and national levels can refugee youth be effectively supported in coping with mental health challenges and integration into new communities.

- Ensuring access to information about available services in the native languages of refugees

Only through coordinated action at the local and national levels can refugee youth be effectively supported in coping with mental health challenges and integrating into new communities.

Strategies for mental health support for refugee youth in educational and social practice

In view of the growing number of young refugees in Europe, including Poland, there is an urgent need to develop and implement effective mental health support strategies. Below are key approaches and initiatives that can contribute to improving the mental well-being of young people with refugee experience.

- School integration and psychosocial support programmes

Schools play a key role in the integration and support of refugee youth. Programmes such as Refugees Well School offer psychosocial interventions in the school environment, promoting the mental and social well-being of teenagers through teacher training, theatre workshops and trauma recovery techniques. Refugees Well School

In Poland, UNICEF, in partnership with Microsoft, has launched an e-learning platform to support teachers working with refugee children, focusing on the inclusion and mental health of all students.

- Strengthening the intercultural competences of educational staff

Training for teachers and school staff on intercultural competence and trauma awareness is essential to effectively support refugee youth. Programmes such as 'Managing mental health as a refugee, asylum seeker and migrant' offer educational resources for those working with migrant youth, increasing their knowledge of mental health and promoting the right to appropriate support.

- Creating safe spaces and support groups

Initiatives such as the Amala Education Programme offer refugee youth access to education and practical life skills, creating safe spaces for learning and personal development.

- Cooperation with non-governmental and international organisations

Organisations such as Save the Children and UNHCR run mental health and psychosocial support programmes for refugee children and young people, offering training for local staff and assistance in accessing healthcare. UNHCR

- Promoting mental resilience and coping strategies

Integrating mental resilience-building interventions, such as cognitive behavioural techniques and mindfulness, into educational programmes can help refugee youth cope with trauma and stress. Research indicates that such approaches can significantly improve the mental well-being of young people. The Guardian

Non-formal education as a tool to support refugee youth

Non-formal education is playing an increasingly important role in supporting young people with refugee experience. It not only complements formal education but is often an alternative to it, especially when young people face administrative, linguistic or cultural barriers that prevent them from fully participating in the school system. Non-formal programmes run by non-governmental organisations, cultural institutions and grassroots local initiatives enable personal development, the restoration of a sense of security and agency, as well as social integration in a safe, non-judgmental space.

Why is non-formal education particularly important for refugee youth?

Young refugees often experience not only trauma, but also a long-lasting sense of exclusion and not belonging. Lack of language skills, cultural differences, adaptation difficulties, housing instability or lack of documents can make school a stressful place for them, rather than a place for development. In such cases, non-formal education – flexible, voluntary, relationship-based and based on shared experience – becomes an extremely important pillar of psychological, social and educational support.

Non-formal education offers a space where young refugees can not only learn and develop, but above all regain their agency, security and empowerment. Activities in this area should be supported by local and national policies and integrated with other forms of support, such as health, psychological and social support. The future of the integration of young refugees depends largely on the quality and availability of such activities.

Barriers to refugee youth access to non-formal education

Despite the growing importance of non-formal education as a tool for integration and psychosocial support for young people with refugee experience, many young people still face serious difficulties in accessing such activities. These barriers are structural, cultural, linguistic, psychological and institutional in nature, and their accumulation can effectively exclude refugee youth from social participation and personal development.

- Language and communication barriers

One of the most serious obstacles is the lack of knowledge of the language of the host country. Information about non-formal activities is rarely available in the refugees' native languages, and the workshops or meetings themselves rarely provide support from interpreters or visual materials. As a result, young refugees are often unaware that such activities are available to them or are unable to take full advantage of them.

- Lack of housing and logistical stability

Refugee families often experience housing instability, are moved between centres or rent temporary accommodation in difficult conditions. The lack of a permanent place of residence and difficult access to public transport significantly limit the possibility of regular participation in activities. This is particularly true for young people living outside large urban centres, where access to non-formal education is limited.

- Low level of trust and experience of trauma

Experiences of violence, discrimination, loss of loved ones or forced migration can result in a deep mistrust of institutions and outsiders. For many young people, participating in group activities with strangers can be a source of severe stress rather than support. If staff are not prepared to work with young people who have experienced trauma, the activities may actually exacerbate their feelings of alienation.

- Insufficient provision to meet real needs

Non-formal education programmes are often designed from the perspective of the majority society and do not always take into account the specific needs, opportunities and limitations of young refugees. There is a lack of activities tailored to different language levels, previous education and cultural differences. Programmes are also often too intensive or insufficiently flexible to respond to the dynamic life situation of participants.

- Institutional barriers and lack of coordination

Many countries, including Poland, lack coherent policies and strategies to support the participation of refugee youth in non-formal education. Measures are often fragmented, dependent on temporary projects and external funding, which makes access to them unequal and unstable. There is a lack of systemic mechanisms for cooperation between non-governmental organisations, schools, local authorities and cultural institutions.

- Economic pressure and family responsibilities

In some families, refugee youth act as interpreters, carers for younger siblings or contributors to the household budget. This means limited free time and the need to take on additional responsibilities, which hinders or even prevents participation in non-formal activities that are not considered a ‘priority’ in everyday survival.

Understanding and eliminating barriers to access to non-formal education is not only a matter of equal opportunities, but also a foundation for effective support for refugee youth.

Recommendations for non-formal education providers working with refugee youth

In light of the growing presence of refugee youth in Europe and the complex challenges they face, non-formal education providers are faced with the task of not only creating valuable programmes, but above all building an environment conducive to integration, well-being and empowerment.

- Design programmes with the participation of refugee youth

Do not create activities ‘for’ young people, but ‘with them’. Involve them as co-creators, consultants and ambassadors of projects. This allows you to better respond to their real needs and gives participants a sense of agency and belonging. Creating space for them to express their own voices also strengthens their commitment and identification with the group.

- Ensure linguistic and cultural diversity

Provide multilingual information materials and translations during the sessions. Make sure that the workshop leaders are familiar with the basics of intercultural communication and are aware of the impact of language (including non-verbal communication) on the reception of content. Take into account cultural differences in terms of gender, time, expression of emotions and sense of space.

- Build a team with the right skills

The team leading the workshop should be trained in working with young people, psychosocial support and have a basic understanding of trauma. It is helpful to have people with migration experience and people who speak the languages of the participants. Training in safe space, trauma, mental resilience and accessibility is recommended.

- Create a safe and inclusive environment

Refugee youth often carry difficult experiences with them, so it is crucial to build a space free from judgement, exclusion and symbolic violence. Ensure clear rules, a safe framework, awareness of boundaries and space to express emotions. You can also introduce optional ‘emotion cards’, anonymous question boxes, alternative forms of participation (e.g. through art or silence).

- Ensure flexibility and continuity of activities

Programmes should be flexible in terms of time and topics, allowing them to be adapted to the changing situation of participants (change of residence, family responsibilities, etc.). It is also crucial to create development paths: from participant to volunteer to group facilitator, which builds a sense of agency and continuity.

