

Crisis intervention strategy for attempted suicide in children and adolescents: interactionist perspective

Estrategia de intervención en crisis para el intento de suicidio en niños y adolescentes: perspectiva interaccionista

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Abstract

An intervention strategy is presented for suicide attempt in children and adolescents during the crisis period, based on the approach of symbolic interactionism. Using a qualitative approach and hermeneutic methodology, 18 in-depth interviews were analyzed of children and adolescents with at least one suicide attempt and of psychiatrists, psychologists and general practitioners who have treated this type of cases. Two types of drive to suicide surged, each with two subtypes: The anomic type with "ambivalent" and "desperate" subtypes. The exalted type with subtypes: "matchstick" and "matchstick in gasoline." For each type were defined specific intervention strategies. It is necessary to discriminate the various types and subtypes of drive to suicide as an essential aspect to make appropriate interventions adapted to the needs of each case.

Keywords: Suicide Attempted, Symbolic Interactionism, Crisis Theory, Children, Adolescents.

Resumen

Se presenta una estrategia de intervención para el intento de suicidio en niños y adolescentes durante el periodo de la crisis, fundamentada en el interaccionismo simbólico. Con enfoque cualitativo y metodología hermenéutica, se analizaron 18 entrevistas en profundidad a niños y adolescentes con al menos un intento de suicidio y a psiquiatras, psicólogos y médicos generales que han atendido casos de intento. Emergieron dos tipos de empuje al suicidio, con dos subtipos cada uno: El tipo anómico, con subtipos "ambivalente" y "desesperado". El tipo exaltado, con subtipos: "fosforito" y "fosforito en gasolina". Para cada uno de ellos se definieron estrategias de intervención específicas y claramente definidas. Es necesario discriminar los diversos tipos y subtipos de empuje al suicidio como aspecto imprescindible para realizar intervenciones pertinentes y ajustadas a las necesidades de cada caso.

Palabras claves: Intento de suicidio, Interaccionismo Simbólico, Teoría de la Crisis, Niños, Adolescentes

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Introduction

According with the World Health Organization (WHO, 2012), every year almost a million persons commit suicide in the world, which supposes a global mortality rate of 16 persons for every 100.000 inhabitants, or a death every 40 seconds. Likewise, it reports that every day there is an average of almost 3.000 persons who end their life, and at least 20 persons try to commit suicide for each one that does it.

Suicide ranks today among the top three global causes of death in people 15-44 years old and the second cause in the group of 10-24 years old, which is now regarded as the highest risk group in a third part of the countries (WHO, 2009). In persons 15 to 19 years old, it has global rates of 8.0 to 9.5 per 100,000 inhabitants and 0.6 per 100,000 inhabitants between 5 and 14 years old. (WHO 2010).

WHO calculates that for year 2020, the magnitude of suicide will grow in 50 per cent, that is to say, it will reach 1.5 million deaths per year. Although traditionally the greater rates of suicide have been registered among males of advanced age, the increase of incidence and prevalence is a worrisome problem in young people, as shown in the statistics. That is why this group is considered the greatest risk in almost all the countries of the world, and it is recognized as a public health problem. (WHO, 2013, 2014a).

For the WHO (2014b), the intervention of suicide is one of its priorities, as shown in its Action Plan on mental health 2013-2020 and included in one of its objectives. "Objective 3: To apply promotion and prevention strategies related to mental health" (pg.17), with a clearly stipulated goal for the same one: "World goal 3.2: the rate of suicides will diminish in 10 % in the countries"(p.18).

The perspective of suicide in Colombia shows suicide rates of 5.02 per 100 000 inhabitants, making it the fourth leading cause of violent death in the country (National Institute of Legal Medicine and Forensic Sciences, 2014). Rates of incidence and prevalence of the problem have increased in recent years, responding to the pattern of global growth of the phenomenon reported by the WHO from 60% in the last 45 years. (WHO, 2012).

The National Study of Mental Health 2003 shows that 12.3% of Colombians presented suicidal intentions at any point in their lives, 4.1% have carried out suicide plans and 4.9% have made suicide attempts. By differentiating the data by age group, one observes that the greater prevalence of suicidal behavior throughout life is among the group of 30-44 years old, but if one considers only the year 2012, the prevalence was greater in youngsters between 18-29 years old. (Posada-Villa, Rodriguez, Duque & Garzon, 2007)

In Colombia, about 200 youngsters under 18 year old kill themselves every year, that is why suicide has been recognized as a problem that specially affects the youngest population, particularly people between 15 and 24 years old (CES University, Ministry of Health of Medellin; Harvard - WHO Consortium of Psychiatric Epidemiology, 2012). Between January and July 2013, the country reported 948 cases of suicide; of which 768 were men and 180 women. The age range in which more cases were recorded for both sexes was 20 to 24 years old, with 128 cases of men and 25 women. According to the department, Cundinamarca ranks first with 139 records followed by Antioquia with 132 and, in third place, Valle del Cauca with 93 cases (National Institute of Legal Medicine and Forensic Sciences, 2013).

Added to the above, the suicide attempt and suicide in children and adolescents involves one of the highest rates of incidence and prevalence in the Western world (WHO, 2009). That is why; one can understand the enormous need for new intervention strategies that positively influence the situation in a timely, innovative and relevant way.

