Annex 7

Brief Intervention: Information session about suicide

Introduction

The brief information session should encompass the following characteristics in order to be most effective:

- Feedback: information about suicidal behaviours, risk factors, and protective factors should be provided;
- Responsibility: emphasis should be placed on the patient's responsibility for change;
- Self-efficacy: the patient's belief in his or her ability to make successful changes should be strengthened.
- Advice: simple advice on what to change and on how to reduce future health risks should be given;
- Menu: a range of treatment options to select from should be provided;
- Empathy: the situation should be seen from the patient's perspective, while also maintaining a foot outside his or her reality;

The objectives of the information session are the following:

- to provide accurate information about suicidal behaviours;
- to provide accurate information about risk factors and protective factors;
- to face myths about suicidal behaviours;
- to provide advice and recommendations;
- to build the patient's motivation for treatment.

During the session, a pattern of questioning and answering should be avoided, which does not allow the patient to ask questions but just to give short answers. Also, the health worker should not convey the impression of having all the answers to every problem. This would easily move the patient into a passive role. Above all, the patient should not be blamed. It must be made clear that it is irrelevant who is to blame, but that it is a key issue of the session to see what is wrong and what can be done about it.

A non-judgmental approach should be used and labelling should be avoided. During the session, encouragement should be provided and empathy expressed. The health worker should listen carefully and summarize statements in order to reinforce what has been said and to link material that has been discussed.

Above all, the health worker should respond to the patient's individual characteristics and tailor the session to the patient's individual needs using the information provided below, adapting it and delivering it in his own words.

A possible opening of the session would be the following:

“For our session of one hour I have put together some information about suicidal behaviours. I would like to cover some basic points, some of which you may already know and some of which might be quite new. If you have any questions or topics related to suicidal behaviour that are of particular interest to you, please let me know. I would like to make sure that we have a chance to address them. Please feel free to ask any question or to clarify something any time. I would like to make this session as interactive and as helpful to you as possible. Also, I would like to spend some time talking about how you might make use of this information in the future. How does that sound?”

1. What is suicidal behaviour?

Suicidal behaviour covers the whole range from suicidal thoughts, to attempted suicide and completed suicide.

Thoughts about suicide and suicide attempts can be seen as preliminary stages of completed suicide. This means that there is a development from thoughts or ideas about suicide to attempted suicide and from attempted suicide to completed suicide.

Completed suicide includes all deaths in which a willful, self-inflicted, life-threatening act has been performed which has resulted in death. This act with fatal outcome was deliberately initiated and performed. The person knew or expected a fatal outcome. Through this act the person aimed at realizing changes he or she desired. However, the intention may be vague or ambiguous. This means that in most cases the person does not want to die and does not see death as the goal, but the person wants to stop living or the person wants to stop being conscious.

Suicide attempt includes those situations in which a person has performed a life-threatening act with the intent of putting his or her life into danger or giving the appearance of such an intent. However, the life-threatening act has not resulted in death. Attempted suicide has to be seen as a cry for help. The person wants to provoke changes which should make life bearable. It includes acts interrupted by others before the actual self-harm occurs.

Suicidal thoughts include behaviours that move in the direction of a possible threat to the person's life. However, the act which might be lethal has not actually been performed.

2. a How many people commit suicide?

Suicidal behaviour is a personal and family tragedy, causing great suffering to the person concerned and to those close to him or her. On average, a single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it has an impact on hundreds of people.

Globally speaking, suicide rates have been increasing over the last 45 years (Annex, Figure 1). In the year 2000, there were approximately one million people who committed suicide (Annex, Figure 2). This represents a global mortality rate of about 16 suicide deaths per 100,000 population or one death every 40 seconds. Suicide is among the top 10 causes of death in every country, and among the three leading causes of death for young people (15 to 34-year age group).

The highest suicide rates for both men and women are found in Europe, more particularly in Eastern Europe, such as Estonia, Latvia, Lithuania, Finland, Hungary, Russian Federation and in Asian countries such as China and Japan. Medium rates are mostly found in countries of Central and Northern Europe, North America, South East Asia and the Western Pacific, such as Australia, Canada, India, New Zealand, USA. The lowest rates are mostly found in Latin American, Arabic and some Asian countries, for instance in Argentina, Brazil, Kuwait and Thailand. Information concerning most African countries is badly lacking. Some relatively isolated islands have suicide rates surprisingly higher than the regional average, such as Cuba, Sri Lanka, Fiji, Mauritius, Samoa or Seychelles.

The highest suicide rates are currently found in Eastern Europe. However, the highest numbers of suicide are found in Asia. In China and India almost 30% of all cases of suicide in the world are committed.

