

Portrayal of Suicide in Kenyan Television News: Stigma, Sensationalism, and Compliance with Responsible Reporting Standards

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ABSTRACT

Media coverage of suicide has measurable effects on public attitudes and suicidal behavior. Kenyan television news remains entirely unstudied in this regard, and no published evidence exists on whether Kenyan broadcasters meet responsible reporting standards. This leaves journalists, regulators, and mental health advocates without a basis for intervention. Anchored in stigma theory and media contagion theory, this study employed a quantitative content analysis of 43 victim-centered broadcast news stories from four major Kenyan television stations (KTN, NTV, Citizen TV, and K24) aired between 2015 and 2025. Findings reveal pervasive non-compliance. Stigmatizing terminology appeared in 44.2% of stories and sensational vocabulary in 79.1%, while clinical framing was absent in 72.1% of reports. Although 48.8% of stories fully humanized the deceased, 72.1% ignored any mental health history. WHO responsible reporting compliance was consistently low, with a mean Don'ts score of 3.60 out of 8 and a mean Dos score of 0.58 out of 4. These findings suggest that Kenyan television suicide coverage predominantly operates within the Werther risk zone rather than the Papageno protective zone. The study calls on broadcasters, journalism trainers, and the Media Council of Kenya to develop sector-specific responsible reporting guidelines, integrate mental health literacy into editorial workflows, and establish sustained partnerships with mental health professionals as credible expert sources.

Keywords: Suicide Reporting, Kenyan Television, Stigma, Media Contagion, Mental Health Communication

INTRODUCTION

Suicide is a global public health concern, claiming approximately 700,000 lives each year, with the burden falling disproportionately on low- and middle-income countries (WHO, 2023). In Kenya, official statistics from the National Syndromic Surveillance System identify suicide as one of the leading causes of injury-related mortality, though actual numbers are widely believed to be undercounted due to stigma, underreporting, and classification inconsistencies (Ministry of Health Kenya, 2020). What makes the Kenyan situation particularly pressing is the intersection of rising mental health awareness with the continued persistence of media practices that may undermine it.

Television is the dominant source of news for most Kenyan households, reaching both urban and rural audiences through terrestrial and satellite broadcasting (Communications Authority of Kenya, 2023). As a medium, it exerts a documented influence on how audiences understand and respond to health issues, including mental illness and suicide. Research conducted across multiple countries has established that the manner in which suicide is reported has measurable effects on subsequent suicidal behavior, particularly among vulnerable individuals. Sensational, detail-heavy, or stigmatizing coverage can trigger imitative behavior, a phenomenon known as the Werther Effect (Phillips, 1974). Coverage that emphasizes help-seeking, recovery, and the human dimensions of mental illness has been shown to have a protective effect, termed the Papageno Effect (Niederkrötenhaler et al., 2010).

Despite these well-documented effects, Kenyan broadcast journalism has received minimal systematic scholarly attention in relation to suicide and mental health reporting. Across Africa more broadly, studies on media and

mental health remain sparse, with the few existing works focusing predominantly on print media or digital platforms (Quarshie et al., 2021; Oyetunji et al., 2021). In Kenya specifically, existing studies have examined related but distinct areas, with Ogeri et al. (2021) exploring social media in mental health practice and Muchemi et al. (2025) investigating community radio as a tool for youth mental health awareness. Kenyan television, however, remains entirely unexamined as a medium for mental health and suicide coverage.

Problem Statement

The relationship between media coverage of suicide and public health outcomes is well established, and Kenya presents a context in which these stakes are high, and the evidence base is entirely absent. Research conducted in Europe, North America, and parts of Asia has demonstrated that irresponsible coverage increases suicide risk in vulnerable populations, while responsible coverage can reduce it, prompting the WHO and the International Association for Suicide Prevention to issue detailed guidelines for journalists (Domaradzki, 2021; Niederkrotenthaler et al., 2010; Stack, 2005; WHO, 2017). In Kenya, mental health conditions are prevalent, access to professional care is severely limited, and television news takes on an outsized role as a shaper of public attitudes. No published study has examined whether Kenyan broadcasters align with responsible reporting standards or whether current practices risk worsening patterns of stigma and contagion that those standards are designed to prevent (Mutiso et al., 2017; Oyetunji et al., 2021). Without this evidence, broadcasters, journalism trainers, media regulators, and mental health advocates cannot make informed interventions. The Media Council of Kenya (MCK) Code of Conduct addresses harmful content, but its application to suicide reporting is unsupported by any documented analysis of what Kenyan stations are actually producing. This study sought to address that problem directly.

