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SUICIDE RISKS AMONG ADOLESCENTS: A LOOK BEHIND THE BLACK CURTAIN

Norah Al Rohaimi

College of Medicine, Alfaisal University, Riyadh Kingdom of Saudi Arabia

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Correspondence to Author:
Norah Al Rohaimi

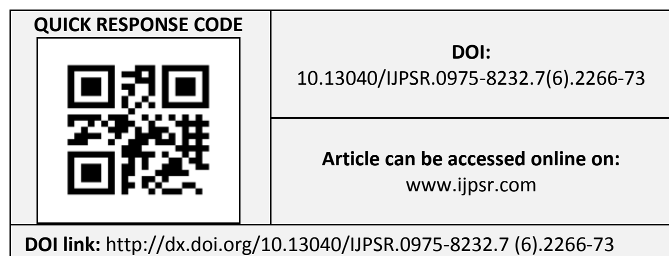
Medical Student, College of Medicine , Alfaisal University, Riyadh Kingdom of Saudi Arabia

E-mail: nalrohaimi@gmail.com

ABSTRACT: This review article investigates the prevalent existence of suicide along with its risk factors and contributing factors leading to the culmination of them all, in an attempt to look behind the black curtain. Suicide is the result of an unbalanced scale between the good and bad. Every year 300,000 teenagers attempt and succeed at suicide worldwide. A set of emotions and unpleasant thoughts develop in a person's mind. The consequences of such ideas resulted in suicide becoming one of the leading causes of death in adolescents worldwide. Suicide is multi factorial in nature and is still under study, but this review explores mainly the etiological factors, including social, economical, psychological, biological and physical factors. Increasing the awareness campaign to educate people on suicide would return as a decreased suicidal number. It is our job as humans to help to decrease these heart shaking losses by suicide. This can be done through offering help and support, and seeking out professional help. This is an integral step toward the recovery of individuals who are under the torment of suicidal thoughts.

INTRODUCTION: Adolescence is one of the most impactful and complex period during a person's lifetime. Throughout this time, our emotions range from happy, optimistic, joyful, and cheerful to confused, unhappy, insecure and afraid. Due to the presence of this set of emotions it is not unexpected that unpleasant thoughts develop in our minds.

Most thoughts of suicide or suicidal ideations are a manifestation of these unpleasant thoughts. In consequence of these thoughts and ideas suicide has made its way to the top of the teenage death list. As of current, suicide is the third leading cause of adolescent death[1].



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Suicide is not an explosion which occurs out of nowhere. Like many reactions it requires a flame which initiates a series of reactions that ultimately results in death. These reactions, just like chemical reactions, have physical signs to be on the lookout for. There are distinct suicidal behaviors that a person should be cautious of at all times. Mood swings, long lived sadness, and unpredictable rage are the red flag signs of suicidal behavoir [2]. These people start to lose hope and slowly withdraw themselves from society [3]. Despite the popular belief that suicide is mainly a product of depression, there are actually several factors that contribute to triggering an individual's inclination towards suicide. There are several triggers that come to mind when asked the question "What do you believed is the main cause of suicide?". The leading replies include depression, social stress, peer pressure, self-doubt, substance abuse and family trouble. These answers vary from primary factors, depression and family troubles, to secondary factors, substance abuse and self-doubt [4].

The root of many emotional problems visible during the teenage year are due to a poor child-parent relationship during childhood [5]. The rise in this kind of relationship is believe to be the reason for the rapid increase in suicide levels. Many parents have failed to realize that their behavior toward their child has a negative impact. The main and most important factor in the relationship is trust. If the parent doesn't show trust toward the child, then the child will feel hurt and that they are not worthy of trust. This is turn will result in an absence of self esteem along with the inability to trust others. This mind set will embed itself deep inside the Person's subconscious. As they get older, this will present itself as the belief that the world around them are liars and they are unworthy of anyone's attention which proceeds into their withdrawn personality. This persona will influence the belief that everything people say is a lie so even if people try to help them during adolescence they will push them away [6].

In recent years the internet has become an integral part of our daily lives. This association has brought forward endless benefits and several drawbacks. One of these drawbacks includes the creation of cyberbullying. Cyberbullying is defined as the use of electronic communication to bully a person, generally by sending messages of an intimidating or threatening nature (Oxford Dictionary). The targets of cyberbullying are twice more likely to commit suicide than those of face-to-face bullying. The anonymity related is what scares people the most. You could be bullied by a complete stranger or your closest friend, however you'd never know. Bullies feel they have the power to say what they want because they do not have to worry about their true identity ever being revealed ("What Makes Cyberbullying Dangerous?"). Everyone feels like they're a king behind the safety of a glass screen.