With regards to gender, suicide rates are on average three times higher in males than in females, globally speaking (Annex, Figure 3). The only exception is China where suicide rates for females are higher than for males in rural areas and similar to the rates for males in urban areas.

With regards to age, there is a clear tendency for suicide rates to increase with age. However, there is a remarkable change in the picture, because currently the number of suicides is higher among young people (Annex, Figure 4). Suicide rates are already higher among young people in one third of all countries, for example in Australia, Bahrain, Canada, Kuwait, Mauritius, New Zealand, Sri Lanka and the United Kingdom.

ADD NATIONAL AND LOCAL INFORMATION ABOUT COMPLETED SUICIDE!

2. b How many people attempt suicide?

In contrast to the situation for data on committed suicide, no national statistics exist for attempted suicide. In general, attempted suicide seems to be 10-20 times more frequent than completed suicide. In several countries attempted suicide is one of the most frequent reasons for hospital emergency admissions in young people.

The majority of attempted suicides occurs among persons below 35 years of age.

The rates of attempted suicide are higher among females than among males.

ADD NATIONAL AND LOCAL INFORMATION ABOUT ATTEMPTED SUICIDE!

3. What pushes people towards suicide or suicide attempt?

It is difficult to accept suicide as a rational act, because the following three criteria would have to be met:

Firstly, the suicidal person knows and fully understands the consequences of his or her act. Secondly, the act is absolutely voluntary. Thirdly, there are no alternatives to escaping the pain and the problems.

These criteria are rarely – if ever – met and that is why there are reservations to accept suicide as a rational act.

People do not know what death is like. It is beyond the capacity of the human brain to understand such concepts as eternity and infinity. Humans cannot grasp what not living is really like. The act of suicide is rarely, if ever, voluntary. It is a road the person feels forced to follow, because he or she can see no other way out of the problems, pain and misery. The life situation seems to be intolerable and problems seem to be overwhelming. But usually, there are other ways out. Somebody else may have to point them out to the person thinking about suicide and may have to support him or her in the efforts to follow the other ways out.

Three features in particular are characteristic of a suicidal person:

- Most people have mixed feelings about committing suicide which is called ambivalence. The wish to live and the wish to die fight a see-saw battle in the person. The person feels an urge to get away from the pain of living and feels the desire to live at the same time. Many suicidal persons do not really want to die. It is just that they are unhappy with life. If they receive support and if the wish to live is increased, the risk of suicide will be decreased.

- Suicide is also an impulsive act. Like any other impulse, the impulse to commit suicide is passing and lasts for a few minutes only or for a few hours. It is usually set off by negative day-to-day events. By taking the edge off the crisis and by playing for time the risk of suicide can be reduced.

- When people are suicidal, their thinking, feelings and actions are constricted or rigid. They constantly think about suicide and they are unable to see other ways out of the problem. They think in a drastic way.

Many suicidal people communicate their thoughts about suicide and their intentions. They often send out signals and make statements about “wanting to die” or “feeling useless”, for instance. These signals must not be ignored.

Whatever the problems, the feelings and thoughts of the suicidal person – they tend to be the same all over the world.

There is a model of the suicidal process to better understand the development towards suicide (Annex, Figure 5). The model shows that suicidal behaviour has a history and that there is a development of gradually increasing seriousness in suicidal behaviour, from suicidal thoughts to suicide attempts and to suicide. Before the suicidal act, there is a process which is highly individual and which may take a different length of time for every person. For long periods, thoughts of suicide may be completely absent, but they may return in response to new stress and strains.

The model tries to provide a better understanding of the communication and interaction between the suicidal people and the people around them. Factors that are taken into account include the person's personality, the role of the environment, the role of stress, other people's reactions and psychosocial and cultural support, protective factors and risk factors. The model wants to show that the suicidal process is affected by numerous different factors.

[This model should be discussed with the patient, taking into account the patient's personal situation and trying to identify individual factors contributing to his or her suicide attempt.]

4. What can be done?

Suicide is a complex problem for which there is no single cause or single reason. It results from a complex interaction of biological, genetic, psychological, social, cultural and environmental factors. It is difficult to explain why some people decide to commit suicide while others, in a similar or even worse situation, do not. However, most suicides can be prevented.

4.a Risk factors of suicidal behaviour

Risk factors and risk situations vary from one continent and from one country to another, depending on cultural, political and economic features. However, all the factors and situations described in the following are frequently associated with attempted and committed suicide.

The detection and management of risk factors is an important step in suicide prevention.

[The risk factors should be discussed with the patient, taking into account the patient's personal situation and trying to identify individual risk factors contributing to his or her suicide attempt. Those risk factors should be discussed that are meaningful to the patient.]

