ISSN 2321-2926

IJIRP

POSTVENTION STRATEGIES TO STOP COPYCAT SUICIDES

Dr.S.Madhuri Paradesi

Associate Professor, Department of Law
Sri Padmavathi Mahila VisvaVidyalayam, Tirupati, Andhra Pradesh

Abstract: *Suicide is a global public health concern, claiming more than 1 million lives each year. Suicide is no gentlemen. Uninvited, it enters one's mind and takes possession, and one weak moment results in a catastrophe. Suicide reminds one of the prowling tiger, hovering in the background, concealed from sight until his chance comes, and then pouncing on the unsuspecting victim, suddenly and without allowing any time to escape.*

A postvention is an intervention conducted after a suicide has taken place, mostly taking the form of support for the bereaved (family, friends, professionals and peers). Compounded risk of copycat suicide looms large on the family and friends of the suicide victim. Postvention is a term that was first coined by Shneidman (1972).

Appropriate and helpful acts that come after a dire event were described by him as postvention. In Schneidman's perspective, "the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered."2 Postvention is a process that aims at assuaging the effects of this stress and helping survivors to handle and deal with the loss they have just experienced.

Introduction:

The World Suicide Prevention Day was formally announced on 10th September, 2003, and each year the International Association for Suicide Prevention (IASP) in collaboration with WHO deploys this day to create awareness with regard to suicide as a leading cause of premature and preventable death.

Suicide is a global public health concern, claiming more than 1 million lives each year.[1] Suicide is no gentlemen. Uninvited, it enters one's mind and takes possession, and one weak moment results in a catastrophe. Suicide reminds one of the prowling tiger, hovering in the background, concealed from sight until his chance comes, and then pouncing on the unsuspecting victim, suddenly and without allowing any time to escape.

Although many factors are instrumental in committing suicide, there is increasing evidence that exposure to suicide in some form can result in imitative or "copycat" suicides. This concept of suicide "contagion" has existed for many years, though, meriting little empirical attention. Several aspects of this phenomenon remain mysterious, leaving postvention strategists with limited capability to identify those at risk and suggest evidence-based postvention strategies. Hence, the issue at hand attains significance as to who is at risk and how can they be helped?

A **postvention** is an intervention conducted after a suicide has taken place, mostly taking the form of support for the bereaved (family, friends, professionals and peers). Compounded risk of copycat suicide looms large on the family and friends of the suicide victim. Postvention is a term that was first coined by Shneidman (1972). Appropriate and helpful acts that come after a dire event were described by him as postvention. In Schneidman's perspective, "the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered."[2] Postvention is a process that aims at assuaging the effects of this stress and helping survivors to handle and deal with the loss they have just experienced.

Interventions acknowledge that those bereaved by suicide may be vulnerable to suicidal behaviour themselves and may develop complex and intricate grief reactions. The primary goal is to support and debrief those affected; and reduce the possibility of copycat suicides.

1. ***Postvention strategies*** includes procedures to reduce the dangers of imitative suicidal behaviour, alleviate and attenuate the distress and extreme anguish of suicidally bereaved individuals, and promote the healthy rehabilitation of the affected group. Postvention can also take many forms conditional on the situation in which the suicide had taken place. Schools and colleges may include postvention strategies in overall crises plans. These strategies have been developed with a view to prevent suicide clusters and to help students cope with the emotions of loss that the suicide of a friend entails.[3] Individual and group counselling may be offered for survivors (people affected by the suicide of an individual).

Postvention strategies to prevent the colossal problem of 'copycat suicides' are multipronged and include:

(a) ***school-based*** suicide postvention programs;

(b) ***family-focused*** suicide postvention programs;

(c) ***community-based*** suicide postvention programs;

Copycat suicide:

A **copycat suicide** is defined as an imitation of another suicide that the person attempting suicide knows about either from local knowledge or due to reports or depictions of the original suicide on television and in other media.

Werther effect:

An abnormal increase of emulation suicides after a widely publicized suicide is known as the ***Werther effect,*** following Goethe's novel *The Sorrows of Yourng Werther*. The ***Werther effect*** not only forecasts an increase in suicides, but the most of the suicides will happen in the same or a similar way as the one publicized. The more similar the person in the publicized suicide is to the people exposed to the information about it, the more likely the age group or demographic is to die by suicide. The increase mostly takes place only in regions where the suicide story was highly publicized. Upon learning of somebody else's suicide, some people decide that action may be appropriate for them also, especially if the publicized suicide was of someone in circumstances similar to their own. Thus, a publicised suicide leads the suicide survivors to the *nadir* of self-damnation and into the dreary depths of deprivation.

