Youth Suicide Prevention Ireland

YOUTH SUICIDE AWARENESS & PREVENTION

Reporting Guidance and Information for Media Professionals

YOUTH SUICIDE PREVENTION IRELAND PUBLICATIONS LIMITED

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Youth Suicide Prevention Ireland

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Overview

Suicide is a serious global public health problem that demands our attention but preventing suicide is no easy task. Current research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from provision of the best possible conditions for bringing up our children and young people, through accurate and timely assessment of mental disorders and their effective treatment, to the environmental control of risk factors.

Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention. Cultural, age- and gender-related variations need to be taken into account in all these activities. In 1999 the World Health Organization (WHO) launched its worldwide initiative for the prevention of suicide.

Portions of this booklet **are taken from** the second revised version of one of the resources prepared which are addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. The revised booklet is the product of continuing collaboration between WHO and the International Association for Suicide Prevention (IASP). It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

Responsible reporting on suicide: a quick reference guide

DO

- **Do provide accurate information about where to seek help**
- **Do educate the public about the facts of suicide and suicide prevention, without spreading myths**
- **Do report stories of how to cope with life stressors or suicidal thoughts, and how to get help**
- **Do apply particular caution when reporting celebrity suicides**
- **Do apply caution when interviewing bereaved family or friends**
- **Do recognize that media professionals themselves may be affected by stories about suicide**

DON'T

- **Don't place stories about suicide prominently and don't unduly repeat such stories**
- **Don't use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems**
- **Don't explicitly describe the method used**
- **Don't provide details about the site/location**
- **Don't use sensational headlines**
- **Don't use photographs, video footage or social media links**

Introduction

Suicide is a major public health problem, with far-reaching social, emotional and economic consequences. There are approximately 800 000 suicides a year worldwide, and it is estimated that at least six people are directly affected by each suicide death.

The factors contributing to suicide and its prevention are complex and not fully understood, but there is increasing evidence that the media can play a significant role in either enhancing or weakening suicide prevention efforts. Media reports about suicide may minimize the risk of imitative (copycat) suicide or increase the risk. The media may provide useful educational information about suicide or may spread misinformation about it.

Source: World Health Organisation 2017

On the one hand, vulnerable individuals are at risk of engaging in imitative behaviours following media reports of suicide, particularly if the coverage is extensive, prominent, sensational, explicitly describes the method of suicide, and condones or repeats widely-held myths about suicide. The risk is particularly pronounced when the person who died by suicide had a high social status and/or can easily be identified with. Reports about suicide that trigger subsequent suicides are often repeated over a longer period. The effect of media reports on increasing suicides is referred to as the "Werther effect", named after the title character in Goethe's novel *The sorrows of young Werther*, who dies by suicide when faced with the loss of his love.

On the other hand, responsible reporting about suicide may help to educate the public about suicide and its prevention, may encourage those at risk of suicide to take alternative actions and may inspire a more open and hopeful dialogue in general. Stories demonstrating help-seeking (positive coping) in adverse circumstances may strengthen protective factors or barriers to suicide and thus contribute to its prevention. Media reports about suicide should always include information about where to seek help, preferably from recognized suicide prevention services that are available on a 24/7 basis. Protective effects of responsible media reporting about suicide have been referred to in the scientific literature as the "Papageno effect", named after the character Papageno in Mozart's opera *The magic flute*, who becomes suicidal when he fears he has lost his love, but is reminded of alternatives to suicide at the last moment and subsequently chooses an alternative route of action.

Media recommendations need to be tailored to traditional media as well as digital media and should aim to reach as many people as possible about suicide prevention. A specific characteristic of digital media is that information can be spread very quickly and, thus, is more difficult to monitor and control. Despite the differences between digital media and more traditional media, findings from research on the effects of traditional media on suicidal behaviour can help inform suicide prevention initiatives in digital media. Conversely, lessons learned about the potential role of digital media in the increase or prevention of suicidal behaviour can help inform suicide prevention initiatives in traditional media.

This resource booklet briefly summarizes the current evidence on the impact of media reporting of suicide, and provides information for media professionals about how to report 01 on suicide, recognizing that there are times when a suicide will need to be reported on the grounds of its newsworthiness. The booklet makes

suggestions about how best to ensure that such reporting is accurate, responsible and appropriate. It is applicable to both traditional and digital media reporting.

This resource booklet acknowledges that the reporting of suicide and its portrayal in various media types differ within and across countries. There are cultural differences in terms of what is appropriate to report and how information about a given suicide is accessed. While this booklet is designed to provide guiding principles about media reporting that apply across cultures, media professionals are encouraged to work with their local suicide prevention community and to draw on local media reporting guidelines, if available. Suicide prevention experts in the area of media reporting are active around the globe, as evidenced by the number of international experts who have contributed to this booklet. They are ready, available and willing to work with media professionals to ensure that reporting of suicide is responsible and encourages accurate messaging and avoids posing a risk to vulnerable persons. In some countries, guidelines for the reporting of suicide have been incorporated into codes of conduct for the press.

The booklet is designed for media professionals working in print, broadcast and online media. Most of the recommendations are relevant to reporting across all media, but some relate specifically to print media or digital media. It is beyond the scope of this resource to address issues which are specific to websites, films, television soap operas or stage plays. For related information, see resources of the Entertainment Industry Council (http://www.eiconline.org/). Reporting on mass shootings and terrorism is addressed in Annex

Scientific evidence of media impacts on suicidal behaviour

Reporting as a risk factor of suicidal behaviour

Source: World Health Organisation 2017

Over 100 investigations have been conducted into imitative (copycat) suicides (i.e. suicides that appear to be directly related to media reports about one or more suicides). Systematic reviews of these studies have consistently drawn the same conclusion: media reporting of suicide cases can lead to subsequent, additional, suicidal behaviours. These reviews also conclude that copycat suicidal behaviour is more likely under some circumstances than others. In particular, repeated coverage and high-impact/high-profile stories are most strongly associated with copycat behaviour. The effect of a report about a suicide on subsequent suicides is greater when the person described in the story is a celebrity and is held in high regard by the reader or viewer. Particular subgroups in the population (such as young people, people suffering from mental illness, persons with a history of suicidal behaviour or those bereaved by suicide) are particularly vulnerable to engaging in imitative suicidal behaviour.

The risk is most pronounced when the characteristics of the person who died by suicide and those of the reader or viewer are similar in some way and when the reader or viewer identifies with the featured person. Additionally, the content of stories also plays an important role: stories that confirm or repeat myths about suicide or that include a detailed description of a particular method of suicide are more likely to result in copycat suicides. However, media reports about suicides written in accordance with media guidelines show strong potential to help prevent suicide and do not usually trigger further suicides.

Positive impacts of reporting

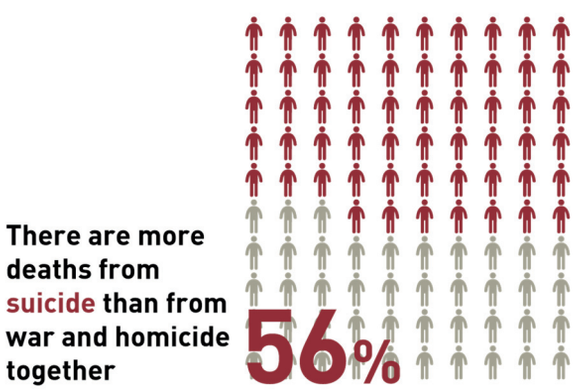
Whereas there is a relatively long history of research on the harmful effects of media reports about suicide, in the last few years more and more research has focused on the potential benefits of responsible media reporting about suicide. Media reports on persons who were in adverse life circumstances but who managed to cope constructively with their suicidal thoughts have been associated with decreases in suicidal behaviour.

Further studies suggest that educative media portrayals featuring how to cope with suicidal thoughts may help reduce suicidal behaviour. A more detailed overview of the scientific literature on media impacts is provided in Annex 3.

Guidance on responsible reporting

Provide accurate information about where to seek help

Information about support resources should be provided at the end of all stories about suicide. The specific resources should include suicide prevention centres, crisis helplines, other health and welfare professionals, and self-help groups. Information about where to seek help should include services that are recognized in the community as being of high quality and accessible 24/7, if available. These resources should provide access to support for persons who are distressed or prompted to consider suicide as a result of the story. The address or contact information of listed resources should be checked regularly to ensure that it is accurate. However, providing a long list of potential resources can be counter-productive; therefore, only a limited number of resources (e.g. one phone number and one website) should be provided.



Source: World Health Organisation 2017

Educate the public about the facts of suicide and suicide prevention, without spreading myths

There are many misconceptions about suicide. Research has shown that media reports that repeat these myths are more likely to trigger imitative behaviour. Studies have also shown that the public tends to recall the myths in "myths versus facts" stories in the media. Some of the most common myths and facts about suicide are listed in Annex 4. Consequently, it is preferable to lead with facts about suicide. Apart from carefully researching facts when discussing suicide, it is always helpful to report on how to prevent suicide, to include the message that people who are suicidal should seek help, and to indicate how to access that help.

Report stories of how to cope with life stressors or suicidal thoughts, and how to get help

Providing personal narratives of people who managed to cope with adverse circumstances and suicidality may help others in difficult life situations to adopt similar positive coping strategies. Stories that integrate educative materials explaining how to get help when faced with seemingly insurmountable difficulties are

also encouraged. These stories typically feature specific ways adopted by others to overcome their suicidal thoughts, and highlight what can be done to get help if one is suicidal.

Apply particular caution when reporting celebrity suicides

Celebrity suicides are considered newsworthy and it is often considered to be in the public interest to report them. However, such reports are particularly likely to induce copycat suicides in vulnerable persons. Glorifying a celebrity's death may inadvertently suggest that society honours suicidal behaviour and thus may promote suicidal behaviour in others. For this reason, special care should be taken when reporting celebrity suicides. Such reports should not glamourize the suicide or describe the suicide method in detail. A focus on the celebrity's life, how he or she contributed to society, and how their death negatively affects others is preferable to reporting details of the suicidal act or providing simplistic reasons for why the suicide occurred. Additionally, care should be taken when reporting a celebrity's death when the cause of death is not immediately known. Media speculation about suicide as a possible cause of a celebrity's death can be harmful. It is more appropriate to wait for the cause of death to become known and to research the specific circumstances carefully. As noted above, reports should always include information about access to support resources for those who are, or might become, distressed or suicidal due to the death.