Suicide and mental disorders

Both in developing and developed countries, the majority (80-100%) of people who commit suicide have a mental disorder which can be diagnosed. It is very common that those who commit suicide suffer from more than one mental disorder.

Depression

Depression is most common in completed suicide.

Everyone feels depressed, sad, lonely and unstable from time to time, but usually those feelings pass. However, when the feelings are persistent and disrupt a person's usual normal life, they are no longer depressive feelings, but the condition becomes a depressive illness.

Feeling sad during most of the day every day is a common symptom of depression. Also, losing interest in usual activities or feeling tired and weak all the time are symptoms. Sleeping too much or too little or waking too early, losing or gaining weight, feeling worthless, guilty or hopeless, feeling irritable and restless all the time, having difficulty in concentrating or in making decisions or having difficulty remembering things or having repeated thoughts of death and suicide are further symptoms of depression.

The risk of suicide is even higher, if a person suffers from persistent sleeplessness, from a severe illness, impaired memory, agitation, panic attacks or shows self-neglect.

There are several reasons why depression is often not diagnosed:

- People are often embarrassed to admit that they are depressed, as they see the symptoms as a "sign of weakness".
- People are familiar with the feelings associated with depression, but they are not able to recognize it as an illness.
- Depression is more difficult to diagnose when the person has a physical illness.
- Patients with depression may present with a wide variety of vague aches and pains which makes it more difficult to diagnose depression.

Alcoholism

Alcoholism (both alcohol abuse and dependence) is frequent among those who have committed suicide, particularly in young people. 5-10% of people who are dependent on alcohol end their life by suicide. At the time of the suicidal act many are found to have been under the influence of alcohol.

Among people with alcohol problems the risk of suicide is increased when they have started drinking at a very young age, when they have consumed alcohol over a long period or when they drink heavily. Also, the risk is increased when they feel depressed, when the physical health is poor, when they perform poorly at work or when the personal life is disturbed and chaotic. Having suffered a recent major interpersonal loss, such as separation from the spouse and/or the family, divorce or bereavement may also increase the risk of suicide.

The presence of both alcohol problems and depression in a person strongly increases the risk of suicide.

Schizophrenia

Suicide is the largest single cause of premature death among people with schizophrenia. Approximately 10% of them ultimately commit suicide.

Schizophrenia is characterized by disturbances in speech, thought, hearing or seeing, personal hygiene and social behaviour; in short, by a drastic change in behaviour and/or feelings, or by strange ideas.

Among people suffering from schizophrenia, the risk of suicide is increased in the early stage of the illness and in young, single, unemployed males. The risk is also increased when the person is prone to frequent relapses, depressed, paranoid/suspicious or highly educated. Early in a relapse, when the person feels to have overcome the problem, but the symptoms recur and early in the recovery, when outwardly the symptoms are better, but internally the person feels vulnerable, the risk of suicide is very high.

Personality disorders

The personality disorders that are more frequently associated with suicide are borderline personality and antisocial personality disorder. Also, impulsivity and aggression have been associated with suicide.

Anxiety disorders

Among anxiety disorders, panic disorder and obsessive-compulsive disorder have been most frequently associated with suicide. Somatoform disorder and eating disorders are also related to suicidal behaviour.

Suicide and physical illness

Suicide risk is increased in chronic physical illness. Also, disability and negative prognosis are correlated with suicide. In addition, there is generally an increased rate of mental disorder, especially depression, in people with physical illness.

Neurological disorders

The increased impulsivity, aggression and chronic disability often seen in persons with epilepsy are the likely reasons for their increased suicidal behaviour. Alcohol and drug abuse contribute to it.

Spinal or brain injuries and stroke also increase the risk of suicide. Recent studies have shown that after a stroke 19% of patients are depressed and suicidal. The more serious the injuries are the greater is the risk of suicide.

Cancer

There are indications that terminal illness, such as cancer, is associated with increased suicide rates. The risk of suicide is greater in males, soon after the diagnosis (within the first five years), and when the patient is undergoing chemotherapy. Pain is a significant contributing factor to suicide.

HIV/AIDS

The stigma, poor prognosis and nature of the illness increase the suicide risk of HIV infected people. The risk is greater at the time of confirmation of the diagnosis and in the early stages of the illness. Intravenous drug users are at still higher risk.

Other chronic conditions

The following chronic medical conditions have a possible association with increased suicide risk:

- diabetes;
- multiple sclerosis;
- chronic renal, liver and other gastrointestinal conditions;
- bone and joint disorders with chronic pain;
- cardiovascular and neurovascular diseases;
- sexual disorders;
- disabilities of walking, seeing and hearing.

