CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

April 22, 1994 / Vol. 43 / No. RR-6

MMWR

Recommendations and Reports

MORBIDITY AND MORTALITY WEEKLY REPORT

Programs for the Prevention of Suicide Among Adolescents and Young Adults

Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), Public Health Service, U.S. Department of Health and Human Services, Atlanta, Georgia 30333.

SUGGESTED CITATION

Centers for Disease Control and Prevention. Programs for the prevention of suicide among adolescents and young adults; and Suicide contagion and the reporting of suicide: recommendations from a national workshop. MMWR 1994;43(No. RR-6):[inclusive page numbers].

Copies can be purchased from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325. Telephone: (202) 783-3238.

Contents

Programs for the Prevention of Suicide Among Adolescents and Young Adults

The following CDC staff members prepared this report:

Patrick W. O'Carroll, M.D., M.P.H.
Office of the Director
Office of Program Support

Lloyd B. Potter, Ph.D., M.P.H.
James A. Mercy, Ph.D.
National Center for Injury Prevention and Control

Programs for the Prevention of Suicide Among Adolescents and Young Adults

Summary

Incidence rates of suicide and attempted suicide among adolescents and young adults aged 15–24 years continue to remain at high levels. In 1992, to aid communities in developing new or augmenting existing suicide prevention programs directed toward this age group, CDC's National Center for Injury Prevention and Control published Youth Suicide Prevention Programs: A Resource Guide. *The* Resource Guide *describes the rationale and evidence for the effectiveness of various suicide prevention strategies, and it identifies model programs that incorporate these strategies. This summary of the* Resource Guide *describes eight suicide prevention strategies and provides general recommendations for the development, implementation, and evaluation of suicide prevention programs targeted toward this age group.*

INTRODUCTION

The continued high rates of suicide among adolescents (i.e., persons aged 15–19 years) and young adults (persons aged 20–24 years) (Table 1) have heightened the need for allocation of prevention resources. To better focus these resources, CDC's National Center for Injury Prevention and Control recently published *Youth Suicide Prevention Programs: A Resource Guide* (*1*). The guide describes the rationale and evidence for the effectiveness of various suicide prevention strategies and identifies model programs that incorporate these strategies. It is intended as an aid for communities interested in developing or augmenting suicide prevention programs targeted toward adolescents and young adults. This report summarizes the eight prevention strategies described in the *Resource Guide*.

TABLE 1. Suicide rates* for persons 15–24 years of age, by age group and sex — United States, 1950, 1960, 1970, 1980, and 1990

	Year				
Age group (yrs)/Sex	**1950**	**1960**	**1970**	**1980**	**1990**
15–19					
Male	3.5	5.6	8.8	13.8	18.1
Female	1.8	1.6	2.9	3.0	3.7
Total	**2.7**	**3.6**	**5.9**	**8.5**	**11.1**
20–24					
Male	9.3	11.5	19.2	26.8	25.7
Female	3.3	2.9	5.6	5.5	4.1
Total	**6.2**	**7.1**	**12.2**	**16.1**	**15.1**
15–24					
Male	6.5	8.2	13.5	20.2	22.0
Female	2.6	2.2	4.2	4.3	3.9
Total	**4.5**	**5.2**	**8.8**	**12.3**	**13.2**

*Per 100,000 persons.

Source: National Center for Health Statistics, CDC.

METHODOLOGY

Suicide prevention programs were identified by contacting suicide prevention experts in the United States and Canada and asking them to name and describe suicide prevention programs for adolescents and young adults that, based on their experience and assessment, were likely to be effective in preventing suicide. After compiling an initial list, program representatives were contacted and asked to describe the number of persons exposed to the intervention, the number of years the program had been operating, the nature and intensity of the intervention, and the availability of data to facilitate evaluation. Program representatives were also asked to identify other programs that they considered exemplary. Representatives from these programs were contacted and asked to describe their programs. The list of programs was further supplemented by contacting program representatives who participated in the 1990 national meeting of the American Association of Suicidology and by soliciting program contacts through *Newslink*, the association's newsletter.