Apply caution when interviewing bereaved family or friends

The views of persons who have experienced a loss from suicide can be a very valuable resource for educating others about the realities of suicide. However, several key considerations should be taken into account when collecting such information and including it in a media report about suicide. There needs to be caution when involving family, friends and others who are grieving over an acute loss and who might be in a crisis situation. A decision to interview someone who has been bereaved by suicide should never be taken lightly. Such persons are at increased risk of suicide or self-harm while they are dealing with their grief. Respect for their privacy should take precedence over writing a dramatic story. In some countries, journalists are guided by a code of conduct when undertaking such interviews.

It is important for media professionals to recognize that, as part of their investigations, they may gain knowledge about a suicide or the deceased that witnesses and/or the bereaved do not have. The publication of such material could be harmful to those who are bereaved by the suicide. Reporters also need to carefully consider the accuracy of any information received from the bereaved during an interview because their recall of specific memories, statements or behaviours of the suicide may be clouded by acute grief.

In instances where reporting is not related to a recent loss, people who have managed to cope with loss due to suicide and want to contribute to a media story can be an important resource for increasing awareness and providing viable options for others on how to cope with similar circumstances. However, even if the actual loss occurred a long time ago, it is important to remember that talking about past experiences with suicide may trigger painful memories and emotions. Persons bereaved by suicide who volunteer to speak with the media may be unaware of the potential personal consequences of widespread public dissemination of detailed private information; therefore, this should be discussed with the individual beforehand, and steps should be taken to protect their privacy. Whenever possible, the bereaved should be shown reports containing their personal accounts prior to publication in order to allow corrections or other changes before publication.

Recognize that media professionals themselves may be affected by stories about suicide

Preparing a story about a suicide may resonate with media professionals' own experiences. The effect can occur in all settings, but may be particularly pronounced in small, close-knit communities where media professionals have strong local connections. There is an obligation on media organizations to ensure that necessary supports – such as debriefing opportunities and mentoring arrangements – are in place for media professionals. Individual media professionals should not hesitate to seek help if they are negatively affected in any way.

Do not place stories about suicide prominently and do not unduly repeat such stories

Prominent placement and undue repetition of stories about suicide are more likely to lead to subsequent incidents of suicidal behaviour than more subtle presentations. Newspaper stories about suicide should ideally be located on the inside pages, towards the bottom of the page, rather than on the front page or at the top of an inside page. Similarly, broadcast stories about suicide should be presented in the second or third break of television news, and further down the order of radio reports or online posts, rather than as the lead item. Caution should be exercised regarding the repetition or updating of the original story.

Do not use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems

Language that sensationalizes suicide should be avoided. For example, it is much better to report on "increasing suicide rates" than on a "suicide epidemic". When reporting on a suicide, the use of language that conveys the message that suicide is a public health problem and identifies risk factors, combined with a message about the prevention of suicide, can help to educate the public about the importance of suicide prevention.

Language that misinforms the public about suicide, normalizes it or provides simplistic explanations for a suicide should also be avoided. Apparent changes in suicide statistics should be verified, as they may signal temporary fluctuations rather than statistically reliable increases or decreases. Out-of-context use of the word "suicide" – such as, for instance, "political suicide" – may serve to desensitize the public to its gravity. Terms like "unsuccessful suicide" or "successful suicide", implying that death is a desirable outcome, should not be used; alternative phrases such as "non-fatal suicidal behaviour" are more accurate and less open to misinterpretation. The phrase "committed suicide" implies criminality (suicide remains a criminal offence in some countries) and unnecessarily increases the stigma experienced by those who have lost a person to suicide. It is better to say "died by suicide" or "took his/her life".

Do not explicitly describe the method used

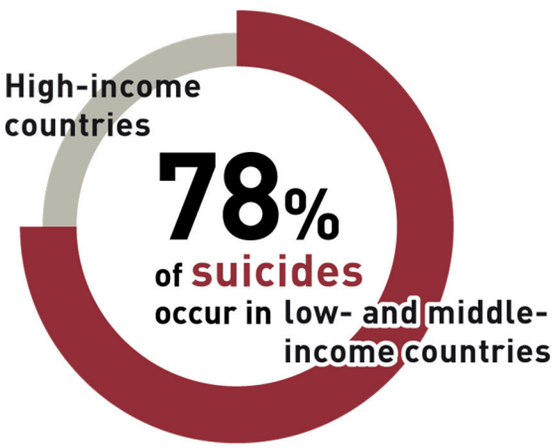
Detailed description and/or discussion of the method should be avoided because this will increase the likelihood that a vulnerable person will copy the act. In reporting an overdose, for example it could be harmful to detail the brand/name, nature, quantity or combination of drugs taken, or how they were obtained.

Caution should also be exercised when the method of suicide is rare or novel. While use of an unusual method may appear to make the death more newsworthy, reporting the method may trigger other people

to use this method. New methods can spread easily via sensationalist media reporting – an effect that can be accelerated via social media.

Do not provide details about the site/location

Sometimes a location can develop a reputation as a "suicide site" – e.g. a bridge, a tall building, a cliff or a railway station or crossing where suicidal acts have occurred. Particular care should be taken by media professionals not to promote such locations as suicide sites by, for instance, using sensation alist language to describe them or overplaying the number of incidents occurring at that location. Similar caution is necessary when reporting about suicides or suicide attempts in educational settings or specific institutions, particularly those for vulnerable individuals (e.g. prisons and psychiatric units/hospitals).



Do not use sensational headlines

Headlines serve the purpose of attracting the reader's attention by giving the essence of the story in as few words as possible. The word "suicide" should not be used in the headline, and explicit reference to the method or site of the suicide should be avoided. If headlines are written by other media professionals than those working on the main text, the author of the main text should work with the headline writer to ensure that an appropriate headline is selected.

Do not use photographs, video footage or digital media links

Photographs, video footage or social media links of the scene of a suicide should not be used, particularly if reference is made to specific details of the location or method. In addition, great caution is required in the use of pictures of a person who has died by suicide. If images are used, explicit permission should be obtained from family members. These images should not be prominently placed and should not glamorize the individual or the suicidal act. Research shows that pictures associated with suicidal acts can be reactivated by vulnerable readers later, such as during a personal crisis, and may then trigger suicidal behaviour. Coordination of editorial work on text and pictures is recommended, as individuals responsible for the text are sometimes not responsible for the use of images. Suicide notes, final text messages, social media posts and emails from the deceased individual should not be published.

Sources of reliable information

Sources of reliable statistics and other information about suicide should be used by media professionals when reporting about suicide. Government statistics agencies in many countries provide data on their annual suicide rates, usually by age and sex. WHO Member States report mortality data, including suicide, to WHO (http://www.who.int/healthinfo/mortality_data/en/). Data and statistics should be interpreted carefully and correctly as some caution should be exercised in making international comparisons of rates,

because countries have different legal regulations and procedures which may influence the way in which deaths are identified, certified and recorded as suicides.

Media professionals should seek advice from local suicide prevention experts when preparing stories about suicide. These experts can help interpret data about suicide, ensure that reports about suicide avoid increasing the risk of copycat suicide, dispel myths about suicidal behaviour, and provide useful information about recognizing and helping persons who are thinking about taking their own lives. National or regional suicide prevention organizations often have specific contact details for the media. Many countries have associations that provide information about suicide. Some of these associations also have a role in suicide prevention, offer support to people who are experiencing suicidal thoughts or have been bereaved by suicide, provide advocacy services, and/or foster research about suicide. In Ireland the co-ordinating body for suicide prevention is the HSE National Office for Suicide Prevention (NOSP).

The International Association for Suicide Prevention (IASP) is the international equivalent of these associations. The IASP website (https://www.iasp.info) includes useful background information for media professionals preparing stories on suicide, including lists of suicide prevention services and media guidelines for reporting on suicide from several countries. Leading experts, suicide prevention services and public health organizations have also developed best practice recommendations for reporting on suicide in multiple languages (http://www.reportingonsuicide.org)

Considerations for digital media

Nowadays people obtain their information from a much broader range of sources than they did in the past, and there is increasing overlap between traditional media and online media. The Internet has become an important platform for information and communication about suicide, especially among young people and persons at high risk of suicide. This booklet can be used for media reporting in both traditional and digital media. However, there are additional challenges with regard to reporting on suicide in digital media and managing potential suicidal content online. Specific guidelines have been created in recent years to address these challenges. It is important to avoid the hyperlinking of suicidal material in social media.

Video or audio footage (e.g. emergency calls) or social media links to the scene of a suicide should not be used, particularly if the location or method is clearly presented. In addition, great caution is necessary when using pictures of a person who has died by suicide. Search engine optimization efforts need to be carefully balanced against the use of harmful wording, particularly when it comes to writing the headline. As is true for traditional media, data visualizations should be carefully checked to prevent the exaggeration or sensationalisation of statistics about suicide. Adequate policies should be established by the managers of media platforms for dealing with potentially suicidal content in the comments sections of digital media, such as online newspapers or print newspapers' websites, and for timely responses to content relating to suicide.

A set of best practices for online technologies (http://www.preventtheattempt.com) has been developed to serve small, medium-sized and large organizations and companies with online representations. Basic, mid-level and advanced-level recommendations are offered about how to integrate online resources with interactive components for suicide prevention. Basic recommendations include: the provision of a help centre with information on supportive resources and Frequently asked questions (FAQ) on suicide, policies on how to respond to potentially suicidal users, regulations on the involvement of law enforcement,

timeliness of responses to suicidal content, and information on where to refer potentially suicidal individuals.