Suicide and sociodemographic and environmental factors

Suicide is an individual act. However, it occurs in the context of a given society and certain sociodemographic and environmental factors are associated with it.

Sex

In the majority of countries, more males commit suicide than females, but more females attempt suicide. The male/female ratio varies from country to country. China is the only country in which female suicides outnumber male suicides in rural areas and are approximately equal to male suicides in urban areas.

Age

Suicide takes place at all ages with the young (15-34 years) and the elderly (over 65 years) being age groups at even higher risk of suicide. The act of suicide depends most importantly on the presence of risk factors and the lack of protective factors.

Marital status

Divorced, widowed and single people are at a higher risk of suicide than married people. Those who live alone or who are separated are more vulnerable.

Occupation

Certain occupational groups, such as veterinarians, pharmacists, chemists, dentists, medical practitioners and farmers have a higher risk of suicide. There is no obvious explanation for these findings, although access to lethal means, work pressure, social isolation and financial difficulties might be contributing factors.

Unemployment

Loss of job, rather than the status of unemployed persons has been found to be associated with suicide. The effects of unemployment are probably mediated by factors such as poverty, social deprivation, domestic difficulties and hopelessness.

Residence

In some countries suicides are more frequent in urban areas, whereas in others they occur more frequently in rural areas.

Migration

People who have moved from a rural to an urban area or to a different region or country are more vulnerable to suicidal behaviour. Migration is associated with problems of poverty, poor housing, lack of social support and unmet expectations.

Life stressors

The majority of those who commit suicide have experienced a number of stressful life events in the three months prior to suicide.

Such stressful life events may be interpersonal problems, e.g. quarrels with spouses, family, friends or lovers. The person may have experienced a rejection, e.g. the separation from family and friends. Loss events may be very stressful, e.g. financial loss or bereavement. Also, work or financial problems, e.g. job loss, retirement or financial difficulties may be perceived as a stressful life event. Changes in society, e.g. rapid political and economic changes may cause stress. There are various other stressors, such as shame or the threat of being found guilty which are of importance.

Easy availability

The immediate availability of a method to commit suicide is an important factor in determining whether or not an individual will commit suicide. Reducing access to the means of committing suicide is an effective suicide prevention strategy.

Exposure to suicide

A small portion of suicides consists of vulnerable adolescents who are exposed to suicide in real life or through the media and who may be influenced to engage in suicidal behaviour.

Previous suicide attempt

Previous single or recurrent suicide attempts are associated with suicide. 10-14% of people who attempted suicide eventually die through suicide.

[The health worker should select the following item only if it is meaningful to the patient.]

4.b Suicidal behaviour in children and adolescents

With regards to children and adolescents, it has been observed that young suicidal people often come from families with more than one problem. Since they are loyal to their parents and sometimes unwilling or forbidden to reveal family secrets, they frequently do not seek help outside the family. There are a number of family patterns that are often, but by no means always, found in children and adolescents who attempt or commit suicide.

One or both parents may suffer from a mental disorder, there may be alcohol and substance abuse or antisocial behaviour in the family or a family history of suicide and suicide attempts can be found. The family pattern may also reveal a violent and abusive family, including physical and sexual abuse of the child. It may be that parents/guardians are found to provide poor care with poor communication in the family, there may be frequent quarrels between the parents/guardians, with tension and aggression or there is a divorce, separation or death of the parents/guardians. Both parents/guardians who have very high or very low expectations may be problematic, just like showing excessive or inadequate authority. They may spend too little time to observe and deal with the child's emotional distress resulting in a negative emotional environment with rejection or neglect. An adoptive or foster family and frequent moves to a different residential area may also represent problems.

In suicidal young people even trivial occurrences may be perceived as threats directed against their self-image and they suffer from a sense of wounded personal dignity. Family disturbances, separation from friends, girl-/boyfriends or classmates, death of a loved one or of another significant person, termination of a love relationship, interpersonal conflicts or losses may lead to suicide attempts or suicide among young people.

Also, legal or disciplinary problems, peer-group pressure, bullying or victimization, poor finances, unwanted pregnancy or abortion are situations and events that may lead to suicide attempts or suicide among children and adolescents.

Disappointment with school results or failure in studies and high demands at school during examination periods may present such risk situations or events as well.

4.c Protective factors against suicidal behaviour

There are not only various risk factors that are associated with suicidal behaviour, but also major protective factors that have been identified to afford protection against suicidal behaviour.

Family patterns

Good relationships with family members and receiving support from the family have been identified as protective factors.

Cognitive style and personality

Confidence in oneself and confidence in one's own situation and achievements, good social skills, seeking help when difficulties arise, seeking advice when important choices must be made, openness to other people's experiences and solutions, and openness to new knowledge are factors providing protection against suicidal behaviours.