Suicide prevention programs on the list were then categorized according to the nature of the prevention strategy using a framework of eight suicide prevention strategies:

- **School gatekeeper training**. This type of program is designed to help school staff (e.g., teachers, counselors, and coaches) identify and refer students at risk for suicide. These programs also teach staff how to respond to suicide or other crises in the school.
- **Community gatekeeper training**. These programs train community members (e.g., clergy, police, merchants, and recreation staff) and clinical health-care providers who see adolescent and young adult patients (e.g., physicians and nurses) to identify and refer persons in this age group who are at risk for suicide.
- **General suicide education.** Students learn about suicide, its warning signs, and how to seek help for themselves or others. These programs often incorporate a variety of activities that develop self-esteem and social competency.
- **Screening programs.** A questionnaire or other screening instrument is used to identify high-risk adolescents and young adults and provide further assessment and treatment. Repeated assessment can be used to measure changes in attitudes or behaviors over time, to test the effectiveness of a prevention strategy, and to detect potential suicidal behavior.
- **Peer support programs.** These programs, which can be conducted in or outside of school, are designed to foster peer relationships and competency in social skills among high-risk adolescents and young adults.
- **Crisis centers and hotlines.** Trained volunteers and paid staff provide telephone counseling and other services for suicidal persons. Such programs also may offer a "drop-in" crisis center and referral to mental health services.
- **Restriction of access to lethal means.** Activities are designed to restrict access to handguns, drugs, and other common means of suicide.
- **Intervention after a suicide.** These programs focus on friends and relatives of persons who have committed suicide. They are partially designed to help prevent or

contain suicide clusters and to help adolescents and young adults cope effectively with the feelings of loss that follow the sudden death or suicide of a peer.

After categorizing suicide prevention efforts according to this framework, an expert group at CDC reviewed the list to identify recurrent themes across the different categories and to suggest directions for future research and intervention.

FINDINGS

The following conclusions were derived from information published in the *Resource Guide*:

- **Strategies in suicide prevention programs for adolescents and young adults focus on two general themes.** Although the eight strategies for suicide prevention programs for adolescents and young adults differ, they can be classified into two conceptual categories:
  - *Strategies to identify and refer suicidal adolescents and young adults for mental health care.* This category includes active strategies (e.g., general screening programs and targeted screening in the event of a suicide) and passive strategies (e.g., training school and community gatekeepers, providing general education about suicide, and establishing crisis centers and hotlines). Some passive strategies are designed to lower barriers to self-referral, and others seek to increase referrals by persons who recognize suicidal tendencies in someone they know.
  - *Strategies to address known or suspected risk factors for suicide among adolescents and young adults*. These interventions include promoting self-esteem and teaching stress management (e.g., general suicide education and peer support programs); developing support networks for high-risk adolescents and young adults (peer support programs); and providing crisis counseling (crisis centers, hotlines, and interventions to minimize contagion in the context of suicide clusters). Although restricting access to the means of committing suicide may be critically important in reducing risk, none of the programs reviewed placed major emphasis on this strategy.
- **Suicide prevention efforts targeted for young adults are rare.** With a few important exceptions, most programs have been targeted toward adolescents in high school, and these programs generally do not extend to include young adults. Although the reasons for this phenomenon are not clear, the focus of prevention efforts on adolescents may be because they are relatively easy to access in comparison with young adults, who may be working or in college. In addition, persons who design and implement such efforts may not realize that the suicide rate for young adults is substantially higher than the rate for adolescents (Table 1).
- **Links between suicide prevention programs and existing community mental health resources are frequently inadequate.** In many instances, suicide prevention programs directed toward adolescents and young adults have not established close working ties with traditional community mental health resources. Inadequate communication with local mental health service agencies obviously reduces the

potential effectiveness of programs that seek to identify and refer suicidal adolescents and young adults for mental health care.

