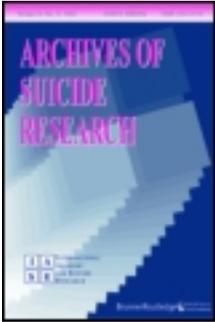


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The influence of television suicide in a normal adolescent population

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Abstract. This cross-sectional study investigated the possible impact of exposure to television suicide on normal adolescents. Students (mean age 14.2 years) from 3 high schools completed a questionnaire on television habits, common television life events, the Youth Self-Report, the Brief Adolescent Risk-Taking Scale and a brief Substance Use Scale.

Students claiming more than two exposures to television suicide took more risks and substances, watched more videos, denied being upset by television, had a history of suicide attempts, knew more of suicide in the community, and had higher depression scores. In those who reported knowing someone who had died from suicide, frequent exposure to suicide on television appeared to contribute to the variance of suicide attempts. In contrast, it contributed little to either depression or suicidal thoughts.

Key words: adolescent, suicidal behaviours, television, influence

The day after a 15-year-old student completed suicide, a friend blocked windows and doors, turning on household gas in the family kitchen with intent to die. Following recovery, she demanded during therapy; “Why shouldn’t I do it; she succeeded, and her life was so much better than mine. I’ve tried before; I thought I might make it this time” (Martin, 1992, p. 28). This vignette graphically illustrates the direct impact of influence (Brent et al., 1989) on an adolescent already considering death. Less direct influence may come from media publicity which “models” suicide, creating “natural advertisements for suicide” (Phillips, Lesyna, & Paight, 1992).

Newspaper suicide stories may lead to imitation (Blumenthal & Bergner, 1973; Hassan, 1995; Motto, 1970; Phillips, 1974; Phillips & Carstensen, 1988; Stack, 1987; Wasserman, 1984), despite equivocal findings (Barracough, Shepherd, & Jennings, 1977; Littman, 1985). Imitation is more likely when the suicide is front page, in large headlines (particularly with “suicide” prominent), heavily publicized, a lengthy report, or concerning political or entertainment celebrities. This suggests “a dose-response relationship” (Phillips et al., 1992).

Evidence for similar effects from television is less clear. Bollen and Phillips (1982) found increased suicides up to 10 days after television news reports about suicide. Effects remained significant after correcting for holidays and unequal variability (Phillips & Bollen, 1985). Multiprogram and highly publi-

cized stories have greatest impact, more affecting youth or those predisposed (Phillips & Carstensen, 1986; 1988). In contrast, Kessler, Downey, Milavsky, & Stipp (1988) noted decreased teenage suicides after newscasts for years 1980–84. Clark (1989) criticized this study for inadvertently diluting the sample with non-celebrity cases and feature stories. Phillips et al. (1992) also criticized the study, and a later reworking (Kessler, Downey, Stipp, & Milavsky, 1989), on methodological grounds and for not restricting attention to multi-program stories.

Holding (1974, 1975) failed to show increased suicidal behaviour following a 10-week fictional series about suicide support. Evidence is not clear (Platt, 1987) regarding increased suicides following a much-publicized British television fictional suicide (Fowler, 1986). In contrast, increased teenage suicidal behaviour was demonstrated after four fictional telemovies (Gould & Shaffer, 1986; Ostroff, Behrends, Lee, & Oliphant, 1985), despite variability between geographic areas (Gould, Shaffer, & Kleinman, 1988). Further, Berman (1988) showed an association with suicidal method following one movie. Strongest evidence for the Werther Effect (Phillips, 1974) is reported by Schmidtke and Häfner (1988).

