



# Suicide Clusters: A Discussion

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# Table of Contents

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<b>EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>INTRODUCTION .....</b>	<b>4</b>
<b>SUICIDE.....</b>	<b>6</b>
<b>SUICIDE CLUSTERS.....</b>	<b>7</b>
<b>THE DEVELOPMENT OF SUICIDE CLUSTERS.....</b>	<b>14</b>
THE ROLE OF CONTAGION .....	16
<i>Summary .....</i>	<i>26</i>
VULNERABILITY, THE ROLE OF COMPLEX TRAUMA AND OPPRESSION.....	28
<i>The Role of Complex Trauma .....</i>	<i>29</i>
<i>The Role of Oppression.....</i>	<i>34</i>
THE ROLE OF NORMALIZATION .....	36
<b>DISCUSSION .....</b>	<b>40</b>
<b>RESPONDING TO SUICIDE CLUSTERS .....</b>	<b>42</b>
<b>APPENDICES .....</b>	<b>48</b>
<i>Determining a Suicide Cluster .....</i>	<i>49</i>
<i>CDC Recommendations for A Community Plan for the Prevention and</i> <i>Containment of Suicide Clusters.....</i>	<i>52</i>
<i>Media Guidelines for Reporting on Suicide .....</i>	<i>53</i>
<b>SUICIDE PREVENTION RESOURCES .....</b>	<b>55</b>
<b>REFERENCES .....</b>	<b>56</b>

## **Executive Summary**

There has been an increase in concern about suicide clusters, particularly within First Nations and Inuit communities across Canada. Clusters refer to an increase in suicides above the number expected for time and location. Clusters also imply relatedness on some level other than just statistical. There are a number of challenges in identifying and studying clusters. These include a relatively low frequency in comparison to suicide in general, problems with definition and consensus as to what constitutes a cluster. Mass clusters, those influenced by media and the deaths of celebrities are harder to study, as it is difficult to establish the connection between these events and suicides. In contrast, point clusters are those found locally (schools, prison, hospital wards, communities) and are easier to track and study.

Suicide clusters, at least in the Western world have existed for thousands of years. In one respect, this makes it somewhat difficult to track their development and identify a number of important processes. Historically, suicide and suicide clusters are recent phenomena within a number of Indigenous communities worldwide. Understanding how clusters developed within these societies could help to clearly identify a number of processes and mechanisms. Contagion is the mechanism in explaining how clusters develop. However, contagion at best accounts for only part of the picture, limited to understanding how suicide (or any other behavior) gets introduced into any population.

Cluster development, at least within Indigenous communities can be traced to increased vulnerability associated with such historical processes as Western colonization and colonialism. These oppressive practices contributed towards cultural/historical trauma and worked to destroy important societal ties, culture and identity. While these helped to establish a pattern, processes such as normalization helped to maintain this pattern once established.

As many First Nations and Inuit communities across Canada, and Indigenous communities worldwide work to reduce suicide and suicide clusters, factors such as cultural continuity, identity, community empowerment and addressing the impact of cultural/historical trauma occupy a central role. In the short term, work consists of efforts to recognize and respond to risk for suicide, developing community responses that help to reduce suicide and minimize its impact.

## Introduction

Each year approximately 1,000,000[2] people worldwide including 4,000 Canadians[3] die by suicide. Suicide is the second leading cause of death among youth age 10 to 24 years[3]. Suicide rates among First Nations and Inuit<sup>1</sup> are five to six times or more the national average[4]. However, a number of First Nations and Inuit communities have suicide rates equal to or lower than the national average. Factors such as community ownership/control and cultural continuity help to explain the difference[5].

Over the past decades, there is increasing concern about the increase in youth suicides and particularly suicide clusters. A suicide cluster is defined as a number of suicides that are greater than could be expected for time and location[6]. Suicide clusters, at least in western society have been recorded throughout history[7]. There is some evidence that clusters within Indigenous populations in North America occurred as far back as the 1700's[8]. Their occurrence is associated with significant historical events (e.g. disease epidemics) and the impact that such factors as colonization and colonialism had on many Indigenous societies.

Suicide, particularly among youth, has prompted many communities, provinces, states and nations to develop suicide prevention strategies. These strategies focus on reducing the frequency of suicidal behaviors (ideation, non-fatal and fatal attempts) and their impact. In Canada one such strategy is the National Aboriginal Youth Prevention Strategy (NAYSPS) through First Nations Inuit Health, Health Canada[9]. While these strategies develop in the face of suicide clusters, there has been little research into clusters in comparison to suicide in general.

This publication provides an examination of suicide clusters and the processes that contribute to their development and maintenance. Many of the factors that contribute to suicidal behavior also contribute to suicide clusters[10]. However, an explanation cannot be possible by studying them as a collection of individual suicides. Clusters are much more than the sum of their individual parts. Across




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<sup>1</sup> First Nations and Inuit is the term used when referring to Canada, while the term Indigenous is used when referring to First People's internationally.

many clusters, there is an element of relatedness; a dynamic connection between suicides that make a cluster that in many situations is more than just statistical. A number of clusters involve individual, family and community relations while others involve relationships through shared histories and environments. Many would argue that relatedness means that individuals know, or know of each other. However, relatedness occurs on many levels, not only a personal relationship or awareness of another.

There are two challenges in addressing suicide clusters. The first is that there are comparatively few studies in the general literature. Much of the work has addressed contagion and particularly the role that media may play. The majority of studies come from the United States, Australia and Europe. There are few studies from Canada. Secondly suicide clusters in the Western world have existed for thousands of years[7]. This makes it difficult to trace and connect larger historical processes in their development. Suicide and suicide clusters are historically a recent event in many Indigenous communities. Before European contact, there were few suicides and from all accounts, it was not part of Indigenous society. This changed in the past five hundred years and the increase in suicide is a result of the massive social change through colonization and colonialism. These historical events provide an opportunity to trace how suicide and suicide clusters developed within a specific society.

This publication examines suicide clusters, their development, maintenance, and actions to address them. A number of common factors contribute to suicide and suicide clusters. This publication begins with a discussion on suicide as a means of orienting the reader to the larger challenge of clusters. The next section examines a number of challenges in defining suicide clusters and provides some generally agreed upon criteria. The discussion then turns to identifying processes that continue towards the development and maintenance of clusters. As there are relatively few studies in this area, an empirically derived framework for understanding many of the processes does not exist. Instead, a heuristic framework that consists of four processes follows. These four processes include:

-  Contagion
-  Complex Trauma
-  Oppression
-  Normalization

Within this framework, contagion introduces the idea of suicide, complex trauma and oppression creates vulnerability, and normalization helps to maintain suicidal behavior. The final section focuses on responding to clusters both in the short and long term. Within the appendices, the reader will find a tool for assisting in identifying clusters and additional suicide prevention resources.

While suicide clusters are discussed from a number of perspectives which at times can appear somewhat dry and academic, the reader should never lose sight of the intense pain experienced by communities before and after a suicide and in the face of a suicide cluster(s). Although suicide clusters appear overwhelming, a number of communities have taken action to reduce their frequency and impact. While we can learn much studying those factors that contribute towards a cluster, we can learn even more from communities that have taken actions to reduce the frequency of suicidal behavior and its impact. Understanding these stories helps to identify those factors that allow these communities to overcome tragedy, loss, grief and trauma that suicide clusters represent. In turn, these stories instill a sense of hope within many communities and help us to understand what is possible to reduce suicide and its impact.

## Suicide

For the most part discussion about suicide involves individuals rather than groups, communities or societies. Factors such as mental illness, addictions, poor problem solving skills and impulsivity are often cited in explaining suicidal behavior[11, 12]. While factors such as difficult family relationships are considered, for the most part the majority of the literature, conferences, education etc. presents suicide as an individual act.

Shneidman[13] states that suicide is best understood as a dialogue in the mind that an individual has with him or herself. A better understanding of suicide is possible by examining what is common among many suicides rather than what is different. Among the ten commonalities Shneidman identifies[14] there is overwhelming psychological pain, a condition he refers to as “Psych-ache”, helplessness/hopelessness, cognitive constriction (where thinking becomes narrowed) and ambivalence. These are the core features of this dialogue[14, 15].

Within this experience there are two key factors, perturbation and lethality, which Shneidman refers to as the “bad parents” of suicide. Perturbation refers to

how upset or distressed, pained someone is and rated as low, moderate or high. Lethality refers to the likelihood that an individual may act upon his or her suicidal thoughts. There are low, moderate and high degrees of lethality. Lethality, not perturbation kills. However help an individual to lower their perturbation (psych-ache) to a just noticeable difference (JND) and many choose to live even if their problems still exist.