Objectives

The general objective of the study was to analyze the portrayal of suicide in Kenyan television news reporting. The following three specific objectives further guided the inquiry:

1. To examine the language and terminology used in Kenyan television suicide coverage.
2. To examine the portrayal of individuals who die by suicide in Kenyan television news.
3. To assess adherence to the WHO guidelines and the MCK Code of Conduct in Kenyan television suicide coverage.

THEORETICAL FRAMEWORK

Stigma Theory

Stigma theory, developed by Erving Goffman (1963), provides a framework for understanding how social processes mark certain individuals as less than fully human. Goffman argued that stigma operates through the attribution of deeply discrediting characteristics that reduce a person from a whole and usual one to a tainted, discounted one. Applied to mental illness, this operates through labeling, stereotyping, social separation, and status loss, all of which are mediated by institutions such as the media (Link & Phelan, 2001). Link and Phelan's extension of Goffman's framework demonstrated that stigma is not merely a matter of individual attitude but is embedded in structural arrangements that give stigmatizing labels their social power. In media contexts, this means that the language and framing journalists choose are not neutral descriptive acts; they reflect and reinforce broader social hierarchies that determine whose suffering is treated as worthy of empathy and whose is attributed to moral failure.

Research has documented that terms such as "committed suicide" carry implicit criminal or sinful connotations absent from medically accurate alternatives such as "died by suicide" (Corrigan et al., 2012; Jamieson et al., 2003). Coverage that frames suicide as a product of weakness or recklessness, rather than as a consequence of treatable illness, reinforces stigma that discourages help-seeking (Reavley & Jorm, 2011). In the Kenyan context, stigma around mental illness is heightened by additional cultural and religious dimensions, with mental illness

frequently attributed to supernatural causes, moral transgression, or personal inadequacy in popular media (Madu & Peltzer, 2004; Mutiso et al., 2017). Stigma theory provides the conceptual vocabulary to identify these processes in broadcast texts and to evaluate their social consequences.

Media Contagion Theory

Media contagion theory holds that the content and style of suicide coverage directly influences the likelihood of subsequent suicidal behavior in the audience. The empirical foundation was established by David Phillips (1974), who demonstrated that suicide rates in the United States rose in the weeks following front-page newspaper coverage of suicides, a finding he named the Werther Effect in reference to Goethe's *The Sorrows of Young Werther*, whose 1774 publication was associated with a wave of imitative suicides across Europe. Stack's (2005) meta-analysis of 55 studies later found that coverage of celebrity suicides was 5.27 times more likely to produce a finding of contagion in the research literature than coverage of non-celebrity cases, a finding that speaks to the elevated risk associated with prominent suicide events. Ueda et al. (2017) further found that social media reporting of celebrity suicides on Twitter was associated with subsequent increases in actual suicides, suggesting that this contagion risk extends beyond traditional media into digital platforms where celebrity deaths attract particularly wide and rapid exposure.

Niederkröthaler et al. (2010) introduced a corrective to the dominant focus on harm by demonstrating that coverage emphasizing coping, help-seeking, and the possibility of recovery was associated with reduced suicide rates in the period that followed, an effect they named the Papageno Effect after the character in Mozart's *The Magic Flute* who is dissuaded from suicide by reflecting on reasons to live. These two effects now form the main evaluative axis of research on media and suicide: coverage that sensationalizes, romanticizes, or provides detailed method information poses contagion risk, while coverage that humanizes victims, acknowledges mental illness, and directs viewers towards resources may reduce it (Domaradzki, 2021). The WHO responsible reporting guidelines are grounded directly in this body of research and provide the normative benchmark against which this study evaluates Kenyan television practices.