Although traditionally intervention strategies on attempted suicide have been placed in the perspective of risk factor (Carmona, Tobon, Jaramillo & Areiza, 2010a; Rojas, 1984), the strategy presented below is based on the approach of symbolic interaction. This perspective allows an approach to the phenomenon of suicidal behavior, and specifically to the suicide attempt. It is different from the traditional, since it facilitates understanding the act from the logic of the actors, starting with the meanings assigned to these and from there offers the essential foundations that allow the design and implementation of contextualized and relevant interventions for each situation. While one thought, that it might be useful for health workers who takes care of children and adolescents with suicide attempt, the strategy is part of a specific psychic space, the one of the crisis. This aspect is especially important when you consider that during the "window of the crisis", four to eight weeks after the suicide attempt – the best conditions exist to generate substantial changes to those aspects that form, from the interactionist theory, the drive to suicide (Slaikue, 1988).

Also, to locate yourself in this approach implies that no standardized, linear or predetermined interventions for taking care of children and adolescents who attempted suicide but, on the contrary, a comprehensive framework is offered from which conditions may determine that in each case, have led the drive to suicide. As a

further aspect, it is possible to point out that considering the time frame of the strategy, as that determined by the theory of the crisis, does not make it relevant to the health workers and other significant persons that are directly related to the child or adolescents. Besides, it potentiates the effect of interventions to maximize the optimal time (gold time) that from this theory is defined for them (up to eight weeks after the suicide attempt).

Thus, this strategy responds to the need to find alternative interventions that respond to the high incidence and prevalence of attempted suicide in children and adolescents, through the creation of a relevant and contextualized strategy in the realities of children, adolescents and their families, and that tends to adequate care, welfare oriented, to mitigate the high risk of re-incidence. A third part of the people who consummate it had previous suicide attempts (Kaplan, cited by Londoño & Zea 2001). It is important to point out, that this proposal is articulated with other researches, which in this line have been carried out in Luis Amigo University Foundation, University of San Buenaventura (Medellin, Colombia) and the Pontifical Catholic University of Puerto Rico, since 2008. They are based in the same theoretical corpus, which lets you create a reference and intervention framework that addresses the phenomenon from different perspectives, and fostering of solidly supported interventions.

Precisely, as a response to the ongoing research it intends to create an intervention strategy for the period of the crisis (up to four weeks after suicide attempt) proposed by the theory of crisis and based on the symbolic interaction under the program "Young researchers and innovators from Colciencias CES University" for the period 2013-2014.

Conceptual Aspects

The symbolic interaction arises in the fourth decade of the twentieth century from the work of George Mead (1999), with Herbert Blumer its main and most recognized theorist. In 1937 he coined the term symbolic interactionism to name a theory which he considered a direct extension of the ideas of Mead (Garrido & Alvaro, 2007). Apart from this author, Blumer picks up input from John Dewey, Charles H. Cooley, William I. Thomas and Erving Goffman, among other sociology and social psychology representative theorists for the construction and definition of this theoretical approach (Ritzer, 1997; Alvaro Garrido & 2007; Blumer, 1982).

Blumer (1982) proposes three basic premises from which one can understand the phenomena associated with humans beings; these are:

1. Human act about things based on the meanings these things have for them, or what is the same, people act based on the meaning attributed to objects and situations around them.
2. The significance of these things surges from the social interaction that an individual has with other actors.
3. These meanings are used as an interpretation process made by the person in his relationship with things they find and are modified through such process.

This view resembles the perspective postulated years ago by Durkheim (1982) on suicide, which he describes as a socially constructed act and points out each society engenders a different kind of drive to suicide, different depending on the dynamics and specific characteristics that surge from the same.

Linked to the interactionist perspective is the role theory (Sarbin, 1996), which serves as an essential basis for the intervention strategy presented. This theory is developed with input from several authors, but mainly thanks to the proposal developed by Erving Goffman (1991, 2001a, 2001b, 2006), who uses the drama to explain the analogical interaction of people and what is constructed from these. Compares life to a scenario in which people interpret some parts called roles that present in the interaction. Each person can develop one or several roles in his daily lives, but always trying to prioritize, consciously or unconsciously, the actions of one of them. The roles will give him a social identity and serve to set him in a position or status in front of the rest of the society, which would be the recipient of the performance of these roles.

The performance of a role, whatever it is, involves a series of actions and individual and associated attitudes, which are usually predetermined by society (audience, in the analogy of Goffman) and therefore the actors, will be judged according to that expectation, depending on whether there is correspondence with what was expected of their "performance." Such specific actions and attitudes of each role are learned through the interaction with the members of the reference groups belonging to people, known as "role-set" or other generalized, other organized and other significant, from a more interactionist perspective.

From the role theory, which involves an interaction between actors, one understands and proposes the suicidal behavior, a way to intervene over it, to obey to the same interactionist logic, conceiving the actor and those around him as it is suggested by Blumer (1982). Those dynamic and active processes take advantage of the ability the actor has to change the meaning in interaction with others.

The modern crisis intervention started from the study undertaken by Eric Lindemann and his colleagues at the reaction of people in the fire of Coconut Grove nightclub in Boston, United States, on November 28, 1942 (Bellak, 1980; Slaikeu, 1988; Roberts, 2000). From those sources, Gerald Caplan (1996) concluded that it is necessary to prevent crises in the early stages of development, treating them efficiently, because otherwise they can lead to disorganization and even mental illness.

Slaikeu (1988) developed the main assumptions of the crisis theory, in which he says it is possible and necessary to identify the trigger event and it may be due to some specific event (pregnancy, birth, home-school transition, disease, etc.) or the transition between stages of development. In addition, the author points out that some of these events are universally devastating such as death or rape, while others do not facilitate the crisis for themselves but must be viewed in the context of total development of the individual. Thus, the impact of these events will depend on the time, intensity, duration, sequence and degree of interference with other developmental events.