- **Some potentially successful strategies are applied infrequently, yet other strategies are applied commonly.** Despite evidence that restricting access to lethal means of suicide (e.g., firearms and lethal dosages of drugs) can help to prevent suicide among adolescents and young adults, this strategy was not a major focus of any of the programs identified. Other promising strategies, such as peer support programs for those who have attempted suicide or others at high risk, are rarely incorporated into current programs.

  In contrast, school-based education on suicide is a common strategy. This approach is relatively simple to implement, and it is a cost-effective way to reach a large proportion of adolescents. However, evidence to indicate the effectiveness of school-based suicide education is sparse. Educational interventions often consist of a brief, one-time lecture on the warning signs of suicide—a method that is unlikely to have substantial or sustained impact and that may not reach high-risk students (e.g., those who have considered or attempted suicide). Further, students who have attempted suicide previously may react more negatively to such curricula than students who have not. The relative balance of the positive and the potentially negative effects of these general educational approaches is unclear.

- **Many programs with potential for reducing suicide among adolescents and young adults are not considered or evaluated as suicide prevention programs.** Programs designed to improve other psychosocial problem areas among adolescents and young adults (e.g., alcohol- and drug-abuse treatment programs or programs that provide help and services to runaways, pregnant teenagers, and/or high school dropouts) often address risk factors for suicide. However, such programs are rarely considered suicide prevention programs, and evaluations of such programs rarely consider their effect on suicidal behavior. A review of the suicide prevention programs discussed in the *Resource Guide* indicated that only a small number maintained working relationships with these other programs.

- **The effectiveness of suicide prevention programs has not been demonstrated.** *The lack of evaluation research is the single greatest obstacle to improving current efforts to prevent suicide among adolescents and young adults.* Without evidence to support the potential of a program for reducing suicidal behavior, recommending one approach over another for any given population is difficult.

RECOMMENDATIONS

Because current scientific information about the efficacy of suicide prevention strategies is insufficient, the *Resource Guide* does not recommend one strategy over another. However, the following general recommendations should be considered:

- **Ensure that suicide prevention programs are linked as closely as possible with professional mental health resources in the community.** Strategies designed to increase referrals of at-risk adolescents and young adults can be successful only to

the extent that trained counselors are available and mechanisms for linking at-risk persons with resources are operational.

- **Avoid reliance on one prevention strategy.** Most of the programs reviewed already incorporate several of the eight strategies described. However, as noted, certain strategies tend to predominate despite insufficient evidence of their effectiveness. Given the limited knowledge regarding the effectiveness of any one program, a multi-faceted approach to suicide prevention is recommended.
- **Incorporate promising, but underused, strategies into current programs where possible.** Restricting access to lethal means of committing suicide may be the most promising underused strategy. Parents should be taught to recognize the warning signs for suicide and encouraged to restrict their teenagers' access to lethal means. Peer support groups for adolescents and young adults who have exhibited suicidal behaviors or who have contemplated and/or attempted suicide also appear promising but should be implemented carefully. Establishment of working relationships with other prevention programs, such as alcohol- and drug-abuse treatment programs, may enhance suicide prevention efforts. Furthermore, when school-based education is used, program planners should consider broad curricula that address suicide prevention in conjunction with other adolescent health issues before considering curricula that address only suicide.
- **Expand suicide prevention efforts for young adults.** The suicide rate for persons in this age group is substantially higher than that for adolescents, yet programs targeted toward them are sparse. More prevention efforts should be targeted toward young adults at high risk for suicide.
- **Incorporate evaluation efforts into suicide prevention programs.** Planning, process, and outcome evaluation are important components of any public health effort. Efforts to conduct outcome evaluation are imperative given the lack of knowledge regarding the effectiveness of suicide prevention programs. Outcome evaluation should include measures such as incidence of suicidal behavior or measures closely associated with such incidence (e.g., measures of suicidal ideation, clinical depression, and alcohol abuse). Program directors should be aware that suicide prevention efforts, like most health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to detect such consequences.

For a copy of the full report, *Youth Suicide Prevention Programs: A Resource Guide*, write to Lloyd Potter, Ph.D., M.P.H., at the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 4770 Buford Highway, Mailstop K-60, Atlanta, GA 30341-3724. Single copies are available free of charge.