Suicide Contagion and Clusters of Suicides:

The publicized suicide serves as a trigger, in the absence of protective and preventive factors, for the next suicide by a susceptible or suggestible person and ignites suicidal tendencies in him. This is referred to as ***suicide contagion***. They occasionally spread through a community, through a school system, or in terms of a celebrity suicide wave, nationally. This is called a ***suicide cluster.*** Suicide clusters are caused by the social learning of suicide-related behaviours, or ***"copycat suicides".*** Those clusters of suicides which have been linked to direct social learning from nearby individuals, and clusters of suicides in both time and space are called ***point clusters. Mass clusters*** are clusters of suicides in time but not space, and have been linked to the broadcasting of information concerning celebrity suicides via the mass media.

2. ***Demographic factors:*** As it is, death moves about at random, without discriminating between the innocent and the evil, the rich and the poor, the young and old. A vast cross-section of the general public is at the mercy of the phenomenon of copycat suicides.

People who are young or old – but not middle-aged – seem to be most susceptible to this effect. At least five percent of youth suicides may be influenced by contagion. Due to the effects of differential identification, the people who attempt to copy a suicidal act tend to have the same age and gender as the triggering suicide.

Copycat Suicides among young people:

There is strong evidence that, among young people, exposure to suicide is a risk factor for future and repeated suicidal behaviour. Also, all young people are at risk following the suicide of a schoolmate, not only those close to the victim or those with pre-

existing mental health issues. Repeated suicidal behaviour occurs when the person committing suicide fails in the attempt and repeats such suicidal behaviour. This is of vital importance because it indicates that everyone who is exposed to suicide should be considered when postvention strategies are developed. There are study proofs that the youngest are most at risk, and that the risk is long-lasting. Many postvention strategies, which typically span the months after a suicide, may not be long enough to truly reduce the risk of contagion, since the suicidal tendencies continue in the suicide survivors even after the counselling program has run its course. Thus, long-standing continued support to the suicide survivors is of pivotal importance.

Several responses are urgently required. Many authors have noted the severe lack of suicide prevention and postvention research.[4] A recent review by Cox and colleagues[5] found few evaluated postvention strategies targeting suicide contagion in young people, suggesting that we know very little about what works to prevent contagion. In-depth studies are required that seek to understand the psychological and cognitive processes that occur in young people following exposure to suicide and how such processes lead to increased ideation and suicidal behaviour. A mechanistic understanding of how this risk is conferred is going to be critical to develop effective intervention strategies. Clearly, further well-designed and comprehensively evaluated prevention and postvention interventions are also the urgent need of the hour.

A unified, concerted and collaborative effort now needs to be directed towards developing evidence-based postvention strategies. We need to know what works in mitigating the risk of contagion and why. Only then can such strategies be confidently utilised to help those most vulnerable to the after-effects of suicide: our youth.

3. Acquaintance with the suicide victim:

It is generally found true that individuals who knew the victim are typically seen to be at greatest risk of being affected by exposure. Similarly, previous poor mental health did not modify the association between exposure and subsequent suicidal tendencies, although previous stressful life events did.

4. Timing:

These suicidal actions tend to happen in the days and sometimes weeks after a suicide is announced.[6] In exceptional cases, such as a widely discussed suicide by a celebrity, an increased level of thinking about suicide may persist for up to one year.

5. Programs

Responding to Loss (RTL)

One of the crisis response programs used to handle postvention at high schools is responding to Loss (RTL). The program is part of the Community Action for Youth Survival (CAYS), which is a three-year adolescent suicide prevention project serving three counties in the Chicago area. The aim of RTL is to provide strategies that will help high school crisis teams develop a structured response to the suicide of any student or member of the staff.[7] There are three components to this program. The first is preparing for Crisis Training, the second is Peer Witness Intervention, and the third is Crisis Consultation. This program proved to be very successful throughout its experimental duration and the participants of the program were largely contented with the training and instruction they received. As a result of this program, several schools have developed or revised their crisis team in response to a suicide. They have done this by following the Preparing for Crisis training aspect of the program and also through consulting with the CAYS program.[8]

LOSS:

The LOSS Program includes a first-response team with the objectives of delivering instant services and resources to the survivors of a suicide at the time of the death. This team comprises para-professional survivor volunteers and staff members of the Baton Rouge Crisis Intervention Center, located in Baton Rouge, Louisiana. The LOSS Program is divergent from other postvention programs in many ways. First, the LOSS team physically goes to the scenes of the suicides to start helping the survivors to deal with their loss as close to the event of death as possible. Members of the team can provide access to the needed resources and can begin the grieving process at the scene of the death. Second, since the LOSS team includes survivor volunteers at the scene, an immediate and

meaningful bond is established between the newly bereaved individuals and the para-professional surveyor team members. This bond allows for the start of a conversation about the grief and the potential for hope of a suicide between the bereaved and the crisis team members. Third, the LOSS team has a strong relationship with other first responders, such as law enforcement, emergency services, fire departments, funeral home representatives, and more. This relationship allows the newly bereaved to have a larger variety of choices with regard to coping with a suicide compared to other survivors who might not have access to this program. This model of postvention provides referrals for additional support to all survivors and individuals at the scene of the suicide.[9] The model of the LOSS Program has changed the scene of the suicide to a more "concerned and caring environment" for all individuals and survivors.10

6. *Factors in suicide reporting:*

Copycat suicides are mostly blamed on the media. A study conducted in 2002 found evidence for "the influence of media on suicidal behaviour has been shown for newspaper and television reports of actual suicides, film and television portrayals of suicides, and suicide in literature." Phillips stated, "Hearing about a suicide seems to make those who are vulnerable feel they have permission to do it," He cited studies showing that people were more likely to engage in dangerous deviant behavior, if someone else had set the example previously.[11]

Most research on suicide contagion has centred on natural experiments in which an initial suicide (often of a celebrity) leads to imitative suicidal behaviour or clusters of subsequent suicidal events, usually associated with insensitive or sensational media coverage. [12] This focus on unusual suicide events and celebrity suicides lowers our confidence in the larger relevance of the findings of the research. In this sense, research on suicide contagion is in its infancy. What have been missing are prospective studies that scrutinise the risk of contagion in association with pre-existing factors such as mental illness, stressful life events and socioeconomic status. Understanding as well as comprehending the effect of these factors on the risk of contagion is crucial to identifying target groups and time frames for effective postvention.

7. *Suicidal Grief:*

The loss of a loved one by suicide is often shocking, painful and unexpected. It stirs up the soul with myriad emotions. The grief that ensues can be intense, complex, and long term. Grief work is an extremely individual and unique process; each person will experience it in his/her own way and at his/her own pace. Grief does not follow a linear path. Furthermore, grief doesn't always move in a forward direction. There is no time frame for grief. Survivors should not expect that their lives will return to their prior state. Survivors must aim to adjust to life without their loved one.

Survivors often struggle with the reasons why the suicide occurred and whether they could have done something to prevent the suicide or help their loved one. Feelings of guilt typically ensue if the survivor believes their loved one's suicide could have been prevented. At times, especially if the loved one had a mental disorder, the survivor may experience relief.

Social Stigma: There is a stigma attached to suicide, partly due to the misunderstanding surrounding it. As such, family members and friends of the survivor may not know what to say or how and when to provide assistance. They may rely on the survivor's initiative to talk about the loved one or to ask for help. Shame or embarrassment might prevent the survivor from reaching out for help. Stigma, ignorance, and uncertainty might prevent family and friends from giving the necessary support and understanding.

Ongoing support: Ongoing support remains important to maintain family and friendship relations during the grieving process. Survivors sometimes feel that others are blaming them for the suicide. Survivors may feel the need to deny what happened or hide their feelings. This will most likely exacerbate and complicate the grieving process.

The above factors aggravate the feelings of suicide among the survivors of suicide, but a stitch in time saves nine, as the old saying goes. Thus, not only support but timely support is of critical importance in preventing copycat suicides. Many survivors find that the best help comes from attending a support group for survivors of suicide where they can openly share their own story and their feelings with fellow survivors without pressure or fear of

judgment and shame. Support groups can be a helpful source of guidance and understanding as well as a support in the healing process. The support groups and volunteers must be ever on their toes, not wanting in the line of duty, but ready to do battle with the vicious eagle of copycat suicide which is geared up to swoop and seize its prey. All round enthusiastic and dedicated efforts are required.

8. Indian context:

Demographic elements:

Suicide is an important issue in the Indian context. More than one lakh lives are lost every year to suicide in our country. In the last two decades, the suicide rate has increased from 7.9 to 10.3 per 100,000. There is a wide variation in the suicide rates within the country. Higher literacy, lower external aggression, a better reporting system, higher expectations, and higher socio-economic status are the possible explanations for the higher suicide rates in the southern states.