Fewer studies consider influences on attempted suicide. Studies of completed suicide predominantly use coroner's data regarding patterns of deaths. Hospital admission data about attempted suicide are more complex to collect. Further, only a small percentage of adolescent attempters seek medical help after attempts (Pearce & Martin, 1993; Smith & Crawford, 1986); the true rate of influence from heavily publicized stories may therefore be hidden. Only one study on community adolescents exists showing "behavioural contagion" (Steede & Range, 1989). No attempt was made to define prior vulnerability (Halasz, 1988; Stack, 1993), and the "dose" (Phillips et al., 1992) was small and implicit.

We still know little about what finally triggers suicide. The impact of television suicide on community adolescents is a legitimate area for further study, seeking preventative measures to combat current levels of adolescent suicidal behaviour.

Australians, like Americans and Canadians, are heavy consumers of television; the violence content is comparable (McCann & Sheehan, 1985). Adolescents watch several hours of daily television; attitudes and behaviours are influenced by what they watch (Rubenstein, 1982; Tonge, 1990; Tribunal, 1979). Although non-specific exposure to television may not be a risk factor for suicide (Centerwall, 1990), college students show significant changes in attitude to suicide, as well as emotional arousal, following films about suicide (Biblarz, Brown, Biblarz, Pilgrim, & Baldree, 1991).

Finally, since 1988, access to hired commercial videotapes about suicide (for instance *Night Mother*, *Heathers* or *The Doors*) has burgeoned. Vulnerable young people have the opportunity to replay sequences of interest over and over, increasing the possible “dose-response relationship”. In this empirical community study we postulated that students with suicidal thoughts or behaviours would more likely have seen episodes of television suicidal behaviour.

Method

Design and sample

The study was completed with ethics approval (Committee on Investigations, Flinders University Medical School). Three high schools were chosen randomly; each serves a defined area population in southern metropolitan Adelaide (population 1 million). Sample socio-economic background reflects that of South Australia. School populations are predominantly white anglo-saxon with about 15% mediterranean/european influence, and less than 1% aboriginal students.

Research ideas, questionnaires and plan were discussed in person with school principals, who consented after discussion with teaching staff and parents. An information/assent letter went to parents with the weekly school newsletter two weeks prior to commencement. Questionnaire copies were made available for parents at school offices. All year 10 students present on the day completed the confidential questionnaire with no discussion, in the classroom, during one period of teaching time (approx. 40 mins.). Questionnaires were collected the same day.

Measures

Television habits. Students were asked about quantity, viewing frequency, favourite programs and global responses.

Life events. The questionnaire asked about frequency of experience of 8 life events to compare real life to television experience (possible responses Never, One or Two, More than Two). We chose not to use a life event scale (e.g., Coddington, 1972) because, in this study, we were specifically interested in the impact of self-reported experience of suicide on television, and not in life events as a global issue or total score. Marriage, childbirth, divorce and funerals were chosen as family developmental life crises commonly depicted in television drama. Surgery and car accidents were chosen as two incidental

real life crises, also frequent on television. Murder was chosen to balance suicide, given the common theme of violence and destruction of person.

Suicidal thoughts and behaviour. The questionnaire contained the Achenbach Youth Self Report (YSR; Achenbach & Edelbrock, 1987). Responses to questions 18 (“I deliberately try to hurt or kill myself”), and 91 (“I think about killing myself”), provided information on “deliberate self harm” and “suicidal thoughts”, respectively (possible responses: Never, Sometimes, Often, referenced to the previous six months). While these questions do not address the broad spectrum of suicide, and “deliberate self harm” includes at least two constructs, they provide a valid and reliable screen for suicidal behaviours (Joffe, Offord, & Boyle, 1988; Rey & Bird, 1991; Ritter, 1990).

Depression. The YSR “Depressed” subscale was used as a measure of depressive thought and affect. While there remain questions regarding the subscale’s relationship with clinical depression, it has been used in previous work (Martin, Clarke, & Pearce, 1993; Pearce & Martin, 1993; Ritter, 1990). Male and female subscales contain some different items, providing scores which are not comparable; gender responses are therefore presented separately.