Framing suicide in this manner provides a starting point in understanding why suicide clusters develop. Like individuals, many groups and communities can experience overwhelming pain. However as Kral[16] points out, many theories of suicide are “perturbation theories”. That is, they help to identify factors which increase psychological pain but do not necessarily explain why individuals, or in this case groups or communities become lethal, adopting suicide as a means of coping.

For example, within Nunavut the suicide rate is disproportionately high in comparison to the rest of Canada and the world. Quoting Nunavut Tunngavik’s Annual Report on the State of Inuit Culture, The Working Group for a Suicide Prevention Strategy for Nunavut[17] point out that the suicide rate for Inuit men between the ages of 19 and 24 is roughly 50 times that of all men in Canada. However, there is no evidence that Inuit men suffer from mental illness at anything like 50 times the rate at which their peers in the south do.

Understanding sharp increases and decreases in suicidal behavior (which clusters represent) become understood as changes at the community and societal level. Using Shneidman’s framework one can ask what has increased perturbation (psych-ache) for communities with suicide clusters and importantly how did the “idea” of suicide become so widely accepted within these communities?

## **Suicide Clusters**

There are a number of challenges in identifying and studying suicide clusters. The first is that while statistically suicide is a low frequency (high impact) event, the occurrence of clusters within the public is less frequent. For example Gould et al, [18] report that clusters occur primarily in youth (ages 15 – 24 years) and account for 5% of all youth suicides. The second challenge, at least in Canada is that a system for reporting clusters does not exist[10]. This means that suicide clusters may be more frequent than recognized, however without a system for reporting



they go under-reported. Recognition of a number of clusters occurs because of published studies, or more frequently through media stories.

In the Western world suicide clusters have existed throughout history[19]. While all agree that suicide clusters do occur, a specific criterion for what makes a cluster does not exist. For the most part there is agreement on a broad definition. As stated earlier, many accept that a suicide cluster is a group of suicides or suicide attempts that occur closer together in time and location than would normally be expected in a given community[6]. Generally the occurrence of an unusually large number of suicides within a limited area within a relatively short period[20]. Methods for statistical confirmation in research have been proposed by Gould et al[21], Chotai[22] and Naus & Wartenberg[23], however these have not been widely adopted for general identification or epidemiological studies.

Statistical verification of suicide clusters is consistent with the field of epidemiology, referring to a closely grouped series of events or cases of disease or other health-related phenomena. With suicide clusters Hazell takes an even broader approach by stating that a cluster is any situation in which “clustering” has been hypothesized including suicide attempts[24]. O’Carroll and Mercy[25] point out that with respect to preventing further suicides it is the perception of the community about the existence of a cluster that should be taken into account rather than statistical verification. A community’s perception about any problem is a central factor in determining whether a community responds and what those responses look like. As Chotai[22] also notes suicide clusters are heterogeneous and there may be different types of clusters rather than a common definition for any cluster.

Joiner[26] differentiates between mass and point clusters. Mass clusters involve suicides that cluster in time and are often associated with the influence that media reports may have, such as suicides by celebrities. Point clusters involve suicides that are close in time or space or both often within institutional settings (e.g hospitals, prisons, schools) or within communities. Many suicides within First Nations and Inuit communities fall in the category of point clusters.

With respect to a specific number that defines a cluster, some authors (e.g Davidson, et al,[27]) suggest 3 or more above what could be expected, Johansson et al,[28] distinguish between statistical clusters and contagious clusters. To define a statistical cluster the increase in suicides from a base rate must be

statistically significant. In a contagious cluster, they suggest three or more cases. Furthermore, they suggest that a suicide cluster refers to deaths by suicide, while the term “cluster of self-destructive behavior” refers to non-fatal suicide attempts. Hazel[24] does not propose a number but as stated earlier suggests *“any circumstance in which clustering has been hypothesized. This definition will include suicide attempts”* (p. 654). Gould et al [18] suggest any number of suicides occurring in close temporal and geographic proximity.

One of the challenges is that while local to national and international suicide rates are calculated, there is no broadly accepted “base rate” for suicide or suicidal behavior. Goldney[29] has suggested that all societies have a base rate of 5 to 10 per 100,000. While biological factors account for this base rate (e.g. genetics, mental illness), anything above this rate is due to psychosocial factors.

However, rates are always relative in comparison to time and location. Suicide rates at the community level can be highly variable which raises questions regarding the time span and geographical location when identifying a cluster. In addition, when should a cluster cease to be a cluster and become part of a much bigger epidemic or pandemic? A cluster implies some limitations on time and geography. However, a number of clusters appear to be part of a bigger picture and have a history within specific communities. For example Shoumatoff[30] discusses a suicide cluster in Brigdend County in Wales consisting of a substantial increase in the past two years. Reports from the Journal of Mental Science[31] identify significant rates of suicide as far back as 1958.

A further challenge is now evident with the Internet, which has no geographical boundaries. On-line suicide pacts and clusters have been identified within nations[32, 33] and internationally[34]. Many involve pacts between strangers who met through the internet and pro-suicide sites[35].

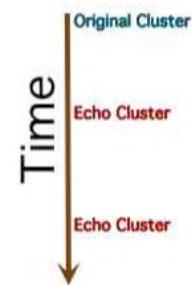
This change has significant consequences for suicide clusters and suicide prevention. Before the Internet, a pact or cluster represented a small percentage of an identified community (considering geographical boundaries) and rarely existed outside of those boundaries. With the expansion of the Internet, suicide does not constitute a percentage of a community; rather, entire communities revolve around suicide. While not all who join and participate in these sites die by suicide, 100% of those involved participate in some form of suicidal behavior (ideation, non-fatal and fatal attempts). In many situations, suicidal behavior is

encouraged. In a Google survey of internet sites concerned with suicide conducted in 2008, Recupero et al[36] found that 11 percent of sites were pro-suicide and easily accessible. While 11 percent may not appear to be a high number, the nature of the Internet and search engines means that they are easily accessible to the general population.

With respect to the percentage of suicides that can be accounted for by clusters as stated earlier Gould et al [7] identify that clusters account for 5% of all youth suicides in the general population. Similarly non-fatal suicide attempts cluster at about the same rate[37]. McKenzie et al[38] report that a cluster accounts for 10% of suicides among those with mental illness. While reports are limited a number indicate that among Indigenous populations the figure is much higher. Given that the population of many Indigenous communities is small (a few hundred to a few thousand), it is not surprising that many if not all of the suicides would constitute a cluster.

For example Wilkie et al[39] discuss the case of a small community in northern Manitoba (population of 1,749) where 6 youth died by suicide within a four month period. During that same period, nineteen additional youth were evacuated from the community for non-fatal suicide attempts. Wissow et al[40], identify an American Indian community in the United States where 15% of suicides constituted a cluster. Bechtold[41] describes an American Indian community where 70% of the suicides were identified as a cluster. Hanssens[42] found that clusters accounted for 77% of all Indigenous suicides over a ten year period within the Northern Territories of Australia.

Hanssens goes on to discuss anecdotal reports of “echo clusters”. Echo clusters refer to clusters that occur over time after the original cluster. While the evidence is anecdotal, and the area is not well researched, it is hypothesized that there is some dynamic which continues to repeat (echo) over time.



There has been an attempt to map the relationships between those in a cluster. For example, Bechtold[41] examined a cluster of 9 suicides over an eight week period in one American Indian community. The relationships within this cluster follow. Bechtold found that:

- Victim 2 died after victim 1, victim 2 was a pallbearer at the funeral for victim 1.

- Victim 2's girlfriend was victim 3's first cousin and victim 3's girlfriend was victim 1's sister.
- Victim 3 died four days after victim 2.
- Victim 4 died 1 month after victim 3, he was a friend of victim 3's mother.
- Victim 5 died the same day as victim 4. No overt relationship with the other four, but he appeared to have been influenced by media coverage of earlier suicides.
- Victim 6 died two days after victim 4 and 5. He was good friends with victim 1 and 3 and had attended the wake of victim 1 with victim 3 and victim 3's girlfriend.
- Victim 7 died one day after victim 6 – he was close friends with victim 3.
- Victim 8 died 2 days after victim 7. He was friends with victims 1, 4 and 6.
- Victim 9 died 3 days after victim 8. He was first cousin to victim 2.