The majority of suicides (37.8%) in India are by those below the age of 30 years. The fact that 71% of suicides in India[13] are by persons below the age of 44 years imposes a huge social, emotional and economic burden on our society. The near-equal suicide rates of young men and women[14] (Age of 19-35) and the consistently narrow male: 24.6% female ratio of 36.6% denotes that more Indian women die by suicide than their Western counterparts. It is estimated that one in 60 persons in our country is affected by suicide. It includes both those who have attempted suicide and those who have been affected by the suicide of a close family or friend. Thus, suicide is a major public and mental health problem, which demands urgent action. Suicide is best understood as a multidimensional, malaise.

Divorce, dowry, love affairs, cancellation or the inability to get married (according to the system of arranged marriages in India), illegitimate pregnancy, extra-marital affairs and such conflicts relating to the issue of marriage, play a crucial role particularly in the suicide of women in India. Poverty, unemployment, debts and educational problems are also associated with suicide. The recent spate of farmers' suicide in India has raised societal and governmental concern to address this growing tragedy. Mental disorders occupy a premier position in the matrix of causation of suicide. Personality disorder was found in 20% of completed suicides. These factors are precipitated with the death of a suicide victim, which acts as a catalyst in the occurrence of copycat suicides.

Clusters of suicides:

The media sometimes gives intense publicity to “suicide clusters” - a series of suicides that occur mainly among young people in a small area within a short period of time. These have a contagious effect especially when they have been glamorized, provoking imitation or “copycat suicides”. This phenomenon has been observed in India on many occasions, especially after the death of a celebrity, most often a movie star or a politician. The wide exposure given to these suicides by the media has led to suicides in a similar manner. Copying methods shown in movies are also not uncommon. This is a serious problem especially in India where film stars enjoy an iconic status and wield enormous influence especially over the young who often look up to them as role models.

The implementation of the recommendation of the Mandal Commission to reserve 27% of the positions for employment in Government created unrest in the student community and a student committed self-immolation in front of a group of people protesting against such a reservation. This was sensationalized and widely publicized by the media. There was a spate of student self-immolation around the country. These copycat suicides caused public outcry and was considered one of the reasons for the fall of the government in power at that time.[15]

Effects of modernisation:

The effect of modernization has led to the breakdown of the joint family system that had previously provided emotional support and stability. This is also seen as an important causal factor in suicides in India.[16]

Religious beliefs and faith in God:

Strength of faith is a protective factor in the minds of people. Those following a certain faith and having belief in God are less prone to copycat suicides. Those who committed suicide had less belief in God, changed their religious affiliation and rarely visited places of worship. Eleven per

cent had lost their faith in the three months prior to suicide. Thus, lack of religious belief is also a risk factor (OR 19.18, CI 4.17-10.37).[17]

Non-Governmental Organisations (NGOs):

India grapples with malnutrition, infant and maternal mortality, infectious diseases and other major health problems and hence, suicide is accorded low priority in the competition for meagre resources, and copycat suicides, much less so. The mental health services are inadequate for the needs of the country. For a population of over a billion, there are only about 3,500 psychiatrists. Industrialization, rapid urbanization, and emerging family systems are resulting in social turbulence, upheaval and distress. The diminishing traditional support systems leave people vulnerable to suicidal behaviour. Hence, there is an emerging and urgent need for external emotional support. The enormity and viciousness of the problem combined with the dearth of mental health services has led to the emergence of NGOs in the field of suicide prevention.

The foremost aim of these NGOs is to provide mental and emotional support to suicidal individuals by befriending them. These NGOs need to focus on bolstering the emotional health of suicidal individuals. Often these centres function as an entry point for those needing professional services. Apart from befriending suicidal individuals, the NGOs have also undertaken raising awareness in the public and media, education of gatekeepers and some intervention programmes. However, there are certain limitations to the activities of the NGOs. There is a wide variability in the expertise of their volunteers and in the services they provide. Quality control measures are inadequate and the majority of their endeavours are not evaluated.

Suggestions regarding measures to prevent copycat suicides:

There is a pressing and desperate need to develop a national plan on an intensified magnitude for prevention of copycat suicides in India.

There is an urgent need to promote and support NGOs, by way of increasing their volunteers, as also educating, expanding and standardising their expertise by providing them with excellent coaching and practical experience. Quality control measures must be made more abundant, profuse and foolproof, and proper and effective methods and techniques of evaluating their endeavours must be efficiently employed and put in place.