- Collaborate with other sectors and institutions

Build partnerships with local schools, social welfare centres, psychological counselling centres and other NGOs. This will enable you to respond more quickly to crisis situations, refer participants to specialist support and avoid duplication of activities. Local support networks strengthen the sustainability and effectiveness of activities.

- Evaluate and learn from participants

Collect feedback from young people regularly, not only at the end but also during the activities. Use visual, narrative and informal methods that are natural and comfortable for participants. Openness to change and flexible adaptation of the programme to the needs of participants are the basis for the effectiveness of non-formal education.

- Consider mental health aspects

Although non-formal education cannot replace therapy, it can complement it. Introduce elements that strengthen mental resilience, teach stress management strategies, and offer space for expressing emotions. It is worth ensuring the presence of a psychologist or someone with psychosocial support skills, even if only on call or in cooperation with a partner organisation.

Non-formal education can be one of the most effective tools for supporting refugee youth, provided that it is conducted consciously, with respect for diversity, based on relationships, trust and genuine partnership with young people. Professional, well-thought-out activities in this area have the power not only to alleviate the effects of trauma, but also to support the development, autonomy and future social activity of participants.

The importance of working with young people from the host country in the process of integration and crisis prevention

In the process of supporting young people with refugee experience, it is not only important to work with the migrants themselves, but also to carry out parallel activities aimed at their peers in the host country. It is these young people – students, neighbours, members of peer groups – who have a direct impact on the atmosphere of everyday relations, the quality of social integration and the level of emotional support available to refugee youth.

- Involving local youth in non-formal education programmes is crucial in three main areas:

Building open attitudes and counteracting prejudice

Young people in host societies often lack sufficient knowledge or contact with people with migration experience. A lack of reliable intercultural education can foster prejudice, misinformation and indifference.

Non-formal programmes – workshops, social projects, local campaigns – enable direct meetings, conversations and co-operation, which effectively reduce distance, strengthen empathy and counteract radicalisation.

- Strengthening social and civic competences

By engaging in integration activities, young people from the host country develop a range of soft skills: cooperation, intercultural communication, solidarity and social responsibility. This shapes a generation of conscious citizens who are ready to work towards an inclusive society.

- Creating a common space and equal relationships

Peers from the host country can act as ‘social bridges’ – helping newcomers adapt, sharing knowledge about everyday life, supporting language learning, or creating joint projects. Such a partnership based on cooperation rather than pity strengthens the sense of self-worth on both sides and fosters the creation of natural bonds. Mentoring programmes, peer groups and activities based on a common goal, such as artistic or sports projects or volunteering, are particularly effective.

Integration is not a one-sided process – it requires the involvement of both migrants and host societies. That is why it is so important that non-formal education programmes are not limited to working ‘for refugees’, but focus on the joint participation of young people from different backgrounds, promote equal relationships and build local communities of solidarity. It is young people, raised in a spirit of openness and responsibility, who have the opportunity to change the social perception of refugees – from a narrative of threat to one of shared development.

Part 6

Resilience how to strengthen the mental resilience of children and young people (worksheets, exercises)

Resilience is a term that refers to an individual's ability to adapt, persevere and recover in the face of difficulties, stress or traumatic experiences. It is the ability to cope with life's challenges and quickly return to balance after going through a difficult period. A person with high resilience is able to maintain healthy mental and emotional functioning despite problems.

The concept of resilience comes from the field of psychology and was introduced to describe the phenomenon of exceptional individuals who, despite adverse living conditions, were able to find themselves and develop in a positive way. It was initially used in the context of research on children who, despite stressful and traumatic experiences, developed healthily and achieved success.

The term ‘resilience’ was introduced into psychology by Emmy Werner, who conducted research on high-risk children, such as those from dysfunctional families or poor backgrounds. Her work showed that some children, despite difficult upbringings, achieved success in life, which inspired researchers to explore the mechanisms of resilience.

Resilience therefore means the ability to adapt in the face of adversity, flexibility in coping with difficulties, and the ability to use life experiences as a source of growth and development.

People with high resilience are able to cope effectively with stress, are more resistant to the negative consequences of difficult situations, and return to emotional balance more quickly. Nowadays, the concept of resilience is widely used not only in psychology, but also in other areas of life, such as education, sociology and management. It is assumed that developing resilience is important for every individual in order to effectively cope with the challenges of the modern world and achieve satisfaction and success in their personal and professional lives.

Resilience is not a static trait, but a process that can be developed and strengthened throughout life. There are many factors that influence an individual's level of resilience, including social support, stress management skills, flexibility of thinking, positive relationships with others, and a sense of self-worth and control over one's life.

Strengthening the mental resilience of children and young people plays a key role in their proper emotional and psychosocial development. Education in stress management skills, building positive relationships and developing self-esteem are important elements in the process of building resilience in young people.

Children and young people who have a high level of resilience are more resistant to negative environmental influences, are more likely to succeed at school and in their personal lives, and cope better with stressful situations and difficult life circumstances. Supporting the development of resilience in children and young people requires the involvement of the entire environment, including parents, teachers, therapists and the local community.

It is also worth noting that resilience is a malleable trait that can be shaped and developed at any stage of life. Even adults can take steps to strengthen their mental resilience by developing stress management skills, building social support, and developing positive thinking and self-esteem.

The development of resilience in children and young people is extremely important for their healthy emotional and psychosocial development. Resilience is a kind of foundation that enables young people to cope with difficult life situations and adapt to changing conditions and challenges. Education on stress management skills, building positive relationships and developing self-esteem are key elements that support the development of resilience in children and young people.

Mental resilience, also known as resilience, plays a key role in the mental health of children and young people. Strengthening this resilience is therefore extremely important, especially in the context of the growing number of suicide attempts and suicides among young people.

Children and young people who have strong mental resilience are more emotionally flexible and better able to cope with life's difficulties. They have the ability to look at problems from a different perspective, find positive ways to solve problems and build healthy relationships with others. These skills can be an important protective factor against the negative consequences of stress and trauma and reduce the risk of self-harming behaviour, including suicide attempts.

Strengthening mental resilience in children and young people is a multifaceted process involving both individual and environmental factors. It requires support from the family, school, local community and the health system. Mental health education, building stress management skills, promoting social support and developing positive relationships are key elements of this process.

Therefore, in the face of the growing problem of suicide and suicide attempts among children and young people, it is necessary to focus on building their mental resilience. Investing in mental health promotion and providing tools and support to develop resilience can help reduce the risk of self-harming behaviour and improve the overall mental well-being of young people.

Strengthening mental resilience in children and young people is a key element in the prevention of mental health problems, including the risk of self-harm and self-harming behaviour. It is therefore important to focus on providing practical tools and support to help young people cope with stress, emotional difficulties and life situations. One of the basic steps in building mental resilience is learning how to cope with stress and negative emotions.

As part of supporting children and young people, it is worth promoting healthy coping strategies, such as developing communication skills, building social support and practising relaxation techniques. Children and young people can also benefit from various forms of physical activity, which have a positive impact on their mental and emotional well-being. It is also important to build awareness and acceptance of their emotions, which allows them to better understand and control them.

In addition, a key element in strengthening mental resilience in children and adolescents is building their self-esteem and self-confidence. By appreciating their achievements, supporting them in developing their passions and interests, and encouraging them to acquire new skills, we can build their self-confidence and positive attitude towards themselves.