Another set of recommendations has been developed for bloggers (https://www.bloggingonsuicide.org) by Suicide Awareness Voices of Education (SAVE). These recommendations are based on the content of guidelines for traditional media, highlighting safety concerns that are frequently encountered in blogs and how to deal with them.

Reporting on mass shootings and terrorism

Research on the imitative effects of media reports about mass shootings and terrorism is not as extensive as research on the copycat effects of media reports about suicides. However, there is some evidence that sensationalist reporting about killings can trigger further homicidal actions. These incidents typically receive considerable media attention, and may or may not include self-directed violence after, or as part of, the murder(s). If such an event includes suicide, it should not be described as a suicide attack or suicide bombing because this magnifies the negative labelling of suicidal behaviour.

Referring to such events as “homicidal bombings” or “mass killings” would be more appropriate because the main purpose of these acts is to kill others; only some of the perpetrators may actually be suicidal. In reporting these killings, it is important to remember that the perpetrator may not be suicidal and may not have a mental illness; most mass shootings are not committed by persons with a diagnosed mental disorder. An international expert team lead by Suicide Awareness Voices of Education (SAVE) has developed recommendations (https://www.reportingonmassshootings.org) for reporting such events – including reducing the media attention on the perpetrators, because such emphasis can potentially lead others to identify with them and be inspired by them to commit similar acts.

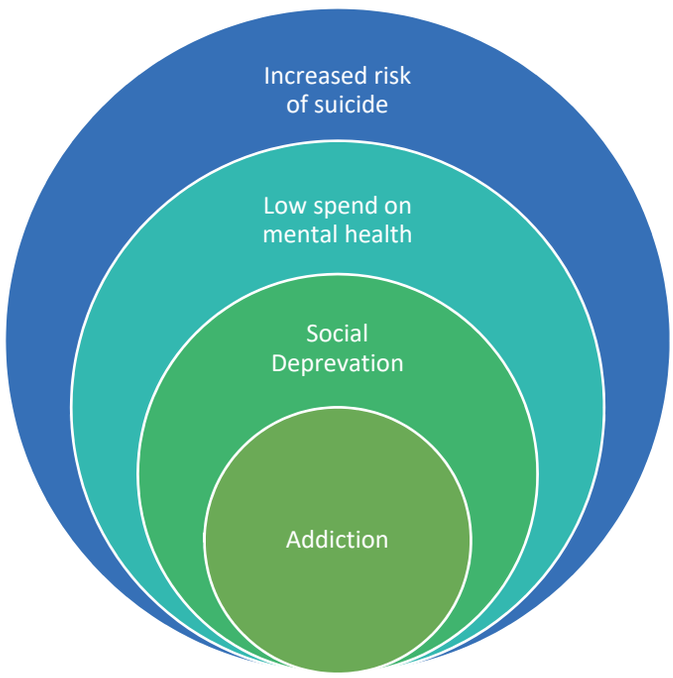
Overview of the scientific literature on media impacts

Harmful media impacts

The earliest evidence of the impact of the media on suicidal behaviour was provided in the late 18th century when Goethe published **‘***The sorrows of young Werther***’**, in which Werther shoots himself because he falls in love with a woman who is beyond his reach. The novel was implicated in a spate of suicides across Europe. Many of those who died by suicide were dressed in a similar fashion to Werther and adopted his method or were found with a copy of Goethe’s book. Consequently the book was banned in several European countries.

The evidence for imitative suicidal behaviours occurring in response to the reporting or portrayal of suicide remained anecdotal until the 1970s when Phillips *(1)* published a study which retrospectively compared the number of suicides that occurred in the months in which a front-page article on suicide appeared in the United States press with the number that occurred in the months in which no such article appeared. During the 20-year study period, there were 33 months during which a front-page suicide article was published, and there was a significant increase in the number of suicides in 26 of those 33 months. Imitation effects were also found by Schmidtke & Häfner *(2)* after the broadcast of a television series.

Since Phillips' study, over 100 other investigations into imitative suicides have been conducted. Collectively, these studies have strengthened the body of evidence in a number of ways. First, they have used improved methodologies. For example, Wasserman *(3)* and Stack *(4)* replicated the findings from Phillips' original study and extended the observation period, using more complex time-series regression techniques, and considered rates rather than absolute numbers of suicide. Second, these studies have examined different media. For instance, Bollen & Phillips *(5)* and Stack *(6)* examined the impact of suicide stories that were given national coverage on television news in the USA and found significant increases in suicide rates following such broadcasts.



Furthermore, although most of the early studies were conducted in the USA and considered suicide only, later studies broadened the scope to Asian and European countries and included a focus on suicide attempts. For example, studies by Cheng et al. *(7, 8)*, Yip et al. *(9)* and Chen et al. *(10)* demonstrated increases in suicides and suicide attempts following the news coverage of celebrity suicides in China (Province of Taiwan and Hong Kong SAR), and the Republic of Korea, respectively. A study by Etzersdorfer, Voracek & Sonneck *(11)* reported similar results following coverage of a celebrity suicide in the largest Austrian newspaper, with increases in suicides being more pronounced in regions where distribution of the newspaper was greatest. More recent studies also assessed the characteristics of the content of media reports before assessing media effects.

This is reflected in studies by Pirkis and colleagues that differentiated various types of media reports on the basis of differences in content *(12)*. They found that repetitive stories reporting suicide methods and reinforcing public misconceptions about suicide were associated with subsequent increases in suicides. Notably, Gould and colleagues found that youth copycat suicides were more likely to be triggered by newspaper stories that were more prominent (i.e. front-page placement or inclusion of a picture), more explicit (i.e. with headlines containing the word "suicide" or specifying the method used), more detailed

(i.e. including the deceased's name, the details of the method, or the presence of a suicide note), and reporting on suicide death rather than suicide attempt *(13)*.

Systematic reviews of studies in the area of media and suicide have consistently reached the same conclusion: media reporting of suicide can lead to subsequent increases in suicidal behaviours *(14-17)*. These reviews have also observed that the likelihood of an increase in suicidal behaviours varies as a function of the time after the news report, usually peaking within the first three days and levelling off by about two weeks *(5, 18)*, but sometimes lasting longer *(19)*. The increase is related to the amount and prominence of coverage, with repeated coverage and high-impact stories being most strongly associated with imitative behaviours *(10, 11, 20-22)*.

Such behaviours are accentuated when the person described in the story and the reader or viewer are similar in some way *(22, 23)*, or when the person described in the story is a celebrity and is held in high regard by the reader or viewer *(3, 4, 7, 9, 22, 24)*. Sensationalist or glamourized reporting on suicides of entertainment industry celebrities appears to be associated with the greatest increases in subsequent suicides *(25)*. Combined evidence across studies has shown that the average increase in suicide rates in the month subsequent to sensationalist news media reporting on a celebrity suicide is 0.26 per 100 000 population, but the estimated effect is even more pronounced for reports on the suicides of entertainers (0.64 per 100 000 population) *(25)*. Media effects also depend on the characteristics of the audience. Some subgroups in the population (young people, people suffering from depression, and persons who identify with the deceased) seem especially vulnerable and are therefore more likely to show increased rates of suicidal thoughts or imitative suicidal behaviours *(18, 26-29)*. Overt description of suicide by a particular method often leads to increases in suicidal behaviour employing that method *(10, 30-33)*.

Protective media impacts

There is also some evidence regarding the potential for the media to exert a positive influence. This evidence comes from studies which considered whether best-practice media reporting of suicide could lead to a reduction in the rates of suicide and suicide attempts. Etzersdorfer and colleagues showed that the introduction of media guidelines on the reporting of suicides on the Vienna subway resulted in a reduction in sensational reporting of these suicides and, in turn, a 75% decrease in the rate of subway suicides and a 20% decrease in the overall suicide rate in Vienna *(34-36)*.

The repeated distribution of these guidelines resulted in an improvement in the quality of reporting about suicide and a reduction in the Austria's national suicide rate, with the positive impact most pronounced in regions with strong media collaboration *(37)*. Studies from Australia, China, Hong Kong SAR, Germany and Switzerland have similarly shown that media guidelines were positively related to the quality of reporting on suicide. However, the effectiveness of media guidelines depends on their successful implementation

(38, 39). Experience from several countries – including Australia (http://www.mindframe-media.info), Austria (http://www.suizidforschung.at), China, Hong Kong SAR (http://www.csrp.hku.hk/media/), Switzerland (http://www.stopsuicide.ch), the United Kingdom (http://www.samaritans.org/media-centre/) and the USA (http://www.reportingonsuicide.org) – provide important insights on the implementation of media guidelines, which could be instructive for other countries.

Further evidence of a possible suicide-protective effect of certain media reports comes from a study by Niederkrotenthaler and colleagues, who found that a specific class of articles that focused on positive coping/mastery of crises was associated with decreases in suicide rates in 12 the geographical area where the published media reports reached a large proportion of the population *(21)*. This protective media potential has been labelled the Papageno effect after the character in Mozart's opera *The magic flute* who considers suicide but changes his plan when reminded of alternatives to dying. Following this first study on the Papageno effect, some other studies have identified protective impacts by media materials that address constructive coping and provide information on suicide prevention *(28, 38, 40)*.

Overall, reviews of media and suicide find that, while there is evidence for both beneficial and harmful impacts of the media on suicide prevention, most research to date has focused on the harmful impacts *(17)*.

Digital media

The very little research that is yet available about the impact of suicide-related depictions online suggests that both protective and harmful effects are possible. Digital media are considered a potentially valuable resource for persons in need of help when suicidal because online media sites are easily accessible and are often used by young people. Persons at risk for suicide frequently report feeling less alienated when using social media and sometimes report that their online activities have reduced suicidal thoughts. This is particularly the case for activities on websites and message boards that offer constructive help and actively avoid normalizing or condoning suicidal behaviour.