The purpose of crisis intervention then, includes the integration of the event with the life of the individual, in order to suggest that there is solution of the situation. The event and its consequences must eventually take their place along other events, as part of a developing experience. This solution is made possible thanks to the material, personal and social resources that allow each individual to face in a different way, the adverse situations.

It is precisely this feature that allows us to understand the importance of adequate intervention with children and adolescents who have committed a suicide attempt

during the "window of crisis" because it is a period during which they have great potential for transformation that, if is used positively will contribute decisively to prevent any further attempt (Rocamora, 2012).

As for suicidal behavior, which includes suicidal ideology, the suicidal crisis and attempt, it is possible to point out that is a highly complex behavior and somewhat vague in its definition. Thus, there can be different conceptual models to address it, among which are highlighted the categorical, dimensional, etiologic and multidimensional models (Rocamora, 2012).

The categorical models are based on the description and observation of symptoms and from them, reach a diagnosis that allow appropriate interventions. These models seek universality in its conceptualization and strategies of approach trying to facilitate from there the approach of the phenomena. Manuals as DSM V and CIE 10 are examples of them.

The dimensional models carry out a qualitative analysis of what is considered healthy from ill, with global approaches that take into account the etiology of the suicidal behavior, the clinical, biographical aspects and the real context.

The etiological models include different explicative trends of the suicidal behavior among them are counted the biological-genetic theory that suggests organic alterations that predispose the psychological based on the analysis of the basic psycho-pathological readings that definitely, determine it. These are sociological theories of Durkheim as its main representative that locate in a social behavior the basic conditions of the suicidal behavior and understand it as surging from them, more than an individual matter.

Finally, the multidimensional models pretend to explain the suicidal behavior from the perspective that integrate different views, among which are the biological, social, individual and psycho-pathological.

The complexity of the phenomenon allows consideration of the multiplicity of perspectives, which can strengthen its approach if done with a flexible, comprehensive and critical look and avoid other dogmatic reductionist type, or at the other end, eclectic.

Methodology

The aim of the project was "To design a strategy for intervention of attempted suicide in children and adolescents during the period of crisis, based on symbolic interaction". The methodology is part of the qualitative approach to hermeneutics methodology. As a technique for data analysis was used the based theory. In-depth interviews were conducted because they are the best means to know in detail the experience of the interviewed, who were directly related with experience or attention of an attempted suicide in children and adolescents and, therefore, actors and main informants to nourish, from their perspective, the development of the strategy proposed in the objective.

Eighteen in-depth interviews were carried out with general practitioners, psychiatrists, psychologists, children and adolescents that at that moment were linked to a process of therapeutic care. According to the interactionist perspective, interviews were carried out in a natural environment for each of the groups. They were done at home, in the doctor's office or in the institutions that provide health services in which they live or work, guaranteeing anonymity and confidentiality for both patients and professionals interviewed, according to

criteria set out in Resolution 8430 of 1993 and with the approval of the relevant ethics committees CES University and CES Clinic.

General practitioners who work or have worked in emergency care in cases of attempted suicide in children and adolescents were selected. General and child psychiatrists with experience in primary care or in consultation with children and/or adolescents who had committed a suicide attempt. Psychologists with experience in dealing with cases of attempted suicide among children and adolescents, especially in the third level of intervention, and children or adolescents between 11 and 18 years old, who had had at least one suicide attempt in a span included among the last four to eight weeks and had psychotherapeutic support at the time of the interview. Inclusion criteria for all of them, was the acceptance of the ethical considerations of the project.

The unit of analysis used was called "The Suicide Role" and the categories of analysis: "Construction of the idea", "Attempted suicide", "Emergency Care", "Therapeutic process", "Perspective", "Previous training", "Social Security System in Health" and "Strategy".

Results

Some general aspects that should be considered by those undertaking an intervention with a child or adolescent with suicide attempt during the period of crisis were found. Furthermore, two kinds of drive to suicide emerged, clearly different and that divide in two subtypes.

General Aspects

The general aspects of the intervention with a child or adolescent who presents a suicide attempt are:

Health staff awareness about the human situation that involves a suicide attempt

It is the first element to be considered in the process of care of a suicide attempt, and even more when it is a child or adolescent. It is the essential axis, from which they may or may not be achieved relevant, innovative and timely interventions. If you do not feel the other as a dignified person who is living a very serious problem in his existence (perhaps the most serious, questioning of his existence), it will be difficult to do something positive for him.

Qualification of health personnel with regard to the requirements of care of a suicide attempt, beyond the organic aspects

If awareness is crucial to good care, it defines the personal qualities of those who are responsible for it, the qualification points to how to it, and because of it is an essential complement to achieving good care. Beyond the theoretical model implemented, it is crucial that health staff have a basic theory and strategy, from which to intervene.

Recognition of the personal aspects involved in the care

Understanding that the person attending is the means by which patient care is done. It is important to consider the personal issues that may emerge from the relationship with children or adolescents with suicide attempt: feelings such as anger, fear, helplessness, avoidance are of frequent occurrence and, as they are acknowledged and controlled, can contribute to improve patient care and welfare of the treated patients.

Recognition of the myths associated with suicide

If the staff is sensitized and trained, it will tend less to be swayed by myths associated

with suicide attempt, which disorient and generate intrusive interventions and on many occasions harmful, due to false assumptions upon which they are based. Some of the most popular myths are (Carmona et al, 2010b):

- Those who attempt suicide do not want to die, they are just bragging or manipulating.
- He who wants to kill himself does not say, and that who says it does not do it.
- If he really wanted to kill himself, he would have done something more serious; he would have thrown himself to the train or have jumped from the tenth floor.
- Suicide cannot be prevented, as it always happens on impulse.
- Talking about suicide with someone who is at risk, may encourage him to do it (p. 34, 35).