Words can be said so easily and they disappear but their scars remain on the victim. However, in cyberbullying the harmful words remain there forever. Once it is accessible by the public the World the words, picture or video will be permanent ("What Makes Cyberbullying Dangerous?"); forever haunting its victim with their presence. Along hand its haunting effect there is no real escape from cyberbullying. It follows you everywhere you go, unlike the face-to-face bullying. If you were to be teased at school, you can look for an escape at home, in the comfort of your own bed. In contrast, once the cyberbullying commences there is no real retreat.

Our cocktail of disaster doesn't stop with bullying or cyberbullying. It branches off to countless others. Currently, one of the most known factors associate with suicide is self-harm. Self-harm has become a hot topic itself, thus people tend to forget the heartbreaking ending of this act. There is a common belief that self-harm is nothing more than a call for attention. Self-harm in the simplest definition is inflicting harm upon yourself. Two very common ways of self-harm are cutting and burning. Self-harm not only provokes suicidal ideations but It's also a major sign for suicide [5, 6]. A person's thighs and wrists are the most common places for self-harm. There are several cases of self-harm where the person cut so deep which led to extreme blood loss which may ultimately lead to an unintended death.

Those who are affected by suicidal thoughts struggle with their dark minds; constantly wrestling against the urge to end their life. In a failed attempt to help decrease the effect of negative thoughts they isolate themselves from society. They believe that if they set themselves apart from everyone then there will become nothing to fuel this horrendous mindset. However, what these people fail to see is that if they are left alone with their thoughts then their thoughts will begin to torment them. Consequently, being alone with their thoughts will slowly start eating them alive, having nothing but negative thoughts as your company will deepen your fall into the dark mindset.

Along with the gloom-ridden thoughts there is hopelessness and impulsivity. The two always come hand in hand. This is because once all hope is lost; you begin to believe that you have nothing to lose. When a person has nothing to lose, they will be impulsive.

When discussing suicide, the topic always revolves around the person committing the act and everyone also around them is forgotten. Suicide physically affects the sufferer and emotionally impacts those

around them. Guilt and shame accompany the sudden grief. The loved ones of the deceased must live with the guilt of not realizing the signs and taking action before it was too late. The shame they experience might also lead to the masking of the true cause of death, so instead of saying it was suicide they would say it was due to illness or injury. New studies show that the emotional impact of suicide is so overwhelming that psychological health care is usually sought after the suicidal death of a loved one.

The loss of human life is tragic and to know that people caused this death is even worse. It is our job as humans to help decrease the heart shaking loss by suicide. If you are worried that a loved one is Suicidal, speak up. To many it is extremely difficult to talk about their emotions, those aiming to end their life are no exception. If you are worried about someone close to you, ask them and tell them about your concerns. You will not make a person suicidal by showing them you care. If anything, allowing a person to vent and express themselves will help decrease the pain they have pain they have [7].

Suicide is the result of an unbalanced scale in our life. This scale is the scale of good and bad. When the scale tips our emotions tip with it and sadly over three hundred thousand adolescents every year suffer due to the imbalance. Three hundred thousand individuals have made the conscious choice of ending their own life. They were walking bombs among us who have reached their limit and exploded in a devastating ending. It is our job as humans to help end the world from this sorrow and we can only do so when we fully understand the triggers of suicide. Along with that we must fully understand the consequence of our actions because many people suffer from that single unkind joke said for a laugh. Suicide for many is considered a taboo topic too hard on the heart to be bluntly spoken about.

This must come to an end because until the world becomes conscious of this heart wrenching topic, suicide rates will continue to progress. In the long run it will end in suicide placing its mark as the top leading cause for adolescent death.

Epidemiology:

Suicide as stated in the Oxford dictionary is the act of killing oneself intentionally. Every year a minimum of 300,000 teenagers commit suicide and succeed at it. Many believe that the people who commit suicide are simply attention seekers and that they are being over dramatic. The people who say this fail to realize the capability of emotions and the human mind. Suicidal behavior is triggered by several different factors; however, these factors wouldn't be of any affect if the person wasn't already having unpleasant thoughts due to vast array of emotions. Our mind is able to utilize these triggers, thoughts and emotions to create a deadly combination[8].