When supporting the development of mental resilience in children and young people, it is also important to pay attention to their emotional and social needs and to tailor the forms of support to their individual needs and abilities. In this way, we can effectively help young people cope with life and emotional difficulties and build healthy and satisfying relationships with those around them.

It is also crucial to encourage children and young people to seek support and help in difficult situations and to raise awareness of available resources and support options. This will enable them to respond more quickly to warning signs and cope effectively with emotional difficulties.

It is also worth promoting openness to discussion about mental and emotional problems and fostering a culture of acceptance and support in schools, families and local communities. By doing so, we can effectively prevent mental health problems and self-harming behaviour and support the healthy mental and emotional development of children and young people.

Worksheets, exercises for teenagers

Card topics:

1. Emotions are not the enemy. Recognising and naming emotions.
2. Instead of suppressing them, express them. Safe ways to express emotions.
3. Map of my resources. What are my strengths?
4. Zone of influence. What can I influence and what can't I influence?
5. When everything is overwhelming me. Strategies for coping with stress.
6. I am OK the way I am. Building self-esteem.
7. How I think is how I feel. Recognising cognitive errors.
8. My inner critic – what to do with it?
9. I am not alone. Who can support me?
10. Safe relationships. What are they and how to create them?
11. Mindfulness in everyday life. Simple exercises for regulating emotions.
12. The body feels too. Stress signals in the body and how to deal with them.
13. Anger that doesn't hurt. Assertively expressing difficult emotions.
14. Difficult conversations. How to talk when it's hard?
15. My boundaries. How to recognise and protect them?
16. Rest is not laziness. Balance between action and regeneration.
17. What strengthens me? Creating your own well-being kit.
18. When I am in crisis. A step-by-step action plan.
19. I have the right to ask for help. Breaking down barriers.
20. Who am I and who do I want to be? Working with identity and goals.

Card 1 – ‘Emotions are not the enemy. Recognising and naming emotions.’

Objective: To develop the ability to recognise, name and understand one's own emotions.

Introduction: Emotions are part of everyday life and play an important role in our development and relationships with others. They are often associated with negative feelings, especially difficult ones such as anger, sadness or shame. However, every emotion carries an important message. Learning to recognise and name them is the first step towards better understanding ourselves and coping with difficult situations.

Exercise 1 ‘My emotional day’

Think about the day that has just passed. Write down:

- What emotions did you experience today?
- When did you feel them?
- What situations triggered them?
- Did you notice any emotions in your body? Where?
- situations in which you feel this emotion,
- signals from your body,
- your typical reactions,
- what helps you when you feel it.

Stop and think:

- How often do you give yourself space to experience your emotions?
- Are there emotions that you try to suppress or ignore? Why?
- Which emotions are easiest for you to express and which are the most difficult?

Exercise 2 ‘Emotion dictionary’

Make a list of at least 10 emotions that you know. Try to group them into pleasant, unpleasant and neutral. Then choose three of them and describe how you think they can affect human behaviour.

Exercise 3 ‘Emotional compass’

Draw a compass where each of the four arms corresponds to a different basic emotion: joy, anger, sadness, fear. Add to each direction:

What am I taking away from this?

Understanding that emotions are not bad, but are signals that tell me what is important to me. I know that I can learn them like a language that helps me understand myself and others better.

Card 2 – ‘Instead of suppressing, express. Safe ways to express emotions.’

Objective: To develop the ability to recognise emotions and express them constructively and safely.

Introduction: Suppressing emotions, especially difficult ones, can lead to psychological tension, frustration and poor mental health. It is important to learn to recognise what we are feeling and find ways to express our emotions in a way that is safe for ourselves and others. Expressing emotions is not just about talking about our feelings, but also about processing and regulating them in a creative way.

Exercise 1 ‘Expression map’

Think about the ways you know and use to express your emotions. Divide a sheet of paper into three columns:

- emotion,
- way of expression,
- is this way safe (for me/for others)?

Then try to add at least three new ways of expressing emotions that you would like to try.

Exercise 2 ‘Feel and write’

Think of a situation in which you felt strong emotions but were unable to express them at the time. Write a short letter to yourself from that moment. How do you feel now? What would you say to yourself then? What emotions arise?

Exercise 3 ‘Creative expression’

Choose one of the difficult emotions you sometimes feel (e.g. anger, fear, sadness) and find a creative way to express it. It can be a drawing, a poem, a collage from newspapers, a piece of music or movement. Don't judge, just let the emotion come out.

Stop and think:

- What do I feel when I express my emotions?
- Do I find it difficult to show certain feelings? Why?
- Which ways of expressing emotions help me feel better?

What am I taking away from this?

The emotions I feel are part of me and I have the right to experience them. Knowing safe ways to express them helps me take better care of myself and my relationships with others.

Card 3 – ‘Map of my resources. What are my strengths?’

Objective: To recognise and strengthen one's own internal resources and develop a sense of agency.

Introduction: Each of us has resources – qualities, skills, values and experiences that help us cope with difficulties and build mental resilience. Resources are not always easily visible, especially in times of crisis. However, becoming aware of them can be a starting point for positive change.

Exercise 1 ‘My resource backpack’

Imagine that you are setting off on the journey of your life. What would you pack in your ‘resource backpack’? Write down everything that makes you strong: skills, experiences, values, character traits, support from other people. Use drawings or symbols if you like.

Exercise 2 ‘Resources in action’

Think of a situation in which you coped with something difficult. What helped you then? What resources did you use? Write it down as a short story or create a comic strip.

Exercise 3 ‘Strengthen your potential’

Choose one of the resources you would like to develop further (e.g. patience, self-confidence, creativity). Write down specific actions you can take in the coming days to strengthen it.

Stop and think:

- Am I able to recognise my strengths?
- What resources are most valuable to me right now?
- When was the last time I was proud of myself?

What am I taking with me?

My resources are part of me. Even if I sometimes forget about them, they are within me and I can draw on them in difficult times. Getting to know and developing my strengths helps me become a more resilient and confident person.

Card 4 – ‘Zone of influence. What can I influence and what can't I influence?’

Objective: To develop the ability to distinguish between areas of influence and those beyond our control, and to strengthen a sense of agency.

Introduction: In everyday life, we experience many situations that can cause frustration, anxiety or feelings of helplessness. We often try to control things that are beyond our influence – other people's behaviour, adults' decisions, the weather, the past. Focusing on what is within our reach allows us to regain a sense of agency and cope better with challenges.

Exercise 1 ‘Circles of influence’

Draw two circles – an inner circle and an outer circle. Inside the first circle, write down things you have influence over (e.g. my decisions, how I spend my time, how I talk to others). In the second circle, write down things you have no influence over (e.g. the weather, what someone else said, other people's decisions). Think about what you want to focus on today.

Exercise 2 ‘Rephrase your thoughts’

Read the following sentences:

- ‘Nobody likes me.’
- ‘I always mess everything up.’
- ‘I can't do it.’

Think about how you can rephrase them, focusing on what depends on you. Write down your own versions of these thoughts.

Exercise 3 ‘My choices’

Describe one situation in which you recently felt helpless. Did you really have no influence? What could you have done differently? What decisions can you make today to improve your situation?