However, the potential to normalize suicidal behaviours, the access to images about suicide and suicide methods, and the creation of communication channels that can be used for bullying and harassment are of major concern *(41, 42)*. There are also pro-suicide sites that describe the specifics of different suicide methods, encourage suicidal behaviour, or recruit individuals for suicide pacts. An increasing number of case studies indicate that message boards can serve as a tool for learning about suicide methods, and can promote suicidal behaviour in vulnerable persons.

An introduction to youth self-harm and suicide

Suicide and self-harm in the youth of Ireland is receiving an increasing amount of coverage over the last number of years, and with good reason. Unfortunately, Ireland is one of the most severely affected countries in the EU in this regard. While there is some recent cause for very cautious optimism, there is much work yet to be done.

While depression and self-harm is far more common in females than males, completed suicide remains far more common in males. In the past, one of the explanations given was that while females were more open about describing their feelings, males tended to "bottle them up", and often resorted to drugs or alcohol to deal with their emotional distress. However, recent work done by the HSE has shown that drug and alcohol misuse is at least as prevalent in teenage females as males, suggesting that we have to look elsewhere for reasons.

While the suicide rate is a very important indicator, by no means does it tell the whole story. The rates of depression in young people are extremely important, because the level of impairment which depression causes can be marked, preventing young people from reaching their potential, and affecting them emotionally, academically and socially.

The issue of self-harm has certainly generated much discussion over recent years, with some research suggesting that children as young as seven years old can engage in such activity. While this is very much the exception, it nonetheless backs up the impression that self-harm in young people is happening at a younger age, and appears to be more widespread. There are many reasons why people engage in self-harm, and it would be wrong to assume that everybody who engages in self-harm is suicidal, and equally it would be incorrect to assume that everybody who engages in self-harm is depressed. Nonetheless, it does represent a worrying act because of its associations.

The most common forms of serious self-harm are cutting (particularly to the arms, but less frequently to the legs, abdomen and torso) or poisoning (particularly with over-the-counter medications), and choking/hanging (which is more common in completed suicides).

The Four Steps to Help Programme

The Four Steps to Help Programme for Schools has been developed and approved by our Advisory Panel which includes a consultant child and adolescent psychiatrist and has been deemed to be age appropriate for ages 16+.

These school visits are fully funded by the YSPI School Visits Programme as part of our outreach work and there is no cost to the school or organisation to book and host a talk.

The talks we present are based on our own "Four Steps to Help Programme" which is designed to increase awareness of suicide prevention and to provide information on the support and resources available to anyone who is concerned about suicide or is concerned about a friend or family member.

The Four Steps to Help Programme for Schools focuses on providing simple, factual guidance for suicide awareness and prevention.

The programme emphasises:

- the importance of awareness of sudden changes in behaviour in friends, family or acquaintances;
- Understanding how to recognise the suicide warning signs, as well as signs of other mental health issues;
- promotion of 'active listening', giving simple listening skills and exercises which can be used in everyday situations;
- emphasis on making appropriate family members or other adults aware of concerns so that action can be taken;
- Practical information on dealing with a crisis situation and how to respond.

We all need to know and understand that there is always someone that we can turn to in our life and talk about the issues facing us without fear of rejection if we are prepared to take the first step. What is much more challenging is being prepared to take that first step for someone else; to face possible rejection or ridicule by being prepared to use the Four Step Programme to potentially save a life.

The Four Steps to Help Programme is a simple introduction to suicide prevention and mental health awareness information. The talks focus on four steps:

Step 1: Watching
This step focusses on raising awareness of the suicide warning signs and encouraging participants to watch out for sudden behaviour changes in their friends and family members.

Step 2: Showing
This step focusses on showing friends and family members that they can discuss any concerns with their friend or sibling, and they can turn to parents and trusted adults for support and advice. This step introduces the Active Listening skillset and provides techniques and examples.

Step 3: Asking
This step focusses on simple techniques for asking someone how they are feeling and encouraging them to feel safe to talk about their concerns. This step builds on the techniques introduced in step 2

Step 4: Helping
This step provides guidance on how to help someone you are concerned about and focusses on getting assistance from a trusted adult or directly from a medical professional. This step also introduces a crisis scenario and provides information on how to deal with the need to get immediate assistance. This step links to the YSPI FreeText Crisis Information service detailed on the back page of this leaflet.

Why awareness and vigilance are so important

Young males in Ireland between ages 10-24 are more likely to die by suicide than by any other cause based on CSO Statistical Data from 2014. Suicides in 2014 were registered at 10 per 100,000 of the population, an increase on previous years with males accounting for 80% of all registered suicide death (CSO Statistical Data 2014) leading to Ireland having the second highest youth suicide rates in the European Union (Eurostat)

We can bring those rates of youth suicide under control if we reach young people at their most vulnerable ages, if we can spot the early signs of distress and do our best to reduce those stressors as much as possible. As teachers we can greatly assist in that process by being aware, knowing what to look for and encouraging our students to do the same.

Fighting stigma

One of the most positive influences we can have is by fighting stigma. There is still a huge amount of stigma attached to suicide, and sometimes this can be institutionalised in schools.

Some students have given us feedback that when they wanted to visit a friend who had attempted suicide they were actively discouraged by some teachers from doing so; although the same teachers had been encouraging their students to visit a young student from their school who had been diagnosed with leukaemia. The students couldn't see how the situations differed but they were being given different advice.

None of us are perfect, and we all have prejudices, but it is so important that we allow our students to develop their own attitudes to issues which challenge them, their friends and peers. This is particularly the case with suicide, where we often still see the young person who has lost their way and tried to end their suffering treated as a perpetrator rather than a victim.

Frequently Asked Questions

1. Why do people die by suicide?

People who die by suicide are often having intense feelings of helplessness and hopelessness and may not see any other way out of their emotional pain. It is important to remember that most people who attempt suicide do not really want to die. They simply want to end the pain they are experiencing.

2. Is it true that people attempt suicide as a cry for help?

The suicide attempt is quite often a conscious or unconscious method for getting others to recognise just how badly the individual is feeling. Yes, suicide attempts are very often cries for help.

3. If someone in a family has completed suicide, are other members of the family tempted to try suicide when they have problems?

If someone in a family has completed suicide, other family members may be tempted because suicidal behaviour has been "modelled' for them. However, suicide behaviours are not inherited in families.

4. Do people ever attempt suicide to "get attention" or to get others to feel sorry for them?

Anyone who attempts suicide in order to get attention desperately needs it. It is tragic when someone feels they need to bargain with their life in order to have their problems taken seriously. Any suicide attempt needs to be taken seriously.

5. If a person attempts suicide and fails, what is the likelihood of them trying again?

One of the important warning signs for suicide is a prior attempt. Anyone who attempts suicide once is more likely to try suicide again than those who have never attempted. However, many people who receive

licensed professional medical and behavioural health care following a suicide attempt may never become suicidal again.

6. Is it true that people who attempt to kill themselves really don't want to die?

Many people who attempt suicide are ambivalent about life. They want to live and die at the same time. But, as noted in number 1, it is not that the person really wants to die, but rather that death may seem like the only way to end the emotional pain the suicidal person may be feeling. It is the pain they want to end usually, not the life.

7. Will a person who is deeply depressed always become suicidal?

While it is true that suicidal feelings often develop in a person who is deeply depressed, the fact that one is depressed does not mean that a person will become suicidal.

8. Does anyone ever impulsively try suicide and then become sorry for making such an attempt?

A person at a particular moment may find the emotional pain being experienced absolutely intolerable. At a given moment, a suicide attempt might impulsively be made which, in retrospect, might be regretted.

9. Does taking drugs or alcohol increase one's chances of becoming suicidal?

Taking drugs or alcohol in excess can exaggerate painful feelings to a point where the feelings become intolerable. In such a state, a person might attempt suicide who otherwise would not go that far.

10. Is a person who attempts suicide mentally ill?

All suicidal individuals are not necessarily mentally ill, though many people who attempt or complete suicide may have symptoms of mental illness, the most common being some form of depression. It is important to note that most depression is of a temporary nature and is treatable.

11. Is it true that gay teenagers are at higher risk for suicide than teenagers in general?

Studies in the US indicate that gay, lesbian and bisexual youth account for some 30% of all youth suicides, yet constitute only about 10% of the total youth population. Thus, it is clear that such youth are at much higher risk for suicide than the youth population as a whole.

12. How can one help a person who is suicidal?

A person who feels that life is too painful is often feeling very worthless, perhaps unloved, perhaps isolated Showing such individuals some real caring, by listening to them, accepting their feelings without judgment, by staying close, and getting others to be supportive, can really help. Giving time and really listening to someone in crisis is critical. It may be important to refer the person to a professional medical or mental health worker at some point.

13. How does talking about suicide help to prevent it?

Talking about suicide diffuses some of the intensity of suicidal feelings. It helps the person get connected to the help that may be needed. It creates a climate of caring and helps to break through the loneliness and isolation a person may be experiencing. By asking someone in crisis if they are suicidal, we give that person permission to talk about possible suicidal feelings, about which they may otherwise feel they cannot, or should not, talk about.

14. Is suicide or attempted suicide against the law?

At one time suicide or attempted suicide was against the law. In some countries it has only been within the last 20 years that suicide has ceased to be a crime.

15. What effects does a suicide have on the individual's remaining family and friends?

The survivors of a suicide are left with complex and often confusing feelings of rage, guilt, despair, grief, loss, shame, etc. Recovery from the loss of a loved one by suicide is a very difficult form of grief to resolve, and may never be completely resolved. It has been estimated that every suicide, on average, has a direct, profound emotional impact on 8 to 12 other people. With some 30,000 suicides each year in the EU, there are consequently a huge number of emotionally impacted "suicide survivors".

16. Why do some people keep secret the fact of a suicide in the family?

Some people keep the fact of suicide in the family a secret out of fear of being blamed or socially ostracized. Fortunately today, much of the historical stigma of suicide is lifting and people are dealing with suicidal death more directly and honestly.