Adolescent risk taking. As noted previously (Martin et al., 1993), there are few simple well-validated questionnaires to measure this potentially serious aspect of adolescent behaviour. The 14 item Brief Adolescent Risk Taking Scale (BARTS), developed by our research unit for use with adolescents, showed a normal curve distribution on a large high school population ($n > 1300$) (Martin et al., unpublished), has content and construct validity, correlates highly with the Achenbach YSR delinquency subscale (Martin et al., 1993) and is a useful screen for risk-taking propensity, although reliability studies are yet to be reported.

Drugs and alcohol. This brief questionnaire, derived from a national survey, contains 10 categories of substances (e.g., Alcohol, Tobacco, Marijuana, Prescribed Drugs). Responses (Never, Once/Twice, 3 to 9, more than 10) are referenced to the previous six months (total score 30). Pearson product-moment, Spearman rho, student’s *t*-test, ANOVA and Chi square were used according to the data type and complexity. Stepwise regression was used to further examine contributions to the variance of depression, risk-taking, substance use and suicide variables.

Results

With a response rate over 90%, 357 students (160 males and 197 females) completed the questionnaire. The mean age was 14.2 years (range 13.4 to 17.6 years).

Television habits

The majority watched 1–3 hours of television a night (61%) with only 16% watching less than 1 hour. More males (26.3%) than females (18.8%) watched more than 3 hours; gender differences were not significant.

Similarly, 58% watched 1–2 videos per week; 32% claiming they watched none. Again, males (13.1%) were more likely than females (6.6%) to watch more than 2 videos ($\chi^2 = 4.36, p < 0.05$). For both genders there was a correlation between daily television hours and weekly videos watched (combined Spearman Rho 0.39, Z corrected for ties 3.87, $p < 0.001$).

The range of program preference, and the relatively small subject numbers, made it difficult to draw conclusions about individual program choice. However, females (73.6%) were almost three times more likely than males (26.4%) to choose “Soopies” as their favourite program (Australian or US content) ($\chi^2 = 30.16, p < 0.001$). Females preferring more violent programs (e.g., China Beach) scored higher on depression (25.00 ± 5.14 compared to 17.00 ± 8.00 , t -value = 4.24, $p < 0.01$, two-tailed), risk-taking (15.64 ± 4.46 compared to 12.40 ± 3.54 , t -value = 2.63, $p < 0.05$, two-tailed), and claimed more suicidal thoughts and acts.

More males (58.0%) than females (28.9%) denied being upset by television ($\chi^2 = 32.53, p < 0.001$); similarly, more males (71.3%) denied being upset by video content (females 41.0%, $\chi^2 = 34.73, p < 0.001$). As many males (5.1%) as females (4.1%) were “often” upset by television programs or video content (2.6% males, 1.5% females).

Watching more television may increase opportunities to see more frequent unpleasant events, leading to more upset. This assumption was not demonstrated for either gender, with a trend for those watching more television to deny upset.

Life events

Few students (Table 1) had not experienced a life event on television, the majority experienced often.

In contrast, real life events are relatively uncommon. We reasoned that any experience of a real life event may have impact on emotional status, whereas only frequent television experience might be influential. In further analysis

Table 1. Comparison of life event experience on television with real life given as percentages; Total $N = 357$

	Never	One or two	More than two
Marriage	36.7	51.1	12.2
Marriage on television	5.6	44.1	50.3
Childbirth	35.8	52.3	11.9
Childbirth on television	23.3	55.7	21.0
Surgery	32.6	56.6	10.8
Surgery on television	9.9	40.8	49.3
Motor vehicle accident (MVA)	49.3	43.3	7.4
MVA on television	9.3	34.6	56.1
Funeral	47.1	43.5	9.4
Funeral on television	17.9	55.8	26.3
Divorce	67.4	27.5	5.1
Divorce on television	28.8	43.2	28.0
Suicide	74.7	21.6	3.7
Suicide on television	31.3	44.6	24.1
Murder	94.4	4.5	1.1
Murder on television	5.3	23.4	71.3

we corrected for this disparity by contrasting any experience (“one or two” *plus* “more than two”) of a real life event against only frequent television experience (“more than two”).

