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SUICIDE

A MEDIA RESOURCE BOOK

Produced by the:

Canadian Association for Suicide Prevention

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SUICIDE: A MEDIA RESOURCE BOOK

Contents

	Page
CASP and these guidelines	3
Suicide prevention and the media	4
Suicide in Canada	5
General facts about suicide	8
▪ Suicide in Canada	
▪ When does suicide occur?	
▪ Who commits suicide?	
▪ Why do people commit suicide?	
Inuit and First Nations communities	10
Terms and definitions	11
Suggestions for reporting on suicide	12
Suggested materials for reprint/broadcast	14
▪ Warning signs of suicide	
▪ How to help	
▪ Who to call	
▪ Myths and facts about suicide	
Further reading	17
Media contacts	18
Membership application for CASP	19

This publication has been adapted for Canadian distribution from "Suicide: A Media Resource Book," produced by the **Ottawa-Carleton Health Department** and the **Canadian Mental Health Association - Ottawa-Carleton Branch.**

CASP AND THESE GUIDELINES

These guidelines are distributed by the *Canadian Association for Suicide Prevention/L'Association Canadienne pour la prévention du suicide* to aid journalists in media reports concerning suicide. The Canadian Association for Suicide Prevention (CASP) is a non-profit organization whose members include professionals, researchers and lay people who promote the goal of treatment, education and research on suicidal behaviour in Canada. CASP holds an annual meeting where researchers and persons involved in suicide prevention share infomation. CASP publishes a directory of suicide prevention and crisis intervention centres in Canada, and has many active task forces working in areas related to suicide prevention. For example, CASP has developed guidelines for suicide prevention in the schools, a glossary of English and French terminology in suicidology (soon to be available in Inuktitut as well), CASP has active research committees, provides model ethical guidelines for crisis intervention and suicide prevention centres, etc.

SUICIDE PREVENTION AND THE MEDIA

This resource book is intended to provide commonly requested information to help journalists report on or research the issue of suicide.

It is not our intent to dictate to the media on how to report on suicide. However, there is evidence to suggest that sensitive reporting may have a positive influence on those people at risk of suicide.

There is also some concern about "copycat suicides" or imitative suicides. Several studies show that the rate of suicidal behaviour increased after news stories about suicide were published, particularly among teenagers and in the immediate geographical area. These studies showed that the more publicity there was, the more imitative suicides resulted. The effect of certain types of reporting on suicidal people may be devastating.

Our primary concern is suicide prevention. We feel that by providing the public with information — about the warning signs of suicide, how to help, who to call, and where to get help — the media could help prevent potential suicides by providing a positive and preventive message to balance the story.

If your media organization does not already have a policy or set of criteria for reporting on suicide, it is hoped that this resource book will help you to formulate one. We ask for your support in this endeavour, and hope you will find the information contained within this resource book useful.

SUICIDE IN CANADA

Figure 1 shows suicide rates in Canada for males and females from 1975 to 1990. Canadian suicide rates overtook US rates during the 1970s and have stayed consistently ahead. A major concern is the increase among young persons since the 1950s, especially males in their late teens and early twenties. Suicide ranks fourth in causes of potential years of life lost among men and sixth as a cause for years of life lost for Canadian women (Suicide in Canada, 1994).