Stop and think:

- What do I really have influence over in my life?
- What helps me regain a sense of control?
- How can I focus on action instead of worrying?

What am I taking with me?

Focusing on what I can change gives me more energy, a sense of purpose and strength. I have control over my thoughts, actions and decisions – and that's enough to take the first step towards change.

Card 5 – ‘Zone of influence. What can I influence and what can't I influen-ce?’

Objective: To learn effective ways of coping with stress and emotional overload.

Introduction: Stress is a natural response to challenges and pressure, but when it lasts too long or is too intense, it can negatively affect our mental and physical health. Young people often experience stress related to school, relationships, expectations or their own future. It is crucial to learn to reco-gnise the signs of stress and have a set of strategies ready to help regulate it.

Exercise 1 ‘My alarm signals’

Think about and write down how your body and mind react to stress. You can divide the sheet into three columns:

- body (e.g. muscle tension, stomach ache, rapid breathing),
- emotions (e.g. anger, fear, sadness),
- thoughts (e.g. ‘I can't do it’, ‘Everyone is against me’). Identify your own signals – this is the first step to responding effectively.

Exercise 2 ‘My SOS plan’

Create a personal action plan for stressful situations. Write down:

- three things you can do right away to calm down (e.g. breathing, music, going for a walk),
- three people you can turn to for support,
- three sentences you can say to yourself to feel better.

Exercise 3 ‘Anti-stress toolbox’

Draw or describe your ‘toolbox’ for coping with stress. What is in it? These can be specific activities (drawing, sports, meditation), words, places, or even objects (e.g., a favourite book, photo, talisman).

Stop and think:

- When was the last time I felt overwhelmed?
- What helped and what made the situation worse?
- How can I support myself in such moments?

What do I take with me?

Stress is part of life, but it doesn't have to control me. I have resources within myself and around me that help me cope with difficulties. When I feel overwhelmed, I can take action, step by step, with kindness towards myself.

Card 6 – ‘I am OK the way I am. Building self-esteem.’

Objective: To strengthen self-acceptance and healthy self-esteem.

Introduction: Every human being deserves respect – including from themselves. Self-esteem is how we perceive ourselves, our abilities, strengths and limitations. It is the foundation of mental health. Unfortunately, many young people experience doubts about their worth, especially under the influence of social pressure, comparisons or negative experiences. It's time to change that – start by getting to know and accepting yourself as you are.

Exercise 1 ‘Self-acceptance mirror’

Draw yourself or look in the mirror and write down at least five things you like about yourself – these can be character traits, skills, passions or values. Avoid physical appearance. Think about what makes you who you are.

Exercise 2 ‘My letter to myself’

Write a short letter in which you address yourself with kindness. Instead of criticism, use praise. Instead of ‘I must’, use ‘I can’. You can end the letter with words of encouragement and support that you would say to your best friend.

Exercise 3 ‘The myth of perfectionism’

Write down the things you feel you are ‘not good enough’ at. Next to each one, write down a realistic view, e.g. ‘I'm not the best at maths, but I'm making progress and trying hard.’ Working on your inner dialogue is an important step towards self-acceptance.

Stop and think:

- How do I talk to myself when I fail at something?
- Am I able to support myself?
- What can I do to build my self-esteem every day?

What do I take with me?

I don't have to be perfect to deserve respect. I am important and enough just as I am. Every day, I can choose to be kind to myself and reject my inner critic.

Card 7 – ‘How I think is how I feel. Recognising cognitive errors.’

Objective: To strengthen mental resilience and develop crisis survival skills.

Introduction: We all experience difficult moments – failures, losses, disappointments, setbacks. Mental resilience does not mean the absence of suffering, but the ability to recover despite it. It is the ability to adapt to difficulties, use one's own resources and seek support when needed. It can be developed step by step, with mindfulness and patience towards oneself.

Exercise 1 ‘My resilience resources’

Think about what already helps you get through tough times. Write down your internal resources (e.g. courage, sense of humour, ability to ask for help) and external resources (e.g. loved ones, a place that gives you peace, values that guide you).

Exercise 2 ‘The story of my strength’

Describe one event in your life in which, despite difficulties, you managed to cope. What helped you then? What decisions were crucial? What does this say about you? This exercise helps you see that you already have more strength within you than you sometimes think.

Exercise 3 ‘My plan for the future’

Think about how you can strengthen your resilience every day. Make a plan: what can you do to take care of yourself? What habits do you want to develop? Who supports you and who would you like to talk to more often?

Stop and think:

- What does resilience mean to me?
- What makes me stronger?
- When do I feel strong, despite difficulties?

What do I take with me?

Resilience is not a shield, but inner flexibility. It is the awareness that setbacks are part of life, but they do not have to define us. I have the right to difficult emotions, but I also have the right to support, to grow and to believe in myself.

Card 8 – ‘My inner critic – what to do about it?’

Objective: To strengthen social competences and skills for building healthy interpersonal relationships.

Introduction: Relationships with other people have a huge impact on our well-being, sense of belonging and security. Good relationships can be a source of support and motivation, while difficult ones can cause stress and self-doubt. Young people often learn how to form relationships through trial and error. It is therefore worth taking the time to reflect on what makes a relationship healthy, how to nurture it, how to recognise toxic patterns and how to set boundaries.

Exercise 1 ‘Map of my relationships’

Draw a map of your closest relationships (family, friends, teachers, online friends, etc.). Think about:

- Which of these relationships are supportive to you?
- Where do you feel like yourself?
- Which relationships do you want to strengthen and which ones do you want to weaken?

This exercise allows you to take a step back and notice patterns in your interactions with others.

Exercise 2 ‘Dialogue with boundaries’

Think about the last time you said ‘no’ even though it was difficult. How did you feel then? Were you able to express your needs clearly and calmly? Now write down examples of situations in which you want to take care of your boundaries. Practise what you can say and how you can behave.

Exercise 3 ‘Recipe for a good relationship’

Write down the characteristics of relationships that give you a sense of security and acceptance. What helps you feel important, listened to, and seen? Then think about what you can bring to the relationship to make it supportive and empowering for both parties.

Stop and think:

- What relationships make me feel good?
- Am I able to be present and attentive when interacting with others?
- How do I show respect – towards myself and others?

What do I bring to the relationship?

Relationships are like gardens – they need care, attention and mutual respect. A healthy bond is not based on perfection, but on a willingness to listen, forgive and be yourself. I have an influence on how I build relationships – and I can develop them with kindness and awareness of my boundaries.

Card 9 – ‘I am not alone. Who can support me?’

Objective: To raise awareness of the forms of emotional support available and to build skills for seeking help.

Introduction: In emotionally difficult times, when we feel sad, overwhelmed or in crisis, it is extremely important to know that we are not alone. There are many forms of support, from loved ones to professionals, that can help us get through difficult experiences. It is important to learn to recognise when we need help and to trust that asking for support is a sign of strength, not weakness.

Exercise 1 ‘My support network’

Make a list of people and places you can turn to in difficult times. Divide them into three categories:

- close people (e.g. family, friends, trusted teacher),
- professionals (e.g. school psychologist, counsellor, helpline),
- safe spaces (e.g. favourite place, group activities, online forum).