Relevant reading of a warning to who performs a suicide attempt

It is of paramount importance to take into account the call of attention of children and adolescents, just as this, the desperate call of attention of a person, so much so that he may even risk his life to demand being heard. Therefore, one should not confuse the wake-up call with a tantrum or act without importance because it is precisely the opposite.

"Then, turning to meaning as the act, then we find that on one hand is an act of despair, which is like a wake-up call that is also found in the investigation, and so we put it. Call the attention means: "Come that I have problems, please listen to me" True. It is not the attention call "ignore me" which many people have, but rather, "Listen to me", "I need you to look at me", "I need to change this", "I need life to change."

Basic conditions of care

Some basic elements to consider are the site where care is performed (lighted and aired), their safety conditions, the chances of maintaining confidentiality, of having sufficient time to attend and not have distractions during the interview, among others, ensure the trust and confidence of the patient to express himself.

Inclusion of the family in the intervention process

While the drive to suicide has always had a crucial family element, inclusion of them in the intervention process is essential if you want to modify such a drive. If they are left aside, the conditions that led to the attempt probably will remain the same and will generate a new attempt in the near future.

The problem of opportunity

Since the crisis theory considers a period of 4-8 weeks within which significant changes can operate in the person that lives it, it is very important to consider this situation in order to take advantage of this "window of the crisis", to generate changes that allow variations in the drive to suicide effectively.

The golden time

Linked to the above, the attending staff should be aware that every minute spent with the patient, every action you make is a unique opportunity to intervene positively, to create conditions for change that in the future, are oriented toward wellness through changing roles. Therefore, every moment should be assumed as if it were the only way to help in the best possible manner.

Types of drives to suicide

Two types of suicide drives were found, which in turn, are divided into two subtypes:

Anomic Drive to Suicide Type

Type in which the child or adolescent is lonely, abandoned, lost, undervalued. Support networks do not offer him security and he feels no solid supports on which to rely when needed. This type of drive to suicide is consistent with that described by Durkheim.

It is caused by the fact that their activity [the people's] is disorganized and that therefore they suffer. Because of its origin, this last species will be called anomic suicide [...]. In anomic suicide, [the society] lacks from the proper individual passions, hereby leaving him the with no brake that regulates the passions (1982, p. 368).

When children or adolescents live in a situation in which the rules and limits are relaxed, relative or ambiguous or do not have the accompaniment, appreciation and support of other significant or organized persons. The conditions for a drive to suicide are generated of the anomic type, pretending, through this intent, to occupy a new place in the reference group, a place where they are recognized and valued or through which they can "be felt and heard" after so long of being silenced.

For the anomic type, the call for attention is centered in a desperate search for other (generalized, organized, and significant persons) that allow him to feel accepted, protected, valued and guided by a support network. It is an anguished cry that demands feeling obligated or sentenced to face to the world alone, without clear rules to follow to achieve success without guidelines about the limits that may or may not transgress in his relationship with others and with himself:

"About eight months later, the child, after we came here, was sad because he started living those statements with psychologists of what had happened. The boy began to decline in his studies, knowing that the whole family began to turn against us, because the relationship with my family, with my mother, my brothers. My brother was the only one supporting us and all at once, he stopped supporting us. Those hearings started, and then I do not know what my mom did, so that no one contacted us. This got the child into a depression, just to see that he would no longer have his cousins that he was not going to be invited to the parties and all that."

Thus, the suicide attempt in the anomic type results in a search for support, accompaniment and help, a call to feel part of a network which gives affection, appreciation and containment. It is also a claim for clear guidelines about what can and cannot do, what should be done or should not be done, with an active accompaniment during the learning process of those limits.

"I do four or five visits a day including Saturdays because with these youngsters, one thing I forgot to tell you is that most of these children are very lonely, they have no mother, no father, and with whom they live is the grandmother. She works in a family home and the only day that she rests is on Saturday afternoon. Then, that day is when I should do the visit, it is my moral and professional responsibility, then I have no time to write."

Psychopathology Associated with Anomic Type

It is common to find in the anomic type some distinctive psychopathological characteristics that should be evaluated and intervened, in case that they appear. These include:

Depressive symptoms: with consequent indifference, anhedonia, apathy, loss of sense of life. In some cases, especially in

younger children, its characteristics are agitation and irritability, very typical of childhood depression.

"When the boy found out, he had a very strong crisis, I went out after him, Mom I do not think I will be able to recover my family, that was my hope (...) He dropped everything, no study, no responsibility and lower and lower. "

Damaged self-scheme: It is common to find that the self-image, self-concept, self-efficacy and self-esteem are quite deteriorated, especially in the subtype of the "overly broad network nodes" (hopeless anomic) because the feeling of being abandoned to their fate and that the calls for help do not receive a positive, consistent response get to undermine each of these dimensions of self-schemes, with the aggravating circumstance that in these cases, while the drive to suicide stays, confirming the anomic message, "the self-fulfilling prophecy is fulfilled", making increasingly difficult to implement change strategies through the emergence of new roles.

Insecurity: the lack of clear boundaries, ambivalence, relaxation and inconsistencies in the rules and limits generate in children and adolescents issues around security in themselves and the world surrounding them. Everything can be and not be, everything is worth and not worth, and everything is presented before his eyes tinged with a feeling of ambivalence and doubt. They have company but it does not work or think they have company when in fact they do not have. Therefore, they grow up, immersed in this anomic world, which essentially offers elements that feed their insecurities.

However, on many occasions anomia is so strong that even in the absence of pathology, the drive to suicide is imminent:

"One often does not see psychopathology in them, but one sees a family network, and you

say to yourself: 'As this is, next week he will return to do the same with this terrible family dysfunction'."

