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“Jumping” and Suicide Prevention



By Robert Olson, Librarian, BA, MLIS

There is a bridge adored and famed
The Golden spine of engineering...

My falling shape will draw a line
Between the blue of sea and sky
I'm not a bird
I'm not a plane

I took the taxi to the gate
I will not go to school again
Four seconds was
The longest wait
“Jumpers” (Sleater-Kinney, 2005)

A suicide can be the most private of acts. An individual, alone and in extreme mental anguish, makes the ultimate decision to sever their bond with this world permanently. No one else may ever know the truth about their silent torment. Even with a suicide note or a message to a loved one, their death is muted and hidden.

When someone dies by jumping from a high place—a building, a cliff, a bridge—it is by its nature a public action. Their secret is out, and the image of the tragedy is an open blemish for all to see.

Suicide by jumping is extremely lethal as **85%** of people who jump from high places will die. Jumping also has the added potential to traumatize those who witness it and endanger the lives of passersby (Beautrais, 2007; National Institute for Mental Health, 2006; Pirkis, 2013).

Jumping as a means of suicide is rare in the West, though in some parts of Asia - Singapore for example - it accounts for as many as **60%** of all deaths by suicide. In North America it is only about **5%**, while in the UK it is **3%** (Beautrais, 2009; National Institute for Mental Health, 2006).

When someone dies by jumping, it is usually from a residential building. These individuals tend to be older and male, and choose to jump from their residences because of easy accessibility and proximity.

Most suicides that occur from more public areas such as bridges or cliffs tend to be done by younger males. They are attracted by the notoriety and reputation of a site; these are known as **suicide hotspots** and are described below. Often, these young men also suffer from severe psychiatric illnesses (Beautrais, 2007).

Despite the rarity of jumping, the image of someone killing him or herself by jumping from a bridge or another high place is a powerful one. It resonates profoundly in the public consciousness.



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I want to look at why people choose to die by jumping, and the struggles that have arisen in trying to prevent these deaths.

Iconic Sites

A suicidal hotspot, also known as an “iconic site” or “suicide magnet,” is almost always a jumping site. It is “A specific, usually public, site which is frequently used as a location for suicide and which provides either means or opportunity for suicide.” The Golden Gate Bridge, the Eiffel Tower, and Niagara Falls are the world’s most infamous hotspots (National Institute for Mental Health, 2006).

Perron (2013) describes what makes a site “iconic.” He lists qualities such as **ease of access**, perceived **lethality** of the jump, **media attention**, and **unique features** such as overlooking water.

Suicides at these iconic sites are far from common, yet they receive a disproportionate amount of media attention and coverage. In 1995, as the 1000th suicide at the Golden Gate Bridge approached, the local media had to be asked to refrain from reporting and commenting on this phenomenon. Rather callously, some radio stations were actually “counting down” in anticipation of the “milestone.” One station went to the crude extreme of offering a case of Snapple to the family of the 1000th jumper! (Friend, 2003). This bridge has been the world’s most frequented suicide location since its construction in 1937. To date, there have been over 1600 suicides.

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The “symbolism and romanticism associated with an iconic site plays a decisive additional role for those who choose to jump from such sites” (Beautrais, 2009, p.9). People will choose a particular site if they believe that it is relatively accessible, if they can avoid disfigurement, and they feel that it will provide them with a quick and certain death. (A major fallacy in the case of the Golden Gate is that jumping from the bridge will help an individual avoid disfigurement and be relatively painless. In reality, jumpers from the enormous bridge encounter extreme internal injuries upon impact and, if they survive the landing, almost always drown or die from

internal bleeding in the aftermath. It is a four second free-fall into massive pain.)

The attraction can be so strong to a given location that an individual will often not even consider an alternative to their choice (Beautrais, 2009). Survivors of attempts at the Golden Gate have described travelling from Oakland where there is a suitable bridge—the Bay Bridge, spoken of as “tacky”—in order to jump from San Francisco’s notorious spot. For someone seeking a seemingly romantic end to their life, the Bay Bridge simply will not do. The Golden Gate is “unrivalled as a symbol: it is a threshold that presides over the end of the continent and a gangway to the void beyond” (Friend, 2003).

The lyrics from the song by Sleater-Kinney that begin this column are seemingly about jumping from the Golden Gate. It is a poignant and powerful tune. Yet it does appear to glamorize suicide from this particular locale.

References to this bridge and suicide are everywhere in popular culture.

More than one suicide at a particular site should always give cause for concern. Although two deaths do not necessarily indicate a hotspot, it nonetheless suggests that the location has appeal for suicidal individuals (Cox, 2013). So when suicides do occur at a site - a particular bridge, for example - what can be done to deter people from jumping from it in the future?

Erection of Barriers

Most bridges are not “hotspots” and most jumping suicides do not occur at such sites. This makes any solution, such as the installation of a barrier, more problematic. An oft-repeated argument is that a suicidal individual may simply go to a similar location that does not have any obstacles.



When discussions about preventing suicides on bridges take place, the issue of constructing physical barriers is perennial. The fact that a properly installed barrier will stop suicides is not up for dispute, yet there is no shortage of people who are opposed to them.

Glasgow (2008) argues that barriers may save lives at one location, but it has not been shown that these barriers will prevent someone from killing him or herself at an alternative place. This effect is referred to as **displacement**. He says that a barrier may also fail to prevent someone from using another means to die by suicide. This is called **substitution**. He further stresses that most people who jump suffer from more severe psychiatric illnesses than people who kill themselves by other means. The presence of this additional factor means that these individuals are less likely to be deterred by barriers.