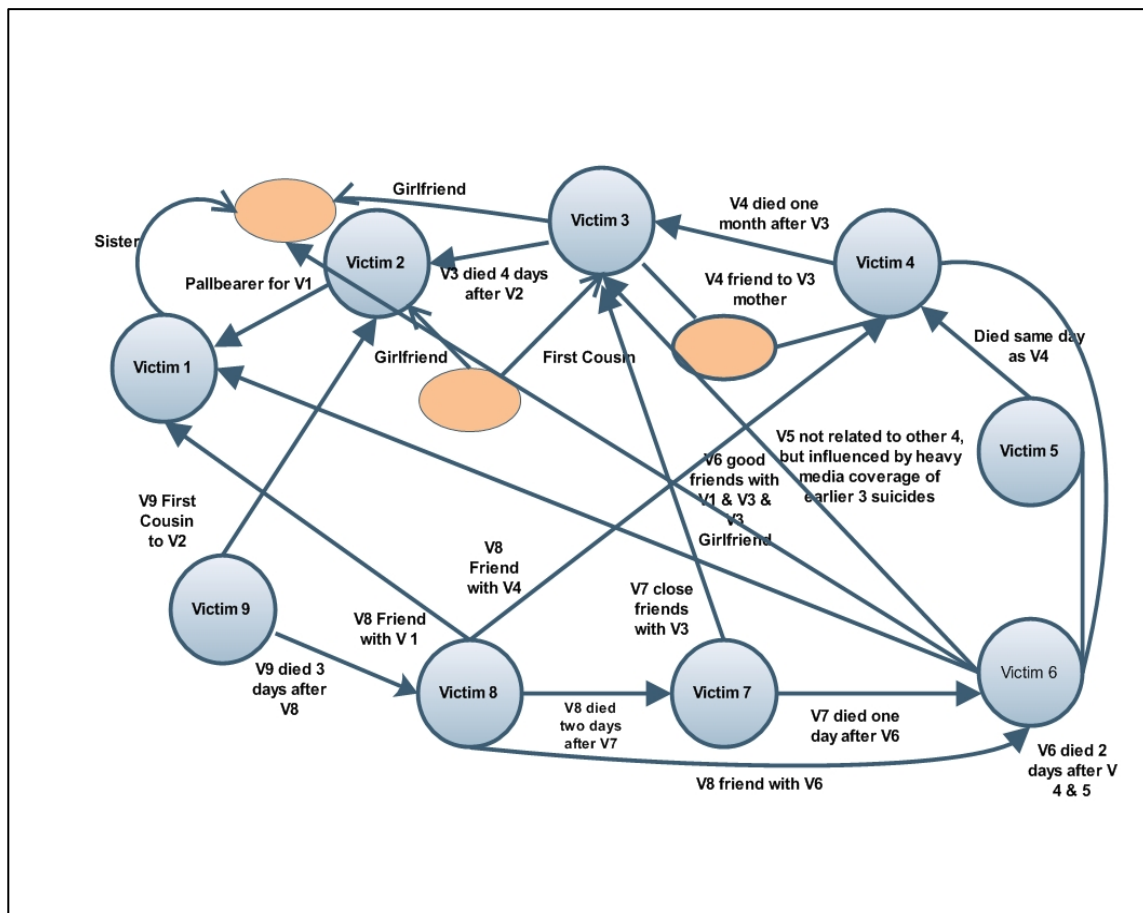


Figure 1 Mapping Relationships within a cluster. V=Victim

Bechtold identified additional cluster ties. Victim 1 died two months after the last previous suicide (identified as Victim A) in the community. Victim A's wife was first cousin to victim 3. Three weeks after the death of Victim 9, victim B made a fatal attempt away from the community. While living outside the community, he visited the community the week before and closely followed the media coverage. Victim C was a young male from the community who died 2 months after Victim 9. Victim D was also a young male from the community who died 4 months after Victim C. Victim C and D were brothers.

Bechtold notes:

*“It was clear that the risk of any individual in the highest risk profile was increased if he was in the interpersonal network of any of the victims. The more networks he was in, the greater the enhancement of the risk”* (p.33).

Wilkie, et al[39] reviewing a cluster of suicides within a small northern Manitoba First Nations community found the following relationships.

- The first victim was a 14 year old boy.
- The second victim was a 16 year old girl who was friends with victim 1. They had been known to talk about suicide and write notes to each other about ending their lives.
- A 15 year old girlfriend of the first two victims died 45 days later. At the time she was staying with the mother of the first victim.
- Two referrals (suicidal ideation) to the health centre were related to victims 1 and 2.

Following Chotai's earlier comments that clusters are likely heterogeneous there appears to be broad differences between clusters in First Nations and Inuit communities and those in the rest of Canada or the Western World. For one, a number of clusters in the Western world (Europe and North America) appear to happen in communities marked by relative affluence and rapid economic growth. Such clusters are described by Austen[43] and Coleman[44]. Clusters do occur in areas of economic deprivation, for example a study by Exeter and Boyle [45] which traced a long term cluster in areas of Scotland which were deemed to be economically deprived.

Almost all clusters described for First Nations and Inuit communities happen within harsh social and economic circumstances. Furthermore, suicide clusters and overall suicidal behavior represent an outcome of historical forces. Many authors, for example Echohawk[46] Tatz[47], Kirmayer[48], Kral and Idlout[49], Wesley-Esquimaux and Smolewski[8], Chandler & Lalonde[50] Hunter and Milroy[51] identify factors such as disruption in and destruction of culture, forced relocation, residential schools, child welfare and overall colonialist practices as having a significant contribution to suicide in Indigenous communities worldwide. Similar histories and impacts exist within Indigenous populations in Canada, the United States, Australia, New Zealand and South America.

Considerable work still needs to take place in developing broadly accepted criteria for defining and identifying clusters. However, features that can help communities identify suicide clusters exist. They include:

- ✚ Acceptance that clusters involve suicides and suicidal behaviour that occur more than what is expected for time and location.
- ✚ While numbers such as two or three above what would be expected are proposed, suspicion regarding a cluster or even the perception of a cluster is enough to justify further investigation and action.
- ✚ Where suicide pacts and clusters occur through the internet, geography is less of a factor. Those involved in helping should attempt to understand connections that exist within a community, and the linkages to on-line communities, especially sites that promote suicidal behaviours.
- ✚ While there is likely a number of features of clusters that are similar, suicide clusters may be heterogeneous. Cultural factors (for example among Indigenous peoples) need to be taken into account when studying and responding to clusters.

Within the appendices of this publication is a tool that can help communities to determine the possibility of a suicide cluster(s). This tool is more appropriate to smaller, rural or isolated communities, rather than larger urban centers. However, it may also be applicable to smaller communities within a larger community (e.g. a neighborhood, a school or hospital community).

Although defining and identifying a suicide cluster(s) is important, understanding the process or processes, by which clusters develop and maintain is necessary. The next section discusses this.

## The Development of Suicide Clusters

There are many questions regarding the processes, mechanisms and pathways by which suicide clusters develop. Some clusters are time-limited while others appear to continue and repeat. As Hanssens[42] comments there is the possibility that a number of clusters *echo* over time. This raises questions regarding those factors that maintain clusters once they develop. While contagion is the process by which clusters develop, as mentioned earlier not all authors agree with its role or with the idea that it can explain all clusters. Secondly as noted by Chotai[22] clusters are likely heterogeneous. Given a variety of clusters, one can ask if there are similar or different processes for their development.

The lack of research into clusters makes it difficult at this time to provide an empirical framework that could account for the development *and* maintenance of all clusters. Rather than attempting to account for all possible types, the following discussion focuses on those found within Indigenous communities. There are a number of reasons for doing this. The first is that suicide is a recent phenomenon within many Indigenous communities worldwide while its existence within Western and Asia societies can be traced back thousands of years. Its frequency within Indigenous communities can be traced to major historical changes such as the impact of disease and colonization[8]. In fact, a number of authors identify suicide as a colonial and postcolonial disorder[46, 52, 53]. Secondly, an absolute increase in suicide observed in a number of Indigenous communities in the past thirty years exists. This makes it possible to trace a number of factors that establishes suicide as an adopted means of coping with stress and distress.

Given the lack of an empirical framework for suicide clusters, the following is a heuristic framework. A heuristic framework is one that is meant to assist in exploring any topic where the empirical evidence is not sufficiently developed[54]. In this case, a heuristic framework attempts to account for a number of processes that contribute to the development *and* maintenance of suicide clusters within Indigenous communities. This framework does not imply that there is an aspect of being Indigenous that contributes to a higher risk for a

suicide cluster. In contrast, any society with a similar historical experience could develop a higher rate of suicides and therefore suicide clusters.