Ambivalent Anomic Subtype

In this subtype, are evident that the ambivalence in teaching and implementation of limits and rules in other significant, organized and generalized, which configures the specific anomic condition. This implies a form of relationship with himself and the world in which "anything goes", as there is no clarity around the references that could provide coherent and consistent lines of direction from which the child or adolescent can compare his performances. That responds, on many occasions, to forms of relationship in which he is given what he wants or is allowed to do what he wants, to go next to situations of inflexibility and very high demands that are combined again with those lax and relaxed, prompting a huge insecurity in him also mediated by an optic in which comes first yes-but-no, I do it but I do not do it, all right, but it is wrong, causing huge confusion and anxiety in him referred to must be and even to being.

"So many times it like fathers do not assume that such breakage or lack of communication affects children and adolescents and focus more on solving their own problems. I do not say that is not important, but how to solve your own pain of divorce and are not so worried about the boy, who also has emotions about that."

Thus, although the persons in charge of providing limits and rules to the child or adolescent may be present in his life, they are unable to take a firm and secure position. This creates conditions in which the child or adolescent does not have security around what he should do or should not do. Thus, providing a notion of "support network that does not control because of excessive laxity".

Intervention Strategies of Health Personnel

- *Building trust*: which is easier if you understand the state of confusion, anxiety, guilt and/or failure in which the child or adolescent finds himself, and from there is promoted an empathetic and caring approach, focused on listening and avoiding blaming or judging the event.

- *Tolerating rejection*: we must consider the attended child or adolescents during the period of the crisis is faced with the failure of their attempt, reason by which he might have a rejection attitude of health personnel in charge of assisting him. This should not be taken as a personal matter, but as part of the process of adapting to the situation, avoiding to confront him or to abandon him to his fate since "if he does not want my help let him go to hell."

- *Pose short and attainable goals*: it is a very useful strategy to restore damaged self-scheme and also to strengthen the therapeutic bond as focused efforts on attainable goals that may be accompanied in their management by attending health personnel.

- *Value and highlight the small goals of children and adolescents*: the tunnel vision is characterized by a focus on the negative aspects and becomes an element that encourages the drive to suicide, by confirming the negative or defeatist perspective of the child or adolescent. While small achievements are valued, progressive training will be carried out, held, by deviating the attention focus from the negatives aspects and thus, diminishing in this way, the negative perception of himself, of others and of the situation.

- *Know what limits and rules are negotiable and which are not*: thus, avoiding that he believes that he may do whatever he wants

"because if you say no, he will kill himself", but also to avoid limiting and controlling him the maximum "because he does not have the opportunity to kill himself." It is necessary to find a balance between the protection and caring of children and adolescents and maintaining their autonomy capacity, as much as circumstances permit it.

- *Return the sense of coherence*: if the child or adolescent is distressed, he feels lost and does not know what to do, the attending personnel should convey peace and security, as well as clarity about what should and should not be done. To get involved by the anguish of the child or adolescent and their family can be a factor of decisive drive to suicide because it confirms everything that has led up to this decision.

- *Include other significant persons*: that may be supportive from this communicative logic and link. You must pay attention to the significant others who can restore security and consistency to the world of children and adolescents and encourage their presence during the period of crisis. They may be close to people, pets and even objects, it is important that they are meaningful to him and help him to regain a sense of control and support of others in his life.

- *Address the communicative style, especially the wording*: Sometimes health personnel serving the child or adolescent rebukes him for having attempted suicide, prompting him on how he should do it. Examples are "if you are going to jump, do it from an eighth floor, from a third one, see what happens." We must be extremely careful with it, because it is a time of high weakness and easily suggestible and that comment can become a trigger for an effective suicide.

"I had the opportunity for example one that told me: "A psychiatrist told me that if I was going to kill myself I should not take this; but next time I should take that one that is really deadly" and obviously, the next time he took that ... How the hell did this man say such a thing?"

Hopeless Anomic Subtype

In this subtype there is a marked absence of people, institutions (family, school) or even other generalized (religion, culture) responsible for providing a network of strong support based on clearly established limits and rules. Thus, there is a strong sense of loneliness and abandonment as no networks provide an active support, because the child or adolescent feels he is not cared, attended or protected, giving him a clear message in which he feels living amid a "Support network that does not contain because of the excessive amplitude between its nodes." Therefore, this role can be defined in a very specific way from the logic of "learned helplessness".

"And they were the ones that said: It is very hard to see little girls alone, that their mother told them in front of us: "The next time you do it, do not bother my life with your problems, if you do not want to be alive, die"; Girls absolutely alone that are not visited by anyone or that someone comes to nag them and tell them:" Look, Look I do not have any money and now I have to pay a co-payment for you."

While children and adolescents are immersed in this subtype, the linking features of it can make them look as nice and quiet, but with a melancholy phase and constant references to his worthlessness or little or no chance to get out of that situation, even though those who come near them say, "you know that none of that will change."

"When it is because there is a depression in between ... see ... it seems to me that I am among those who believe that one as a father has to be aware of children and as a father you know that they are changing. So I questioned myself when ... when you tell them there is a depression, there is an anxiety disorder okay? I had not noticed, 'I did not know'; I say that, but didn't you realize that he was not sleeping, he was not eating, he was irritable, and he was coming in too late, that he began escaping, that his grades started going down; 'Oh yes!, but I thought it was adolescence.'

"So many ... sometimes one says, sometimes one takes side with the parents, with the pain and the whole story of the impulsive boy, and sometimes one takes the boy's side saying, 'Hey! !Open your eyes!, he's hurting, depressed, he is crying for help'".