Figure 1

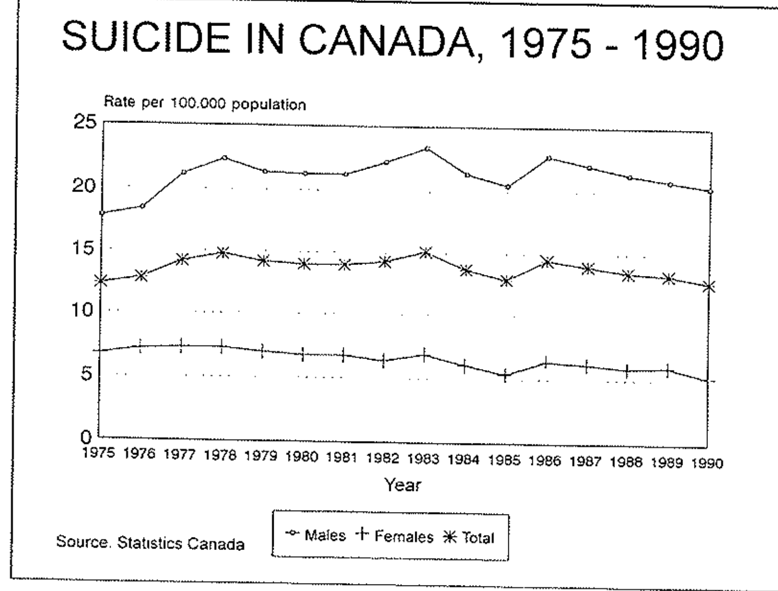


Figure 2 shows suicide rates for 1986-1990 by province in Canada. Rates in the Yukon and Northwest Territories should be cautiously interpreted because of their small base populations and the fact that suicide accounts for a relatively small number of deaths. Quebec and Alberta had the highest rate in 1990. Although Quebec has a higher male suicide rate than Alberta, Alberta has the highest comparative suicide rate in females.

Figure 2

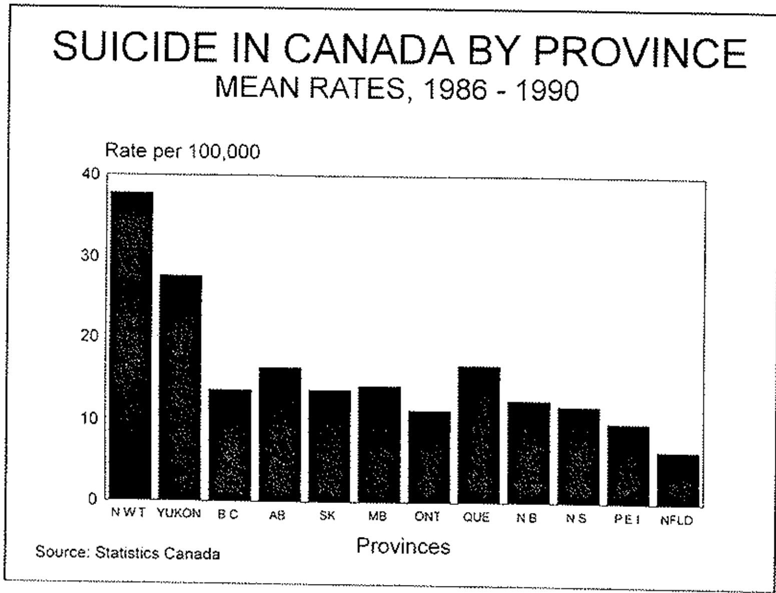
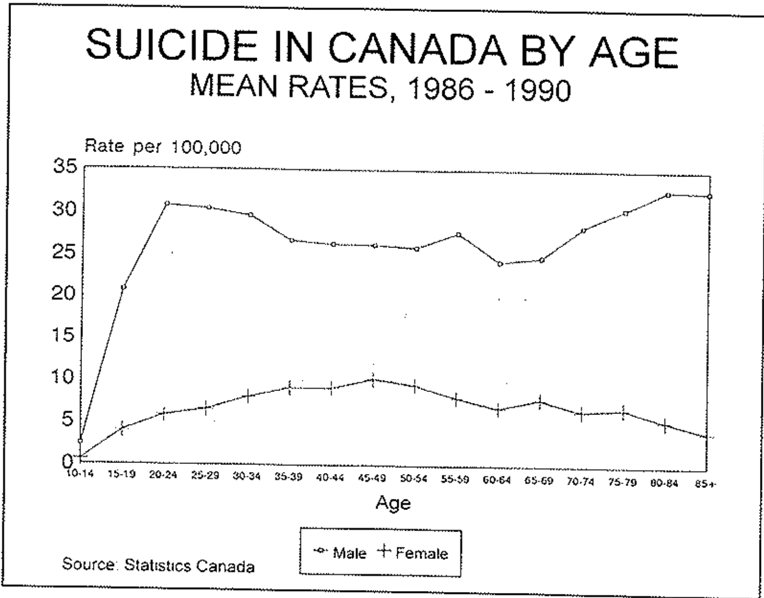
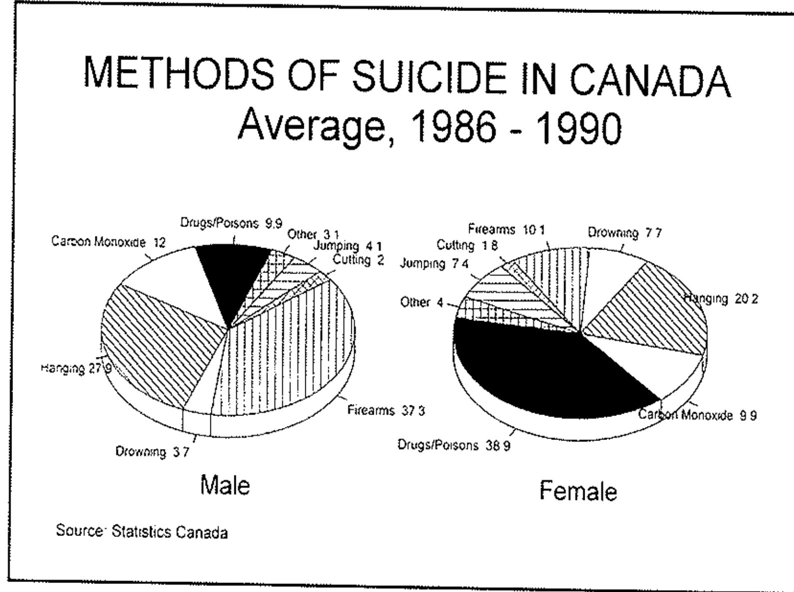