According to the WHO almost 1 million people die from suicide every year, a global mortality rate of 16 per 100,000 or one death every 40 seconds. Suicide is one of the leading causes of death among those aged 15–44 years in both well-developed and developing countries. Also, it has been proven that suicide rates are higher among the male older adults than young adults [9].

The suicide rate in the USA was 11.4/ 100,000 in 1997 although this has subsequently declined slightly due to the improvement of mental health care. As of 2000 the rate is about 10.7/100,000. Starting with the year 1993 to 2004 the rate of suicide among people over the age of 14 was 10–13/100,000 in England and 13/100 000 in the Ireland.

Etiology:

The etiology of suicide is an unknown, mysterious field. There are several theories that are present which aid in the understanding of the etiology: the social theory, psychological theory, and biological theory.

Social theory:

The behaviors related to suicide can be classified as ideations i.e., thoughts, communications, and behaviors and it is self-initiated. These behaviors vary in terms of the presence or absence of intent to die. Also, presence or absence of physical injury sustained. Our main focus in the current theoretical account is on near lethal and lethal

suicide attempts. The suicide attempts possess various qualities: 1) self-initiated, potentially injurious behavior; 2) presence of intent to die; 3) non-fatal outcome[12]. To explain patterns of suicide a French sociologist Emile Durkheim classified the social theories into three categories: the egoistic, the altruistic and the anomic. Egoistic means the people who are not strongly integrated into any social group as well as lack of family integration. For example, he explains why the unmarried are more vulnerable to suicide than the married. Altruistic can be understood by an example that Protestantism which is a less cohesive religion than Catholicism and consequently the Protestants have higher suicide rates among their members. Durkheim believes that individuals who are philanthropic are prone to suicide because of their excessive integration into a group. Anomic refers to social instability with a breakdown in social standards and values. Individuals in this group are thus deprived of customary norms of behavior. This explains why those who experience negative changes in their economic fortunes are more vulnerable to suicide [10].

Psychological theory:
This theory focuses on two principles and it is crucial to distinct between them. First, Joiner's interpersonal theory of suicide states that the coexistence of high levels of perceived burdensomeness, feeling a burden on others and low levels of belongingness, feeling alienated or that you do not belong and being hopeless, that these states will not change and lead to the development of suicidal desire. According to the Second theory, exposure to and encounter with previous painful experiences increases an individual's tolerance for the physical pain of self-harm through habituation processes. This integrates to motivation towards ideation of suicide[13].

Biological theory: The suicidal behavior results from the dual presence of a biologically based vulnerability and an activating psychosocial stressor [14]. Suicide is a complication of all existing psychiatric disorders. It depends on a disposition that includes more hopelessness and more impulsivity which are partly related to impaired serotonergic input into the ventromedial prefrontal cortex. The diathesis is a potential therapeutic target as well as an aim for future suicide research including genetic and neurochemical studies [15]. The genetic factor for suicide may be independent or dependent on genetic transmission of neurochemical disbalances. Studies suggest the relationship between tryptophan hydroxylase and a lifetime history of multiple suicide attempts; which revealed the genetic factor of impulsivity. It was discovered that apolymorphism in humans is related to an abnormality in the control of the serotonin system. A decrease in serotonin levels leads to a decrease in 5-hydroxyindolacetic acid (5HIAA) in the cerebrospinal fluid. These low levels were seen in depressed patients who attempted suicide [10].

Risk factors of Suicide:
A cocktail of the suicidal factors can push any person off that edge, let alone a person who is suffering from an endless stream of unpleasant thoughts. The first ingredient of our cocktail of factors is bullying. Bullying can be defined as the act of using superior strength or influence to intimidate someone; it is usually to force them into performing a specific task. There are several different methods for bullying. Some of the most common methods of bullying include [6]:

1. Calling a colleague, classmate, acquaintance a mean, rude and/or disrespectful name.

2. Provoke, mock and make fun of another person.

3. Spread rumors and/or lies about a person in aim of people disliking them.

4. Using another person's weakness as a punch line for a joke.

5. Posting false accusations online of the bullying victim in the aim of turning people against the victim or getting people to laugh at the victim thus degrading the victim in other people's eyes. This method of bullying is known as cyberbullying.