Reference

1. CDC. Youth suicide prevention programs: a resource guide. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1992.

Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop

The following CDC staff members prepared this report:

Patrick W. O'Carroll, M.D., M.P.H.
Office of the Director
Office of Program Support

Lloyd B. Potter, Ph.D., M.P.H.
National Center for Injury Prevention and Control

Workshop Participants

Eugene Aronowitz, Ph.D.
Westchester Jewish Community Services
Hartsdale, NY

Elisa Bildner
Department of Journalism and Mass Media
Rutgers University
New Brunswick, NJ

Jacqueline Buckingham
CDC
Atlanta, GA

Ronald Burmood, Ph.D.
Omaha Public Schools
Omaha, NE

Perry Catlin
Georgetown Record
Ipswich, MA

Molly Joel Coye, M.D., M.P.H.
New Jersey Department of Public Health
Trenton, NJ

Karen Dunne-Maxim, M.S.
University of Medicine and Dentistry of New Jersey
Piscataway, NJ

Michael Fishman, M.D.
Office of Maternal, Child, and Infant Health
Health Resources and Services Administration
Rockville, MD

Sandra Gardner
Teenage Suicide
Simon and Schuster
Teaneck, NJ

Madelyn Gould, Ph.D., M.P.H.
Division of Child Psychiatry
Columbia University
College of Physicians and Surgeons/ New York State Psychiatric Institute
New York, NY

Myra Herbert, L.I.C.S.W.
Fairfax County Public Schools
Fairfax, VA

Joseph Jarvis, M.D., M.S.P.H.
University of Nevada School of Medicine
Reno, NV

Pamela Kahn
ABC News
Washington, DC

Diane Linskey
Public Health Foundation
Washington, DC

Eve Moscicki, Sc.D., M.P.H.
National Institute of Mental Health
Rockville, MD

Patrick O'Carroll, M.D., M.P.H.
CDC
Atlanta, GA

William Parkin, D.V.M., Dr.P.H.
New Jersey Department of Health
Trenton, NJ

Jordon Richland, M.P.A.
Public Health Foundation
Washington, DC

Judy Rotholz
New Jersey Department of Health
Trenton, NJ

Workshop Participants (Cont'd.)

Joy Silver
Association of State and Territorial Health Officials
McLean, VA

Robert Spengler, Sc.D.
Vermont Department of Health
Burlington, VT

Rosalind Thigpen-Rodd, M.H.A.
New Jersey Department of Health
Trenton, NJ

John Welch
Bergenfield Health Department
Bergenfield, NJ

Robert Yufit, Ph.D.
American Association of Suicidology
Northwestern University Medical School
Chicago, IL

Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop

Summary

In November 1989, a national workshop that included suicidologists, public health officials, researchers, psychiatrists, psychologists, and news media professionals was held to address general concerns about, and specific recommendations for, reducing the possibility of media-related suicide contagion. These recommendations, which are endorsed by CDC, outline general issues that public officials and health and media professionals should consider when reporting about suicide. These recommendations include a depiction of those aspects of news coverage that can promote suicide contagion, and they describe ways by which community efforts to address this problem can be strengthened through specific types of news coverage.

INTRODUCTION

Suicide rates among adolescents and young adults have increased sharply in recent decades—from 1950 through 1990, the rate of suicide for persons 15–24 years of age increased from 4.5 to 13.5 per 100,000 (*1,2*). In comparison with older persons, adolescents and young adults who commit suicide are less likely to be clinically depressed or to have certain other mental disorders (*3*) that are important risk factors for suicide among persons in all age groups (*4*). This has led to research directed at the identification of other preventable risk factors for suicide among young persons.

One risk factor that has emerged from this research is suicide "contagion," a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide (*5*). Evidence suggests that the effect of contagion is not confined to suicides occurring in discrete geographic areas. In particular, nonfictional newspaper and television coverage of suicide has been associated with a statistically significant excess of suicides (*6*). The effect of contagion appears to be strongest among adolescents (*7,8*), and several well publicized "clusters" among young persons have occurred (*9–11*).