Figure 3



Rates for males are consistently higher than females in North America, although women attempt suicide more frequently than men. Figure 3 shows mean suicide rates by age. Although there is much emphasis on teenage suicide, the highest male rates are those in their 20's and people over age 65. Female rates peak around age 45 in Canada. Figure 4 shows methods of suicide in Canada in 1986-1990.

Figure 4



Several studies on suicidal ideation have found that at least 7% of Canadians had considered suicide at some point in their lives and 10% to 15% report having thought about killing themselves during the previous year.

GENERAL FACTS ABOUT SUICIDE

Suicide in Canada

In total, more than 3,500 Canadians kill themselves each year. Canada's national suicide rate is 14 per 100,000 people.

Suicide was first recognized as a major public health problem in 1974 when suicide ranked as the fifth leading cause of early death. Today, suicide consistently ranks within the top ten causes of death in Canada, and the second leading cause of death for 15- to 24-year-olds. It is estimated that for every completed suicide, there are up to 100 attempts or more.

When does suicide occur?

- suicide rates are higher in the spring and fall;
- suicide can occur in clusters within a local area. An imitative or 'copycat' effect is possible for persons who have been having suicidal thoughts, are experiencing similar stresses and are the same age, sex and race;
- people planning to commit suicide often communicate their plans to others.

Who commits suicide?

- people with a previous episode of suicidal behaviour have a 35 to 50 times greater risk of completing suicide than the overall population;
- mental disorders are a factor in more than half of the suicides in North America. These people typically suffer from some form of depression;
- substance abusers have a 7 times greater risk of completing suicide:
- persons bereaved by suicide, especially family members, are 8 times more likely to complete suicide themselves;
- males complete suicide more than 3 times as often as females;
- Native Canadians and, in particular, young Native males are generally considered to be at high risk. However, some traditional native communities have had no suicides in the past 50 years;
- people in custody in jails or prisons have a suicide rate 3 times higher than the general population.