We could discern no relationship between frequency of experience of real life *or* television events and claimed upset by television.

We expected an association between experienced real life events and recall of seeing that event on television. Experience of real life events may influence what is watched; conversely, seeing the television event may prompt recall of a real experience. Indeed, life experience of family childbirth, surgery, motor vehicle accident (MVA), divorce and suicide were associated with claimed frequent experience of the same event on television (Table 2). The relationship is not perfect and, even with a stringent 1% level for chance, there are some associations for which a simple commonsense explanation is not available. The association between suicide experience and television childbirth held true for both males and females, but may be an artifact of students in one school having had a human relations course including childbirth videos. Over 55% students reported more than two exposures, and this happened also to be the school with the highest reporting of suicide exposure.

A strong association existed between experience of completed suicide and exposure to television suicide (Table 2); true for both genders. When only the two schools with the lowest reporting of exposure to suicide were examined

Table 2. Associations between some/frequent experience of real life event and reporting of frequent exposure to same event on television

	(Chi Square)							
	Event in real life							
	Marr.	C/birth	Surg.	MVA	Fun.	Div	Sui.	Murder
On television								
Marriage		5.31	5.87	5.27			6.32	
Childbirth		4.36		6.40		5.44	12.76**	
Surgery		6.50	7.06*				3.87	
MVA				11.00**				
Funeral						4.63	9.13*	
Divorce					4.78	12.21**		
Suicide			4.90	9.18*	6.96*		11.92**	
Murder				9.62*			4.00	

For clarity, Chi square results not included if the probability >0.05
 $p < 0.01$; ** $p < 0.001$.

the association became even stronger ($\chi^2 = 20.21$, $p < 0.001$), supporting the overall apparent relationship. This association is not simply a question of television event frequency; else television murder, a frequent event, might show more associations.

Depression

The YSR depressed subscale mean scores were similar to reported studies (females 18.43 ± 10.18 , males 11.33 ± 6.40). An overall 6.7% scored >2 SD above gender mean ("depressed case", females 8.3%, $N = 16$, males 4.6%, $N = 7$).

As expected, more depressed students claimed more suicidal behaviours. ANOVA demonstrated differences in depression scores between "never", "sometimes" and "often" suicidal thoughts groups (males, F -test 12.83, $p < 0.001$; females, F -test 47.01, $p < 0.001$), with post-hoc Scheffé significant (1% level) for all comparisons except male sometimes/often. Similarly for deliberate self harm, ANOVA demonstrated differences between the three groups (males, F -test 11.07, $p < 0.001$; females, F -test 35.45, $p < 0.001$), post-hoc Scheffé significant (1% level) for all comparisons except male and female sometimes/often.

For both genders, those with higher depression scores watched less television (F -test 3.70, $p < 0.05$). However, "depressed cases" were distributed equally across viewing frequency with the most depressed males watching more television, the most depressed females watching less.

For both genders those highly upset by TV also scored more depressed (combined F -test 11.32, $p < 0.001$). Only 8 of 23 “depressed cases” denied being upset by TV.

Frequent real life events were associated with “depressed case” status, but only suicide reached significance ($\chi^2 = 10.50$, $p < 0.01$). There were no significant associations between depression and events seen on television.

Twenty-six variables were available in this study for multiple regression onto depression. Suicidal behaviours are more likely to *follow* depression and were removed with other variables failing to reach a partial $F > 2.0$. Of the reduced set (nine variables) in stepwise regression, four variables contributed a small 11.3% to the variance of depression (real suicide adjusted R^2 0.05, risk 0.08, childbirth 0.10, upset by video 0.11). No television variable contributed to depression.