Think about in what situations you could reach out to them and what such a conversation would look like.

Exercise 2 ‘What is holding me back?’

Write down the thoughts that come to mind when you think about asking for help (e.g. ‘I don't want to be a burden’, ‘others have it worse’). Transform them into supportive statements (e.g. ‘everyone deserves help’, ‘I have the right to talk about how I feel’). Working on mental barriers is the first step towards open communication.

Exercise 3 ‘Letter to yourself in a crisis’

Write a letter to yourself from the future – from the perspective of someone who has gone through a difficult time and knows that help was important. What would you like to say to yourself then? What words of encouragement and support would you need at that moment? You can keep this letter and refer to it when you feel worse.

Stop and think:

- Do I know where and from whom I can seek support?
- What signs do I recognise in myself that I need help?
- Do I allow myself to be weak and ask for support when I need it?

What do I take with me?

I don't have to carry everything on my own. Everyone has the right to care, presence and to be heard. Support can come in many forms – it is worth knowing where to look for it and trusting that there are people who want to help.

Card 10 – ‘Safe relationships. What are they and how to build them?’

Objective: To understand the importance of safe relationships in young people's lives and to develop skills for building healthy interpersonal relationships based on mutual respect and trust.

Introduction: Relationships are an integral part of our lives – they affect our well-being, self-esteem and development. During adolescence in particular, young people learn what healthy and safe relationships are. However, it can sometimes be difficult to distinguish between supportive relationships and toxic or burdensome ones. That is why it is important to learn about the characteristics that define relationships based on mutual trust, communication and empathy.

Exercise 1 ‘Relationship map’

Draw a map of your most important relationships (family, friends, acquaintances, teachers). Next to each person, write how you feel in that relationship: safe, comfortable, insecure, stressed? Think about what makes some of these relationships more supportive than others.

Exercise 2 ‘What is a safe relationship?’

Think of a situation in which you felt really good and safe in a relationship. What were the characteristics of this relationship? What made it special? Based on this, write down the characteristics of a safe relationship (e.g. honesty, mutual respect, the ability to be yourself, boundaries).

Exercise 3 ‘What to do when a relationship is no longer safe?’

Think about what you can do when you feel uncomfortable in a relationship. Who can you ask for help? What signs might indicate that a relationship is no longer good for you? Make a list of boundaries you want to maintain in your relationships with others.

Stop and think:

- Which relationships in my life are truly supportive?
- Can I say ‘no’ when something hurts me?
- What does being in a healthy relationship mean to me?

What do I take with me?

I have the right to relationships in which I am respected, listened to and can be myself. A safe relationship is one in which I feel comfortable, can talk about my emotions and know that my boundaries are respected. Building such relationships is a process, but it is worth investing in because good relationships are one of the foundations of our mental resilience.

Card 11 – ‘Mindfulness every day. Simple exercises to regulate emotions.’

Objective: To introduce the basics of mindfulness as a tool to support everyday emotional balance, helping with concentration, self-regulation and stress reduction.

Introduction: Young people's everyday lives can be full of stress, uncertainty and emotional ups and downs. School, relationships, expectations, social media – all of these can lead to overload. Mindfulness is a way to pause, notice what is happening inside and around us, and respond consciously instead of acting automatically. Regular mindfulness practice can help us understand ourselves better, reduce stress and strengthen our mental resilience.

Exercise 1 ‘Breathing as an anchor’

Sit comfortably. Close your eyes or focus your gaze on a single point. Concentrate solely on your breathing. Do not change it – just observe it. Feel the air entering your nose, filling your lungs and then flowing out. If your thoughts drift away, that is normal. Notice this and return to your breathing. Practise for 3–5 minutes a day.

Exercise 2 ‘Mindful eating’

Take something to eat – e.g. a raisin, a square of chocolate or a piece of apple. Before you eat it, look at it carefully. What does it look like? How does it feel? Smell it. Now eat it very slowly, paying attention to every taste, texture and temperature. This exercise shows how many things we do automatically, without awareness.

Exercise 3 ‘Body scan’

Lie down or sit comfortably. Close your eyes. Focus your attention on different parts of your body – starting with your feet, then your legs, torso, arms and finally the top of your head. Pause for a moment on each part and check: how do I feel? Is there any tension? Is it warm? Cold? Don't judge – just notice. You can do this exercise in the evening before going to bed.

Stop and think:

- Can I stop and focus on the present moment?
- What emotions do I feel most often during the day?
- Do I give myself space to rest and notice myself?

What am I taking with me?

Mindfulness is not magic – it is a daily practice of being with yourself in the here and now. I don't have to be ‘perfect’, I don't have to control everything. But I can learn to react more calmly, more attentively and with greater care for myself. A breath, a moment of silence, a few minutes of focus – these are small steps that can bring about a big change.

Card 12 – ‘The body feels too. Stress signals in the body and how to deal with them.’

Objective: To raise awareness among young people about the physical signs of stress and to develop their ability to recognise and regulate signals from their bodies.

Introduction: Stress is not just a mental state – we also feel it in our bodies. When we experience strong emotions, our bodies react immediately. Stomach ache before a test, tense shoulders during an argument or a racing heart in a stressful situation are just some of the physical signs of stress. The ability to notice these signals and respond appropriately is an important step towards building mental resilience.

Exercise 1 ‘Body map’

Draw the outline of a human figure. Think about it and mark the places where you most often feel tension or stress (e.g. neck, jaw, stomach). What are these feelings – pain? Tingling? Pressure? Talk about it with someone close to you or write down your thoughts on a piece of paper. Do you know any techniques that can help relieve pain or tension?

Exercise 2 ‘Movement as a release of tension’

Choose a form of movement that you enjoy – it can be walking, dancing, yoga or stretching. During the activity, pay attention to how your body changes – how do you feel at the beginning and after 10 minutes of movement? Does the tension decrease? Movement is an effective way to relieve stress.

Exercise 3 ‘The 5-4-3-2-1 technique’

This exercise combines mindfulness with bodywork. Stop and notice:

- 5 things you see,
- 4 things you hear,
- 3 things you feel,
- 2 things you smell,
- 1 thing you can taste or feel in your mouth. This technique helps you to ‘ground’ yourself in the here and now and reduce your anxiety levels.

Stop and think:

- Where in my body do I most often feel tension?
- What situations affect my body the most?
- Can I notice and understand the signals coming from my body?

What do I take with me?

My body is my ally. It sends me signals when something is wrong – it's worth learning to listen to them. Understanding the physical signs of stress helps you react faster and take better care of yourself.

Card 13 – ‘Anger that doesn't hurt. Assertively expressing difficult emotions.’

Objective: To develop the ability to recognise and constructively express emotions, especially anger, in an assertive, non-harmful way that promotes healthy relationships.

Introduction: Anger is an emotion that arises in response to frustration, injustice or boundary violations. It is completely natural and necessary – it informs us that something is wrong. The problem arises when we are unable to express it in a healthy way – we suppress it, explode or direct it against ourselves. Assertive expression of anger is the ability to talk about it directly, but with respect – towards ourselves and others. This allows us to take care of our needs without hurting others.