Thanks to them, they may be people "easy to approach and that clearly understand what happens", which can lead to a confusion while the despair that drives to say "yes to everything because we know that nothing will change" is not equivalent to the adherence to treatment.

Intervention Strategies of Health Personnel

- *Recovery of value as a line of work*: This is the basic center of the intervention strategy, since around it; all the other actions are tied. A clear and transparent relationship on part of the treating person that focuses primarily on the positive aspects of the child or adolescent, without forgetting his limited autonomy potential is a first step to restore his worth.

- *Try not to blame, do not judge*: they are two aspects that contribute substantially to the recovery worth. You should be careful not to use any of these alternatives in the intervention with children or adolescents while they are very irrelevant for containment and drive enhancer.

- *Pay attention to other significant persons as drive and support*: detect those other significant persons that offer support, backing and positive engagement, especially those that can break the tunnel vision.

- *Propose small achievable goals*: if the worth and confidence of the child or adolescent are damaged, an alternative to foster containment in the day to day and future projection is to propose attainable goals that will strengthen this trust, as they feel that they can really achieve them.

- *Strengthen the notion of future when it appears, but not impose it*: it is frequent that in front of fear for the possible recurrence of suicide attempt the child or adolescent are offered different intervention alternatives for the future through which one seeks that they cling to life. However, this can backfire because, paradoxically, it can confirm the difficulties that have led them there, instead of modifying them. It is preferable to start building that perspective with him, accompanying him in the process, and making sure that it is his own perspective that one that is showing the way out of the tunnel.

- *Recognize the feelings aroused by attention (poor little thing or desperate)*: the attitude of the child or adolescent can arouse intense feelings of pity or rejection from the health personnel. You must pay attention to them, in order not to repeat the relational models that have led them there, and offer a loving but firm bond that is betting on the emergence of an autonomous and able being, who does not have to generate pity or rejection of others in order to be himself.

Drive to Exalted Suicide Type

Type in which the others (organized, generalized and significant persons) form a

net from which the child or adolescent learns that he can and must assume a position in which to be recognized as subject, he must attack, insult or behave in an active and impulsive way. The role that drives to suicide is divided into two subtypes: the exalted "matchstick" and another associated with the consumption of substances, the exalted "matchstick in gas".

In the exalted type, the drive to suicide is formed in an interactionist context in which others generate crash situations, confrontation or discomfort in front of which the child or adolescent finds no resolution alternative mediated by reflection, control of impulse or sublimation. Therefore, it assumes the role of a rebellious person who finds a place in front of the other, as long as it is characterized by rebelliousness or aggression, traits that become his identity against the other, keeping the dynamic link that drives to suicide.

"She started with a pencil until she made wounds and started bleeding profusely. One day, I told her: be careful that tip is going in and who will stop that, but when we started looking, it was not that she wanted to die, in quotes, it was a game and always did it when she had tantrums, she did it when she exploded in anger and the whole story was about something that she felt they did not let her do or that she felt she could not do."

Sometimes, and as a part of the role assumed, the consumption of drugs appears as an additional element that increases the problems, while facilitating the loss of inhibitory control, it deepens the characteristics of the expected role and accentuates the drive to suicide providing the child or adolescents a "tool" that allows them to be what they should be (or at least what they believe or are expected to be). In the exalted type the call for attention becomes a desperate cry of the children or adolescents, by means of which they look

anxiously for alternatives that allow them to find a place in the world, where they are acknowledged and valued, and that is not mediated by aggression. Thus, through the attempts they look for alternative to release pressure that they feel not only from the only way they know to do that -aggressive- but also by the only way validated and permitted by the others around him, inasmuch as through it they recognize their identity.

"Most of the children do it more ... I mean, get hurt or hurt themselves for an impulsive story or under the effect of substances".

It is in this context that the attitude of the exalted type child or adolescent must be read, after he has committed an attempt, he will probably be more aggressive, less reflective and more "problematic" for the emergency services. Since the way to resolve what he wants to change, will always be marked by the role assigned to him, and all intents for change, paradoxically will be marked by such characteristics.

Psychopathology Associated to the Exalted Type

You will often see some distinct psychopathological features in this type, which should be evaluated and intervened, in such case that they appear. These include the following:

Difficulties in self-regulation: the child or adolescent is unable to expect gratification and, therefore, before the invasive feeling of frustration for waiting, he acts impulsively, in a desperate and reckless manner, without a calculated analysis of the situation and an assessment of the consequences of the act. Problems with self-regulation are specifically evident through low impulse control and poor frustration tolerance.

Poor impulse control. Generally they are children or adolescents who find it difficult

to wait, "be patient" and not act under the pressure of their desires. The poor impulse control is evidenced when the child or adolescent responds or acts impulsively and thoughtlessly without considering the consequences, motivated and directed by overflowing emotions. Phrases like "I told you not to catch it." "Can't you wait?" "Coming, coming ..." illustrate the mediation by adults with this type of behavior.

"Well, what I remember of children and adolescents who have had a suicide attempt, they are impulsive and very, very much of the impulsive type. I do not remember that I had one, like a psychotic patient or a patient with an established mental illness that is unbalanced and so that is the reason for the suicide attempt, no; they have been more impulsive".

Low tolerance for frustration: frustration tolerance is directly related to the ability of the child to tolerate those situations in which things "do not go as he wanted and when he wanted," delaying or denying the gratification of his desires; very rare feature in children or adolescents with a drive to suicide of the exalted kind.