Cultural and sociodemographic factors

Social integration, e.g. through participation in sport, church associations, clubs and other activities, good relationships with schoolmates or work colleagues, good relationships with teachers or superiors and support from relevant people can also be found among protective factors.

5. What is available?

In 1996, the United Nations issued a document in which the importance of a guiding policy on activities related to suicide prevention was highlighted and which became a landmark in the subject. The following is stated in this document:

"Suicide is a global tragedy … the suicide problem has been generally neglected or ignored all around the globe … In many countries, suicide attempts are one of the main reasons for hospital emergency admissions and treatment of young people, putting a heavy burden on their health-care systems … In addition to the many millions of persons who, for reasons of social and emotional suffering and loss of hope, commit or attempt suicide, there are the innumerable others, such as family members, friends, colleagues and care-givers, whose lives are profoundly affected … In most cases, the tragedy of suicide can be prevented … Rising to the challenge of preventing suicidal behaviour is the basic human motive behind the call for countries to develop national strategies for suicide prevention and for relevant organizations to assist them in this most needed and urgent endeavour."

The strong taboo on suicide that still exists and the distress it arouses and has aroused throughout history make it difficult to approach the problem of suicide in an open way. To this day, suicidal behaviour is associated with shame, uneasiness and guilt. However, by openly discussing suicidal thoughts they turn from a problem to be hidden to a problem to be solved.

For the prevention of suicide, the following approaches are of importance:

- A few mental disorders are significantly associated with suicide. Therefore, the early identification and the appropriate treatment of those mental disorders are important strategies for the prevention of suicide. Mood disorders, alcohol and other substance misuse, schizophrenia and personality disorders are particularly relevant in this respect. The education of primary health care personnel in the identification and treatment of people with mood disorders results in a reduction of suicide rates among those at risk. Also, new medication for both mood and schizophrenic disorders with less side effects increases adherence to treatment and better outcomes. The reduction of the stigma which is still attached to people with mental disorders helps these people coming forward to receive treatment at early stages of the disease, when treatment is more efficient.

- Evidence of the efficacy of restriction of access to means of suicide is available from several countries. The reduction of availability of sedatives and toxic substances, such as pesticides, demonstrated a decrease in suicide rates. The detoxification of gas, that is the removal of carbon monoxide from domestic gas and from car exhausts, is another example for the reduction of suicide rates. Legislation which regulates sales, ownership and storage of guns, the introduction of mechanisms that distance guns from bullets and the incorporation of trigger blocking devices have also proven to be effective in reducing suicide rates. It is crucial to reduce the access to the means of committing suicide as a strategy of effective suicide prevention.

The treatment after attempted suicide should be effective in helping people who are troubled by suicidal thoughts and effective in reducing the rate of repeated suicide attempts and completed suicide.

The following approaches are of importance in the treatment after attempted suicide:

- The psychological treatment tries to modify factors, such as problem-solving skills, particularly interpersonal problem solving, or feelings of hopelessness. The therapist helps the person to try

out new ways of overcoming obstacles. It seems likely that problem solving has the effect of reducing hopelessness in people who have previously been unable to see any way out of a seemingly insoluble situation. Also, skills and techniques to deal with depression, anxiety and stress and to cope with interpersonal and emotional difficulties are taught. The aim of the treatment is to empower the person to apply whatever is learnt during the therapy to later and other situations in a flexible way.

- Pharmacological interventions are usually aimed at the specific treatment of a psychic or somatic disorder that may be the underlying cause for an attempted suicide. They may also be aimed at the actual prevention of suicide by mostly sedative procedures.

ADD UP-TO-DATE INFORMATION ABOUT LOCAL RESOURCES, INCLUDING ADDRESS, TELEPHONE NUMBER AND CONTACT PERSON, SUCH AS:

suicide prevention centres;
crisis intervention centres;
health professionals;
volunteer organizations;
telephone emergency or crisis lines, lifelines, hotlines;
telephone counselling;
resources for medical, psychological, social interventions and for therapy;
aftercare programmes for people previously treated in hospitals;
school-based programmes.