A study of the Bloor Street Viaduct in Toronto and the suicides that occurred from 2003 and 2007 found evidence of this type of location displacement. After the barrier was erected in 2002, suicides at the site were eliminated. However, the rate of jumping suicides in the surrounding local area remained unchanged during this period. The authors found that suicides began occurring at other bridges in the area.

They also determined that the viaduct had nothing distinguishing about it, and nothing that would designate it as a "hotspot". Despite being the second most popular suicide site in North America before the barrier installation (second to the Golden Gate), the authors concluded that it was a "weak suicide magnet". It is not a particularly beautiful structure, nor is the area in which it is located. It overlooks roads instead of water, and has none of the mythic and romantic connotations that an iconic site usually has. Nevertheless, the barriers did what they were designed to do by stopping suicides. Unfortunately, the barriers could not prevent displacement (Sinyor, 2010).

Others are opposed to barriers on **aesthetic** grounds. Perhaps the most infamous case of opposition is the resistance to the implementation of a barrier on The Golden Gate Bridge. The argument put forth is that the scenic beauty both of the bridge and its surrounding area would be compromised. Although this struggle has gone on for decades, there is hope that a safety net – a possible alternative to a barrier - may finally be installed: <http://nyr.kr/1kNQhEb>

Other arguments against barrier installation have been that the **cost of barriers** is too great to justify saving such a relatively small number of lives. Another is that the **engineering challenges** that come with the installation of barriers to existing structures are too expensive and substantial to overcome, and that the money earmarked for prevention would be better spent in **other areas of mental health**. Perhaps the most cynical of all, however, is the argument that these **suicides are inevitable** and that no amount that is spent on prevention will stop them from occurring (Beautrais, 2009).

Some have found contrary results in the study of suicide barriers. Perron (2013) studied the Jacques Cartier Bridge in Montreal, long a suicide hotspot. An attempt was made to stem the rash of suicides by constructing a barrier in 2004. Unlike what happened with the Bloor Street Viaduct barrier, there was no displacement to other bridges in the area despite there being several in the near vicinity. The most interesting finding, however, was that there was a sharp decrease in the local suicide rate after the barrier was installed. This may suggest that substitution of means of suicide did not occur either.

Another significant study looked at the Grafton Bridge in Auckland, New Zealand. Barriers were erected in the 1930's based on a coroner's recommendation. Complaints were raised for decades concerning the "unsightliness of the barriers," and there were repeated calls for their removal. City Council acquiesced in 1997, and the barriers were removed. In 2001, however, researchers discovered a five-fold increase in suicide in the preceding four year period. They then took the unprecedented action of installing brand new barriers with an "improved, curved design". After these were installed, the suicides stopped entirely (Beautrais, 2009).

One sound argument for the erection of barriers is that it allows for a "buying of time" that gives the individual a chance to reconsider his or her actions. This is a critical opportunity for intervention. In his memoir of a suicide attempt from the Golden Gate Bridge, Kevin Hines describes his regret the moment he stepped off the bridge (2013). He was suffering from bi-polar disorder, and he recounts his bus ride



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to the infamous bridge as one filled with ambivalent thoughts. He wavered between his seemingly determined decision to die, and an alternative wish to be “found out” and rescued. His wish to die, unfortunately, won out, and as he jumped the rail he remembered saying to himself “What have I done? I don’t want to die. God, please save me!” (p. 60).

Very few people survive a jump from the Golden Gate Bridge. Only **25** of the **1600+** people who have jumped from the landmark have lived to talk about it. Hines survived because he had both the presence of mind and desire to live to turn around and land feet-first in the water. This is the only way that anyone has ever survived the fall.

This seems to be a common experience shared by people who survive an attempted suicidal jump - they decide that they want to live immediately after they leap. Evidence of this shared experience can also be found in the documentary, **The Bridge** by Eric Steel (2006). The filmmakers spent a year filming suicides and thwarted attempts from the Golden Gate Bridge. It is chilling and illuminating when the attempt survivors all state during separate interviews that they regretted their suicidal decision. It is interesting to imagine that the existence of an impassable barrier could have helped in delaying their suicidal acts or stopped them entirely.

Best practices recommend that barriers should be added to sites which become popular, and that they should also be considered as a feature in the design of new structures.

This was corroborated by an important study by Pirkis, et al. (2013) which examined nine studies of interventions at suicidal hotspots. They concluded, “There is strong evidence that installing structures like barriers or safety nets at known jumping sites is an effective suicide prevention strategy” (p.547).

Some recommendations in the design of barriers include: having a **minimal visual impact on the bridges** and **surrounding geography** and **natural environment**; being **cost-effective** to construct and install; and ensuring that they are **structurally stable** and easy to maintain (Beautrais, 2009).

Suicide barriers will not deter all suicides, and, perhaps obviously, barriers should be augmented at certain “hotspots” with other practices that prevent suicide. Some of these additional prevention measures include: encouraging **help-seeking** (installing signage and telephone access); increasing **third-party intervention** (closed circuit television, security patrols); providing **guidance on responsible media reportage** of suicide; having modified **pedestrian access**; or the installation of **temporary barriers** (Cox, 2013; Beautrais, 2009).

Whether a site of repeated suicides requires a barrier or another prevention measure should not be up for debate. If suicides have occurred previously in the location, I would argue that it is worth the expense. Even one suicide is too many.

Suicide affects us all, and when it is done in such a public manner its effects are greater still. Barriers and other prevention methods may not stop an individual from ultimately taking his or her life because the act of suicide is far too complex to be solved with a single preventative measure. Nevertheless, multiple efforts to prevent suicide are reflective of a compassionate society that cares about and, thus, attempts to protect its vulnerable citizens.

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