As illustrated below there are four processes - Contagion, Complex Trauma, Oppression and Normalization that are involved in the development and maintenance of suicide clusters.



**Figure 2: Development of Suicide Clusters within Indigenous Communities**

The introduction of the *idea* of suicide and suicidal behavior takes place through the process of Contagion. Contagion by itself does not predict that those in a particular culture or community will develop suicidal behaviors or clusters. Similar to disease there has to be a process by which the population is weakened and susceptible. The common vulnerability in many Indigenous populations consists of a significant history of Cultural/Historical Trauma and Oppression. The degree of vulnerability equals the severity of the destruction that has taken place. However, this does not mean that everyone in the population becomes weak or suffers from poor emotional health. There are protective factors that allow a large percentage to meet developmental challenges and grow into healthy adults and communities.

Once the possibility of suicide similar to any behavior exists, the question then turns to whether that behavior will maintain or decrease. One of the strongest processes for maintaining any behavior is the degree to which it becomes “normal”. In this respect, there are processes that normalize suicide much as they normalize any social behavior.

Although to some extent this heuristic framework reflects a linear process, in reality it consists of the interaction of complex processes over time. At any time, questions exist as to the state of each of these processes. For example, what makes suicide as an idea contagious for that period, and are there new modes for its “transmission”? What are the symptoms of cultural/historical trauma and how



prevalent are they? What oppressive practices exist and are they different now than in the past? What are the possible indicators that suicide becomes normal? Importantly are there ways of reversing normalization? Understanding each of these processes and how they interact is important in working to reduce the development and maintenance of suicide clusters. A discussion on each process follows.

## The Role of Contagion

Contagion, the influence of suicidal behavior on subsequent behaviors as the primary process in the development of suicide clusters is the leading explanation. Similar to disease emotions and behavior can “infect” others. To date this is the most widely cited process although not all authors agree with its role in suicide clusters (e.g. Joiner[26, 55], Chotai[22]). Joiner[55] questions the evidence to support suicide contagion particularly with what he refers to as “mass clusters” (those influenced by media). He comments that the concept of contagion is poorly formed and difficult to prove. For example, how can one connect a highly publicized media story about suicide without knowing if someone in the general public even read the story?

Instead, Joiner proposes that those at risk already constitute a cluster through a process he calls *assortative relating*. That is, those with similar characteristics group together before a suicide cluster. Additional stress (e.g. a suicide) increases the vulnerability of an already vulnerable group and suicidal behavior increases. Rather than contagion, there is already a pre-existing vulnerability to suicide. Chotai[20] supports this idea however adds that it is not necessary that individuals know each other or have a relationship. Connections exist through location or other factors. Chotai refers to this process as *assortative susceptibility*. This does not necessarily dismiss the idea of contagion as many ideas and behaviors including suicide are contagious. These include smiling, yawning, laughter, obesity, financial markets, violence, etc.[56-59]). Other examples include adolescent sexual behavior and pregnancy[60], binge eating[61], substance abuse[62] and depressive moods[63]. What it does suggest is that various explanations for suicide clusters may better explain different aspects of suicide clusters, for example how they develop, under what conditions they impact and how they are maintained.

At this time, a specific theoretical/empirical framework for suicide contagion does not exist[10]. Suicide contagion and the transmission of disease are

compared. For example, Hazell[64] refers to the infectious disease model when explaining suicide contagion by using concepts such as “host susceptibility”, “modes of transmission”, “degree of virulence” and “dose dependency” to explain the development of clusters. Authors such as de Leo and Heller[65] examine the role that social modeling plays in the transmission of suicidal behavior. Taiminen[66] views contagion as the result of intra-psychic forces such as projective identification. Projective identification involves individuals at risk who identify with another who has died by suicide.

The suspicion that suicidal behavior can influence others has existed for well over a century. Farr[67] in 1841 wrote:

*“No fact is better established in science than that suicide is often committed from imitation. A single paragraph may suggest suicide to 20 persons. Some particulars of the act, or expressions, seize the imagination, and the disposition to repeat, in a moment of morbid excitement, proves irresistible.”*

During the 19<sup>th</sup> century, medical literature recommended that the popular press limit reports of suicide because of the belief that knowledge of suicide could stimulate some persons to kill them self. The rationale was that there were those within society who contained a “psychological sensitivity” to such influences[68].

While a specific theoretical framework for suicide contagion does not exist, frameworks that account for biological, emotional and social contagion do exist and can assist in clarifying a number of aspects of suicide contagion. Contagion itself is an interactive process. This interactive process consists of the characteristics of those ideas / behaviors that are contagious, and characteristics of those who are affected.

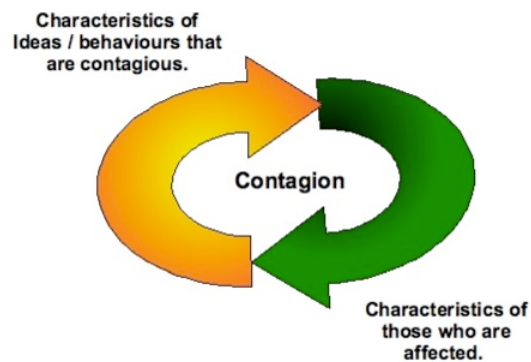


Figure 3: Contagion Cycle

### *Characteristics of those influenced.*

All of us experience times where others influence our ideas and behaviors. The simplest example of this is yawning. Exposure to yawning increases the chance that one will yawn. Regardless of how hard one may try to resist yawning many eventually yawn. Repeated exposure to yawning (thoughts, ideas, illustrations) will increase the probability that the reader of this publication will yawn.



Yawning like many behaviors occur because human beings are “wired”<sup>2</sup> to imitate others. This ability to imitate is important as it is impossible to learn all behaviors by trial and error[69]. Authors such as Bandura[70] have recognized for a long time that much of human social behavior consists of imitation. Imitation helps us to learn those behaviors that allow us to survive and develop.

Research over the past decades has identified clusters of “mirror neurons” in the brain[71-74]. These are neurons that activate and fire in the same way when observing the behavior and emotions of others. These same sets of neurons activate and fire when we experience the same emotions and behaviors as others. So, as I watch another person demonstrate some behavior (e.g. a hand gesture), the same neurons involved in his or her behavior are activated in my brain.



Figure 4: Mirror Neurons[1]

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<sup>2</sup> “Wired” refers to a biological capacity for the development of specific behaviors. For example language, walking, etc.

This ability to imitate is important for developing an understanding of another's perspective or experiences. Understanding another through imitation as Meltzoff[75] states gives us the feeling that they on some level are "like us". This ability helps us to "synchronize" (match) our feelings with those of another, which is necessary for the development of empathy. Much of this synchronization happens on an unconscious and non-verbal level[76]. For example research has found that when we look at sad faces, the size of the pupil we look at influences our pupil size[77]. Additionally, watching emotionally expressive faces particularly strong emotions can evoke similar emotions in ourselves[57]. Furthermore as social creatures, we are always scanning others to assess their emotional state. The reader can identify with situations in which the atmosphere of the room was particularly joyful or equally depressing and how that influenced their mood.

Development proceeds from *imitation* to *synchronization* to *empathy*. While empathy is based on imitation and synchronization it also requires that one understands another's feelings without confusion between oneself and another[78]. While one can develop insight into another's feelings, behaviors and motivations, there is recognition of the necessity of maintaining emotional and psychological boundaries. The role of imitation and synchronization in suicide contagion and particularly clusters can be understood in respect of how much one sees him or herself like another. How much they identify with that person(s) and their situation as being like their own. However, this lacks the higher order recognition involved in empathy of one's feelings are their own. Especially with respect to their emotional state and more precisely the intensity of emotional pain or as Shneidman[15] refers to it the degree of "psych-ache" they are experiencing. Furthermore, the more people with similar experiences and shared states of pain (or psych-ache) the greater the vulnerability.

After a point, one ceases to identify individuals in pain and starts to recognize the role of entire communities in pain and overwhelming pain. To a certain degree this reflects Joiner[55] and Chotai's[22] observations regarding assortative relating and assortative susceptibility. However it could more accurately be referred to as assortative "vulnerability" where overwhelming pain as Shneidman has commented serves as the motivation for relief[13]. The section on Historical/Cultural Trauma and Oppression contains a detailed discussion on vulnerability. Increased vulnerability is only half of the equation for contagion.

The other half has to do with the “potency” of suicide as a contagious idea and behavior discussed next.