Annex

Figure 1. Global suicide rates since 1950 and trends until 2020

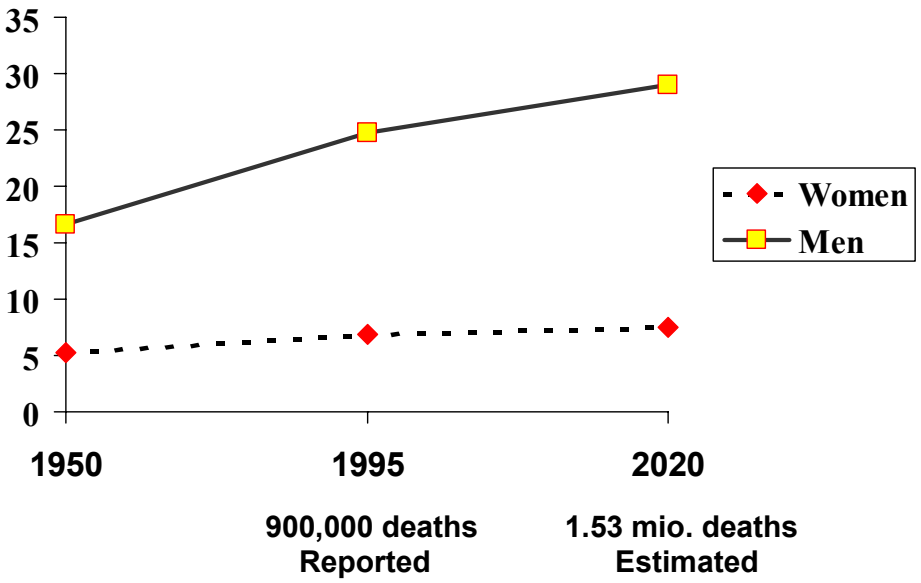


Figure 2. Evolution of global suicide rates 1950-1995 (per 100,000)

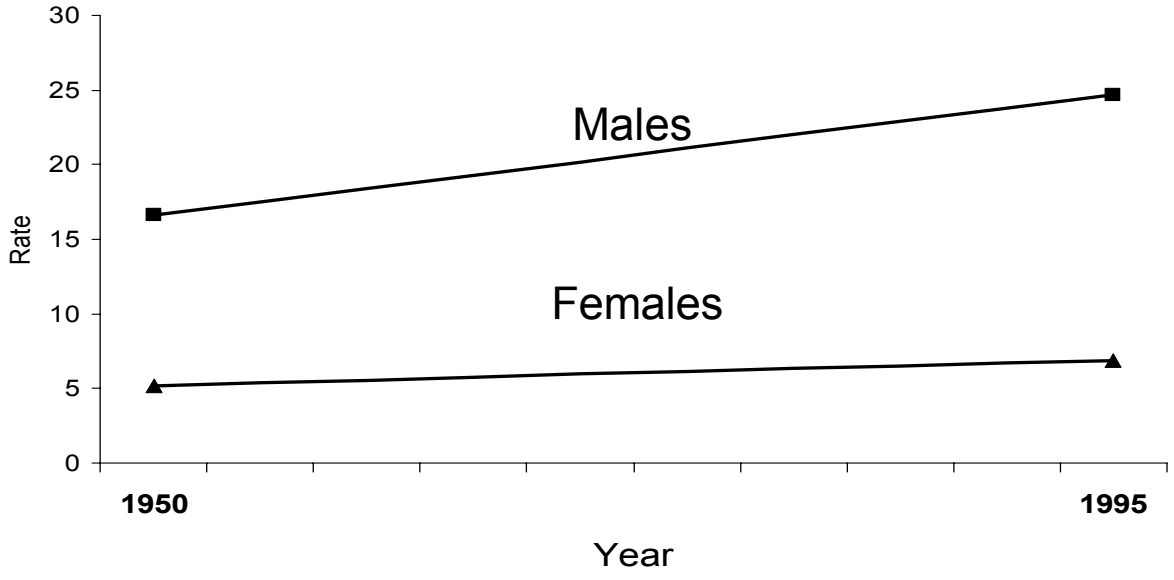
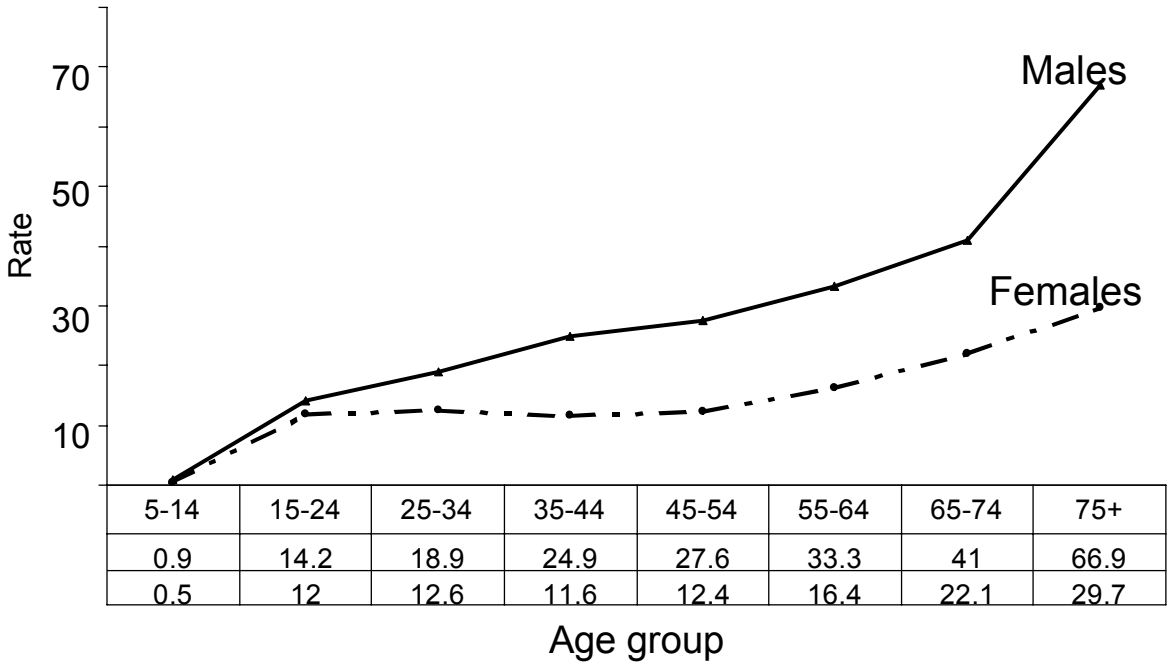