LITERATURE REVIEW

Media Coverage of Suicide and Its Effects

The literature on media and suicide now spans multiple disciplines and is extensive. The foundational insight established by Phillips (1974) and replicated across dozens of national contexts is that exposure to suicide-related media content can trigger imitative behavior. Gould et al. (2003) reviewed the empirical literature and concluded that evidence for contagion effects is robust, particularly for young people, who are especially susceptible to identification with depicted individuals. Pirkis and Blood (2010) further found that the risk of contagion is highest when coverage includes specific method details, romanticizes or glorifies the death, and presents the deceased as similar to the target audience.

The Papageno Effect has received growing scholarly attention since Niederkröthaler et al.'s (2010) original study. Till et al. (2017) found that media coverage emphasizing suicidal ideation being overcome through coping was associated with reduced suicidal ideation in exposed readers, reinforcing the argument that responsible coverage is not simply a matter of avoiding harm but of actively providing a protective resource for vulnerable audiences (Calvo et al., 2024). Research on language in suicide reporting has consistently shown that terminology carries embedded moral judgments: Jamieson et al. (2003) found that stigmatizing language in news coverage was negatively correlated with public willingness to support mental health funding, while research on terminological framing has demonstrated that exposure to the phrase "committed suicide" is associated with greater stigmatizing attitudes towards people with mental illness compared to exposure to the clinically preferred alternative "died by suicide" (Whitley & Wang, 2017).

Suicide Reporting in the African Context

Research on media and suicide in sub-Saharan Africa is considerably less developed than in the Global North,

reflecting broader inequities in research capacity and funding. Quarshie et al. (2021) studied Ghanaian online media coverage of suicide and found that the dominant pattern was non-compliance with WHO guidelines, with stigmatizing framing throughout, and the vast majority of reports mentioning the specific method. Oyetunji et al. (2021) reached similar conclusions in a study of Nigerian newspaper coverage, noting that stigmatizing language was the norm and WHO guidelines were rarely followed. Both studies call for training interventions and regulatory frameworks to shift journalistic practice.

In the Kenyan context, research on media and mental health has focused mainly on social media and its role in awareness campaigns rather than broadcast journalism (Ongeri et al., 2021). Mutiso et al. (2017) documented widespread stigmatizing attitudes towards mental illness among the Kenyan general public, attributing these in part to media representations equating mental illness with violence and moral failure.

WHO Guidelines, Journalist Practice, and Stigma

The WHO has issued and periodically revised guidelines for responsible media coverage of suicide since the 1990s, most recently updated in 2017, with a further revision issued in September 2023 that incorporated growing evidence on the Papageno effect and added guidance on decriminalization advocacy (WHO, 2023). These guidelines advise against broadcasting the method or location of suicide, using romanticizing or sensationalizing language, presenting suicide as a solution to life problems, or identifying the deceased in ways that compromise bereaved families' privacy. They recommend including crisis resource references, using clinically accurate language, contextualizing deaths within the broader landscape of mental illness and treatment, and consulting mental health professionals (WHO, 2017).

Compliance with these guidelines is uneven, even in high-income countries. Pirkis et al. (2019) assessed Australian broadcast coverage and found that while explicit method reporting had declined following training interventions, sensationalism and stigmatizing language remained common. Thom et al. (2012) reviewed New Zealand coverage and found that fewer than half of the stories mentioned mental illness as a contributing factor, and fewer than a quarter included crisis resource references. Studies from South Asia document even lower rates of compliance (Arafat et al., 2020). The relationship between media-reinforced stigma and reduced help-seeking is well documented across this literature: Clement et al. (2015) identified stigma as one of the main barriers to seeking mental health treatment, and Wyllie et al.'s (2025) scoping review confirmed that suicide-related stigma consistently reduced help-seeking intentions across multiple affected groups, including those with a history of suicidal ideation, suicide attempts, and those bereaved by suicide. In Kenya, where the ratio of psychiatrists to population stands at approximately 1 per 500,000 (WHO, 2020), the deterrent effect of media stigma in an environment where structural access barriers are already severe carries amplified public health consequences.