### *Characteristics of Contagion*

Dodds and Watts[79] propose that contagion is the result of either dosage or threshold effects as illustrated in the figure to the right. *Dosage effects*, similar to the infectious disease model occur when one person infects another (or more). A one-time exposure is sufficient to explain why a disease infects others (for example a child in third grade coming to class with the measles). In contrast, *threshold effects* suggest that it is many exposures over time that results in infection. Each of these exposures is not enough to explain why someone becomes infected, but collectively they do.

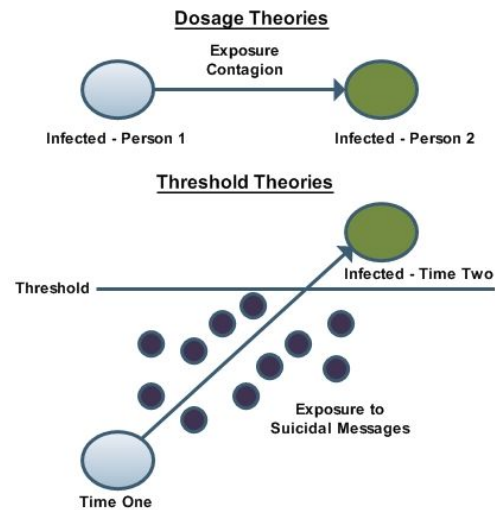


Figure 5 Dosage and Threshold Effects

Malcolm Gladwell’s[80] discussion of the tipping point is one example of threshold effects. The tipping point, a term borrowed from epidemiology, indicates a moment when an idea, trend or social behavior crosses a threshold and “tips”. By tips, Gladwell means it increases in frequency and spreads quickly. “Tipping” exists in many behaviors from fashions and fads to suicide. Given the relative rapid increase in suicidal behavior within many First Nations and Inuit communities in the past few decades, suicidal behavior has “tipped” in those communities.

Gladwell contends that social epidemics (including suicide) involve three “laws”. The *Law of the Few* indicates that there are specific people who are key in determining the development of an epidemic. In Bechtold’s[41] examination of a suicide cluster (discussed earlier) he was able to identify specific individuals and importantly the relationships between those involved in this cluster. The more networks of suicidal people that one was involved with, the higher the risk for suicide.

The *Power of Context* states that people's behavior always takes place in context of what is happening in their environments. With respect to suicide this context involves as Shneidman[14] has discussed intolerable pain. In this respect, one can examine those circumstances both recent and historical that have contributed to this pain. Within this framework, one does not have to venture too far to identify that for Indigenous peoples worldwide that pain consists of colonization, colonialism, historical/cultural trauma and oppression. In a large respect, this "music" (discussed in the next section) continuously plays in the background of people's experience.

The *Stickiness Factor* is concerned with those characteristics of an idea or behavior that makes it stick with people. With respect to suicide, one can ask if there are their characteristics that increase its likelihood of "sticking" with people. Work by Heath and Heath[81] have identified six principles that increase the "stickiness" of any message.

These include:

1. Simplicity
2. Unexpectedness
3. Concreteness
4. Credibility
5. Emotions
6. Stories

In comparing suicide with each of these six principles, it is easy to see how it can stick particularly in vulnerable situations. In the face of intense and overwhelming pain it offers a simple solution – when I am dead my pain will be gone. While familiar to some degree suicide is still a low frequency/high impact event and still somewhat unexpected. The option is readily available and there are ample descriptions of methods by which to suicide, especially on the Internet. The credibility of the act increases with suicides of celebrities and those within one's community, family and friendship circle. There are intense emotions associated with suicide before and after the act. While obviously directed at one's self, suicide can also be a means of lashing out at others. Finally, suicide exists within many stories, arts and literature, music and people's daily experiences. There are concerns regarding the role of both fictional and non-fictional stories (eg. media). Particularly with modeling and reinforcing suicidal behavior.



In addition to the potency of the messages regarding suicide, there is the issue of how the idea of suicide spreads. One perspective on the contagious aspect or spread of the idea comes from the field of memetics. Memetics proposes that ideas and behaviors like genes reproduce and spread[82]. “Memes” are the units of ideas and behavior that copy and distribute. For example, a story on suicide takes place during the evening’s television news broadcast. Those who see this broadcast talk about it the next day to others who in turn discuss it with their family and friends. In this way the “suicide meme (idea)” spreads. This does not mean that those who see or discuss act on it, only that it spreads through the population.



Figure 6: Suicide Meme

When suicide contagion is discussed many think of the issue in terms of “dosage” effects (single exposure). While the infectious disease (dosage) model attempts to explain suicide contagion, there are questions as to how a single or even limited exposure to the suicide of another can result in such a drastic outcome. Suicide and suicidal behavior occurs due to multiple exposures over time to suicidal messages and behaviors, which then pass a *threshold* making it more likely that an individual(s) will consider suicide. As the idea of suicide spreads and continuously circulates, it can occupy a larger social and emotional space especially if other ideas (e.g. life messages) decrease.

Take the example of a 17-year-old young man who is feeling increasingly despondent, helpless and hopeless. If one could track his time, the question arises as to how many suicidal messages he experiences. While each of these messages will not have the same intensity or potency, some will be more relevant to him (for example those by family, friends, peers, celebrities). If we were able to track his time we find out that in a two month period he is exposed to media stories about suicide (including fictional television, film, music) a web site that promotes suicide, the suicide of another student in his school, provocative statements about suicide from his peer group and so on. This young man may be in an environment where he and others (peers) continuously reinforce each other’s suicidal thoughts and where there is an increase in “suicidal talk”. The

earlier example by Wilkie et al[39] where two youth continued to exchange notes discussing suicide is an example of this as are pro-suicide chat rooms on the internet. This young man's suicide now becomes an event in another person's exposure to suicide.

Although suicide as an idea / behavior is viewed as contagious, it should be kept in mind that many feelings associated with suicide are also contagious and easily transmittable. For example, depressive affect[63] and aggression[83] have been found to be contagious among youth. Emotional reactions to suicide (eg. increased anxiety and fear) transmit rapidly across many in the community.

The eventual expression of suicidal behavior will depend on the context in which it happens and dynamics involving "priming" and "potency". Exposure to suicidal ideation, ideas and acts is said to "prime" others[84]. **Priming** refers to the effect that an idea or behavior has on subsequent behaviors. In comparison, once a well is "primed" it is much easier to draw water. Once ideas and behaviors are "primed", they require fewer exposures to activate them. If however no other sources of activation are available they will dissipate over time[85]. Priming introduces the "possibility" of suicide as a means to manage difficulties and overwhelming pain. The degree to which it "primes" an individual is due to a complex set of factors (biological, psychological, social and spiritual) but its effect is increased or minimized due to a number of protective factors. These include adequate health (individual, family and community), social supports, positive coping skills etc.

**Potency** refers to the strength of the "message", "idea", "behavior" that is being transmitted. In this respect, one can consider both verbal and non-verbal messages. Suicide message potency always increases when enacted. That is the more associations made to the idea of suicide, the stronger the message will become. As these associations are made they form schemas which are easily accessible in times of stress and distress. The more references to suicide, the stronger the schema. One outcome of a non-fatal attempt is that the individual has now crossed the line from thought to action and has in one sense a template (schema) for further suicide attempts[86].



### Media and suicide contagion

Media influence on suicidal behavior is the most studied area and represents a unique example of suicide contagion. It has been suggested that under certain circumstances news stories about suicide can be viewed as “advertisements” for suicidal behavior[87]. In this respect and consistent with what is discussed above the quality of media stories can contribute to the potency of messages regarding suicide. Recognizing this all suicide prevention associations, national and international including the Centers for Disease Control and World Health Organization have published guidelines for media reporting of stories about suicide. The appendices contain a listing of on-line resources for these guidelines.

It is not the reporting of suicide per se that produces contagious effects; it is a number of characteristics of these stories that is thought to result in increased suicidal behavior[88]. The “potency” of the message includes the following:

- A feeling of identification of audience members with the suicide victim.
- Where details and methods of suicide are described.
- The story is repeated or portrayed dramatically or prominently.
- The story and details are highly sensationalized.
- Where suicides of celebrities are reported.
- The provision of overly-simplistic explanations (e.g. teen fails test, kills himself).
- Where suicide is normalized or presented as an inevitable outcome.
- Where information on warning signs and community resources for help are missing.