These findings have induced efforts on the part of many suicide-prevention specialists, public health practitioners, and researchers to curtail the reporting of suicide—especially youth suicide—in newspapers and on television. Such efforts were often counterproductive, and news articles about suicides were written without the valuable input of well-informed suicide-prevention specialists and others in the community.

In November 1989, the Association of State and Territorial Health Officials and the New Jersey Department of Health convened a workshop* at which suicidologists, public health officials, researchers, psychiatrists, and psychologists worked directly with news media professionals from around the country to share their concerns and

*CDC, which participated in developing the concepts for discussion and assisted in the operations of this workshop, supports these recommendations. Funding for the workshop was provided by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

perspectives on this problem and explore ways in which suicide, especially suicide among persons 15–24 years of age, could be reported with minimal potential for suicide contagion and without compromising the independence or professional integrity of news media professionals.

A set of general concerns about and recommendations for reducing the possibility of media-related suicide contagion were developed at this workshop, and characteristics of news coverage that appear to foster suicide contagion were described. This report summarizes these concerns, recommendations, and characteristics and provides hypothetical examples of news reports that have high and low potential for causing suicide contagion (see Appendix).

GENERAL CONCERNS AND RECOMMENDATIONS

The following concerns and recommendations should be reviewed and understood by health professionals, suicidologists, public officials, and others who provide information for reporting of suicide:

- **Suicide is often newsworthy, and it will probably be reported.**

  The mission of a news organization is to report to the public information on events in the community. If a suicide is considered newsworthy, it will probably be reported. Health-care providers should realize that efforts to prevent news coverage may not be effective, and their goal should be to assist news professionals in their efforts toward responsible and accurate reporting.

- **"No comment" is not a productive response to media representatives who are covering a suicide story.**

  Refusing to speak with the media does not prevent coverage of a suicide; rather, it precludes an opportunity to influence what will be contained in the report. Nevertheless, public officials should not feel obligated to provide an immediate answer to difficult questions. They should, however, be prepared to provide a reasonable timetable for giving such answers or be able to direct the media to someone who can provide the answers.

- **All parties should understand that a scientific basis exists for concern that news coverage of suicide may contribute to the causation of suicide.**

  Efforts by persons trying to minimize suicide contagion are easily misinterpreted. Health officials must take the time to explain the carefully established, scientific basis for their concern about suicide contagion and how the potential for contagion can be reduced by responsible reporting.

- **Some characteristics of news coverage of suicide may contribute to contagion, and other characteristics may help prevent suicide.**

  Clinicians and researchers acknowledge that it is not news coverage of suicide *per se*, but certain types of news coverage, that promote contagion. Persons concerned with preventing suicide contagion should be aware that certain characteristics of news coverage, rather than news coverage itself, should be avoided.

- **Health professionals or other public officials should not try to tell reporters what to report or how to write the news regarding suicide.**

  If the nature and apparent mechanisms of suicide contagion are understood, the news media are more likely to present the news in a manner that minimizes the likelihood of such contagion. Instead of dictating what should be reported, public officials should explain the potential for suicide contagion associated with certain types of reports and should suggest ways to minimize the risk for contagion (see Appendix).

- **Public officials and the news media should carefully consider what is to be said and reported regarding suicide.**

  Reporters generally present the information that they are given. Impromptu comments about a suicide by a public official can result in harmful news coverage. Given the potential risks, public officials and the media should seek to minimize these risks by carefully considering what is to be said and reported regarding suicide.

ASPECTS OF NEWS COVERAGE THAT CAN PROMOTE SUICIDE CONTAGION

Clinicians, researchers, and other health professionals at the workshop agreed that to minimize the likelihood of suicide contagion, reporting should be concise and factual. Although scientific research in this area is not complete, workshop participants believed that the likelihood of suicide contagion may be increased by the following actions:

- **Presenting simplistic explanations for suicide.**

  Suicide is never the result of a single factor or event, but rather results from a complex interaction of many factors and usually involves a history of psychosocial problems (*12*). Public officials and the media should carefully explain that the final precipitating event was not the only cause of a given suicide. Most persons who have committed suicide have had a history of problems that may not have been acknowledged during the acute aftermath of the suicide. Cataloguing the problems that could have played a causative role in a suicide is not necessary, but acknowledgment of these problems is recommended.