METHODOLOGY

This study is situated within a post-positivist philosophical paradigm, which holds that social phenomena, including the content of media texts, exhibit patterns that can be measured and described systematically, even though observation is always shaped by prior theoretical commitments (Creswell & Creswell, 2023). A post-positivist orientation is appropriate here because the study applies a pre-established, internationally validated instrument derived from WHO guidelines to a defined corpus of broadcast texts, and it seeks to establish quantifiable patterns of compliance and non-compliance that can be compared across stations, time periods, and prior studies. Television news broadcasts were understood not as neutral accounts but as socially produced texts whose language, framing, and omissions carry ideological and public health implications. This recognition shaped the construction of the coding instrument without displacing systematic measurement as the primary mode of inquiry. The study combined quantitative content analysis with interpretive discussion of why the documented patterns matter, an approach that enabled both enumeration of observable features and contextualized explanation of their significance.

Content analysis was the chosen method, selected because it enables systematic, replicable examination of a defined corpus of media texts, supports quantification of both presence and absence of specific features, and allows direct comparison with prior studies using equivalent coding frameworks (Krippendorff, 2019;

Neuendorf, 2017). The corpus comprised 43 victim-centered broadcast news stories drawn from the YouTube archives of KTN, NTV, Citizen TV, and K24, the four stations that collectively dominated general-interest television news in Kenya (Communications Authority of Kenya, 2023), covering January 2015 to December 2025. Stories were included through purposive sampling when an individual victim, survivor, or bereaved family member served as the main subject of the report. Identification was carried out through keyword searches using the terms “suicide,” “died by suicide,” “commits suicide,” “kujiua,” “kujitua uhai,” and “afya ya akili,” yielding a final sample distributed as follows: KTN (n = 12), NTV (n = 14), Citizen TV (n = 9), and K24 (n = 8).

Each story was coded against nine variables organized into three clusters benchmarked against WHO guidelines (2017) and the MCK Code of Conduct: language and terminology (terminology classification, sensational vocabulary, and clinical framing); victim portrayal (tone, humanization index, and acknowledgment of mental health history); and adherence to responsible reporting standards (composite scores derived from WHO Don’ts, WHO Dos, and the MCK Code). To ensure intercoder reliability, a randomly selected subsample of 10% of the corpus (n = 4 stories, drawn from all four stations) was independently coded by a second coder following completion of coder training on the instrument definitions and decision rules. A 10% reliability subsample is the standard minimum for content analysis studies (Lombard et al., 2002; Neuendorf, 2017). Cohen’s kappa was calculated for all variables requiring interpretive judgment, with a minimum acceptable threshold of 0.70 (Landis & Koch, 1977). The obtained kappa values exceeded this threshold across all variables, thus confirming adequate intercoder agreement before full coding proceeded. Quantitative findings were analyzed using descriptive statistics, with results reported as frequencies, percentages, and mean values. Since all data were derived from publicly available archival broadcast material, the study raised no human subjects concerns.

FINDINGS

This section presents the results of the content analysis organized around the three study objectives: language and terminology, portrayal of individuals who died by suicide, and adherence to WHO guidelines and the MCK Code of Conduct. The focus throughout is on patterns observed across the corpus as a whole, reflecting the aggregate character of Kenyan television suicide coverage during the period.

Language and Terminology

Terminology Classification

The most prevalent pattern in the corpus was the use of stigmatizing terminology. The phrase “committed suicide” appeared in 19 of 43 stories (44.2%), making it the single most common terminological pattern in the sample. Responsible language, that is, “died by suicide,” “took their life,” or the Swahili equivalent “*amejitua uhai*,” was used in 15 stories (34.9%). A mixed pattern, defined as the co-occurrence of both responsible and stigmatizing language within the same story, was found in 9 stories (20.9%). In practice, this typically took the form of responsible usage in the reporter’s narration alongside stigmatizing language in on-screen lower thirds or YouTube titles, thereby exposing a disconnect between spoken editorial choices and production-level decisions. No story relied exclusively on criminalizing language such as “killed himself” or “killed herself,” although such phrasing occasionally appeared as a sub-element within mixed-terminology stories.

Table 1: Terminology Classification by Station

Station	Responsible	Stigmatizing	Mixed	Total n
KTN	3 (25.0%)	7 (58.3%)	2 (16.7%)	12
NTV	5 (35.7%)	3 (21.4%)	6 (42.9%)	14
Citizen TV	2 (22.2%)	6 (66.7%)	1 (11.1%)	9
K24	5 (62.5%)	3 (37.5%)	0 (0.0%)	8

Note. Responsible = “died by suicide” or equivalent; Stigmatizing = “committed suicide”; Mixed = both types within a single story. Percentages are within-station proportions.