Figure 3. Distribution of suicide rates (per 100,000) by gender and age, 1995



5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
0.9	14.2	18.9	24.9	27.6	33.3	41	66.9
0.5	12	12.6	11.6	12.4	16.4	22.1	29.7

Age group

Figure 4. Changes in the age distribution of cases of suicide between 1950 and 1995

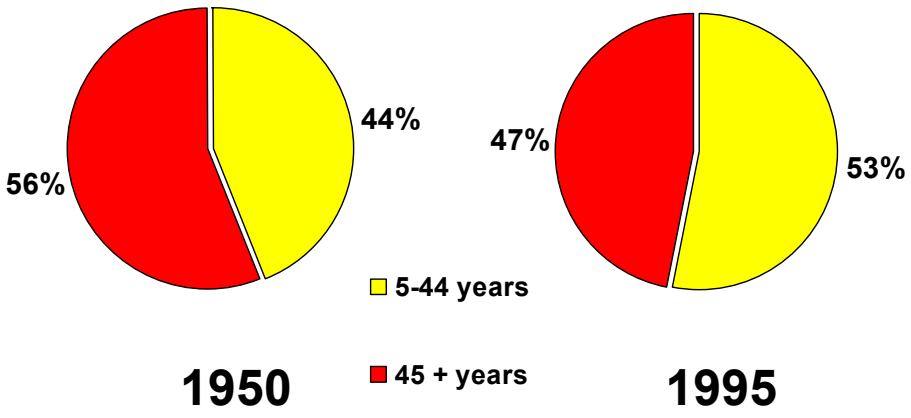


Figure 5a. Risk factors, stress and acute triggers for suicidal behaviour.

RISK FACTORS

Suicidal propensity inherited and/or acquired due to stress

STRESS

- Relationship problems
- Violence and psychic trauma
- Social stress, poverty, unemployment
- Psychiatric illness
- Alcohol and drug abuse
- Somatic illness, pain

ACUTE TRIGGERS FOR SUICIDAL BEHAVIOUR

- Separation, loss, relationship conflicts
- Financial problems, bullying, harassment
- Different negative and traumatic life event
- Relapse or exacerbation of illness
- Narcissistic injury

Adapted from *Stress-vulnerability model and development of the suicidal process from suicidal ideation to suicide*. Wasserman D, 1999. (Source: Wasserman D (editor). Suicide: An Unnecessary Death. London. Martin Dunitz. 2001. p.20. With permission from the editor).

Figure 5b. Observable and non-observable suicidal behaviour in the suicidal process.

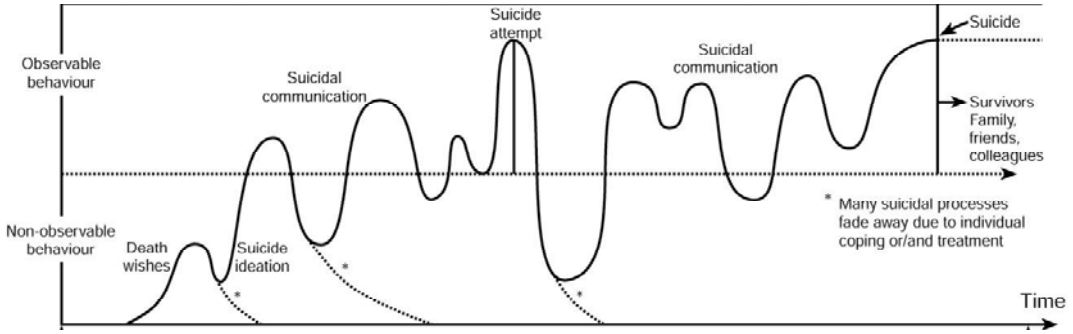


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Figure 5c. Protective factors against suicidal behaviour.