- **Engaging in repetitive, ongoing, or excessive reporting of suicide in the news.**

  Repetitive and ongoing coverage, or prominent coverage, of a suicide tends to promote and maintain a preoccupation with suicide among at-risk persons, especially among persons 15–24 years of age. This preoccupation appears to be associated with suicide contagion. Information presented to the media should include the association between such coverage and the potential for suicide contagion. Public officials and media representatives should discuss alternative approaches for coverage of newsworthy suicide stories.

- **Providing sensational coverage of suicide.**

  By its nature, news coverage of a suicidal event tends to heighten the general public's preoccupation with suicide. This reaction is also believed to be associated with contagion and the development of suicide clusters. Public officials can help minimize sensationalism by limiting, as much as possible, morbid details in their public discussions of suicide. News media professionals should attempt to decrease the prominence of the news report and avoid the use of dramatic photographs related to the suicide (e.g., photographs of the funeral, the deceased person's bedroom, and the site of the suicide).

- **Reporting "how-to" descriptions of suicide.**

  Describing technical details about the method of suicide is undesirable. For example, reporting that a person died from carbon monoxide poisoning may not be harmful; however, providing details of the mechanism and procedures used to complete the suicide may facilitate imitation of the suicidal behavior by other at-risk persons.

- **Presenting suicide as a tool for accomplishing certain ends.**

  Suicide is usually a rare act of a troubled or depressed person. Presentation of suicide as a means of coping with personal problems (e.g., the break-up of a relationship or retaliation against parental discipline) may suggest suicide as a potential coping mechanism to at-risk persons. Although such factors often seem to trigger a suicidal act, other psychopathological problems are almost always involved. If suicide is presented as an effective means for accomplishing specific ends, it may be perceived by a potentially suicidal person as an attractive solution.

- **Glorifying suicide or persons who commit suicide.**

  News coverage is less likely to contribute to suicide contagion when reports of community expressions of grief (e.g., public eulogies, flying flags at half-mast, and erecting permanent public memorials) are minimized. Such actions may contribute to suicide contagion by suggesting to susceptible persons that society is honoring the suicidal behavior of the deceased person, rather than mourning the person's death.

- **Focusing on the suicide completer's positive characteristics.**

  Empathy for family and friends often leads to a focus on reporting the positive aspects of a suicide completer's life. For example, friends or teachers may be quoted as saying the deceased person "was a great kid" or "had a bright future," and they avoid mentioning the troubles and problems that the deceased person experienced. As a result, statements venerating the deceased person are often reported in the news. However, if the suicide completer's problems are not acknowledged in the presence of these laudatory statements, suicidal behavior may appear attractive to other at-risk persons—especially those who rarely receive positive reinforcement for desirable behaviors.

CONCLUSION

In addition to recognizing the types of news coverage that can promote suicide contagion, the workshop participants strongly agreed that reporting of suicide can have several direct benefits. Specifically, community efforts to address this problem can be strengthened by news coverage that describes the help and support available in a community, explains how to identify persons at high risk for suicide, or presents information about risk factors for suicide. An ongoing dialogue between news media professionals and health and other public officials is the key to facilitating the reporting of this information.