The evidence for media influenced suicides comes from a number of sources, both fictional and non-fictional. The most famous case of the impact of fictional accounts involved reporting of increased suicides after the publication of “The Sorrows of Young Werther”[89]. Goethe’s novel involved the unrequited love of Young Werther who after rejection ended his life. The story was popular across Europe with many young men copying his style of dress and ending their lives. While widespread imitation of Werther’s suicide did not receive conclusive demonstration (which claimed numbers in the thousands), many European countries banned the book. The term “Werther Effect” refers to an increase in suicides after the publication of a story about suicide. The influence of fictional stories in a variety of media (print, television, music and plays) on suicide rates is

mixed. Overall the linkage between fictional stories and an increase in suicides is weak [90] in comparison to non-fictional stories about suicide [91].

With respect to non-fictional stories the largest percentage of studies have focused on newspaper, television and radio non-fictional reports [91, 92]. One aspect of media stories involves the description of methods. For example, Etzersdorfer et al [93] found an increase in firearm related suicides after extensive reporting of an Australian celebrity's suicide involving a firearm. Likewise, Hawton et al [94] reported an increase in drug overdoses presenting to emergency departments after the portrayal of an overdose in a television drama. Marzuk et al [95] reported an increase in suicides by asphyxiation after the publication of *Final Exit* (a book on suicide methods which was highly publicized).

A study by Tousignant et al, [96] tracked an increase in suicides based on media stories measured against criteria for reporting. They found that many news stories did not follow criteria based on recommendations by suicide prevention associations on media reporting. Following a highly publicized story of a well-known Quebec reporter there was an increase in hanging-related suicides, particularly in the municipality where he lived. One of the difficulties in associating an increase in suicides with a media story on suicide is determining that those who engaged in suicidal behavior in fact knew of or read the story. Cheng et al, [97] interviewed 124 suicide attempters after an extensively covered story about a celebrity suicide in Taiwan. They discovered that out of the 124 attempters (after the story) 23.4% reported that the story influenced their decision to attempt suicide.

Evidence for a media contagion effect has included situations where media stopped coverage, or changed practices in how stories were covered. With the construction of the Vienna subway system there was an increase in subway suicides. Many felt that mass media coverage of these suicides was a contributing factor. With publication of media guidelines and a media education campaign the number of subway suicides decreased by 80% [98].

Significant concern for media contagion emerged after the announcement of Kurt Cobain's suicide [99]. Cobain, guitarist for Nirvana, credited with developing the Seattle "grunge" sound received considerable attention, as did his lifestyle and personal problems. . The aftermath of Cobain's suicide was compared to the suicide of Marilyn Monroe (in which there was a documented increase in

suicides)[99]. A number of features helped to reduce the possibility of contagion. For one media (for the most part) consulted with suicide prevention associations and discussed important features of the stories that would help to reduce copycat effects. The messages were framed around “great artist, great music...stupid act, don’t do it; here is where to get help”.

Many services within Seattle (where he died) provided outreach, support and education, particularly during the memorial vigil. His widow’s reactions and grief helped to de-romanticize his death and showed that it had a serious impact on her. The director of the local suicide prevention service also spoke at the memorial and provided information and crisis numbers. It was felt that these actions helped to minimize the impact and in comparison to Marilyn Monroe’s suicide resulted in fewer copycat suicides[99].

Engaging media cooperation in reporting on suicides has met with mixed reaction. Media often evaluate the harm done versus the “newsworthiness” of the story and their felt obligation to report[100]. Blood et al[101] through a qualitative analysis of media stories found that reporting is often skewed towards an over-representation of suicide by violence and unusual methods. Jamieson reports that using qualitative analysis of media stories based on criteria and recommendations from suicide prevention associations in addition to meetings between suicidologists and media can have an impact on the subsequent quality of media stories. There are a number of instances where the media has been successfully engaged and it is felt that the outcome was more socially responsible reports[102]. For example the use of a survey with journalists and meetings between a researcher and editor were found to produce a better quality of reporting on stories about suicide[103].

## Summary

The role of contagion in suicidal behavior is recognized. While a specific theoretical/empirical framework has yet to be developed, contagion is an interactive process between the characteristics of those influenced and characteristics of those ideas and behaviors that are contagious. Human behavior is highly imitative. While this can be positive, it can also lead in certain situations (emotionally vulnerable) to identify with the negative behavior and emotional states of others. The risk with understanding that another is “like me” can also

involve “over-identification” with that person adopting their ideas and behaviors. Characteristics that increase contagion include where particular ideas and behaviors pass a threshold increasing the risk that they in turn repeat. “Priming” and message “potency” play an important role and media stories on suicide are examples of this.

Many aspects of contagion help to introduce and spread various ideas and behaviors within the general population. With serious and significant ideas such as suicide, there are aspects of the message that can “stick” particularly within vulnerable populations. Apart from issues of general vulnerability there are questions regarding the vulnerability within specific populations (e.g. Indigenous) discussed in the next section.

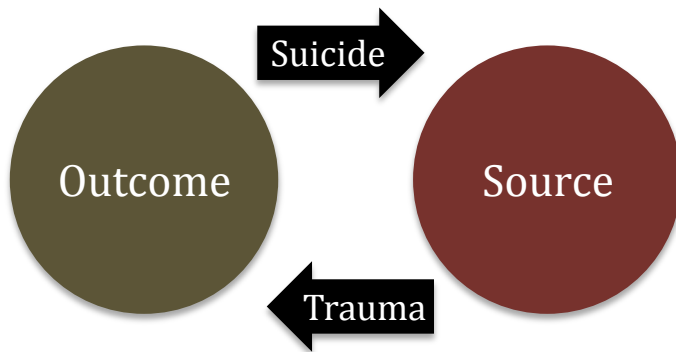
## **Vulnerability, the role of complex trauma and oppression.**

While many aspects of contagion apply to the public, the process by which any identified group can be vulnerable requires examining their history and social environments. While European contact has existed for 500 plus years, it is only during the past few decades that the suicide rate within a number of Indigenous communities and particularly youth has increased dramatically. Comparatively higher suicide rates and clusters within Indigenous populations do not mean that there are characteristics of Indigenous heritage that increases the risk for suicide. Higher suicide rates and clusters involve historical and social conditions. Any society that experienced these conditions would equally experience similar outcomes. Cultural/historical trauma and oppression are factors that increasingly link to higher suicide rates and other negative outcomes.

## The Role of Complex Trauma

Many Indigenous communities worldwide have experienced significant trauma on many levels from individual to societal. The relationship between suicide and trauma has long been established[104]. Suicide is one outcome of traumatic experiences and a source of trauma within itself. As an outcome, suicidal behavior is associated with childhood abuse (physical, sexual, emotional) and neglect, rape, domestic and community violence[105-107].

A number of features make suicide a traumatic event. These include the suddenness and violence of the death, witnessing or discovering the body, multiple deaths by suicide, dynamics of shame and blame, associated feelings of fear and intense anxiety. Given that suicides involve significant themes of loss for family, friends, etc. much of the long-term impact can be described as traumatic grief[108].



One significant factor in the experience of traumatic grief has to do with post-traumatic shame and guilt. Post-traumatic shame and guilt involves the notion that one should have or could have done something to prevent the suicide or in some way was responsible for the suicide. The greater the feelings of failure, shame and guilt the greater the chance for the bereaved/impacted to consider suicide[109].

As one father stated when discussing the suicide of his daughter:

*“I spent many months after her death convinced that I had murdered her. Feeling this way brought on some very real feelings that perhaps suicide was a way for me to make amends. After all, not only was I a failure as a father, but as a husband for putting my wife through this hell. (p. 45).”[110]*

Prigerson et al[111] found that among young adults the presence of traumatic grief (after a friends suicide) was associated with a five times greater likelihood of developing suicidal ideation. When assessing individuals and communities for

the impact of suicide(s) it not just shame, but blame that increases the risk for post-traumatic reactions and traumatic grief[112].

It follows then that more frequent the incidents of suicides within the life of an individual or community, in addition to other traumatic events and circumstances the closer the reactions fit within a framework of *complex trauma*. The concept of “complex trauma” developed partly in recognition that many descriptions of trauma, including the DSM-IV diagnosis of Post Traumatic Stress Disorder, were inadequate in describing the range of traumatic events and circumstances and their impact. The impact of trauma, and particularly the DSM-IV, has focused on single traumatic episodes[105, 106, 113].