Suicidal ideation

More than 26.7% of the sample claimed some suicidal thoughts in the previous six months (females 30.6%; males 22.1%). Rates of frequent ideation (“often”) were similar (males 7.6%, females 7.7%). There was no relationship between ideation and television/video frequency; nor with being upset by TV, even for *frequent* suicidal thoughts.

The only association existing between suicidal thoughts and any life event (16 Real + TV) was with real life suicide exposure ($\chi^2 = 15.75$, $p < 0.001$). However, in multiple regression onto suicidal ideation, suicide exposure did not reach a partial $F > 2.0$. Subsequent stepwise regression entered 5 variables (DSH adjusted R^2 0.26, depression 0.36, risk 0.38, real MVA 0.39, real murder 0.39) contributing a total 39.2% to the variance of suicide thoughts (F -Test 117.61, $p < 0.001$). No television event variable contributed to the variance of suicide ideation.

Deliberate self harm (DSH)

Similarly 15.8% students claimed to have “hurt or tried to kill” themselves within the previous six months, (4.2% “often”). Males were more likely to claim DSH, “sometimes” (16.5%) and “often” (5.1%). A strong association existed between suicidal thoughts and DSH ($\chi^2 = 78.60$, $p < 0.001$) with 44.2% (42 of 95) of those with thoughts also claiming DSH and 75% (42 of 56) with DSH also having suicidal thoughts.

There was no relationship between DSH and television frequency, nor with claimed upset, even for those with *frequent* episodes of self harm. However, males claiming DSH were significantly more likely to watch more than two videos per week ($\chi^2 = 8.25$, $p < 0.01$).

Several significant associations existed for deliberate self harm; television surgery ($\chi^2 = 9.33, p < 0.01$), television funeral ($\chi^2 = 9.41, p < 0.01$), television suicide ($\chi^2 = 16.92, p < 0.001$), and real suicide ($\chi^2 = 15.50, p < 0.001$). Six variables entered stepwise regression (suicidal thoughts adjusted R^2 0.26, video frequency 0.31, real murder 0.34, depression score 0.36, TV suicide 0.37 and gender 0.38) contributing a total 37.9% of the variance (F -test 118.28, $p < 0.001$). While suicidal thoughts contributes most of the variance for DSH, video frequency and TV suicide both appear to contribute.

Risk-taking

Means for risk-taking (male 13.30 ± 4.20 , female 12.40 ± 3.54) are similar to previous work (Martin et al., 1993; Martin, Hazell, Sandercock, & Giannakoureas, unpublished). Risk-taking correlated with depression (male $r = 0.24$; female $r = 0.32$). ANOVA demonstrated significant differences in risk-taking between "never", "sometimes" and "often" groups, for both suicidal thoughts (F -test = 21.10, $p < 0.001$) and DSH (F -test = 18.70, $p < 0.001$). Post-hoc Scheffé tests were significant (1% level) for all comparisons.

Males scoring higher on risk-taking watched more television ($F = 4.44, p < 0.02$) and more videos ($F = 5.68, p < 0.02$). Higher risk-taking scores were significantly associated (1% level) with frequent exposure to all television life events, as well as exposure to more than two MV accidents, or suicides. However, few variables reached partial $F > 2.0$ in multiple regression. Stepwise regression with 8 residual variables entered 5 variables, contributing a total 47.1% of the variance of risk-taking (substance use adjusted R^2 0.39, upset by TV 0.41, suicidal thoughts 0.44, TV frequency 0.46, TV suicide 0.47). Upset by TV had a negative standard coefficient of -0.15 suggesting the more upset students claimed to be, the less likely they were to be risk-takers. Substance use contributed 38.7% of the total variance of Risk-taking.