References

1. National Center for Health Statistics. Health, United States, 1991. Hyattsville, MD: US Department of Health and Human Services, Public Health Service, CDC, 1992.
2. National Center for Health Statistics. Mortality data tapes [machine-readable data tapes]. Hyattsville, MD: US Department of Health and Human Services, Public Health Service, CDC, 1993.
3. Shaffer D, Garland A, Gould M, Fisher P, Trautman P. Preventing teenage suicide: a critical review. J Am Acad Child Adolesc Psychiatry 1988;27:675–87.
4. O'Carroll PW. Suicide. In: Last JM, Wallace RB, eds. Maxcy-Rosenau-Last public health and preventive medicine. 13th ed. Norwalk, CT: Appleton & Lange, 1992:1054–62.
5. Davidson LE, Gould MS. Contagion as a risk factor for youth suicide. In: Alcohol, Drug Abuse, and Mental Health Administration. Report of the Secretary's Task Force on Youth Suicide. Vol 2. Risk factors for youth suicide. Washington, DC: US Department of Health and Human Services, Public Health Service, 1989:88–109; DHHS publication no. (ADM)89-1622.
6. Gould MS, Davidson L. Suicide contagion among adolescents. In: Stiffman AR, Felman RA, eds. Advances in adolescent mental health. Vol III. Depression and suicide. Greenwich, CT: JAI Press, 1988.
7. Gould MS, Wallenstein S, Kleinman MH, O'Carroll PW, Mercy JA. Suicide clusters: an examination of age-specific effects. Am J Public Health 1990;80:211–2.
8. Phillips DP, Carstensen LL. The effect of suicide stories on various demographic groups, 1968–1985. Suicide Life Threat Behav 1988;18:100–14.
9. CDC. Cluster of suicides and suicide attempts—New Jersey. MMWR 1988;37:213–6.
10. CDC. Adolescent suicide and suicide attempts—Santa Fe County, New Mexico, January 1985–May 1990. MMWR 1991;40:329–31.
11. Davidson LE, Rosenberg ML, Mercy JA, Franklin J, Simmons JT. An epidemiologic study of risk factors in two teenage suicide clusters. JAMA 1989;262:2687–92.
12. O'Carroll PW. Suicide causation: pies, paths, and pointless polemics. Suicide Life Threat Behav 1993;23:27–36.

Appendix

Examples of Hypothetical News Reports* with High and Low Potential for Promoting Suicide Contagion

Report with High Potential for Promoting Suicide Contagion

Hundreds turned out Monday for the funeral of John Doe, Jr., 15, who shot himself in the head late Friday with his father's hunting rifle. Town Moderator Brown, along with State Senator Smith and Selectman's Chairman Miller, were among the many well-known persons who offered their condolences to the City High School sophomore's grieving parents, Mary and John Doe, Sr.

Although no one could say for sure why Doe killed himself, his classmates, who did not want to be quoted, said Doe and his girlfriend, Jane, also a sophomore at the high school, had been having difficulty. Doe was also known to have been a zealous player of fantasy video games.

School closed at noon Monday, and buses were on hand to transport students who wished to attend Doe's funeral. School officials said almost all the student body of 1,200 attended. Flags in town were flown at half staff in his honor. Members of the School Committee and the Board of Selectmen are planning to erect a memorial flag pole in front of the high school. Also, a group of Doe's friends intend to plant a memorial tree in City Park during a ceremony this coming Sunday at 2:00 p.m.

Doe was born in Otherville and moved to this town 10 years ago with his parents and sister, Ann. He was an avid member of the high school swim team last spring, and he enjoyed collecting comic books. He had been active in local youth organizations, although he had not attended meetings in several months.

Alternative Report with Low Potential for Promoting Suicide Contagion

John Doe, Jr., 15, of Maplewood Drive, died Friday from a self-inflicted gunshot wound. John, the son of Mary and John Doe, Sr., was a sophomore at City High School.

John had lived in Anytown since moving here 10 years ago from Otherville, where he was born. His funeral was held Sunday. School counselors are available for any students who wish to talk about his death.

In addition to his parents, John is survived by his sister, Ann.

* The names of persons and places in these examples are fictitious and do not refer to an actual event.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 783-3238.

The data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday. Inquiries about the *MMWR* Series, including material to be considered for publication, should be directed to: Editor, *MMWR* Series, Mailstop C-08, Centers for Disease Control and Prevention, Atlanta, GA 30333; telephone (404) 332-4555.

☆**U.S. Government Printing Office: 1994-733-131/83073 Region IV**