



Pathways to Severe Depression and Elevated Suicidal Risk in Adolescents: Insights from Two Contrasting Case Studies

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Abstract

Adolescent suicide constitutes a major public-health challenge in India. This paper reports a comparative case analysis of two higher-secondary students who met criteria for extreme depression and high suicidal risk. Data were obtained through the Beck Depression Inventory (BDI), detailed clinical interviews, and psychosocial histories. The first case concerned a 17-year-old urban girl whose primary stressors were chronic parental discord, domestic violence, and compulsory enrolment in an unwanted academic stream. The second case involved an 18-year-old rural boy whose risk profile was shaped by paternal suicide, economic hardship, romantic rejection, and substance use. Both adolescents recorded BDI scores in the extreme range and had histories of multiple suicide attempts. The findings illustrate how family pathology and socioeconomic trauma can independently and interactively generate severe depressive states and suicidal behaviour. Implications for school-based screening and multi-layered intervention are outlined.

Keywords: adolescent depression, suicidal behaviour, case study, family conflict, socioeconomic adversity, India, Beck Depression Inventory

Introduction

Suicide ranks among the foremost causes of death in the 15–19-year age group in India. Depression is the most frequently identified proximal risk factor. Although large-scale surveys have established prevalence figures, comparatively few studies have examined the lived sequences of events through which multiple stressors coalesce into high suicidal risk.

Case-study methodology permits close examination of these sequences within their natural contexts. The present paper analyses two deliberately contrasted cases drawn from a larger mixed-methods investigation conducted among higher-secondary students in Durg district, Chhattisgarh. The aims are to map the distinct psychosocial trajectories leading to extreme depression and repeated suicide attempts, to compare an urban family-pathology pathway with a rural socioeconomic-trauma pathway, and to extract practical recommendations for early detection and intervention.

Method

Design and Sampling: An explanatory sequential design guided the parent study. Five hundred students completed the Beck Depression Inventory. Those scoring in the extreme range were invited for qualitative follow-up; ten adolescents ultimately participated. The two cases presented here were selected for maximal contrast in demographic background and dominant risk factors.

Participants

- Case A: 17-year-old urban female (pseudonym Preeti), Class 12, private English-medium school.
- Case B: 18-year-old rural male (pseudonym Sumit), Class 12, government school.

Written informed consent was obtained from participants and guardians. Institutional ethics approval was secured. Identifying details have been altered.

Data Collection: Depression severity was measured with the 21-item Beck Depression Inventory; scores of 40 and above indicated extreme depression. Semi-structured interviews explored family climate, academic experience, interpersonal relationships, substance use, physical health, and suicidal history. Interviews were conducted in the participants' preferred language, audio-recorded with permission, transcribed, and subjected to thematic analysis.

Case Narratives

Case A – Preeti

Preeti resided in a five-member joint household of stable economic standing. Her father's regular alcohol use and recurrent verbal and physical disputes with her mother produced an atmosphere she described as "emotionally unsafe." Against her stated preference she was enrolled in the mathematics stream. Although she maintained satisfactory peer and teacher relationships and took part in sports and art, she withdrew markedly at home.

Her BDI score exceeded 42. She reported two suicide attempts that she linked directly to prolonged exposure to parental conflict and emotional neglect. Pharmacological treatment had been initiated but caused pronounced drowsiness, intensifying social isolation. Structured psychotherapy had not yet begun.

Case B – Sumit

Sumit lived with his mother and younger sister following his father's death by suicide. Household income derived from small-scale agriculture averaged approximately one lakh rupees annually. The father had a long history of alcohol dependence, repeated suicide attempts, and chronic illness. Sumit selected the science stream out of genuine interest, yet academic performance declined under the combined weight of emotional preoccupation and a failed romantic relationship. He earned roughly ten thousand rupees monthly as a wedding photographer to support the family. Occasional tobacco, alcohol, and cannabis use occurred under peer influence. A childhood head injury and a persistent skin condition added further distress.

His BDI score was 40. Three prior suicide attempts were recorded. At assessment he was receiving both medication and regular counselling, which had produced partial symptomatic improvement.