Exercise 1 ‘How does anger manifest itself in my body and behaviour?’

Think about how you know when you are starting to get angry. Fill in the blanks below:

- What happens to my body when I get angry? (e.g. I clench my fists, my heart beats faster)
- What thoughts most often come to mind?
- What words or actions come most easily to me then? Discuss your answers with a friend or an adult. Is it possible to recognise anger before it erupts?

Exercise 2 ‘I message’

We often express anger through accusations (‘because you always...’, ‘it's your fault...’). Replace them with ‘I’ statements:

- ‘I feel... (emotion)’
- ‘when... (description of the situation)’
- ‘because... (explanation)’
- ‘I would like... (need, request)‘ Example: “I feel frustrated when you interrupt me because I feel like you're not listening. I would like you to let me finish.’

Exercise 3 ”My ways of defusing anger’

Make a list of safe ways to release tension when you feel angry. These could include: taking a short walk, taking a cold shower, writing a letter (even if you don't send it), drawing, shouting into a pillow, talking to someone you trust. Which of these do you already know? Which ones would you like to try?

Stop and think:

- Can I recognise when I am angry?
- What do I usually do when I feel angry?
- Does my anger hurt others or myself?

What do I take with me?

Anger is not bad. It is an important signal that something is wrong. I have the right to feel and express it.

Card 14 – ‘Difficult conversations. How to talk when it's hard?’

Objective: To develop the ability to conduct difficult conversations in an empathetic, open and constructive manner. To build courage in communicating one's feelings and needs while respecting the emotions of the other party.

Introduction: Conversations that touch on difficult topics – such as conflicts, misunderstandings, unpleasant experiences or boundaries – are inevitable. They can cause tension, fear of rejection or misunderstanding. But it is precisely then that good communication and mindfulness are most important. Avoiding difficult conversations often leads to growing tensions and misunderstandings. A courageous but kind conversation can be a step towards improving relationships and better understanding of oneself and others.

Exercise 1: ‘What do I feel before a difficult conversation?’

Think about what you think and feel when you know you have a difficult conversation ahead of you. Fill in the blanks:

- What thoughts come to mind?
- What emotions do I feel?
- How does my body react? Do these reactions help or hinder the conversation? How can they be mitigated or tamed?

Exercise 2 ‘A difficult conversation step by step’

Practise conducting a difficult conversation using the following model:

- Take care of the time and place – choose a quiet environment.
- Start with your intention – ‘I want to talk to you because this relationship is important to me.’
- Talk about yourself: “I feel... when... because...’
- Express your need: ”I would like...’
- Give the other person space – ask them how they feel and what they think.
- Look for a solution together. Write down your example statement, starting with ‘I want to talk to you because...’

Exercise 3 “Words that help – words that hurt”

Make a list of phrases that build conversation (e.g. ‘I understand that this is difficult for you’, ‘Thank you for telling me’) and those that destroy it (e.g. ‘You always do that’, ‘Don't exaggerate’). Think about what phrases you can use to make the conversation more empathetic and less confrontational.

Stop and think:

When was the last time I had a difficult conversation? What went well and what didn't?

- How did I feel afterwards?
- What can I improve next time?
- What am I taking away from this?

Difficult conversations require courage, but also mindfulness and empathy. It's not just about expressing your feelings, but also about being willing to listen to the other person.

Card 15 – ‘My boundaries. How to recognise and protect them?’

Objective: To help young people recognise their emotional, physical and mental boundaries and learn how to express and protect them in their relationships with others.

Introduction: Boundaries are invisible lines that define what is okay for us and what crosses our comfort zone. Everyone has the right to set their own boundaries that are in line with their values, needs and emotions. Taking care of boundaries is not selfish – it is respect for oneself and others.

Exercise 1 ‘My map of boundaries’

Divide a sheet of paper into three parts and label them: physical boundaries, emotional boundaries, and time boundaries. In each section, write down what respecting these boundaries means to you and what situations make you feel uncomfortable.

Exercise 2 ‘How do I feel when my boundaries are crossed?’

Think of a situation in which someone violated your boundaries. Describe:

- How did you feel?
- How did you react?
- What would you have liked to say or do differently?

Exercise 3: Assertive ‘no’

Imagine a few situations in which you have to say no – e.g. someone asks you to do something you don't have the strength or desire to do. Write down how you could respond:

in a firm manner,

but kindly,

with respect for yourself and the other person. Practise these responses out loud.

Stop and think:

- Do I ever cross other people's boundaries?
- Can I recognise when my boundaries are being violated?
- What can I do to take care of myself in such moments?

What do I take with me?

Boundaries are not walls, but a way to build healthy relationships. They allow us to feel safe, secure and be ourselves – in line with our own values and needs. Practising recognising and expressing boundaries is an important step in building self-esteem and respect for others.

Card 16 – ‘Rest is not laziness. It is a balance between activity and regeneration.’

Objective: To understand the importance of rest and regeneration in everyday life. To learn how to maintain a balance between activity and quiet time. To reinforce the belief that self-care is an important part of mental health.

Introduction: Contemporary culture often rewards constant activity, achievement and being ‘busy’. In such a world, rest is sometimes mistakenly perceived as weakness or laziness. However, it is precisely the ability to pause, take care of one's own needs and regenerate that allows us to function effectively and maintain mental well-being. A balance between activity and rest is not a luxury, but a prerequisite for healthy development.

Exercise 1 ‘My daily energy balance’

Think about what your typical day looks like. Draw a simple timeline and mark the following:

- moments when you feel most stressed or tired,
- moments that are a source of energy and peace for you,
- how often you take breaks during the day. Summarise: does your day include time for regeneration? What can you change?

Exercise 2 ‘My personal set of micro-breaks’

List at least 5 short activities that you can do to relax and take a break from your responsibilities (e.g. listening to music, going for a walk, deep breathing, contact with

nature, dancing, taking a short nap, taking photos). Describe what makes each of them work for you. Stick the list somewhere where you can easily see it.

Exercise 3 ‘My beliefs about rest’

Think about it:

- What do I think about people who rest often?
- Do I have beliefs such as ‘I have to earn my rest’ or ‘rest is a waste of time’?
- What belief would I like to strengthen in myself? Write down one sentence that will accompany you from today onwards as a new, supportive approach to rest.

Stop and think:

- When was the last time I allowed myself to just rest?
- What signals does my body give me that it needs regeneration?
- How can I ensure that I rest regularly?

What do I take with me?

Rest is not a reward – it is a basic need. Consciously planning time for regeneration is an expression of self-care. Regular rest helps maintain energy, creativity and mental balance. Taking care of yourself is not selfish – it is wisdom and responsibility for your own health.

Card 17 – ‘What strengthens me? Creating your own *well-being kit.*’

Objective: To identify personal sources of strength and develop an individual set of activities to support mental and emotional health. To develop self-awareness and the ability to take care of oneself in difficult moments.

Introduction: Each of us has our own ways of coping with stress, fatigue or sadness. Some are supportive and safe, others less effective or even harmful. It is worth consciously building your own ‘well-being kit’ – a set of tools, activities and rituals that help you regain balance, calm your emotions and regain your inner strength.

Exercise 1 ‘What makes me stronger?’