17. What are the most common methods used by teenagers to attempt or complete suicides?

Lethal methods for attempting suicide by teenagers include guns, hanging, carbon monoxide, jumping, and drug overdoses. Auto accidents account for many deaths, but it is often difficult to determine whether the death is suicide or an accident.

18. Do more men or women make attempts on their lives?

Although about three times as many women attempt suicide than do men, about four times as many men complete suicide than do women. This is due to the fact that men use more lethal methods, such as guns or hanging, while women are more likely to attempt suicide by using pills.

19. Does everybody think about suicide at least once in their lifetime?

At some point in their lives, most people have at least fleeting thoughts of suicide, especially in times of personal crisis but it does not mean a person will die by suicide.

Myths about suicide

1. People who talk about suicide seldom mean it and can, in fact, be regarded as low risk to attempt suicide.

FALSE Quite often people who talk about suicide do attempt suicide. Eighty percent of those who kill themselves have left definite warning signs. One of the major clues is talking about suicide. Many times people make statements about suicidal intentions to see how others respond, to see if anyone cares enough to ask about what is going on. It is important to treat all talk about suicide seriously. The talk may be a cry for help.

2. The fact that someone has attempted suicide once greatly reduces the risk of a second attempt.

FALSE A suicide attempt is considered a cry for help. Once an attempt is made, the person is at higher risk for making another attempt or completing suicide. Statistics show that 10 percent of those who attempt suicide will eventually kill themselves, two percent within a year. Many others will make further

attempts but survive. Young people are, in many instances, likely to make successive attempts. The elderly, on the other hand, are more likely to die with a first attempt. Of course, not everyone who attempts suicide once will try again.

3. Women attempt suicide more often than men.

TRUE It is estimated that women make 3 times as many suicide attempts as men. However, it is also estimated that men actually complete suicide four times as often as women. In other words, suicide attempters tend to be female, while suicide completers tend to be male. One of the reasons for this statistical disparity is that men tend to use more lethal means, such as guns, than women use when attempting suicide.

4. Suicide now ranks among the leading causes of youth death in the European Union.

TRUE Each year in the European Union there are approximately 30,000 reported deaths by suicide, in general, making it one of the leading causes of death.

5. Most suicides occur "out of the blue" without any warning signs.

FALSE Although suicide often comes as a shock and seems to have happened with great suddenness and without warning, the truth is that there are clear and identifiable warning signs in the majority of cases. The problem is that: a) not all the warning signs are obvious (some are subtle) and b) not everyone knows what the warning signs are. That is why suicide awareness education is so important, so people can both recognize the warning signs and respond to them by helping a person in crisis.

6. Asking someone if they are thinking about suicide will put the idea in their head.

FALSE Asking someone if they are thinking about killing themselves can be a scary thing. However, it is important to know that asking the question will not put the idea in someone's head. It will not reinforce the idea, if the person is already thinking about suicide. It will not cause the person to kill themselves. Many times, after being asked, a person finds it a real relief to talk about it with someone else, someone who cares enough to ask. Asking the question gives the person permission to talk about it. It may well be the first step in getting the person some needed help.

7. Teenagers rarely attempt suicide, although they may frequently think about it.

FALSE In all likelihood, teenagers make more suicide attempts than any other age group. So not only do teenagers frequently think about suicide; they also frequently attempt it (at a rate of about 500,000 attempts per year in the United States). Perhaps two percent of all high school students have made at least one suicide attempt. One study suggested that half of all teenagers have "seriously considered" suicide by the time they graduate high school. Suicide is a very serious issue for this age group.

8. Suicide attempts mean a person has ambivalent feelings toward life and death.

TRUE Studies indicate that the vast majority (perhaps as many as 95%) of people who attempt suicide either do not want to die or are not sure. They are ambivalent. Part of them wants to live. Part of them wants the emotional pain they are experiencing to stop. While struggling with, often times unbearable emotional pain, they think about or plan a way out, often giving signals of their distress to significant persons around them. Suicidal people almost never want to die; they just want the pain to go away.

9. Improvement following a suicidal crisis means that the suicidal risk is over.

FALSE A large number of suicides occur within the first several months following signs of "improvement" in the condition of a person in crisis. This may well be the time when the person finally has the energy to

put morbid thoughts and feelings into effect and possibly attempt suicide. Relatives, friends and health care professionals need to remain especially vigilant during this apparent "improvement" period.

10. Suicide is inherited or runs in the family.

FALSE Suicide is an individual problem but risk factors can include a family history of suicide and other health and behavioural health issues that may or may not put a person at risk for suicide. Other individual and family lifestyle issues can also be risk factors for suicide including the use of drugs and alcohol.

11. All suicidal individuals are mentally ill and suicide always is the act of a psychotic person.

FALSE All suicidal individuals are not necessarily mentally ill, nor is suicide always the act of a psychotic person. Many people who attempt or complete suicide may have symptoms of mental illness, the most common symptom being some form of depression (Most depression is treatable and temporary in nature). Some studies do indicate that between 40 and 60 percent of people who died by suicide were at the time experiencing an episode of depression.

12. The incidence of suicide among the poor and deprived is substantially higher than among the advantaged.

FALSE Suicide is quite democratic. It is neither the poor man's curse nor the rich man's disease, but is represented proportionately among all levels of society based on advantage or disadvantage.

13. At least half of all people who complete suicide leave notes explaining their action.

FALSE Studies have showed that only approximately 15 to 20 percent of those who complete suicide leave any type of note, and not all notes provide explanations of the person's actions. One of the difficult realities many survivors of suicide (family members and significant others left behind) must come to terms with in many cases, is the fact that they will never really know why someone completed suicide.

14. The elderly have the highest rate of suicide for any age group.

TRUE For many people, their so called golden years are anything but golden. Age inevitably brings with it certain losses. Friends and relatives die, careers come to a close, and physical health begins to fail. It can be a difficult and even depressing time of life - a time when many are at heightened risk for suicide.

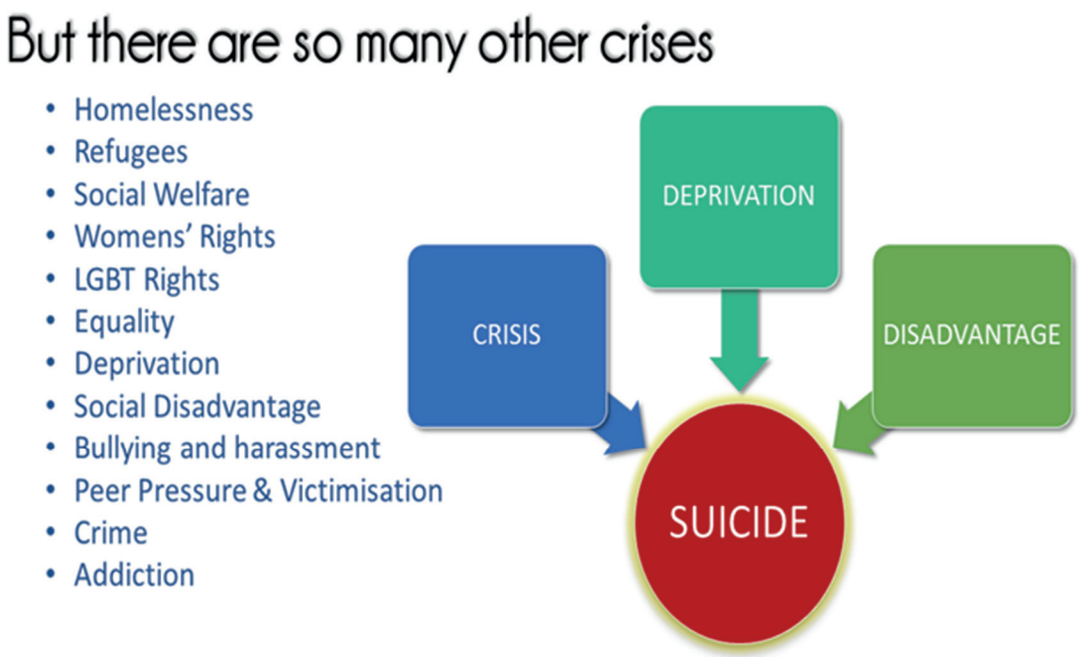
What should I be watching for?

Some of the underlying causes of youth suicide and self-harm

Much work has been done to try to clarify the reasons why young people kill themselves. We know that young people who are depressed are more likely to go on to complete suicide, but it is important to state that it is still only a relatively small percentage. It is also the case that drug and alcohol misuse is certainly more common in those who die by suicide.

Drugs and alcohol tend to have a two-fold effect. The first is that they, in time, act as a depressant, making low mood more likely. The second is that they tend to decrease inhibitions, and therefore remove the internal controls whereby one prevents oneself from engaging in self-harm or suicide. It is also important to be aware that drug and alcohol misuse can be a marker, in any young person, for increasing levels of unhappiness or distress. It is not unusual for those who are unhappy to turn to drugs or alcohol to give themselves a lift, but, as has been mentioned, the effect is short lived and is replaced by a further deterioration in mood.

When young people self-harm, they give a variety of reasons, but certain themes quickly emerge. The most common of these is the break-up of a relationship, or other peer difficulties.



Another common situation is difficulties at home within the family, and such difficulties can either be of longstanding duration or acute. Less frequently young people describe a build-up of pressure, either academic or otherwise, which generally leads to mounting levels of tension and stress and a feeling that a young person cannot cope. If this happens in the context of a personality which is somewhat perfectionistic and rigid in nature, where a young person does not allow themselves the option of "failure", the result can be catastrophic because a young person's problem-solving competence in such situations becomes significantly impaired, as does their list of possible remedies.

This issue of problem-solving difficulties is a recurrent one in young people because in many cases of self-harm a young person's ability to generate an alternative solution is defective. This happens for a variety of reasons.

The first of these is that, for many young people, their ability to put words to their feelings is at a relatively undeveloped stage. Even though we live in an age where psychological terminology is far more part of the common usage than it was in the past, there is still often a gap between a young person's awareness of the meaning of a term and their ability to apply it to their own situation.