Much of the work on trauma involves the DSM diagnosis of Post Traumatic Stress Disorder (PTSD). PTSD involves exposure to a life-threatening experience, which occurs outside of daily normal experience. The traumatic event involves actual or threatened death or injury (physical or emotional) to a person or others and where they experience intense feelings of fear, helplessness, or horror[114]. With PTSD there are three broad categories of symptoms; where the event is re-experienced (flashbacks, dreams, etc.) avoidant and/or numbing of feelings, actions memories, and hyper-arousal including sleep disturbances irritability or anger outbursts, problems concentrating, hyper-vigilance and exaggerated startle response[115]. Many of the definitions of trauma within this framework have focused on a single event (e.g. assault, natural disaster,

For many, trauma does not consist of a single episode but exposure to multiple traumatic events and circumstances that occur over time, or where one type (e.g. child sexual abuse) lasts for years. “Relational Trauma” refers to traumatic events that occur within the context of a relationship (family, community) In other publications multiple trauma over time is known as “cumulative trauma” some authors, notably Van der Kolk have referred to it as a “Developmental Trauma Disorder”[116].

However it is referred to, complex trauma goes well beyond what is typically defined as traumatic[117]. Often individuals with complex trauma have histories of a large variety of traumatic events spanning years and even decades. Their experience does not consist of discrete traumatic experiences so much as ongoing traumatic experiences[105]. As Roy[118] discovered, those who made their first suicide attempt before age 20 scored high on the presence of childhood trauma. There was a direct relationship between trauma and suicide attempts. Those who

made three or more attempts had higher childhood trauma scores<sup>3</sup> than those with two attempts who had higher scores than those with one attempt who also had higher scores than those with no attempts.

Symptoms of complex trauma often include significant problems with affect regulation (managing feelings), disturbances in attention and consciousness, disturbances in self-perception, chronic problems with relationships, somatic difficulties (persistent physical complaints without medical explanations), disturbances with making meaning (viewing the world through a dark lens, having difficulty finding meaning in life)[105].

One feature of trauma experienced by a number, but not everyone, involves the re-enactment of the trauma and specifically a traumatic event (e.g. suicide). Healthy resolution of trauma (including traumatic grief) involves integrating the experience within a person's life. Integrating refers to understanding the trauma, how it fits into one's life, what one can learn from it and use that knowledge to continue with life. Making meaning of the trauma is an important core feature of healing[119]. Without this one becomes "stuck". One means of trying to understand the trauma can involve a compulsion to repeat the trauma. This compulsion can range from post-traumatic play (re-enacting the traumatic event through play) often seen in children[120], to repetition of the actual event (e.g. suicidal behavior)[121]. Additional suicidal behavior (non-fatal attempts) in part, may be an attempt on the part of children and youth to gain insight, or understand suicide. This underscores the need for engaging youth, helping to address their questions and feelings about suicide, managing the presence of traumatic grief, providing support and teaching effective coping skills.

It is not just the presence of multiple and ongoing traumatic events and circumstances but the feeling of being caught, trapped without a means of escape that contributes to complex trauma.

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<sup>3</sup> Childhood Trauma Scores refer to the number of traumatic events (e.g. abuse) experienced during childhood.



As Briere and Laktree[113] observe,

*“Social and economic deprivation, as well as racism, sexism, homophobia, and homelessness, not only produce their own negative effects on children and adults, they also increase the likelihood of trauma exposure and may intensify the effects of such victimization (p2)”.*

When assessing the role of complex trauma, suicide and suicide clusters, the role that historical vulnerability plays is considered. For First Nations and Inuit communities this involves the presence of cultural/historical trauma. As noted by Wesley-Esquimaux and Smolewski[8] cultural/historical trauma is not a disease, but a cluster of events that impact people and communities in many ways.

*“Historical trauma disrupts adaptive social and cultural patterns and transforms them into maladaptive ones that manifest themselves in symptoms. In short, historical trauma causes deep breakdowns in social functioning that may last for years, decades or across generations”*

Because the damage is at the societal level, it creates a specific vulnerability that over time can lead to additional trauma for individuals, groups, families and communities. As Rechtman[122] observes, in the case of long-term traumatic events there is a close relationship between the individual’s clinical history and the collective history of his/her ethnic group.

The first experience of historic trauma on a grand scale took place between 1517 and 1720 with the introduction of European diseases such as smallpox. As Wesley-Esquimaux and Smolewski[8] discuss the introduction and spread of these diseases resulted in mass deaths and profound terror. Many of the experiences were similar to plagues in Europe and Asia. The population faced destruction with little understanding of the cause. Traditional medicines and European medicines were ineffective. The physical symptoms of small pox with its disfigurement created additional fear and led to complete breakdown in families with members abandoning each other. The complete breakdown in community contributed to famine and starvation. Those who survived not only had to contend with overwhelming traumatic grief but with their own disfigurement. In response, a number took their lives.

In contrast to European experiences with the plague, there was no period of recovery. Indigenous people continued to experience social destruction through

colonizing and colonialism. This destruction includes forced relocation, destruction of culture and eventually experiences such as residential school and child welfare practices continued to traumatize generations in addition to the challenge of inter-generational transmission of trauma. These historical difficulties have also contributed to substantial inequities in health and levels of poverty in contrast to Western populations. [123, 124]

A trauma pathway (as illustrated to the right) helps to connect historical trauma and recent traumatic events. Colonization results in considerable destruction of social and cultural ties resulting in historical/cultural trauma. One consequence of this is increased disintegration and fragmentation of cultural and community ties leading to increased vulnerability for complex/relational trauma.

In addition to the colonial practices that resulted in government and church destruction of Indigenous life, (e.g. residential school system, removal of Indigenous children), there were numerous reports of physical, sexual and emotional abuse at residential schools. For many First Nations and Inuit children the education process at these schools was brutalizing and had a major impact on intergenerational parenting. The fact that the government and church viewed their roles as “caretakers” of Indigenous peoples fits within a framework of relational trauma.



The consequence of historical/cultural trauma has involved not only complex/relational trauma expressed across generations, but impoverishment of economic and social systems for Indigenous peoples. Suicide and suicide clusters are not so much an outcome as they are an integral part of complex/relational trauma. Any culture experiencing similar historical processes and traumatic events will end up with complex/relational trauma. Research by Robin et al[125], Manson[126] in the United States and the Aboriginal Healing Foundation in Canada[8] have found higher incidents of trauma related disorders among Indigenous communities. The higher the number of traumatic incidents the greater the risk for trauma related disorders.

The fact that similar colonial histories has produced almost identical outcomes and conditions in Canada, the United States, New Zealand, Australia and South America would confirm this. In each of these countries, the disproportionate rate of suicide and clusters suicide between Indigenous and Western populations is similar.

The above examines the development and impact of complex trauma and cultural/historical trauma. It identifies how suicide clusters are one “manifestation” of the impact. However, as Denham[127] points out, this is only part of the story. There are stories of resilience that underscores the need to examine those factors that allow those affected to create meaning out of this history, both remote and recent. The value of trauma narratives in the context of historical/cultural trauma is that they allow for the identification of strengths and coping strategies.

### **The Role of Oppression**

A number of authors[47, 48, 52, 128, 129] view higher suicide rates among First Nations and Inuit communities as an outcome of oppression, both recent and historical. These views range from the destruction of cultural/societal ties to outward genocide. While oppression has played a major role in cultural/historical trauma, it merits its own discussion.

Authors such as Chrisjohn[129, 130] and Thira[128] point out that one of the difficulties with the current view of cultural/historical trauma (specifically “Residential School Syndrome”) is that it can easily characterize Indigenous peoples as “sick”. When one examines historically the attitudes towards Indigenous peoples, this attitude of being “sick” (or dysfunctional) is the most recent invalidation. Earlier attitudes have viewed Indigenous peoples as “savage”, “heathen” and “deficient”. The implication of these attitudes is that there is always something “wrong” with Indigenous peoples that requires outside intervention. Furthermore, this continued view of Indigenous people as inadequate justifies many actions on the part of the oppressor. Chrisjohn and Thira contend that if a “sickness” is to be diagnosed it should focus on the oppressors who have an affinity for destroying cultures and removing children.