Sensational and Morally Charged Vocabulary

Sensational vocabulary was present in 34 of 43 stories (79.1%). Of these, 16 stories (37.2%) registered a high count of three or more loaded terms per story, and 18 (41.9%) registered a low count of one to two terms. Only 9 stories (20.9%) were entirely free of sensational or morally charged vocabulary. Frequently recurring terms across the corpus included “shocking,” “bizarre,” “disturbing,” “tragic end,” and “botched attempt.” The presence of sensational vocabulary correlated with lower WHO Don’ts compliance scores, consistent with overlap between the sensationalism sub-items in the compliance coding scheme.

Clinical and Mental Health Framing

Clinical or mental health framing was the least common language variable in the corpus. Only 12 of 43 stories (27.9%) employed clinical language such as “depression,” “psychiatric condition,” “mental illness,” or “acute emotional distress.” The remaining 31 stories (72.1%) framed the events without any reference to mental health, relying instead on police statements, family testimony about triggering events, or descriptive accounts of the method or circumstances of death. Stories that did employ clinical framing were disproportionately concentrated in the post-2022 period, suggesting an emergent but still partial shift towards health-framed journalism in more recent years.

Portrayal of Individuals Who Die by Suicide

Victim Portrayal Tone

The most common portrayal tone was neutral, recorded in 19 stories (44.2%). Sympathetic framing appeared in 12 stories (27.9%), concentrated in reports involving young victims, children, or individuals situated within narratives of structural disadvantage such as school-fees poverty or unemployment. Blaming framing was recorded in 10 stories (23.3%), concentrated in coverage of murder-suicide cases in which perpetrators killed family members before taking their own lives, a pattern in which editorial condemnation was explicitly directed at the deceased. Cautionary framing, in which the death was positioned as a warning to audiences, was recorded in 2 stories (4.7%).

Humanization Index

The median humanization score across the full sample was 1, indicating partial humanization on a three-point scale ranging from 0 (none) to 2 (full), and the distribution was moderately favorable relative to other variables. Full humanization was recorded in 21 of 43 stories (48.8%), with these stories featuring names, ages, family descriptions, community roles, or accounts of the deceased’s personality and aspirations. Partial humanization appeared in 16 stories (37.2%), where only one individualizing detail, typically a name or occupational title, was provided. Complete absence of humanization was recorded in 6 stories (14.0%), with coverage functioning as statistical or institutional reporting that reduced victims to data points or anonymous case numbers.

Paradoxically, the absence of humanization did not uniformly correlate with poor compliance on other variables. Several stories with no humanization were public-health feature packages that deliberately avoided naming or personalizing victims as a responsible-reporting measure, thus confirming that low humanization can reflect either a deficit or a deliberate editorial choice depending on story type.

Acknowledgment of Mental Health History

Acknowledgment of prior mental distress, a diagnosis, or help-seeking behavior was absent in 31 of 43 stories (72.1%) and present in only 12 (27.9%). In the absence of such acknowledgment, stories typically attributed the suicide to a single, immediate external trigger, such as a failed examination, a romantic dispute, a financial loss, or a family conflict, without any reference to underlying vulnerability or prior mental health history. This monocausal narrative structure was the dominant explanatory frame for individual deaths in the corpus.

Adherence to WHO Guidelines and the MCK Code of Conduct

WHO Don'ts Compliance Score

The mean WHO Don'ts compliance score for the sample was 3.60 out of a maximum of 8 (SD = 1.40), representing an overall compliance rate of 45.1%. The median was 3, meaning the typical story complied with fewer than half of the eight “don't” criteria. More than half of all stories, 24 out of 43 (55.8%), violated the majority of criteria, indicating widespread non-compliance. Only 5 stories (11.6%) achieved high compliance. Analysis of individual sub-items revealed the following violation rates: detailed method description was violated in 84% of stories; exact location details in 79%; oversimplified causal framing in 72%; sensational headlines in 67%; and reproduction of suicide notes or final messages in 33%. A temporal comparison indicated improvement: pre-2022 stories (n = 15) had a mean Don'ts score of 3.00, while post-2022 stories (n = 28) averaged 3.93, suggesting a measurable but partial improvement over the latter part of the sample period.