Young people discover, as this ability improves, that they can develop some sense of control by being able to articulate their own internal world, and their developing capacity for abstract thought allows them to discuss these topics in a different way. It is also important to remember that our brains work in a way that makes it more difficult for us to think creatively and flexibly about a difficult situation if we are emotionally aroused. Our ability to generate solutions, to estimate risk, to predict the responses of others, and to manage ourselves through such difficult situations is never as good when we are agitated or distressed as when we are calm. We tend to "catastrophise" whereby we imagine the worst possible outcome and therefore react, which can involve self-harm.

Self-harm also develops as part of an on-going pattern. While it may start in a situation where people feel acutely distressed, it often becomes a means of regulating one's levels of discomfort. Hard though it is to believe, young people who cut themselves while highly distressed describe, not a sense of pain, but a sense of relief. There are many theories as to why this may happen, but fundamental to understanding this dynamic is to realise that, for a young person, cutting themselves may not always be a painful or a distressing act.

Essentially, young people harm themselves (either by cutting or by overdosing, or by drug or alcohol misuse) to get rid of unpleasant feelings. It can create a cycle whereby they believe that the only way to get rid of such feelings is to carry out that specific act, and a pattern ensues. That is the reason why many people who harm themselves on one occasion go on to repeat such an act. It is by no means always a suicidal gesture, and while a very unhelpful way of coping, must be seen in context. In this regard, cutting is the most common method of self-harm which becomes repetitive.

Overdoses tend to be more serious, and are far more likely to have lethal intent. Hanging and choking are almost always lethal with respect to intent and must be taken very seriously. The one exception to this is that many young children, either in their early teens or perhaps younger, can engage in either breath-holding or asphyxiation games in order to induce an altered state of consciousness. While this does not, generally, have lethal intent, it is quite likely that, in situations where people carry this out alone (by using a ligature) they may be unable to release the ligature in time, and this has led to loss of consciousness, and even death.

Cyber Bullying

One of the reasons frequently given by young persons who harm themselves is social exclusion by peers or indeed overt bullying. Traditionally, this took the form of either physical aggression or a form of relational victimisation whereby a young person was in some way excluded or teased. With the dramatic increase in communication technologies, the means by which this can be perpetrated have increased, in a way which is extremely difficult to monitor.

Under the umbrella term of cyber bullying come a variety of forms of victimisation which include the use of mobile telephones and computers.

These include abusive messages, spreading rumours, posting photographs either via mobile phone or on social network sites. A further and sinister development is the filming of physical aggression perpetrated on the young person and its transmission to others.

It is extremely difficult to police these forms of communication, in many ways because the technological awareness of teenagers is often far ahead of that of their parents.

In addition, while previously there was just one telephone in a house, and nobody would dare ring after 9.00 p.m. or so, young people with mobile phones or computer access can be busy communicating well into the early hours, when others are asleep. One of the dreadful consequences of being the victim of such bullying is the fact that 'nowhere is safe'. While previously one knew where to avoid, the sense of vulnerability as a consequence of being cyber bullied is much greater.

It is extremely important that young people learn both how to protect themselves and also to report victimisation of others. What can appear to be a "prank" or "teasing" can be highly distressing and has certainly lead to numerous episodes of self-harm, and indeed worse.

Suicide Clusters

Suicide clusters are a recent phenomenon, and cause tremendous concern. With the mushrooming of reality television has come a level of exhibitionism which was previously not in evidence. It has led to a

situation where many vulnerable young people lay bare their inner-most thoughts and emotions for an audience, particularly when distressed.

When one adds to this the possibility of networking with other like-minded individuals on the internet, one can see very clearly how suicide clusters can form. While there are still a number of extremely worrying situations where friends will engage in some sort of suicide pact, the geographical dispersal of those involved in internet-based suicide clusters makes it extremely difficult to penetrate and to prevent.

Again, as with cyber bullying, because of the technological awareness of teenagers compared with most adults, the only way of monitoring such situations is by being able to address these topics in a very open way where young people are not blamed for the sites they frequent, in order that they can feel safe to disclose things that particularly concern them.

It is also true that, albeit rarely, clusters can develop in a single geographic location. It tends to be among a disaffected peer group, and it is often facilitated by drug and alcohol use. It is certainly the case that, with any situation where a young person dies by suicide, the level of suspicion must be high that others may be considering the same thing. In such situations, one finds that groups of youths tend to cluster together, and it feels as if adults are excluded.

Nonetheless, what does often happen is that, while teenagers may not talk to adults about their feelings, they certainly may talk about others within their group, and by networking together, a group of concerned adults (including teachers, parents, youth leaders etc.) can build up quite a detailed picture of the various levels of vulnerability within the group.

Furthermore, in the wake of such bad news, a sense of unresolved loss in others may often be triggered, and therefore the index of suspicion among others, not intimately connected with the core group, must still be high. In such situations, the National Education Psychology Service has a very coherent plan for how best to manage a situation within a school setting, and schools or other Youth organisations are often well advised to seek outside advice on how to manage such situations.

It is a time of intense vulnerability and anxiety, particularly among adults. The tendency for young people to idealise the deceased is very common, and, because one is always so reluctant to speak ill of the dead, it is very difficult to challenge. In time, such intense feelings diminish, but vigilance must remain high for those who continue to show depressive features.

Warning signs and behavioural changes

While suicide is, by its nature, a terminal act, one must be vigilant for the tell-tale signs of a lowering of mood or of other at-risk behaviours. Unfortunately, not every incident of suicide can be predicted, as, even with the benefit of hindsight, it appears clear that some young people tragically kill themselves in an impulsive manner which could not have been foreseen, even by their nearest and dearest. However, it makes it all the more important that we pay very close attention to signs of depression or increasing impulsivity which can lead to timely interventions where appropriate.

Depression is a condition which previously had been considered unusual in teenagers and vanishingly rare in pre-teens. We now know that the incidence of depression, while uncommon, is very much a concern in pre-teens, and rising through adolescence. It is more common in girls than boys, and its incidence increases with age, until it reaches adult levels.

Depression is characterised by low mood, increasing irritability, social withdrawal, poor concentration, and is often accompanied by alterations in sleep pattern and appetite. The thinking patterns which are common in depression are self-critical, finding fault with many things, pessimistic regarding the future and discounting anything which may appear to be of value or benefit to the person. Essentially, it is the very opposite of “rose tinted glasses”.

While most cases of depression are mild to moderate, and resolve within a month or two, some cases become more serious. Teenagers with depression create difficulties for themselves by virtue of their irritability, their deteriorating school performance, their social withdrawal and their resultant behavioural

difficulties and lack the flexibility to get themselves out of such situations, because of their low mood. Therefore they can become alienated from family, and sometimes from their friends.

For teenagers, who take so many of their values and their points of reference from their peer group, to fall out with friends, particularly when they have already fallen out with their families, causes huge difficulties, thereby perpetuating and indeed deepening the cycle. In such cases, particularly when teenagers become agitated and angry, self-harm is often an accompanying concern.

One can see, for such teenagers, how drugs or alcohol might offer a temporary reprieve. Nonetheless, it remains that most episodes of drink and drug use by teenagers is of an experimental type, at least initially, and then often part of a peer activity. It is certainly not the intention to make excuses for it, but merely to point out that it is common, and it is usually not associated with mental illness.

Many teenagers, especially boys, are quite impulsive by nature. This can often be seen in the context of young people with ADHD (Attention Deficit Hyperactivity Disorder) but is not restricted to this. For such teenagers, who struggle with deferred gratification, the likelihood of an impulsive act of self-harm is greater than for the general teenage population.

While in some ways such acts are more easily excused, and indeed occasionally explained away because of the impulsivity, when one thinks further about it, one realises that the level of impulsivity actually makes it more difficult to plan prevention strategies compared to those whose acts of self-harm are the result of the more protracted planning.

Main Indicators

Probably the most important indicator that a young person is struggling with something will be a sudden change in their behaviour. So, for example, the young person who is very outgoing in class, the class clown, suddenly became very quiet, very withdrawn, you might be grateful but you would probably think 'That's strange. I wonder what's up there'.

If you are involved with teams then there is usually somebody in the team who is first at practice, helps with the equipment, very keen. If they were suddenly to turn around and say that were not going to practice, that they were "not interested", "can't be bothered", you would probably take notice of that change anyways.

- The young person who has always been very keen on studying and suddenly they're cutting school, they just don't care.

- The young person who was always very interested in looking after their body, who has always been eating salads and suddenly, they've been down to the chipper every lunch time stuffing their faces.

- The young person in the class who has always been academic, very keen to be top of the class. Suddenly they're always late or missing school….why?

It's these kinds of sudden changes in behaviour that you will already take note of, but you might not have been aware of the wider potential issues that this behavioural change may indicate.

General Warning Signs

If someone is seriously depressed and thinking of attempting suicide there are often warning signs that family and friends can pick up on. Noticing and acting upon these warning signs could save a life. Most people who are considering suicide are willing to talk about their problems if someone shows they care. Don't be afraid of discussing the subject with someone you think may be suicidal. Talking about suicide won't 'plant the idea' in someone's head. This is a myth. If you are wrong, you're at least showing a friend you care. If you are right, you could save their life.

Sometimes stress or a traumatic event like bereavement can trigger suicidal thoughts in a vulnerable person. For this reason it's important to ask a friend who is going through a tough time how they are coping and if they need some support. Having someone to talk with can make all the difference.

Warning signs can include but are not limited to:

- Withdrawing from family and friends.
- Having difficulty concentrating and thinking clearly.
- Sleeping too much or too little.
- Feeling tired most of the time.
- Gaining or losing a significant amount of weight.
- Talking about feeling hopeless or guilty.
- Talking about suicide or death.
- Self-destructive behaviour like drinking too much or abusing drugs.
- Losing interest in favourite things or activities.
- Giving away prized possessions.
- Mood swings.