When you mention bullying you'd assume only the victim is being harmed but actually both the victim

and perpetrator are at risk of an elevated chance of thoughts and thriving attempt at death[16]. Peer harassment, more often to the victim more than the culprit, is known to contribute toward depression, decreased self-worth, loneliness, and hopelessness. If a person's self-worth decreases, then their belief that they deserve to live will simultaneously decrease. In due time the cascade of endless thoughts will end with the person seeking to end their own life.

Factors that increase risk of suicide:

Demographic factors: More males commit suicide than females, whereas more females tend to attempt suicide than males [17, 18]. Age related risk factors for suicide at certain life stages and emphasize that young adults of ages 25 to 34 years have an increased risk of suicide as a result of experiencing more psychological strains with age [19]. The suicide rate for males, are at 14.1 per 100,000, was four times higher than the female rate of 3.3 per 100,000. Elderly suicide victims were significantly more likely to have a physical health problem contribute to their death (55.8%), while the 19 and younger, 20-34, and 35-64 age groups only had physical health problems contribute to their deaths 1.9%, 5.5%, and 16.9% of the time, respectively [20].

Marital status also contributes to the risk of suicide; men who are widowed, divorced, or unmarried are at increased risk of suicide whereas no such risk is evident for women [21]. Marriage appeared protective against suicide for both genders but more so for men. While divorce, has been associated with increasing the risk of suicide by almost three folds but this is far more pronounced among the young in both gender [22].

Socioeconomic factors:

Suicide mortality rate is higher in the group with a lower educational level. Moreover, the risk of suicide decreased with the educational level everywhere. The risk of suicide is found greater in tenants than in elders for both men and women[24]. Analysis using measurements of unemployment, education and occupation are all likely to demonstrate equal inverse associations with suicide attempts.

Psychiatric:

Research has proven that over 90% of those who commit suicide have been psychiatrically diagnosed at the time of death. Mood disorders such as depression and mania along with Schizophrenia are all associated with suicide. Psychiatric disorders and emotions contribute to a large part of the suicide factors [25]. It is believed by people that suicide is all faked and set up but perhaps it is all very real. There is an endless array of emotions that a person can feel; many of them are connected with suicide. Feelings of entrapment, defeat, lack of worth and belonging are all highly accounted as triggers of suicide [6]. The presence of any psychiatric disorder has been demonstrated as a consistent risk factor for suicide; 90 - 98% of all individuals who die by suicide meet the criteria for at least 1 psychiatric disorder [26]. Additionally, the rate of suicide among bipolar patients is significantly higher. The lifetime history of suicide attempts is significantly higher in bipolar II than bipolar I patients [31].

Family factors:

Family factors include family psychopathology, abuse, loss of a parent (death, divorce), intra-familial relationships, and familial cohesion are significantly associated with suicidality. In adolescents, this factor is one of the most common ones to be found and manipulated. The assessment of family relationships enable appropriate care to be provided for the adolescent and their family.

Stressful family events are strongly associated with increased risk for self reported suicide attempts. Besides, there are more factors that contribute, such as improper parental rearing behavior, separation from parents, and social problems of the family members [28].

All problems bestowed upon us have some kind of solution. Many people resort to suicide to end the excruciating pain they are in. Sometimes all they need is someone to show them they truly care, someone to talk with openly about suicidal thoughts and feelings. There are several common beliefs about those who chose to end their own life, most of which are completely false. The first misconception is that those who are willing to end their own life are crazy [7].

Assessment:
A thorough interview with the patient is necessary to asses the current mental status of the patient. This assessment is necessary to identify if the patient is either a harm to themselves or others [33].

The Evaluation and Triage model provides a five step process through which the assessment of suicide is possible. The model identifies the presence of key warning signs along with risk factors. Determination of the relevant risk factors from different sources, such as medical records, treatment providers, family and friends, is the first step of the model. The second step is to establish the internal factors and external factors. The internal factors revolve around the patient's ability to cope in stress, and their frustration tolerance. The external factors handles the patient's social support. During the third stage, the clinician discusses with the patient's recent plans and behaviors of suicide. The level of risk intervention is verified during the fourth stage. This is brought forth through a set of factors specific to the predicatively of suicide. The final stage tackles the documentation of the patient in regards to discharge, in addition to the necessary information which the friends and family are informed of [35].

The model classifies patients into three categories: low risk, moderate risk, and high risk. Low risk patients are those who have suicidal ideations, however they have no intent on committing suicide. Moderate patients include those who have ideations and have created a plan to commit the act. However, they do not aim to carry out the plan. Finally, high risk patients have their suicide planned and intend to execute the plan. Along with that, they suffer from prominent agitation, impulsivity, and psychosis [34].