Why do people commit suicide?

Nobody knows why some people commit suicide and others don't. Possible explanations vary and include a variety of social, psychological or even biological factors.

Research does, however, suggest that certain social and physical/medical factors are linked with higher suicide rates, including:

- marital status: more divorced people than married people commit suicide;
- job pressures: a significant number of males experienced considerable career difficulties immediately prior to their suicide;
- employment status: people who are unemployed are more likely to commit suicide than those who are employed. For every 1 per cent increase in the jobless rate, there was a 4 to 5 per cent increase in suicides;
- social factors: stressful conditions, social mobility and social isolation are linked to suicide, including undesirable social conditions, crowded living arrangements, low-quality housing, involvement in crime, drug and alcohol abuse, solitary living and transient habits;
- physical illness: a strong link exists between physical illness and suicide;
- mental disorders: people who commit suicide are more likely to have had a major mental disorder than people who die a natural death;
- stress: suicide attempters have been found to experience stressful events at four times the rate of the rest of the population.

INUIT AND FIRST NATIONS COMMUNITIES

Canadian First Nations and Inuit communities report rates that range from zero to 15 times that of the general population. The average suicide rate within First Nations and Inuit communities is from three to five times the Canadian population rates.

Mental health practitioners and researchers working within First Nations and Inuit communities appear to agree that acculturation is a major factor that has contributed to the higher rates of suicide within many of these communities. Studies show that native people whose beliefs and values promoted an interdependent and cohesive community, and who had limited contact with the dominant culture, demonstrated the lowest rates of suicide. When contact occured, those communities that managed to maintain a strong interdependent and cohesive community maintained low suicide rates. Many of these groups were identified as having kept traditional beliefs and cultural practices intact.

Another major factor that has contributed to the high rates of suicide is the absence of sustainable economies to replace the traditional ones, which have been largely destroyed through contact with the dominant culture. Most First Nations and Inuit communities are primarily dependent upon non-native society to provide for most of the communities' basic needs (e.g. food, shelter, health care). Consequently, there are few opportunities within these communities for meaningful employment and activities that can provide "a purpose for life." Poverty and life-long dependence upon welfare are often the norm. Many native youth perceive their future as hopeless and fall into patterns of self-destructive behaviour, which often leads to suicide.

TERMS AND DEFINITIONS

When you are talking to suicide prevention professionals, here are some of the terms they use and what is meant by them:

- **SUICIDE:** intentional, self-inflicted death; often referred to as completed suicide.
- **SUICIDAL BEHAVIOURS:** A broader term that describes many types of non-accidental self-harm activities including suicide. Suicidal behaviours include:
  - **SUICIDE ATTEMPTS:** Where there is a clear death intent.
  - **PARASUICIDES:** Where there is an attempt with little or no intent to die.
  - **SUICIDE PLANS:** Where there is a specific plan developed but not implemented.
  - **SUICIDE IDEATION:** Where there is a pattern of thoughts about suicide.

The Canadian Association for Suicide Prevention supports the use of conventional international terminology where suicide is limited to intentional self-inflicted death. When another person causes death, such activities may fall into the broad category of "euthanasia." Care should be taken to distinguish between suicides and euthanasia:

- **ACTIVE EUTHANASIA (sometimes referred to simply as EUTHANASIA):** When a person initiates activities which result in another person's death at the expressed wish of a person who is terminally ill. The intent in euthanasia is to alleviate uncontrollable anguish or suffering.
- **MERCY KILLING:** When an individual initiates activities which result in the death of persons who are terminally ill, but incapable of requesting or giving consent to this act, usually because they are not conscious (for example, a permanent coma).
- **PHYSICIAN ASSISTED SUICIDE:** When a physician provides a person with the means for suicide or information about how to commit suicide, for example, by prescribing a lethal dose of a poison or providing such.