Additional warning signs that a teen may be considering suicide:

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent or rebellious behaviour, running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomach-aches, headaches, fatigue, etc.
- Not tolerating praise or rewards

IMPORTANT NOTE

If someone mentions suicide, take it seriously. If they have expressed an immediate plan, or have access to prescription medication or other potentially deadly means, do not leave them alone. Get help immediately.

Teen specific warning signs

Talking about suicide	Any talk about suicide, dying, or self-harm, such as "I wish I hadn't been born," "If I see you again..." and "I'd be better off dead."
Seeking out lethal means	Seeking access to guns, pills, knives, or other objects that could be used in a suicide attempt.
Preoccupation with death	Unusual focus on death, dying, or violence. Writing poems or stories about death.
No hope for the future	Feelings of helplessness, hopelessness, and being trapped ("There's no way out"). Belief that things will never get better or change.
Self-loathing, self-hatred	Feelings of worthlessness, guilt, shame, and self-hatred. Feeling like a burden ("Everyone would be better off without me").
Getting affairs in order	Making out a will. Giving away prized possessions. Making arrangements for family members.
Saying goodbye	Unusual or unexpected visits or calls to family and friends. Saying goodbye to people as if they won't be seen again.
Withdrawing from others	Withdrawing from friends and family. Increasing social isolation. Desire to be left alone.
Self-destructive behaviour	Increased alcohol or drug use, reckless driving, unsafe sex. Taking unnecessary risks as if they have a "death wish."
Sudden sense of calm	A sudden sense of calm and happiness after being extremely depressed can mean that the person has made a decision to die by suicide.

General risk factors

LOSSES:

1. The break-up of a romantic relationship
For an adolescent the loss of such a relationship is traumatic in many cases. His or her world has come crashing down. Behind many a macho exterior or sour grapes attitude is a sensitive and hurting young person. Trite expressions like "Things will get better in time" or "There are other fish in the sea" show no sensitivity for the hurt the young person is feeling and deny that the pain is real.

2. The death of a loved one
The pain of separation by death can be so great that the young person might be driven to join that person in death. Furthermore, the grief process often does not include the young person in the family. Many adults do not consider the possibility that the grief that a young person is experiencing at the death of a close family member is as profound as their own.

3. The death of a pet
Consider the teenager whose only true listener is the dog. The dog is there to listen and to love and to never pass judgment. And if that dog should die?

4. The loss of a job
For many teenagers, "job" means maturity and independence. Take away the job? What happens to the independence?

5. Losing face
Consider the boy who publicly stated he was aiming to be a team captain and didn't make it. Consider the student who wanted to attend a prestigious college but got a rejection instead, and everyone knows it

6. Divorce
The loss of a parent through divorce is more traumatic than is commonly admitted. Many teenagers feel responsible for the break-up of the marriage. The imagined or actual fear of a possible divorce is also tremendously painful for the teenager.

PRESSURES:

1. School Pressure
The need to achieve high marks, time to accomplish several major assignments simultaneously, involvement in too many extracurricular activities, demands of school sports, college applications.
2. Peer Pressure
The need to find acceptance, group morals, conformity to clothing styles, drugs, alcohol, sex, and bullying to name just few.
3. Parental Pressure
Success, money, the right college, the right friends, good marks, conflict between the need to control and the need to be independent, marital problems between parents, "get a job", clothing, music, the parent who wants to be a "friend", lectures rather than examples.

LOW SELF-ESTEEM:

1. Physical Unattractiveness

Consider the young man who thinks that physically he does not match his peers. Consider the young lady who thinks she's plain and homely. Consider the effect of skin blemishes at debs' time.

2. Never the first

Consider the young man or the young lady who always feels like a second choice when it comes to dating or being chosen for anything.

3. Sexuality

Consider the pain and agony of the teenager who is caught between the two worlds of sexuality and who is terrified to speak to anyone about this for fear of ridicule. Consider the young person whose fear of being homosexual is based on a lack of fundamental sexual knowledge.

4. Clothing

Consider the teenager who, influenced by the media blitz and by teenage styles, judges importance or lack thereof by the type of clothes he or she is forced to wear.

5. Physical Disability

Consider the teenager who must not only cope with a physical problem, but also with the unkind remarks and glances of others.

6. Academic Disability

Consider the teenager whose older brother or sister was a "genius" and is constantly reminded of the difference between them.

LACK OF COMMUNICATION AND LACK OF HOPE:

1. Isolation and loneliness

Many teenagers feel so isolated and alone that they are convinced that there is no one to help them and that no one really cares. Whether this is true or not is irrelevant. What matters is that this is how they perceive it, and so they suffer in silent isolation.

2. Without a future and hopelessness

Consider the teenager who instead of looking to the future with expectation is overwhelmed with a sense of hopelessness. All hope in the future has been lost.

Teen specific risk factors

The teenage years can be emotionally turbulent and stressful for all teenagers. Teenagers face pressures to succeed and fit in. They may struggle with self-esteem issues, self-doubt, and feelings of alienation. For some, this leads to suicide. Depression is also a major risk factor for teen suicide.

Other risk factors for teenage suicide include:

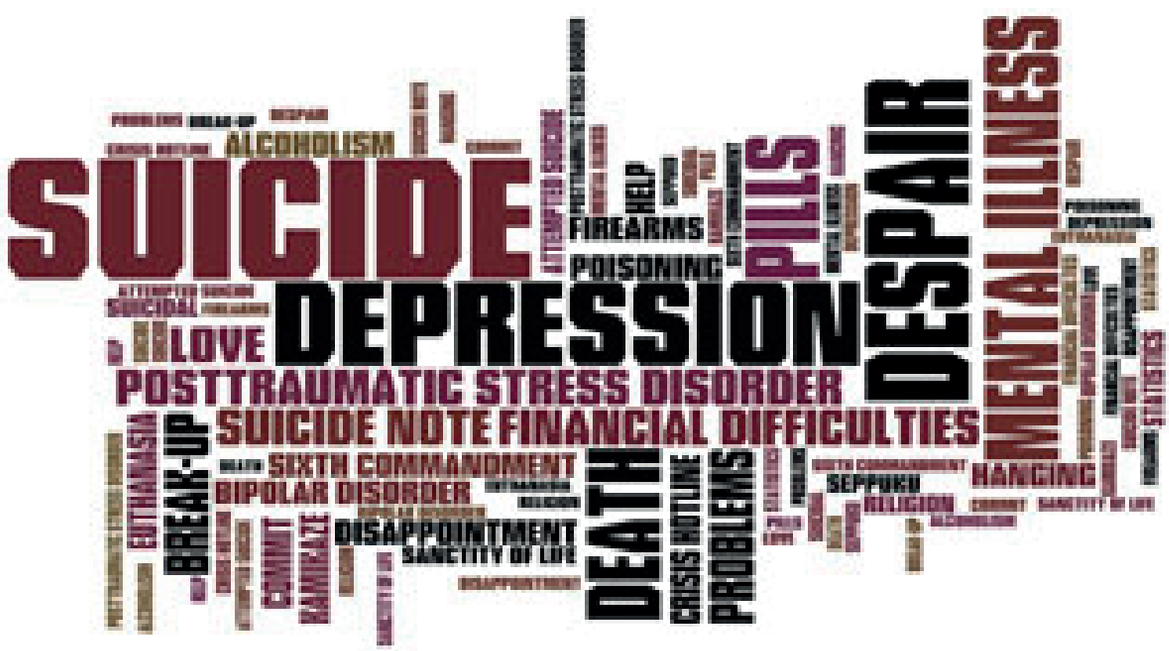
- Childhood abuse
- Recent traumatic event
- Lack of a support network
- Availability of means of suicide
- Hostile social or school environment
- Exposure to other teen suicides

The Dangerous Calm

The "Dangerous Calm" is a recently highlighted mental health phenomenon. A student may show sudden changes of behaviour, often to quite a significant extent. The student then reverts back to their normal disposition and behaviours.

In 95% of cases this would be perfectly normal as everyone has times of depression, sadness, ill-temper etc. But in 5% of cases this reversion to normal behaviour can mask a life decision by the student. Some students can make a decision in their depressed state that appears to provide a solution to all their problems and, as a result of that decision, their behaviour normalises.

Unfortunately that decision can often be a decision to take their own life, and because that decision becomes internalised and part of a coping strategy, it can remain dormant unless challenged or diagnosed. This is why it is so important that sudden changes in student behaviour are noticed, reported and acted upon.



Basic guidelines on how to help

When an adult becomes aware of a young person's emotional distress or their self-harm, it comes about either because an adult has, through vigilance or information received, developed an opinion that a young person is at risk, or else a young person has taken the initiative in discussing their concerns with an adult.

Firstly, it is worth considering what the qualities are in an adult that makes a young person feel they can confide in them.

Tolerant and accepting

The issue of stigma regarding psychological difficulties is one which has been widely discussed, and is very much seen as a barrier to intervention. Young people are far more likely to approach those whom they know have a tolerant and accepting attitude towards psychological difficulties rather than those whom they perceive to be disparaging or intolerant of such problems. Therefore, the way in which one discusses or talks about psychological problems already sets the scene for whether or not a teenager is likely to approach in case of difficulties.

Respect

Another significant point is the central importance of the respect which the adult shows to the young person. It cannot be over emphasised that for a young person to describe their own internal world at a time when they feel close to crisis takes a huge amount of courage, and the response of the adult is crucial.

Not judging or trivialising

The most important aspect is to listen carefully and calmly without judging and without jumping to conclusions. Not only must the adult respect the young person, but they must also respect their account of their difficulties. In other words, one cannot trivialise the symptoms, cannot say, in a dismissive way,

that everybody experiences such symptoms, or indeed that the young person has much to be thankful for and aren't there those who have much greater difficulties.

Allow the young person to talk

It is not a time, when listening to a young person's story, for drawing premature conclusions or cutting them short. The young person is the expert in their own story. It is also worth remembering that young people, in describing such symptoms, may not always feel ready to describe their most pressing concerns, and often, especially if there are particular on-going stressors, may provide a "test case" of such difficulties in order to see how the adult responds.