Alongside the Evaluation and Triage model, Tool for Assessment of Suicide Risk (TASR) is also used for the assessment of patients. It aids in the analysis of people who've presented with suicidal thoughts. TASR involves the basic elements of those who are at risk. They include: age, sex, family history, psychiatric illness and symptoms risk profile: depression, hopelessness, interview risk factors: substance abuse, suicide ideation and level of suicide risk: low, medium, high [37].

Diagnosis:
Characteristics of depression that usually occur in children, adolescent and adults include: a persistent sad and irritable mood, apathy, avolition, anhedonia, significant change in appetite and body weight, insomnia, hypersomnia, and/or lethargy [29]. Psychotic symptoms such as hallucinations, delusions, formal thought disorder and psychomotor disturbances such as catatonia in unipolar depressed patients and schizophrenic patients are associated with suicide [30]. The Columbia-suicide severity rating scale is used to determine the severity of a patient. The scale provides a checklist which covers the risk factors along with protective factors for sociality. It incorporates all current relevant variables allowing the clinician to opt to the best treatment plan for the patient[36].

CONCLUSION: Suicide remains a serious cause of mortality worldwide. However, suicide is a preventable mortality. Although not all of them are preventable, most are manageable by professional health care providers who are trained to identify the signs of suicidal behavior and can approach them. By increasing awareness campaigns that educate people on suicide and stopping the taboo on this topic, the prevalence of suicidal mortality would be decreased.

The loss of human life is tragic and should be prevented in any way possible. It is our job as humans To help end these heart shaking losses heart shaking losses caused by suicide. Offering help and support is an important step towards the recovery of a person whose been taken over by the darkness.

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REFERENCES:

1. Iglesias EB, Rio EF, Amador A and Fernandez-Hermida JR: Attachment and substance use in adolescence: A review of conceptual and methodological aspects. Adicciones 2014; 26, 77-86.
2. Goldberg J: Recognize the Warning Signs of Suicide.WebMD. http://www.webmd.com/mental-health/recognizing-suicidal-behavior 2014.
3. Yadwad BS and Gouda HS: Is attempted suicide an offence?. Journal of Indian Academy of Forensic Medicine 2005; 27 (2).
4. McLean J, Maxwell M, Platt S, Harris F and Jepson R: Risk and Protective Factors for Suicide and Suicidal Behaviour: a Literature Review. Scottish Government Social Research. Edinborough 2008.
5. Hawton K, Saunders KE and O'connor RC: Self-harm and suicide in adolescents. The Lancet 2012; 379(9834), 2373-2382.
6. Hawton K, Saunders KE and Connor RC: Suicide 1, Self-harm and suicide in adolescents. Lancet Psychiatry 2012; 379.
7. Smith M, Segal J and Robinson L: Suicide Prevention: How to Help Someone who is Suicidal. Retrieved 2014.
8. Harder HG, Rash J, Holyk T, Jovel E and Harder K. Indigenous Youth Suicide: A Systematic Review of the Literature. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 2012; 10(1).
9. Reddy MS: Suicide Incidence and Epidemiology. Indian Journal of Psychological Medicine 2010; 32(2), 77–82.
10. Masango SM, Rataemane ST and Motojesi AA: Suicide and suicide risk factors: A literature review. South African Family Practice 2008; 50(6), 25-28.
11. Dumesnil H and Verger P: Public Awareness Campaigns about Depression and Suicide: A Review. Psychiatric services: ps.psychiatryonline.org 2009; 60 (9).
12. Van Orden KA, Witte TK, Cukrowicz KC, Braithwaite S, Edward A, Selby EA and Joiner TE: The Interpersonal Theory of Suicide. Psychological Review 2010; 117(2), 575–600.
13. Nock MK and Connor RC: Suicide 2, The psychology of suicidal behaviour. Lancet Psychiatry 2014; S2215-0366(14)70222-6.
14. Aubin H, Berlin I and Kornreich C: The Evolutionary Puzzle of Suicide. International Journal of Environmental Research and Public Health 2013; 10: 6873-6886.
15. Mann JJ: Neurobiology of suicidal Behaviour. Neuroscience 2003; 4.
16. Hinduja S, and Patchin J: Bullying, Cyberbullying, and Suicide. Archives of Suicide Research 2010; 14(3), 206-221.
17. Gaynes BN, West SL, Ford CA, Frame P, Klein J and Lohr KN: Screening for Suicide Risk in Adults: A Summary of the Evidence for the U.S. Preventive Services Task Force. Annals of Internal Medicine 2004; 140 (10).
18. Qin P, Agerbo E and Mortensen PB: Suicide Risk in Relation to Socioeconomic, Demographic, Psychiatric, and Familial Factors: A National Register– Based Study of All Suicides in Denmark, 1981–1997. American Journal of Psychiatry 2003; 160,765–772
19. Zhao S and Zhang J: Suicide Risks among Adolescents and Young Adults in Rural China. International Journal of Environmental Research and Public Health 2015; 12, 131-145.
20. Manion T, Akinyem A, Nooraddini I and Haile E: A Comparison of Suicide Characteristics and Precipitating Circumstances by Age Group among Maryland Residents: Data from the Maryland Violent Death Reporting System, 2003-2009. Suicidology 2012; 3,131-137.
21. Fukuchi N, Kakizaki M, Sugawara Y, Tanji F, Watanabe I, Fukao A and Tsuji I: Association of marital status with the incidence of suicide: A population-based Cohort Study in Japan. Journal of Affective disorder 2013; 150 (3), 879-885.
22. Corcoran P. and Nagar A: Suicide and marital status in Northern Ireland. Soc Psychiat Epidemiol 2009.
23. Walker R and Flowers K: Effects of race and precipitating event on suicide versus nonsuicide death classification in a college sample. Suicide and life threatening behavior 2011; 41(1), 12–20.
24. Lorant V, Kunst A, Huisman M, Costa G and Mackenbach J: Socio-economic inequalities in suicide: a European comparative study. British Journal of Psychiatry. 2005; 187, 4 9 -5 4.
25. Bertolote J. and Fleischmann A: Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry 2002; 1:3.
26. Ilgen M, Bohnert A, Ignacio R, McCarthy J, Valenstein M, Kim H and Blow F: Psychiatric Diagnoses and Risk of Suicide in Veterans. Archives of General Psychiatry 2010; 67(11):1152-1158
27. Consoli A, Peyre H, Speranza M, Hassler C, Falissard B, Touchette E, Cohen D, Moro M and Revah-Lévy A: Suicidal behaviors in depressed adolescents: role of perceived relationships in the family. Child and Adolescent Psychiatry and Mental Health 2013;7:8
28. Xing X, Tao F, Wan Y, Xing C, Qi X, Hao J, Su P, Pan H and Huang L: Family Factors Associated With Suicide Attempts Among Chinese Adolescent Students: A National Cross-Sectional Survey. Journal of Adolescent Health 2010; 46(6), 592–599.
29. Gene-Cash R: Depression in Children and Adolescents: Information for Parents and Educators. NASP/ Social/Emotional Development.
30. Ndetei D, Pizzo M, khasakhala L and Kokonya D: A Cross sectional study of Co-occuring suicidal and Psychotic symptoms in Inpatients at Mathari Psychiatric Hospital, Nairobi, Kenya. Prime care companion Journal of Clinical Psychiatry 2009; 11(3). 110-114.
31. Nemeroff C, Compton M and Berger J: The Depressed Suicidal Patient Assessment and Treatment. Depression and Suicidality.
32. Scott K and Barrett A: Dementia syndromes: evaluation and treatment. Expert Review of Neurotherapeutics 2007; 7(4): 407–422.
33. Neely L, Tucker, J, Carreno J, Grammer G and Ghahramanlou-Holloway M: Suicide risk assessment and management guidance for military psychologists. The Military Psychologist 2014.
34. McDowell A, Lineberry T and Bostwick J: Practical Suicide-Risk Management for the Busy Primary Care Physician. Mayo Clinic Proceedings 2011; 86(8):792-800.
35. Jacobs D: A Resource Guide for Implementing the Patient Safety Goals on Suicide. Suicide Assessment Five-step Evaluation and Triage (SAFE-T). School Mental Health - Resource Guide 2007.
36. Posner K, Brent D, Lucas C, Gould M, Stanley B, Brown G, Fisher P, Zelazny J, Burke A, Oquendo M and Mann J: Columbia-Suicide Severity Rating Scale (C-SSRS). Baseline Version 2008; 1/14/09
37. Kutcher S and Chehil S: Sun Life Financial Chair in Adolescent Mental Health: The Tool for Assessment of Suicide Risk for Adolescents (TASR-A): How to use the TASR – A 2007.

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