Table 2: WHO Don'ts Compliance Scores by Station

Station	Mean score	Compliance rate	Majority violations	High compliance
KTN (n = 12)	3.08	38.5%	8 (66.7%)	0 (0.0%)
NTV (n = 14)	4.14	51.8%	6 (42.9%)	3 (21.4%)
Citizen TV (n = 9)	3.44	43.1%	6 (66.7%)	1 (11.1%)
K24 (n = 8)	3.63	45.4%	4 (50.0%)	1 (12.5%)

Note. Majority violations = stories where the WHO Don'ts score was 3 or below (fewer than 4 of 8 criteria met). High compliance = stories scoring 6 or above. Percentages are within-station proportions.

WHO Dos Inclusion Rate

The WHO Dos inclusion rate was the weakest compliance measure in the study. The mean Dos score across the sample was 0.58 out of 4 (14.5%), and 33 of 43 stories (76.7%) included none of the four recommended supportive elements: helplines or crisis resources, a mental health expert source, a framing of suicide as preventable, or a coping or recovery narrative. Only 9 stories (20.9%) included two or more of these elements. The maximum was achieved by a single story (an NTV feature package on youth mental health broadcast in 2022), which included all four. The pattern indicates that across all stations, the provision of protective resources to viewers was largely absent from suicide coverage and remained the dimension of responsible reporting most consistently neglected.

MCK Code of Conduct Alignment

The mean MCK Code alignment score was 1.49 out of 3 (49.7%). The majority of stories, 26 of 43 (60.5%), met only one of the three MCK sub-criteria. Thirteen stories (30.2%) met two sub-criteria, and only 4 stories (9.3%) achieved full alignment. These four fully aligned stories were all post-2022 public-health or data-driven reports rather than breaking-news bulletins. The most common MCK violations involved sensationalism and privacy breaches against bereaved families, the latter typically manifested through footage of grieving relatives filmed outside mortuaries without consent. Graphic content violations were less frequent but present in stories that displayed on-screen lower-thirds identifying specific method details or broadcast photographs of the scene.

Table 3: Summary of All Nine Variables Across the Full Sample (N = 43)

Variable	Key finding	Compliant rate
Terminology	Stigmatizing = 44.2%; Responsible = 34.9%; Mixed = 20.9%	34.9%
Sensational Vocabulary	79.1% any sensational terms; 37.2% high (3+ terms)	20.9% (none)
Clinical Framing	Absent in 72.1% of stories	27.9%

Victim Tone	Neutral 44.2%; Sympathetic 27.9%; Blaming 23.3%	27.9% sympathetic
Humanization Index	Full 48.8%; Partial 37.2%; None 14.0%; Median = 1	48.8% full
Mental Health History	Absent in 72.1% of stories	27.9%
WHO Don'ts (0–8)	Mean 3.60/8; 55.8% majority violation	45.1%
WHO Dos (0–4)	Mean 0.58/4; 76.7% included nothing	14.5%
MCK Code (0–3)	Mean 1.49/3; 60.5% minimal compliance; 9.3% fully aligned	49.7%

Note. WHO Don'ts: 8-item composite (0–8); higher scores indicate greater compliance. WHO Dos: 4-item composite (0–4); higher scores indicate more supportive elements included. MCK Code: 3-item composite (0–3).

DISCUSSION

The Language of Stigma and Institutional Reproduction

The finding that stigmatizing language was the single most common terminological choice, appearing in 44.2% of stories, is consistent with, and in some respects surpasses, patterns documented in comparable African contexts. Quarshie et al. (2021) found that Ghanaian online media routinely used criminalizing and stigmatizing terminology, and Oyetunji et al. (2021) reported similar patterns in Nigerian newspapers. This study confirms that broadcast journalism in Kenya participates in this regional pattern, standing in contrast to the documented decline of such language in parts of the Global North following sustained journalist-training interventions (Pirkis et al., 2019).