Substance use

The overall mean was 5.89 ± 4.20 , the mode was 3.00 and a positive skew existed (1.23). Male and female scores were so similar that the sample was treated as a whole. A correlation existed between substance use and depression ($r = 0.20$) and "depressed cases" took significantly more substances (8.57 ± 6.08) than the rest of the sample (5.68 ± 3.83) (unpaired t -value 3.34, $p < 0.001$). ANOVA demonstrated a significant difference in total substance use scores between "never", "sometimes" and "often" groups for suicidal thoughts (F -test 11.59, $p < 0.001$) and DSH (F -test 10.79, $p < 0.001$).

Watching more television was associated with taking more substances. For instance, viewing six or more videos a week was associated with substance

Table 3. Summary characteristics of those claiming frequent exposure to television suicide

	0–2 episodes	N	>2 episodes	N	unpaired <i>t</i>	<i>p</i>
Depression						
Male	10.8 ± 6.1	114	12.8 ± 7.0	44	1.73	0.09
Female	17.8 ± 9.9	151	21.7 ± 10.5	38	2.11	0.04
Risk-taking						
Male	12.9 ± 4.2	114	14.2 ± 4.1	45	1.83	0.07
Female	11.9 ± 3.4	153	14.4 ± 3.6	39	4.04	<0.001
Substance use	5.5 ± 3.8	267	7.2 ± 5.1	85	3.21	<0.01
					χ^2 (1df)	<i>p</i>
TV >3 hours/night	19.9%	53	27.1%	23	1.98	NS
>3 Video/week	7.1%	19	17.7%	15	8.19	<0.01
Upset by TV	60.8%	161	51.2%	43	2.40	NS
Upset by video	46.0%	122	43.9%	36	0.12	NS
Suicidal thoughts	25.2%	67	33.3%	28	2.14	NS
Suicidal acts (DSH)	11.3%	30	30.1%	25	16.92	<0.001

use (substance score 10.71 ± 7.85 , *F*-test 3.62, $p < 0.01$). Those “often upset” by television (8.44 ± 5.80) or video (8.86 ± 3.09) scored significantly higher than the rest of the sample (post hoc Scheffé 1% level).

Significant positive associations existed between substance use and television events (childbirth, surgery, suicide and murder) and real life events (MVA, funeral, divorce, suicide and murder). However, only 8 variables entered stepwise regression. Risk-taking took up the majority of the 41.7% contribution to the variance (risk-taking adjusted R^2 0.38, real suicide 0.41, real divorce 0.42). No television variable contributed to the variance for substance use.

Are students who are aware of television suicide different?

The key issue for this study is whether those claiming frequent exposure to television suicide are different from the remainder of the sample.

Table 3 sets out a summary of major variables, showing they take more risks, use more substances, watch more videos, claim less upset from what they see and have a history of more DSH including suicide attempts. They also tend toward higher depression scores.

Knowledge of a completed suicide is a confounding variable given that 33 of 84 students (39.3%) claiming frequent exposure to TV suicide also claimed knowledge of suicide in real life, compared to 20.5% for the remaining sample

Table 4. Summary characteristics of those claiming knowledge of completed suicide in real life

	Never	<i>N</i>	1,2, or More	<i>N</i>	unpaired <i>t</i>	<i>p</i>
Depression						
Male	10.7 ± 5.8	123	14.4 ± 8.1	28	2.87	<0.01
Female	16.9 ± 9.7	133	21.8 ± 10.2	59	3.21	<0.01
Risk-taking						
Male	12.8 ± 3.1	128	15.4 ± 5.0	29	3.08	<0.01
Female	11.9 ± 3.2	135	13.5 ± 4.0	60	2.90	<0.01
Substance Use						
	5.3 ± 3.8	263	7.8 ± 4.9	89	5.06	<0.001
					χ^2 (1df)	<i>p</i>
TV >3 hours/night	25.5%	67	11.2%	10	7.89	<0.01
>3 Video/week	8.4%	22	12.4%	11	1.25	NS
Upset by TV	57.3%	149	61.8%	55	0.55	NS
Upset by video	43.9%	114	50.6%	44	1.19	NS
Suicidal thoughts	19.9%	52	47.2%	42	25.12	<0.001
Suicidal acts (DSH)	11.5%	30	29.2%	26	15.50	<0.001

($\chi^2 = 11.92$, $p < 0.001$). When suicide knowledge is controlled for, the relationship between TV suicide and DSH loses significance.