Case-Specific Remedial Measures

Remedial Measures for Case A (Preeti) Immediate and sustained psychological intervention is required. Regular sessions with a trained clinical psychologist or psychiatrist, preferably employing Cognitive Behavioural Therapy (CBT) or trauma-focused approaches, should aim to strengthen emotional regulation, challenge hopelessness, and develop healthier coping strategies.

Family therapy is essential. Both parents need structured psycho-education regarding the psychological impact of ongoing conflict and domestic violence on an adolescent. The father should be encouraged to enter a de-addiction programme for alcohol use. Open communication channels within the household must be deliberately rebuilt so that Preeti feels emotionally safe at home.

Academic support should include a review of her stream placement. Where feasible, a shift toward subjects aligned with her interests (or at least supplementary career counselling) can reduce chronic demotivation. Teachers and school counsellors should monitor her participation in sports, art, and peer activities, using these as protective resources.

Medication side-effects (marked drowsiness) require review by the treating psychiatrist so that sedation does not further isolate her. A safety plan, regular risk monitoring, and gradual re-engagement with school and creative pursuits form the remaining pillars of recovery.

Remedial Measures for Case B (Sumit) Continued psychiatric care and regular psychotherapy remain foundational. CBT combined with grief-focused work can help him process the trauma of his father's suicide and the pain of romantic rejection.

Substance-use counselling and peer-pressure management programmes should be introduced promptly to reduce reliance on tobacco, alcohol, and cannabis as coping mechanisms.

Given his demonstrated skill and interest in photography, structured vocational guidance and professional training in this field can enhance self-esteem and provide a constructive livelihood pathway, simultaneously addressing economic pressure.

Family support needs strengthening. The mother and sister can be guided in providing consistent emotional availability without overburdening them. School-based counselling and monitoring of academic engagement are recommended. Community-level awareness and linkage to any available economic-support schemes for single-parent rural households would further reduce structural stress.

A written safety plan, regular follow-up, and gradual expansion of positive peer and activity networks complete the intervention package.

Discussion

The two narratives reveal distinct yet partially overlapping routes to extreme depression and high suicidal risk.

In Case A the dominant pathway was chronic family invalidation—parental violence, alcohol misuse, and enforced academic placement. The resulting erosion of emotional security and personal agency is consistent with evidence that thwarted family belongingness mediates the link between interpersonal stress and suicidal ideation, and that academic-stream mismatch constitutes a potent stressor in the Indian educational system.

In Case B the dominant pathway was cumulative trauma and material adversity—paternal suicide, economic precarity, romantic rejection, and substance use. This configuration aligns with literature linking intergenerational suicide, poverty, and early substance involvement to elevated adolescent suicide risk.

Shared features across both cases included profound hopelessness, progressive social withdrawal, and repeated suicide attempts—clinical markers repeatedly associated with transition from ideation to action among depressed adolescents. The urban case was driven primarily by relational and autonomy-related stressors; the rural case by loss, economic strain, and behavioural risk. The contrast supports ecological models that locate adolescent suicidality at the intersection of micro-level (family, school) and macro-level (socioeconomic) determinants.

The case-specific remedial measures outlined above illustrate how intervention must be tailored to the dominant pathway while still addressing common elements such as hopelessness, safety planning, and restoration of agency.

Practice and Policy Implications

- Routine, brief depression screening in higher-secondary schools can identify high-risk students before crisis occurs.
- Family-focused interventions addressing communication, conflict, and parental mental health are essential when domestic pathology is present.
- Greater student voice in academic-stream selection and career guidance matched to interest may reduce a major chronic stressor.
- Integrated care combining medication, cognitive-behavioural or trauma-informed psychotherapy, and, where indicated, substance-use counselling offers the most promising recovery pathway.
- Rural adolescents require additional attention to livelihood support and stigma reduction; urban adolescents may benefit especially from autonomy-enhancing and family-communication interventions.

Limitations

Findings rest on two intensive cases and retrospective self-report; statistical generalisation is not possible. The value of the study lies in the transferable insight it provides into risk pathways rather than in prevalence estimation.

Conclusion

These two cases demonstrate that extreme adolescent depression accompanied by high suicidal risk arises from the interplay of family pathology, academic constraint, interpersonal loss, socioeconomic adversity, and profound hopelessness. Early identification inside schools, multi-level psychosocial intervention, and context-sensitive support systems are required to interrupt such trajectories and safeguard young lives.

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