The theoretical framework provided by Link and Phelan (2001) helps explain why the persistence of stigmatizing terminology matters beyond stylistic convention. When journalists default to “committed suicide,” they reproduce a discursive structure that encodes the act as a moral failing or a transgression of social rules, whose roots lie in the historic criminalization of suicide in English common law. Research on terminological framing has demonstrated empirically that exposure to this language increases stigmatizing attitudes towards people with mental illness (Whitley & Wang, 2017), and the present finding that this language continues to dominate Kenyan broadcasting suggests that these attitudinal effects are being reproduced at scale. Given Mutiso et al.’s (2017) finding that stigmatizing attitudes towards mental illness are prevalent in Kenya and are shaped by community-level cultural frameworks, the additive effect of terminological stigma in broadcast contexts is a matter of public health consequence.

The prevalence of mixed coding (20.9%), referring to stories that contain both responsible and stigmatizing terminology within the same report, deserves particular attention. Rather than representing a coherent editorial position, this pattern reflects a production-level inconsistency: the terminology a journalist chooses when scripting a report does not necessarily carry through to text overlaid by a graphics editor or uploaded by a digital team. This exposes the architecture of newsroom production, where individual reporters may be more language-aware than production editors, or where training uptake among on-air journalists has not been matched by equivalent change in graphic production workflows. This mirrors the structural inconsistencies observed by Thom et al. (2012) in New Zealand broadcast media, where language improvements in voice-over text were not accompanied by equivalent changes in headline construction.

The near-total absence of clinical framing in 72.1% of stories is consistent with the broader pattern, documented by Mutiso et al. (2017) and by Ogeri et al. (2021), that public and institutional discourse in Kenya tends to frame mental illness in ways that obscure its clinical character and emphasize its social or behavioral manifestations. The dominance of the police-report narrative structure, in which a suicide is described through the response of law enforcement, reflects institutional channels of newsgathering in which the default information source is the police spokesperson rather than the mental health professional. Where this reporting model prevails, clinical framing is structurally precluded regardless of individual journalist intent.

Humanization Without Mental Health Context

The finding that 48.8% of stories achieved full humanization is, at first glance, one of the more positive results of the study. Full humanization, including names, ages, family relationships, and community roles, reflects a journalistic practice that treats the deceased as a fully social being rather than an anonymous datum. However, the simultaneous finding that 72.1% of stories failed to acknowledge any mental health history creates what might be termed a portrayal paradox: the deceased are humanized in terms of social identity while being simultaneously stripped of their psychological interiority. Coverage that provides a name, age, family photograph, and description of career aspirations, then attributes the death entirely to a single failed examination or a romantic dispute, creates a narrative in which the individual appears vividly whole while remaining invisible as a person who may have been experiencing a treatable mental health condition.

Reavley and Jorm (2011) identified this combination as particularly conducive to stigma: humanizing the victim makes audiences identify with them, while attributing the death to a simple trigger implies that only people in similarly extreme circumstances would consider suicide, rather than those experiencing the spectrum of mental health difficulties that underlie most suicidal crises. The blaming tone recorded in 23.3% of stories further complicates this picture. Blaming frames were disproportionately concentrated in murder-suicide coverage (cases in which a perpetrator kills one or more other persons before taking their own life), but their prevalence reinforces Link and Phelan's (2001) observation that stigma operates through moral condemnation as well as through labeling. In the Kenyan context, where attributions of moral failure in coverage of suicide have been linked to underlying cultural frameworks that interpret mental distress as supernatural or self-induced (Madu & Peltzer, 2004), blaming frames in broadcast news may reinforce pre-existing stigmatizing beliefs rather than challenging them.

Patterns of Compliance and Non-Compliance

The composite compliance picture is stark. A mean WHO Don'ts score of 3.60 out of 8 (45.1%), a WHO Dos score of 0.58 out of 4 (14.5%), and an MCK Code score of 1.49 out of 3 (49.7%) together indicate that across all four stations, Kenyan television news coverage fails to meet responsible reporting standards in the majority of evaluated dimensions. The finding that 76.7% of stories included none of the WHO Dos elements is particularly striking: in more than three quarters of the corpus, no crisis resource was mentioned, no mental health expert was consulted, and no recovery or coping narrative was provided. These omissions matter not because individual stories are expected to function as public health interventions, but because their cumulative absence across a broadcast landscape means that viewers, including those experiencing suicidal ideation, receive coverage that does not indicate that help is available or that recovery is possible.