Table 4 summarizes the main associations with knowledge of real life suicide, showing these students as a group watch *less* TV and *more* claim upset. They are significantly more depressed, suicidal, risk-taking and substance using, and more have made suicide attempts.

Discussion

This study is the first attempt to describe empirically how television habits and life events experienced through television may influence suicidal thoughts and behaviours in a normal adolescent population. As a pilot study it is cross-sectional, uncontrolled, relies on self-report and many independent variables were studied. In using the 1% level as excluding a chance effect, we may have ignored some associations worthy of further study. Equally, there are limited socio-demographic or family data, and clearly these cannot be ignored (Martin & Waite, 1994). Finally, we have previously criticized some of the key questions used (Martin et al., 1993), as not addressing the complexity of the suicide spectrum.

Despite these valid criticisms, interesting results emerge which deserve further study. First, the study confirms adolescents as heavy consumers of

television and video. While males and females differ little in frequency of television watching, more males watch extreme amounts, watch fewer soaps and in general deny being upset by television or video. Overall, gender differences for being upset may relate to choice, mental set regarding content, or reporting bias; these issues need further examination. The small subgroup of females who watch extreme amounts and/or prefer violent content, appear more disturbed, a pattern similar to our findings on music preference (Martin et al., 1993).

In general, those watching more television and more frequent videos are less depressed. Given higher levels of depression are associated with increased upset by television, it may be that depressed adolescents avoid television. However, there is a gender effect – “depressed case” females tend to watch less television and “depressed case” males watch over 3 hours per night and more than 3 videos per week.

It was no surprise that life events were reported as more frequent on television than in real life. Surprisingly, some young people deny seeing such events on television; 31% had not seen reported or fictional suicide on television. Although they watched more TV, particularly videos, students reporting frequent exposure to television suicide were different; they had higher risk-taking, substance use, and depression scores, and were less upset by what they see. Furthermore, they reported more suicide attempts. Simple associations support this; regression analysis even suggests frequent exposure to television suicide makes a small independent 1.3% contribution to deliberate self harm in this study. It could be argued that suicide attempters report episodes of television suicide because they are more likely to notice it. However, there is there no parallel association for suicidal thinking or depression, both of which have such strong associations with attempts.

Equally complex is the strong association between knowledge of a suicide, reporting of frequent television suicide, and a personal attempt. A prior personal attempt could make the adolescent more aware of a completed suicide in a peer or in the community. Conversely, the death of a peer might normalize suicide (Goldney, 1989) as just one option in response to apparently insoluble personal problems, and therefore influence a personal attempt. Only a prospective study can tease out the sequencing of these events. However, our results suggest a tantalising conclusion; that against a background of psychological disturbance, with prior knowledge of a real life suicide, television suicide may contribute to a personal attempt. If Phillips et al. (1992) are correct about dose-response, repeated exposure may influence the attempt that leads to death. Phillips and others looked retrospectively at deaths from suicide. This study, investigated cross-sectional associations with deliberate self harm, which as a construct certainly includes attempted suicide but may

include other less serious types of self-harm. Further prospective work is necessary to clarify the spectrum of suicide and its relationship with media influence.

A key question is whether this study in any way confirms the proposition that exposure to television suicide can lead to suicide. The study did not seek information on dose-response – what kinds of stories were seen, whether the suicides were famous; how often each story was seen. Despite this, the fact that exposure to television suicide, in a normal population of adolescents, can be shown to make even a tiny contribution, not to depression or suicidal thinking, but to the act of deliberate self harm is intriguing. There is clearly a place for further study of these associations.

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