PROTECTIVE FACTORS

Suicidal resilience, inherited and/or acquired during antenatal life, upbringing and adult life

Cognitive style and personality
- A sense of personal value
- Confidence in oneself and one's own situation and achievements
- Seeking help when difficulties arise
- Seeking advice when important choices must be made
- Openness to other people's experiences and solutions
- Openness to learning
- Ability to communicate

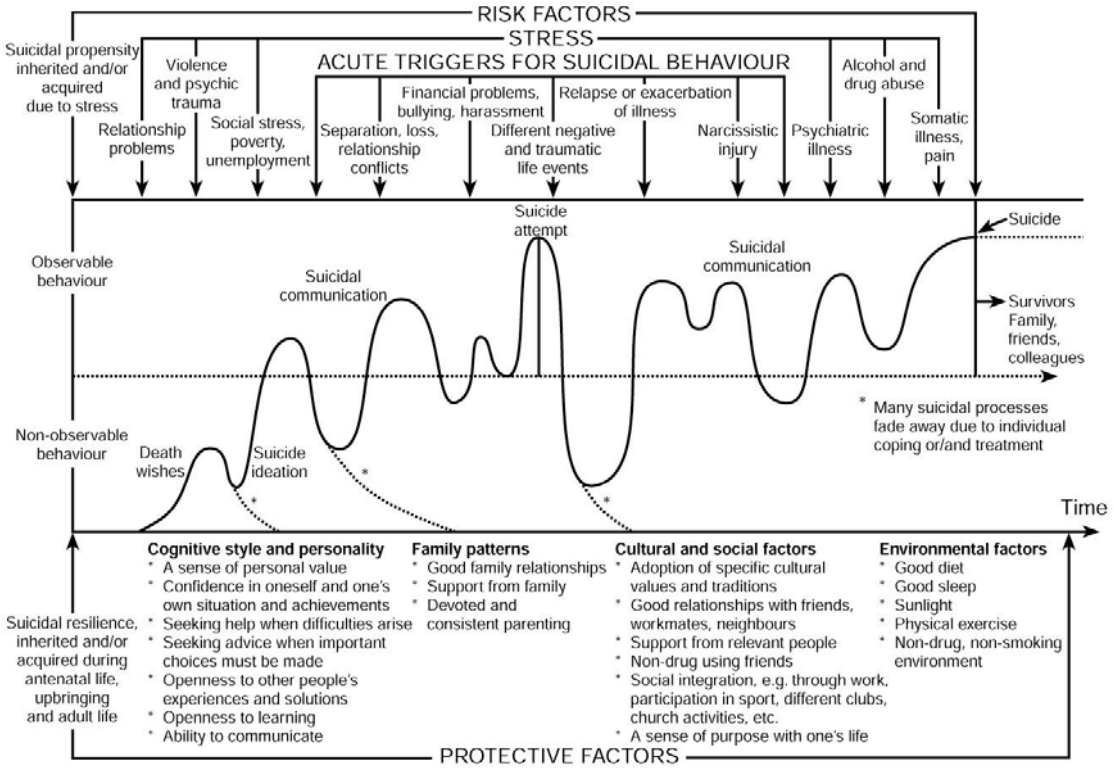
Family patterns
- Good family relationships
- Support from family
- Devoted and consistent parenting

- **Cultural and social factors**
- Adoption of specific cultural values and traditions
- Good relationships with friends, workmates, neighbours
- Support from relevant people
- Non-drug using friends
- Social integration, e.g. through work, participation in sport, different clubs, church activities
- A sense of purpose with one's life

Environmental factors
- Good diet
- Good sleep
- Sunlight
- Physical exercise
- Non-drug, non-smoking environment

Adapted from *Stress-vulnerability model and development of the suicidal process from suicidal ideation to suicide*. Wasserman D, 1999. (Source: Wasserman D (editor). Suicide: An Unnecessary Death. London. Martin Dunitz. 2001. p.20. With permission from the editor).

Figure 5d. Stress-vulnerability model and development of the suicidal process from suicidal ideation to suicide. Wasserman D, 1999.



Source: Wasserman D (editor). Suicide: An Unnecessary Death. London. Martin Dunitz. 2001. p. 20. With permission from the editor.