Projection as a defense mechanism: It is characterized because the person assumes that everything that happens to him is the fault of others, without taking personal responsibility for their actions. The existence of projection in the exalted type must be taken into account while the interventions by health workers are mediated, hindering, at least initially, the psycho-educational actions and all those that promote self-reflection about the consequences of the act.

Thus, children and adolescents who assume this role find it very difficult to accept and tolerate failure. They do not translate into learning but as a source of intense frustration and, therefore, seek to address their discomfort immediately through

impulsive actions. This leads them to be classified as aggressive (colloquially) or disruptive (as a diagnostic category) and addressed or treated as such.

"Yes, and that made me furious, the truth is that I first went to cry in the basement, to be alone because I had a fight with my parents, they said I was not a good son, they did not deserve to have a son like me. The two of them were lying because it was late, it was about 11 or 12 at night, then I ran and went to the basement, then my mom came to get me at the basement, I said I wanted to be alone and went to the terrace and already I had the thoughts if I should jump or not. "

However, it considers that his attitude responds to the logic of a role, reason why the actions focused on individuals and specifically in their ability to control themselves without an intervention in the role, that drives them to do it, it will be at least insufficient.

"Matchstick" Exalted Subtype

In this subtype, children or adolescents respond in a reactive way to discomfort through the passage to the act without there being any kind of containment or reasoning. Generally, it occurs after they are abused, battered, attacked or a limit has been imposed on them that they consider unacceptable.

The type of link established in the "matchstick" exalted subtype involves a great deal of distress and aggressiveness for which there are no discharge pathways mediated by reason or the word, and they respond more to an instrument of the act than a real metacognitive process. Therefore, when the child or adolescent speaks, he is really hitting with his words; more acting through them than trying to communicate with them, to express his anger or his subjective experience.

"Interviewer: Let's talk about that time that the two of us know, when you go to the terrace and look out to the emptiness, because of the fact that you've taken a picture means you looked at it. What led you to do that on this day?"

That day I talked with XXX and had a real bad conversation which made me feel very bad, then I started to fight with my parents, then came XXX, and being with him made me feel bad because I remembered what he did to me, then why do I have to keep being there and she had talked to me about him."

This way of acting of aggressive type can be seen both in an active way (which has already been noted) as passive, in which the deep and prolonged silences, unable to look straight at the eye or rebel against any guidelines given by the treating persons, are clear expressions of it.

It is very important to take into account that this is and has been the way the child or adult has found to have an identity and although this supports in "being aggressive", "being a bad person," "being violent" or "being rude and mouthy" it does not fail to be his identity. As such, it is formed through an interactionist process that, finally allows him to feel the sensation of being someone in front of others, even though these seems to be problematic to them.

"Then there, referring to this I have seen a lot, as they generate them, without wanting, but generate blame, that is, speaking bad about the other parent and how it has been painful for them the process, they overload the child. The child often do not know what to feel, does not know how to say it and what he does is what is manifested through his behavior: that they punish, criticize, sanction him more; then it gradually becomes a snowball, until the child cannot take anymore and ends up doing something against himself."

Thus, the type of bond that is proposed in this subtype is paradoxical, as it is through aggression (against himself or against others) that it is established and like this, it should be assumed initially, if you want to encourage some sort of change. This implies a large demand for the health personnel, reason for which they should evaluate not only their way of bonding, but also their capacity for tolerance and waiting (something which he will have to have, instead of the patient), while the patient is able to initiate ways of linking.

Intervention Strategies of Health Personnel:

- *Do not respond in an exalted way to an exalted bond:* in face of frustration and intense discomfort that can generate the big difficulties of attention associated with this type, it may be possible that the attending person responds in the same way the child or adolescent, getting carried away by the discomfort that this generates. It is of utmost importance to avoid this type of response as it only confirms the type of bond that has driven him to suicide, increasing in that way the risk of another incidence.

- *Set non-negotiable limits (hopefully few) and others that are flexible:* It must be defined very clearly and precisely what are those non-negotiable limits, such as attention under the influence of drugs or alcohol and which may be flexible, for example, schedules and places of care. This will help set minimum standards conditions for the therapeutic relationship and emotional restraint.

- *Find alternatives of emotional release different from aggression:* such as sports, walking, writing or drawing, which must be chosen according to the characteristics of each child or adolescent. Either way, the important thing is to find alternatives for release that release him from some emotional pressure.

- *Detect other organized or generalized significant things that drive and contain suicide:* such as it has been suggested in other types, it is necessary to detect the other significant things that contain or drive to suicide in order to potentiate the presence of the first and to limit the seconds to its maximum.

- *Mediate time of presence:* although traditionally they have established more or less fixed the times and frequency of therapeutic processes in this type of drive to suicide it may be important to make flexible the duration and frequency of consultations, reducing the first and increasing the second. This could make easier the establishment of a positive *rapport* and planning of appropriate intervention strategies to the logical linking of children or adolescents.

- *Use more clarification than confrontation:* given his impulsive and reactive characteristics, it is preferable to use less confrontation and more clarification. This may gradually promote insight ability and lower the barrier of defense mechanisms, without the therapist getting to be as threatening, altering the therapeutic bond.

- *Implement impulse control and frustration tolerance strategies:* they must be clear, precise, concrete and plausible so the child or adolescent can reach them. They should suggest a progressive, orderly and feasible way so that they strengthen confidence in himself and in the treating person.

"Matchstick in gas" Exalted Subtype

This subtype is characterized by a response to problematic situations mediated by impulsive acts, but potentiated by consumption of substances. Thus, the configuration of exalted subtype is added an external factor that potentiates exponentially the risk of death by increasing

the drive to suicide by inhibiting impulse control and low tolerance to frustration, already altered.