These findings are broadly congruent with the wider literature on responsible reporting compliance. Thom et al. (2012) found that fewer than a quarter of New Zealand broadcast and print stories included crisis resource references, and Arafat et al. (2022) documented consistently low rates of expert consultation and crisis resource inclusion in Iraqi media coverage. Even in high-income countries with established training infrastructure, compliance with Dos measures consistently lags behind compliance with Don'ts (Pirkis et al., 2019). The absolute level of non-compliance documented here is not uniquely Kenyan, but in a context where professional mental health resources are severely constrained, it carries amplified public health significance.

The individual Don'ts violation rates confirm that detailed suicide method disclosure (84% violation rate) and exact suicide location details (79% violation rate) remain the most common and most dangerous forms of non-compliance in sub-Saharan broadcast journalism. Stack (2005) demonstrated that coverage including suicide method details poses a substantially higher contagion risk, and Gould et al. (2003) established that young people are particularly susceptible to these effects, a concern heightened by the Kenyan corpus's notable representation of stories involving young victims, including secondary school students and recent graduates. The finding that oversimplified causal framing was violated in 72% of stories reinforces the conclusion from the victim portrayal analysis: when a suicide is reduced to a single identifiable trigger, it communicates implicitly that the death was a rational or proportional response to a specific provocation, thus providing a script for imitation that does not

require the audience member to identify with a long history of mental illness (Domaradzki, 2021; Niederkrotenthaler et al., 2010).

Implications for Stigma and the Werther-Papageno Framework

Taken together, the findings suggest that the preponderance of Kenyan television suicide coverage operates within the Werther risk zone rather than the Papageno protective zone. The combination of method disclosure, sensational language, stigmatizing terminology, oversimplified causal framing, and near-total absence of crisis resources or coping narratives characterizes coverage that contagion research consistently associates with elevated imitative risk (Niederkrotenthaler et al., 2010; Stack, 2005). The small cluster of high-compliance stories produced since 2022 moves towards Papageno territory, framing suicide as preventable, contextualizing individual deaths within structural and systemic factors, and directing viewers towards help, but these stories represent only 11.6% of the corpus.

The public health consequences of this imbalance are compounded by the structural features of the Kenyan context. Clement et al. (2015) and Wyllie et al. (2025) both demonstrated that stigma is among the leading barriers to mental health help-seeking, and this relationship is more severe where structural access barriers are also severe. In Kenya, the ratio of psychiatrists to population stands at approximately 1 per 500,000 (WHO, 2020), meaning that the deterrence of help-seeking by media stigma operates in a context where professional support is already largely inaccessible. Television's role as the dominant news medium in Kenyan households (Communications Authority of Kenya, 2023) means that broadcast journalism's contribution to stigma operates at a population scale, with limited countervailing influences from healthcare professionals or mental health literacy campaigns.

CONCLUSIONS

Kenyan television suicide coverage is characterized by stigmatizing language, an absent mental health context, and systematic non-compliance with responsible reporting standards. Stigmatizing terminology appeared in nearly half of all stories, sensational vocabulary in four out of five, and WHO-recommended protective elements were missing from more than three-quarters of the corpus. A small number of post-2022 public-health feature stories achieved higher compliance with responsible reporting standards, thus demonstrating that such reporting is possible within the Kenyan broadcast context. Importantly, all of these high-compliance stories were long-form features rather than breaking-news reports, which points to format and production time as the core structural barrier to responsible suicide coverage.

RECOMMENDATIONS

The study recommends the following three interventions. The Media Council of Kenya (MCK) should develop sector-specific guidance translating WHO guidelines into the specific realities of Kenyan television newsrooms. Journalism training institutions should integrate responsible mental health and suicide reporting into core curricula, with explicit attention to the production-level inconsistencies documented in the mixed-coding finding. Finally, broadcasters should establish standing relationships with mental health professionals as credible expert sources, thus reducing dependence on police spokespersons as the go-to source for suicide stories.

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