Make a list of things that help you feel better in difficult moments. Think about activities, people, places, and thoughts that have a calming, inspiring, or energising effect on you. Divide them into three categories:

- Things I do on my own
- Things I do with others
- Things I can do in a crisis

Exercise 2 ‘Create your own wellness kit’

Based on the list above, create your own kit in graphic form – it can be a drawing, collage, diagram or list with icons. Place it in a visible place or keep it in a notebook.

It is good if it includes specific actions, e.g. ‘I will listen to a playlist of my favourite music’, ‘I will talk to someone I trust’, ‘I will make myself a cup of tea and wrap myself in a blanket’.

Exercise 3 ‘What doesn't work?’

Think about ways of coping with difficulties that do not bring you relief or have negative effects (e.g. isolation, avoiding conversations, social media, impulsiveness). Write them down and think about how you can replace them with more supportive activities.

Stop and think:

- When was the last time I did something supportive for myself?
- What works best for me when I am stressed?
- What small things make me feel cared for?

What do I take with me?

Taking care of your well-being is not a one-time activity, but a process that requires mindfulness and consistency. Your well-being first aid kit may change and evolve – the most important thing is that it is yours. In difficult moments, it can become an invaluable source of strength and support.

Card 18 – ‘When I am in crisis. A step-by-step action plan.’

Objective: To develop the ability to recognise moments of crisis and implement a practical action plan that will help rega- in control, a sense of security and access to support.

Introduction: A mental health crisis is a moment when emo- tions become overwhelming and everyday functioning is seve- rely disrupted. It can occur suddenly or build up gradually. In such a state, it is important to have an action plan in place – something you can refer to when it is difficult to think rationally. Such an individual ‘lifeline’ allows you to take care of yourself, seek support and avoid impulsive decisions.

Exercise 1 ‘Recognise your state’

Consider:

- How do I recognise that I am in crisis? (e.g. thoughts such as ‘I can't do it’, physical symptoms, emotions)
- What usually causes me severe stress or feelings of helplessness?
- What signals does my body and mind send me? Write down your answers to better recognise the early signs of a crisis.

Exercise 2 ‘Action plan for difficult moments’

Create your own personal action plan. You can answer the following questions:

- What can I do when I feel that ‘something is wrong’? (e.g. I will call.../go for a walk/lock myself in my room and listen to music)
- Who can I ask for help? Write down names, phone numbers, places.
- What places and situations help me feel safe?
- What thoughts or phrases can I repeat to myself to calm down?
- What should I NOT do (e.g. isolate myself, make impulsive decisions)?

Exercise 3 ‘Emergency card’

On a separate sheet of paper, prepare your ‘emergency card’. It should include:

- 3 things you can do to calm down
- 3 people you can turn to
- 3 thoughts that support you Keep it in your wallet or phone so that it is always at hand.

Stop and think:

- Do I know what helps me in a crisis?
- Do I have someone I can trust?
- Do I allow myself to ask for help?

What do I take with me?

A crisis does not mean failure – it is a sign that you need care, pause and support. Having a plan of action makes it easier to get through difficult moments and take care of yourself. Support is available – it is important to reach out for it.

Card 19 – ‘I have the right to ask for help. Breaking down barriers.’

Objective: To make young people aware that asking for help is not a sign of weakness, but of strength. To recognise internal and external barriers that prevent them from seeking support.

Introduction: Many young people find it difficult to ask for help – not because they don't need it, but because they fear judgement, rejection or believe that they ‘should cope on their own’. However, every person, regardless of age, has the right – and the need – to seek support from others. The ability to ask for help is an important emotional and social skill that is worth developing.

Exercise 1: ‘What is holding me back?’

Think about why you sometimes don't ask for help even when you need it. Write down:

- My thoughts that block me (e.g. ‘I don't want to be a burden’, ‘others have it worse’)
- My emotions that arise at that moment (e.g. shame, fear, anger)
- My experiences (e.g. have I ever been rejected when asking for help?)
- Close people (family, friends)
- Trusted people (teacher, psychologist, coach)
- Institutions and places where you can seek help (e.g. helpline, counselling centre, website) Mark the sources of support you are willing to turn to.

Stop and think:

- What would change if I allowed myself to ask for help?
- What do I lose by not doing so?

Exercise 2 ‘Help is strength’

Think about a situation when someone helped you – how did you feel then? Or maybe you helped someone else and it was important? Write down these memories. Think about how your views on asking for support have changed.

Exercise 3 ‘Who can help me?’

Create a personal support map. Include:

What do I take with me?

Asking for help is courage, not weakness. It is acknowledging your needs and giving yourself a chance for support, care and understanding. It is also an expression of trust in others – and trust is the foundation of healthy relationships and mental well-being.

Card 20 – ‘Who am I and who do I want to be? Working with identity and goals.’

Objective: To encourage young people to reflect on their identity, values and directions for development. To build a sense of agency and check the consistency between the ‘present self’ and the ‘future self’.

Introduction: Adolescence is a time of intense self-discovery. Young people try to answer questions such as: Who am I? What is important to me? Where am I going? Reflecting on identity and values allows young people to consciously build self-esteem and choose goals that are in line with what really matters to them. This exercise helps them to pause and take a close look at themselves – here and now, and in the future.

Exercise 1 ‘Me today’

Draw a silhouette (you can replace it with an outline of a figure). Inside, write down the characteristics that you consider to be yours (e.g. emotions, beliefs, skills, interests, values). Outside, write down how others perceive you. Do you see any differences? What are they?

Exercise 2 ‘Me in the future’

Imagine yourself in 5-10 years. Think about:

- Who do you want to be as a person?
- What values will be important to you then?
- What skills do you want to develop?
- Where do you want to be – physically, professionally, relationally? Write down your answers in the form of a list or description. If you want, you can draw or create a visual map of your future.

Exercise 3 ‘My values, my goals’

Look at the values that are important to you. Choose the 5 most important ones (e.g. honesty, family, freedom, development, empathy, loyalty). Next to them, write down how you can implement them in your everyday life – starting now. Then write down 3 goals you want to achieve in the coming year. Mark which values support them. This will help you consciously move in a direction that really means something to you.

Stop and think:

- What makes me feel like myself?
- Are my decisions in line with what is really important to me?
- Do I give myself the right to change?

What am I taking with me?

Identity is not something fixed – it shapes and matures. Consciously working on who you are and who you want to be is an important step towards self-discovery and life satisfaction. It is worth returning to these questions from time to time and checking again: is the path I am on my own?

Summary

To summarise the publication, we present materials from the educational campaign ‘127 empty seats’, which we conducted as part of the project summary.

Between January and February 2025, our partners disseminated campaign content in the Tri-City area and Antalya. The main target audience was secondary school students, who also took part in meetings with local authorities, lectures at the Gdynia Sports Centre and workshops led by psychologists.

The campaign was held under the slogan ‘127 empty seats’ and enjoyed a great response from the public. All posters can be downloaded from the website of the organisation coordinating the activities – instytutwiedzy.pl.

Social campaign ‘127 empty seats’ – a collective cry of silence

In 2024, 127 children and teenagers took their own lives in Poland. This is not just a shocking statistic – it represents 127 tragedies that could not be prevented. Every day, an average of six young people attempt suicide. The numbers are not anonymous. Each one is someone's name, an unfinished story, an unheard voice, an emptiness that remains.