"Then there are substance consumption, that unbalances them completely, or then in that case, if there is an acute intervention, he can with the psychiatrist and general practitioner, but it almost always is because of difficulties at the family level or academic pressures or social or environmental situations, then they can be managed in the field of outpatient or external consultation, which is basically what is done."

In addition to the already mentioned for the "matchstick" exalted subtype, the subtype link with the exalted "matchstick in gas" becomes problematic as to altered states of consciousness, the first action that should be performed before any intervention of therapeutic type is detoxification, after which you can conceive the contact.

"It's a group that is very complex and is already having alcohol, it has substance consumption, a group that begins to have a problem, which is that under the influence of alcohol potentiate many of these family situations or those these emotional situations or personal situations that lead him to this "

However, even if the detoxification can be achieved, there are elements that may complicate the way to build links. The first is the possible existence of a withdrawal syndrome, to which any figure appearing in the picture will be on second or third level of importance, in as much as the only valid and necessary link for the child or teen in these conditions is the drug. Therefore, whatever the patient says or does will be directed to getting drug, to meeting this need, "clouding" the bond as it may appear quite subdued and reflective around his situation, recognizing all that the treating person wants, as long as he "leaves him alone" or

"discharges him" and he can return to continue consuming, or he can attack him and abuse him in order to fight against that which limits his access to consumption.

"So alcohol control, control of such things, mostly alcohol. The others not so much, yes the alcohol, the alcohol is the number one trigger, especially since, terminations of dating, fights with mom and dad, end ... for example, it is a time when they did not do well in school. They are not able to cope it in front of the house, they go and have a few drinks, and dad and mom have already threatened them. Teenage pregnancy, when they suspect to be pregnant it is another thing, it is a double risk, because one also has, you always will have, to evaluate and watch as it is with drinks and without drinks. And even if without drinks one does not have much risk, you are at high risk of consuming drink again, since you have an addiction so to speak. If you are very well without drinks, you will have to keep in mind that you will drink and you will relapse; such patients are high risk and still very difficult."

Finally, other complications may occur related to the link and are those that have to do with the level of cognitive or emotional impairment in the child or adolescent, because of consumption. Sometimes it is so deep, that it becomes very difficult to choose interpretative interventions, limited to those characteristic of support, including placement in specialized institutions.

Intervention Strategies of Health Personnel:

- *Recognize the communicative style:* it is important to remember that if the link and communication style are located in the aggressive spectrum, the confrontation "the fight" with the child or adolescent proposes, should be avoided.

- *Consider the possible cognitive impairment or withdrawal syndrome:* initially assessment and intervention should

be directed towards these factors of organic nature to later assess them relative to the emotional spectrum.

- *"In hell it is cold":* keep in mind that some of these children and adolescents are willing to say anything as long as they are discharged or left alone.

- *Form networks for information and containment triangulation:* if possible, do not stay only with the version of the child or adolescent, and contrast it with the family, parents or friends.

- *Control the environment:* watch out for those aspects of the environment that may drive the suicide attempt to generate strategies that allow containing, avoiding or modifying these conditions.

Conclusions

The symbolic interaction provides an ideal framework for the foundation of an intervention strategy in attempted suicide in children or adolescents during the period of crisis, in a contextualized and relevant manner in case to case that allows to get near, from the perspective of the actors, from the symbolic logic which has generated the drive to suicide. Since that reading it is possible to distinguish different types and subtypes of drives, each of which include its own characteristics and, with them, specific intervention strategies that optimize and potentiate the results.

This is especially important if you consider that strategies have centered their intervention focus on the lapse within the period of the crisis, which requires that the actions taken by both the health personnel and by significant others of the child or adolescent, respond to the premise of

"golden time". Therefore, it is strengthened by reading the drive to suicide, through types and subtypes clearly described, defined, and limited by intervention strategies defined for each of them.

Awareness of health personnel is an aspect of vital importance if we want to have adequate interventions in the attempted suicide in children or adolescents. From this perspective, it is not enough to have information on how, but to emphasize on what and from where it is going to intervene, including in this reflection the related personal aspects.

The type of drive to anomic suicide has great similarities with the anomic type already described by Durkheim in 1982 and with that one surging from the research done by Carmona, Tobon, Jaramillo and Areiza (2010a). Such intervention is based on the restoration of trust and confidence, through interactions that promote the consolidation of other stable person (from the interactionist perspective) to allow the child or adolescent recovery of a sense of "value for others" and "to have a clear place in the world".

The type of drive to exalted suicide requires of a form of quiet link that facilitates spaces of controlled discharge, reestablishing sublimation possibilities and changing the drive through the encouragement of the redefinition of the others (interactionist perspective), that rather than blaming, judging or assaulting a child or adolescent tend to recognize him as a subject, with

alternatives of being and getting in touch with the world.

It is essential to include the family in the process of intervention of attempted suicide with children or adolescents. Even though they are and important part in the drive to suicide, they are in the process of change.

The golden time for intervention is one of the basic criteria for good care: the small period you have to talk to children or adolescents who have had a suicide attempt is a unique opportunity that treating persons are going to have to generate any change in the drive. Therefore, doing it well, consciously, well informed and with much love, make the difference between life and death of a person.

However, the benefits of the strategy, one of its limitations is related to the lack of knowledge of the health personnel of this theoretical perspective -the symbolic interactionism, its interpretative possibilities and intervention. Thus, the need to qualify the health personnel, especially emergency services in the conceptual and interventional framework that is based is essential.

It is important to include in for future research the perspective of nurses, as they are essential in the care of the suicide attempt as caregivers responsible for the containment of children or adolescents, at the same time that as bond with their families and the rest of treating health personnel.

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