Persons who are severely handicapped and are unable to commit suicide and subsequently die as the result of actions by a physician are cases of active euthanasia.

SUGGESTIONS FOR REPORTING ON SUICIDE

As suicide prevention professionals, we suggest that media coverage of suicidal behaviour project an objective yet preventive message, as well as educate and inform the public about the subject. Many local media organizations agree that suicide should only be reported if:

- it occurred in a public place;
- the victim was prominent;
- it was a symbolic protest of some perceived wrong.

It is best to avoid reporting the specific details about the method of death, or give simplistic cause-effect reasons for suicide, such as "Teen kills himself to avoid jail sentence", or "Boy kills himself because of braces" or cultural stereotypes (e.g. "Chinese man kills self"). Although we feel that downplaying the suicide story would be desirable, we realize that this is not always possible because of the news value of some suicide stories.

Instead, suicide prevention experts recommend that the media balance the possible negative effect a suicide story may have by publishing or broadcasting helpful information the reader/viewer/listener may use if they feel at risk or if they know of someone at risk.

We also recommend that the media use terminology that projects a positive and preventive message about suicide whenever possible. As the following examples illustrate, choice of wording can have a positive or negative effect on your audience.

AVOID PHRASES LIKE ...	USE PHRASES LIKE ...
"a successful suicide attempt"	"a suicide"
"an unsuccessful attempt"	"a suicide attempt"
"suicide victim"	"a suicide completer" or "a completed suicide"
"suicide-prone person"	"person at risk (of suicide)"
"stop the spread/ epidemic of suicide"	"help prevent suicide"

"Suicide survivor" is the term commonly used by bereaved families/associations to denote a friend or family member of a person who died of suicide. It does not refer to a suicide attempter who did not die as a result of his/her attempt.

SUGGESTED MATERIAL FOR REPRINT/BROADCAST

Suicide prevention experts believe it is important to provide helpful suggestions and information on suicide prevention whenever the media depicts or makes reference to suicide.

On the following pages, we have included information on the warning signs of suicide, how to help, who to call, and myths/facts about suicide. Whenever possible, we recommend that some of this information be printed or broadcast as part of, or simultaneously with, a suicide story to offset the possible negative effects of the suicide, most notably the imitation effect.

In the case of electronic media, we feel that even a brief mention of a distress line phone number may have a beneficial effect.

WARNING SIGNS OF SUICIDE

Most people who commit suicide have given warning signs beforehand. But unless you know what to look for, these signs can be easily missed.

If someone you know does any of the following, they may be exhibiting suicidal behaviour:

- threatens suicide
- talks about wanting to die
- shows sudden changes in behaviour, appearance, mood
- appears depressed and sad
- has previously attempted suicide
- uses drugs or alcohol excessively

HOW TO HELP

If someone you know exhibits any signs of suicidal behaviour, you can help them by doing the following:

- Listen openly and calmly. Don't expect to solve the problems, just listen. Don't be afraid to talk about suicide or the problems that have caused the suicidal behaviour. Problems don't get worse by talking about them.
- Show you care. If they confide in you that they have been thinking about suicide, tell them and show them how much you care.
- Don't agree to keep their suicidal thoughts a secret. Get a professional to do a suicide risk assessment and don't leave the person alone.
- Get professional help. Tell them you know their life is difficult right now, but there are people who can help. Help them to find professional help and support them in doing so.
- Don't ignore threats. Don't try to change the subject or ignore threats because you're scared. This may look like you don't care.
- Don't offer simple advice. To a person thinking about suicide, the problems look major and unsolvable right now.
- Don't tell them they're selfish to consider suicide when their life is so good. You will make them feel guilty as well as depressed.
- Don't say "suicide is the easy way out". There is nothing easy about suicide.