Don't guarantee confidentiality

In situations where young people describe episodes of abuse, either physical sexual or emotional, it is absolutely critical that the adult does not give a guarantee of confidentiality to the young person, however much the young person seeks it. To do so, while often based on compassionate grounds, serves to compromise the adult, to undermine the rights of the parent, and indeed on occasion to thwart due process (when the issue is more appropriately dealt with by the civil authorities).

Listening

In a situation where an adult forms the impression, either from their own observations or from information passed on from others, that a young person is particularly low in mood, or at risk of self-harm or indeed suicide, an approach needs to be made to the young person.

It may well be that the adult who has formed the impression is the best person to do so, or perhaps there is another adult with a more developed relationship with the young person who might be more appropriate. In either event, once the initial approach is made, the importance of listening empathically and without judgement to the young person's answers is critical.

Discussion does not cause suicide

There is a diminishing, although unfortunately still prevalent, mistaken belief that discussing the topic of suicide is merely implanting this into the young person's mind. This is not true.

It is important that, in situations where it appears that it needs to be asked, the adult does not shy away from asking very specifically about whether or not the young person feels their life is no longer worth living, whether or not they have in any way harmed themselves in the past, or whether they have plans to do so in the future. It is crucial that the adult can tolerate the young person's distress, because this is very containing and comforting for the young person.

Under 18s

In either event, if one is dealing with a young person under the age of eighteen, it is essential that the young person's parents be first informed. The one exception to this is if there are sufficient grounds for concern that a young person has been the victim of some form of abuse at home and that his or her parents may not have the young person's best interest at heart, then one should approach the civil authorities, most often the HSE Child Protection Team.

Getting support

However, in the more usual situation, it is important that young people can be reassured, in so far as possible, that their feelings are both validated but also that help is available, and that advice can be given on whom to contact.

In situations where there is a level of unhappiness without any concern regarding self-harm or suicide, then there may well be people locally, either within schools, youth clubs or other organisations, who can support the young person. If there are concerns regarding self-harm or significantly lower mood, then parents are best advised to discuss matters with their family G.P. who will know both the family history and also the range of appropriate local options.

Helping – Do's

Do befriend when appropriate
Do consider the possibility of suicide
Do focus on the pain
Do ask if suicide is on their minds
Do get involved
Do allow them to express feeling
DO LISTEN
Do make life an option for them
Do be non-judgmental
Do get help and support for yourself as well
Do stay with the person at risk

Helping – Don'ts

Don't lecture or moralise or give advice
Don't think it is a passing phase
Don't brush off feelings with inane remarks
Don't be afraid that you will instil the idea
Don't do nothing
Don't trample on feelings
DON'T TALK TOO MUCH
Don't dare them to follow through with suicide
Don't react verbally or physically with shock
Don't go it alone
Don't leave the person alone
Don't promise not to tell anyone

Mental Health Awareness Programmes

Some schools are now finding a positive benefit in incorporating suicide awareness and prevention into a wider mental health programme for the school. Mental Health weeks are a good way of doing this.

Other areas of mental health can then be added such as nutrition, exercise, online behaviour, stress management etc. This makes the "heavier" subjects such as depression, mental illness, addiction and suicide more palatable for the students.

In the case of suicide awareness we can only provide our programme to students aged 16 upwards so generally transition, 5th and 6th years. This would be a good guideline age according to our medical panellists.

Providing young people with coping skills

Perhaps the most important subject we can teach our young people is how to cope with the challenges that life presents to each and every one of us. Techniques for dealing with stress and emotions are learned through the modelling of behaviour, trial and error, practice, and more practice through life experiences, and the process of maturing.

Young people must be taught to recognise that they need to constantly develop techniques and strategies for coping, and to continue to build the necessary skills throughout their lives. This takes a conscious effort, careful thought and practice. Each individual develops his or her own methods and styles of coping with difficulties and stress in their lives. They are as personal as each individual's personality. As we guide and support our students' educational growth and development, so too must we guide, support and reinforce the development of good positive coping skills in our students. While we cannot and should not make decisions for our students, we can help them to become aware that they have "choice" and "control" in their lives.

With choice and control come the ability to learn and develop positive ways of coping with the stresses of life, which are inevitable.

Our task then becomes one of facilitating the exploration of healthy, positive coping techniques, providing support, helping students to grow and mature and helping them in their quest to acquire the "tools" to cope with their emotions and life situations.

What can I do for my children?

- Be open to discussing difficult or "taboo" subjects with age-appropriate young people
- Don't be afraid to use the words: suicide, self-harm, cutting etc.
- Don't be afraid to challenge young people
- Be aware of the new challenges facing young people
    - Cyber-bullying
    - Online Blackmail
    - Coercion & intimidation
    - Sexualisation by peers
- **Be approachable**

The role of the listener

For many people the role of listener can be a bit unnerving. Generally we are much more used to talking than listening. In terms of assisting a young person who wants to express themselves to us we need to become more passive.

The funny thing is that listening seems to be so challenging when actually it can be quickly and easily learnt by using the techniques of Active Listening. Active Listening is widely used by helplines such as the Samaritans as it allows a consistent approach, established empathy but, importantly, also allows the listener to keep distance between themselves and the person who wants to talk.

General guidance

It is actually ok to ask young people about their mental state. We need to know where their thoughts are going even though it may seem challenging.

So how do you ask a young person about their thinking?

- DO be yourself. Let the person know you care, that he/she is not alone. The right words are often unimportant. If you are concerned, your voice and manner will show it.
- DO Listen. Let the suicidal person unload despair, ventilate anger. No matter how negative the conversation seems, the fact that it exists is a positive sign.
- DO be sympathetic, non-judgmental, patient, calm, accepting. Your friend or family member is doing the right thing by talking about his/her feelings.
- DO offer hope. Reassure the person that help is available and that the suicidal feelings are temporary. Let the person know that his or her life is important to you.
- **If the person says things like, "I'm so depressed, I can't go on," ask the question: "Are you having thoughts of suicide?" You are not putting ideas in their head; you are showing that you are concerned, that you take them seriously, and that it's OK for them to share their pain with you.**
- DON'T argue with the suicidal person. Avoid saying things like: "You have so much to live for," "Your suicide will hurt your family," or "Look on the bright side."
- DON'T act shocked, lecture on the value of life, or say that suicide is wrong.
- DON'T promise confidentiality. Refuse to be sworn to secrecy. A life is at stake and you may need to speak to a mental health professional in order to keep the suicidal person safe. If you promise to keep your discussions secret, you may have to break your word.
- DON'T offer ways to fix their problems, or give advice, or make them feel like they have to justify their suicidal feelings. It is not about how bad the problem is, but how badly it's hurting your friend or loved one.
- DON'T blame yourself. You can't "fix" someone's depression. Your loved one's happiness or lack thereof, is not your responsibility.

Active Listening

"Active Listening" is simply the offering of friendship by one ordinary human being to another at a time of crisis or loneliness. An Active Listener doesn't need to have professional status or authority, but is simply a fellow human being who cares. The purpose of Active Listening is to listen, accept, care and empathise.

LISTEN
Allowing the person with a problem to express and to talk without being judged.

ACCEPT
Allowing the person to stay in neutral and accept their feelings as they are.

CARE
Allowing one human being to reach out to another human being with respect.

EMPATHISE
Allowing the listener to hear where the speaker is coming from and allows us to be sensitive to another's feelings or ideas even when we don't agree.

The purpose of Active Listening is not to give advice, instruct, solve problems, or judge. It is to respect the worth and value of another human being through Listening, Accepting, Caring, and Empathising.

Characteristics of good active listening

A good Active Listener is someone who:

Does	Does not
listen more than talk	× offer opinion or judgments
direct the conversation to the painful feelings	× belittle or minimise concerns
have compassion for sufferer	× discuss one's own problems
risk being foolish	× give advice
attempt to be available at all times	× express shock or surprise
remain willing to share another person's pain	× patronise or probe
respect confidences	× offer platitudes and clichés
listen	× make promises that cannot be kept
accept	× interpret, lecture or diagnose
empathise	× Say "I know just how you feel."
	× fail to pay attention or care

Attitude of the listener

YOU ARE NOT LISTENING TO ME WHEN...

- × You do not care about me;
- × You say you understand before you know me well enough;
- × You have an answer for my problem before I've finished telling you what my problem is;
- × You cut me off before I have finished speaking;
- × You find me boring and don't tell me;
- × You feel critical of my vocabulary, grammar or accent;
- × You are dying to tell me something;
- × You tell me about your experience making mine seem unimportant;
- × You are communicating with someone else in the room;
- × You refuse my thanks by saying you haven't really done anything.

YOU ARE LISTENING TO ME WHEN...

- ✓ You come quietly into my private world and let me be me;
- ✓ You really try to understand me even if I'm not making much sense
- ✓ You grasp my point of view even if it goes against your own sincere convictions;
- ✓ You realize the hour I took from you has left you a bit tired and drained;
- ✓ You allow me the dignity of making my own decisions even though you think they may be wrong;
- ✓ You do not take my problem from me, but allow me to deal with it in my own way;
- ✓ You hold back your desire to give me good advice
- ✓ You do not offer me religious solace when you sense I am not ready for it;
- ✓ You give me enough room to discover for myself what is going on;
- ✓ You accept my gift of gratitude by telling me how good it makes you feel to know you have been helpful

Summary

There is strong support for the contention that sensationalist media reports about suicide can lead to subsequent additional suicidal behaviours (suicides and suicide attempts). These time-limited increases in suicides are not simply the early occurrence of suicides that would have happened anyway (if this were the case, they would be followed by a commensurate decrease in suicide rates); they are additional suicides that would not have occurred in the absence of the inappropriate media reporting.

Studies of the potential protective effects of responsible media reporting of suicide have started only quite recently and the evidence for the benefits of this type of reporting is currently emerging.

Media professionals should exercise caution in reporting on suicide, balancing the public's "right to know" against the risk of causing unintentional harm.

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