In response to these dramatic figures, a social campaign called ‘127 empty seats’ was launched as part of the ‘Strong minds – preventing crises among young people’ project. Its aim was not only to raise awareness of the scale of the problem, but above all to give a voice to those who no longer have one – and to those who can still regain it.

Symbols of emptiness

- ‘127 empty seats’ – exactly the number of seats on an articulated bus in Gdynia. It runs through the streets of the city every day, but imagine it empty. No laughter, no conversations, no trips to school or to meet friends. Only the echo of what could have been.
- ‘127 empty seats’ – these are four classrooms at the Refrigeration and Electronics School Complex in Gdynia, which could have been filled with dreams, plans for the future, anxiety before final exams and the joy of friendship. Now they are a symbol of how much we as a society could have missed.
- ‘127 empty seats’ are the empty rows in the stands of the Gdynia Stadium, from which no cheering will ever be heard again. They are also an entire SKM train carriage that will never take anyone to their first day of university or their dream job interview.

The campaign deliberately uses powerful symbols. Because only powerful images can break through indifference. Only moving metaphors can stop us for a moment in our daily rush. **Because each of these empty spaces carries a story that we did not have time to hear.**

The ‘127 empty seats’ campaign is more than just a moving message. It is a public call to action. To courageously face the mental health crisis among children and young people. To have conversations that can save lives. To show empathy, which has the power to break down the barriers of loneliness. To offer support – even when we don't know exactly what to say.

Each ‘empty seat’ is not only a tragedy that ended prematurely. It is also a reproach to the entire system, which failed to help, which was not ready to listen, understand and act. The campaign reminds us that every loss could have been prevented. That behind every silence there may be a tragedy that needs to be seen.

End the silence – reach out for help

As part of the campaign, we remind you that help is available, free of charge and around the clock. One phone call is all it takes to not be alone in a difficult moment. One conversation is enough to break the spiral of thoughts leading to tragedy.

Helpline numbers:

- 116 111 – 24-hour helpline for children and young people. Free calls, chat also available: https://116111.pl/czatuj

- 800 12 12 12 – Children's Ombudsman helpline, available 24 hours a day, 7 days a week. Chat: https://www.czat.-brpd.gov.pl

- 800 012 005 – ‘Talking Phone’, daily from 11:00 to 20:00.

Let's not let silence be the answer.


Sto dwadzieścia siedem.
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Sto dwadzieścia siedem.
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WEJŚCIE 8
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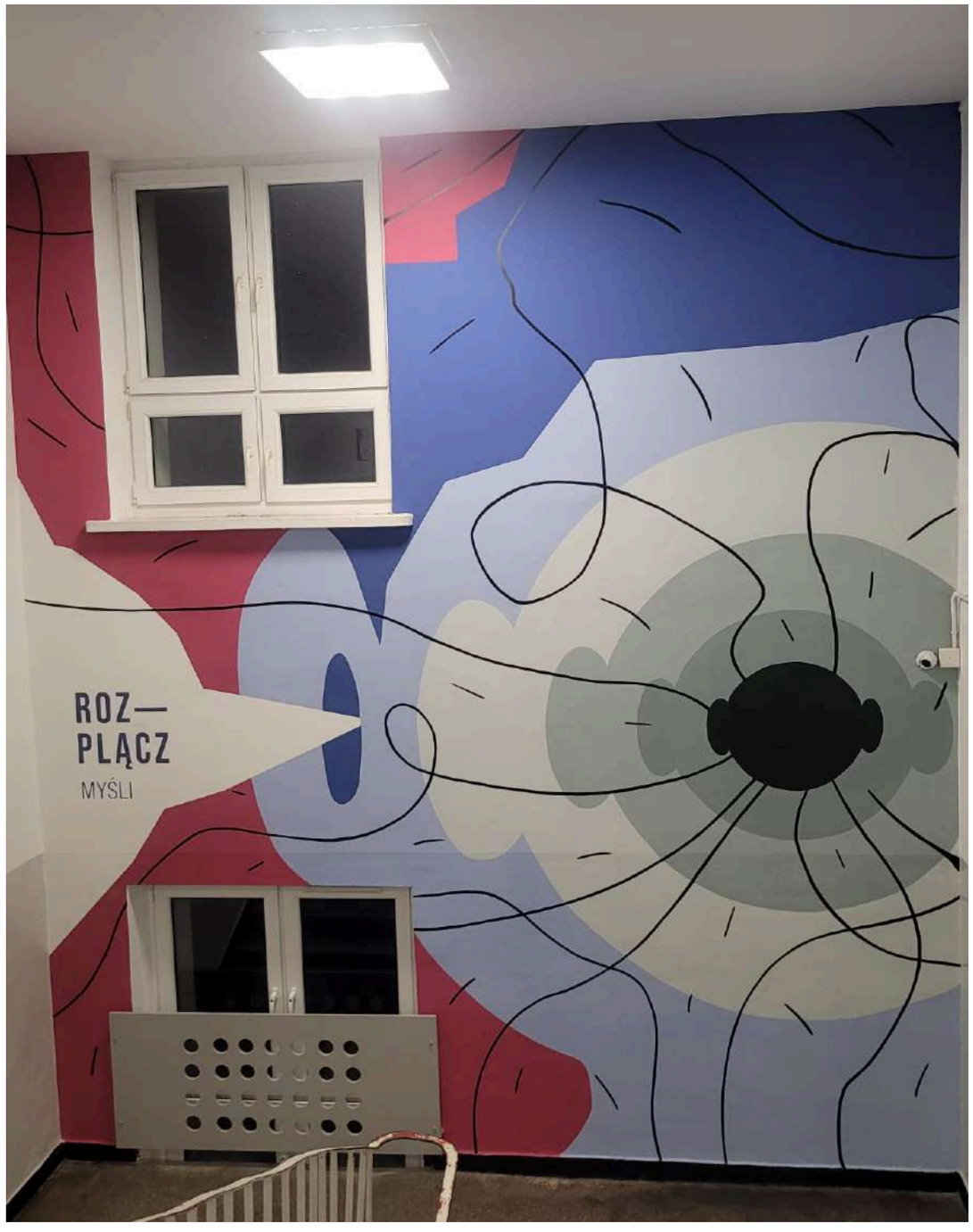
An additional, extremely important element of the project was the creation of a mural entitled ‘Untangle Your Thoughts – Strong Minds’ at the Leonid Teliga Primary School No. 34 with Integrated Classes in Gdynia. The work on the mural was both artistic and educational-therapeutic in nature. School pupils, teachers and invited guests, including young people participating in the ‘Strong Heads’ project workshops, were involved in its creation.

The mural is a visual summary of the main ideas of the project – concern for the mental health of young people, destigmatisation of emotional crises and promotion of openness and mutual support. Its symbolism refers to the process of ‘untangling’ difficult thoughts, emotions and experiences, which was one of the leitmotifs of the workshops. The resulting composition not only decorates the school space, but also serves as a communication tool, addressing important issues in a way that is accessible and friendly to young audiences.



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