WHO TO CALL

If someone you know exhibits any signs of suicidal behaviour, suggest that they call a 24-hour crisis line, help line, or hospital emergency department.

The Canadian Association for Suicide Prevention publishes a national directory of suicide prevention and crisis intervention services in which you may find telephone numbers of local centers.

MYTHS AND FACTS ABOUT SUICIDE

Here are some of the common myths that we encounter in our work in suicide prevention along with our understanding of the facts and assumptions behind these misconceptions.

Myth 1

"Only a certain type of troubled person tries suicide".

False. All types of people have committed suicide. We've all heard stories about people with "everything going for them" who committed suicide. However, by and large, people who have had previous attempts, mental illness or major life problems are at a higher risk.

Myth 2

"People who say they are going to kill themselves are faking to get attention — therefore ignore them".

False. Do not ignore threats. Every depressed person ***requires attention*** and their threats are their attempt to get what they need. When you feel that depressed, you're entitled to get help.

Myth 3

"When people think about suicide, they are fully intent on dying — why stop them? It's their decision."

False. People usually have mixed feelings about dying, and few commit suicide without letting others know how they are feeling. They give clues which are really cries for help.

Myth 4

"Once the depression lifts, the risk of suicide is over".

False. Sometimes people actually seem unusually cheerful before their suicide, as if they feel relieved that they have finally made a decision. To us, it looks like the depression is over, but the danger is still there.

Myth 5

"By mentioning suicide to a depressed person, you risk putting that idea into their head".

False. Many people contemplate suicide at one time or another. The suicidal person usually feels very alone with their problems. Your willingness to talk openly will come as a great relief.

Myth 6

"Suicide happens without warning".

False. At least 80% of people who die from suicide have given clues.

FURTHER READING

The following resource materials may be useful should you wish to learn more.

Andrushko, B. *Helping Each Other After Suicide.* Ontario Funeral Service Association: Toronto, Ontario, 1989.

Armstrong. S. Reason to Live: A Special Report on Youth Suicide. *Canadian Living,* 12 (3) (1987), p. 39-51.

Boldt. M. Towards the Development of A Systematic Approach to Suicide Prevention: The Alberta Model. *Canada's Mental Health,* 33 (2) (1985), p. 2-4

Canadian Association for Suicide Prevention Directory of Suicide Prevention and Crisis Centers in Canada, 1994 (updated regularly).

Littman. S.K. Suicide Epidemics and Newspaper Policies and Suicide Stories. *Canada's Mental Health,* 30 (4) (1985) , p. 8-9

National Task Force on Suicide in Canada. *Suicide in Canada.* Ottawa. Ontario, Health & Welfare Canada, 1987 (updated version 1994).

Pell. Bryan and Watters, Derek. Newspaper Policies and Suicide Stories. *Canada's Mental Health,* 30 (4) (1982), p. 8-9

Moore. S.L. and Tanney. B.L. (Eds) Suicide in Older Adults: Selected Readings. Suicide Information and Education Centre. Calgary. Alberta. 1991.

MEDIA CONTACTS

Resource material is also available from:

Canadian Association for Suicide Prevention
201-1615 10th Avenue SW
Calgary, Alberta
T3C 0J7

The Suicide Prevention and Education Centre (SIEC)
c/o Library Coordinator
201-1615 10th Avenue SW
Calgary, Alberta
T3C 0J7
(403) 245-3900

SIEC is a computer-assisted resource library housing over 30,000 print and audiovisual materials on suicide. It is the largest data base in North America.

N.B. If you have comments/suggestions or you would like additional copies of this resource book or a copy of our directory of suicide prevention and crisis intervention centres in Canada, please contact the Canadian Association for Suicide Prevention.

MEMBERSHIP APPLICATION FOR CASP

CANADIAN ASSOCIATION FOR SUICIDE PREVENTION

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