Efforts must be directed towards reducing availability and consumption of alcohol, drugs, prescription drugs for depression, etc., by spreading awareness about their dangerous leanings towards copycat suicides. The government and the public must equally take up the cudgels in this matter.

Availability of and access to pesticide must be strongly discouraged, and made more stringent and authenticated.

There is urgent need for promoting responsible media reporting of suicide and related issues. The marketing malady of sensationalising suicide by the media must be put down by the authorities with an iron hand, and strict laws regarding the same must be introduced and implemented.

Focus must be bestowed on providing emotional support to those bereaved by the tragedy of suicide of near ones, and to assuage their mental distress to the utmost, and soothe and alleviate their emotional turbulence. The emotional baggage that they carry is a hunting ground for suicidal thoughts, and volunteers must aim at reducing these to the minimum, or more so completely.

Concerted efforts must be made for improving the capacity and mettle of primary-care workers and specialist mental-health services in order to fight with fortitude the dangerous devil of copycat suicides.

Efficient and effective training of gatekeepers like teachers, police officers and practitioners of alternative system of medicine and faith healers would go a long way in combating the menace of copycat suicides.

Conclusion:

There is a pressing need to develop a national plan for prevention of copycat suicides in India. The priority areas are reducing alcohol availability and consumption, reducing the availability of and access to pesticide, promoting and supporting NGOs, promoting responsible media reporting of suicide and related issues, providing support to those bereaved by suicide, improving the capacity

of primary care workers and specialist mental health services and training gatekeepers like teachers, police officers and practitioners of alternative system of medicine and faith healers.

Thus, 'copycat suicides' is a multifaceted problem and hence suicide prevention programmes should also be multidimensional. In India, prevention of copycat suicides is more of a social and public health objective than a traditional exercise in the mental health sector. The time is ripe for mental health professionals to adopt proactive and leadership roles in prevention of copycat suicides and save the lives of thousands of young Indians.

References:

1. Suicide prevention (SUPRE). *Geneva (Switzerland): World Health Organization; 2011.*

2. Shneidman E. *Deaths of man* New York: Quadrangle Books, 1973.

3. Poland S. Suicide intervention in the schools New York: Guilford, 1989.

4. Huisman A, Pirkis J, Robinson J. Intervention studies in suicide prevention research. Crisis2010;31:281–4

5. Cox GR, Robinson J, Williamson M, et al. Suicide clusters in young people: evidence for the effectiveness of postvention strategies. Crisis 2012;33:208–14.

6. Sisask, Merike; Värnik, Airi (2017-01-04). "Media Roles in Suicide Prevention: A Systematic Review". International Journal of Environmental Research and Public Health.

7. Underwood M & Dunne-Maxim K. Managing sudden violent loss in the schools New Jersey State Department of Education and State Department of Human Services; and University of Medicine and Dentistry at New Jersey, Community Mental Health Center at Piscataway, 1993.

8. Grossman, J., Hirsch, J., Goldenberg, D., Libby, S., Fendrich, M., Mackesy-Amiti, M., ... Chance, G. (1995). 'Strategies for school-based response to loss: Proactive training and postvention consultation. Crisis, 16(1), 18-26.

9. Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. Crisis, 25(1), 30-32.

10. Campbell FR. Suicide: An American form of abuse. New Global Development (XVI), 2000.

11. Niederkrotenthaler T, Fu KW, Yip PS, et al. Changes in suicide rates following media reports on celebrity suicide: a meta-analysis. J Epidemiol Community Health 2012;66:1037–42

12. Bohanna I, Wang X. Media guidelines for the responsible reporting of suicide; a review of effectiveness. Crisis 2012;33:190–8.

13. National Crime Records Bureau. Government of India: Ministry of Home Affairs; 2005. Accidental Deaths and suicides in India.

14. Mayer P, Ziaian T. Suicide, gender and age variations in India? Are women in Indian society protected from suicide. Crisis. 2002;23:98–103.

15. Vijayakumar L. Altruistic suicide in India. Arch Suicide Res. 2004;8:73–80.

16. De Leo D. In: The interface of schizophrenia, culture and suicide, Suicide Prevention-Meeting the challenge together. Vijayakumar L, editor. Orient Longman; 2003. pp. 11–41.

17. Gururaj G, Isaac M, Subhakrishna DK, Ranjani R. Risk factors for completed suicides: A case-control study from Bangalore, India. Inj Control Saf Promot. 2004;11:183–91.