Tatz[47] points out that suicide among Indigenous communities and particularly youth is different from suicide experienced in Western communities. While one can examine economic and social disparities, the biggest difference is the result of

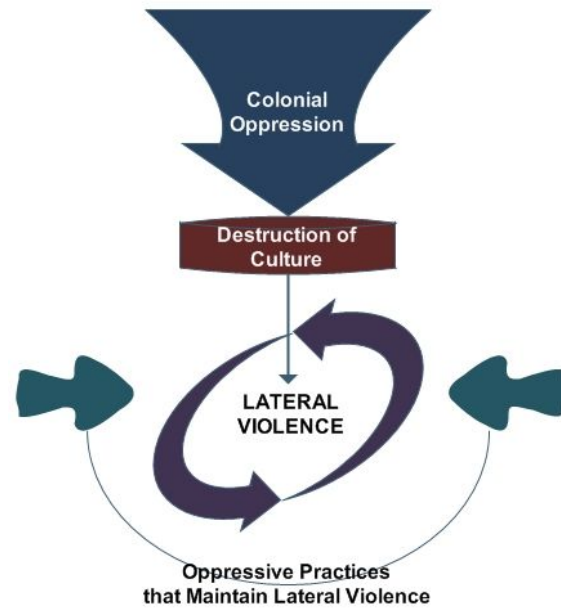
history with one group representing the oppressed and the other the oppressors. This history of oppression includes colonialism, racism, marginalization, etc. Tatz has proposed that suicide among Indigenous youth is an expression of anger rather than feelings of helplessness and hopelessness. In one sense, it is a form of social protest against the historical conditions and oppression experienced by Indigenous communities. Suicide is both a reaction to, and escape from this oppression. Tatz's term for this is "seeking freedom in death".

Kral[52] has recently come to refer to suicide among Inuit youth as a postcolonial disorder. A significant increase in suicide rates occurred after a number of significant changes in Inuit culture brought about by colonialist practices. These changes, specifically with respect to gender roles, love and sexuality have left many youth, particularly males, angry and confused. Suicide and other behaviors represent the expression and acting out of this anger and confusion.

The impact of a relentless oppression throughout history that devalued and disempowered First Nations and Inuit peoples contributes to the phenomena of suicide clusters in youth. In earlier historical periods, this time of adolescence was truly a transition from childhood to adulthood and was much different than it is today. For one the period of adolescence was much briefer and there were cultural rituals and traditions that helped with this transition. Secondly, an important part of adolescence is the consolidation of an image of who one is and how they fit into the world. This image included a sense of competency, control and power, the idea that I can have a positive impact on the environment. Strong communal ties and the idea that there is already an important role for you reinforced this image; you did not necessarily have to discover it.

With the continued devaluing, disempowerment and destruction of Indigenous peoples over generations, youth have no culturally sanctioned ways of feeling competent, in-control and powerful, recognizing that the concepts of "power" are different in many traditional Indigenous communities. The only area of control left is with their bodies and lives. For many youth this is the only "capital" they have left to negotiate life. Suicide for many provides a sense of control, a means of having an impact on others and their environment.

One outcome of oppression is *lateral violence*. Lateral violence occurs when people feel powerless to oppose or fight against an oppressive cultural system that they are living in, or in this case forced to live within[131]. Generations of degradation of Indigenous peoples, oppressive and colonialist practices have left many feeling helpless and hopeless with respect to effecting change particularly with those who were the oppressors. With no suitable outlets for its expression, this oppression is turned inward and toward each other (family and community members)[131]. Lateral violence involves domestic and community violence, abuse, substance abuse *and* suicides. Lateral violence becomes a self-perpetuating cycle particularly where continued violence (including suicide) and trauma produce more violence and trauma.



The active destruction of First Nations / Inuit people has now transformed into more subtle forms[129]. From historical examples that included giving cholera-laced blankets in the 1800's to government policies that focused on “killing the Indian in the child”, these more recent forms can be observed in oppressive practices that are maintained through the apathy and indifference of the dominant culture towards social, economic and health concerns and importantly progress.

### **The Role of Normalization**

Many are concerned that the frequency of suicidal behavior will lead to and has led to its acceptance as a “normal” behavior. Normalization involves much more than the acceptance of an idea or behavior as normal. There are questions as to how an idea/behavior enters the realm of social norms, rituals, customs and even social expectations. As an idea/behavior becomes normal what function does it perform, that other ideas/behaviors, norms, rituals, customs and social expectations previously fulfilled? At what point does suicide change from a behavior that one chooses to that where there is also an *expectation* to behave in a “suicidal” way?

Osit states that normalization occurs when there is repeated exposure to a previously unfamiliar behavior. With continued repetition and exposure, it loses its novelty and eventually becomes familiar. Previously unfamiliar ideas and behaviors then integrate into a person or group's schema and value system. As people adopt these behaviors and attitudes as their own, it becomes *normal* for them[132].

Joiner[133] discusses how the development of suicidal behavior for individuals is made possible through increasing desensitization and lowering the threshold towards suicide. In the same way, communities and societies can also experience desensitization towards suicide or any behavior and where the threshold for that behavior becomes lowered. There has been a proliferation of research in the past decades regarding the exposure to violence through media (films, television, music) and its role in desensitizing children[134]. The same exists with constant exposure to suicide. Kral[16, 135] proposes that suicide, like many ideas, has much in common with societal norms about a wide range of behavior (e.g. divorce, abortion, sex, politics, consumer behavior and fashion).

Any behavior, suicide included becomes a norm with repeated frequency, beliefs and attitudes that it is normal, where reinforced (directly and indirectly) and a lack of sanctions (social, legal, etc.) when it occurs. While there may be contagious or other aspects of suicidal behavior, suicide within a particular group, if not the larger society is part of the repertoire of normal behaviors. Given this, it is not surprising that youth and others will view suicide as one of a limited number of responses to difficulty because it is an accepted society norm. Taken to the next step suicide is then actively promoted as is now witnessed in a number of Internet chat groups and web sites.

While concerning, community clusters and Internet communities organized around suicide may serve another function. As Niezen[136] has discussed, one of the paradoxes of suicide clusters is that they provide a common identity for youth who are alone, emotionally isolated and disconnected. The fact that they continue to "infect" each other with suicidal talk reinforces a fractured identity. Suicide brings them together and provides, albeit fragile, a sense of community.

Mehlum[137] comments that many internet sites offer youth a chance to discuss suicidal feelings and an opportunity to question their decision to act on these feelings. Many of these youth may not have others in their social worlds to which they can turn to and are looking for others to talk to. The difficulty as Baume et

al[138] discuss is that many youth are initially ambivalent, however through continued involvement with pro-suicide chat groups they experience peer pressure and encouragement to act on their suicidal feelings.

With increased frequency, suicidal behavior can come to represent a rite of passage for youth. As children mature into adolescents, they increasingly look towards their peer group for behaviors that define the peer group and are acceptable (although they may not be acceptable to adults). This is true for a wide range of behaviors, positive and negative (e.g. delinquency, violence, drug/alcohol use). Suicidal behavior and the focus on suicide may come to define adolescent life with a number of youth feeling left out if they do not engage in suicidal behavior.

The idea that suicide is a sanctioned means of getting attention can be reinforced by the reality that many times the only times that youth receive attention is when they go into crisis and become suicidal. One can also extend this to the reality that many communities do not receive attention until their suicide rates increase dramatically and they catch the attention of the media. When suicide serves a function within the community (alerting to a situation, bringing people together, etc.) its strength is increased. Kral and Idlout[49] discuss how within a number of Inuit communities, suicide has become the means of negotiating the usual ups and downs of relationships and conflicts. Suicidal threats control romantic relationships and parent child disagreements.

Anecdotally<sup>4</sup> care providers within communities with high suicide rates discuss how suicide has become the means for managing daily disappointments and challenges. Threats of suicide control relationships, or even in situations where a child receives a low mark on their project (e.g. a parent enforces a curfew and the child threatens suicide, or in response to a bad mark there is the threat of suicide). This type of emotional blackmail leaves many (particularly parents and teachers) feeling handcuffed and helpless. This creates a vicious cycle in that children as they mature require boundaries and limits in order to feel that the world is a safe secure place. Threats of suicide can lead to increased fear in parents and teachers, which then causes them to either withdraw which then leaves children with greater insecurity or over-control. Threats of suicide increase as a means to gain control (engage others) and the cycle continues.

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<sup>4</sup> Based on the author's experience of touring many First Nations and Inuit communities as part of various projects.

Niezen[136]raises the concern that suicide given the lack of other opportunities, provides the means for communities to come together. Many attend funerals for suicide victims, mourners speak highly of the deceased, and there are displays of affection towards the deceased that did not exist in life. As Neizen comments, “death is one of the only avenues towards sympathy, notoriety and love”. For youth who are alive, they get the messages that the only time you are valued is when you are dead.

In addition to the normalization of suicide within any identifiable group, normalization takes place through the expectations, beliefs and behaviors of others towards an identifiable group. For example, outsiders and others come to view suicidal behavior, substance abuse, violence etc. as a “normal” part of daily community life of an identified group or culture. Many times media stories tend to paint community life for First Nations and Inuit people as revolving around continual dysfunction. Claxton-Oldfield and Keefe[139] in a study focused on stereotypes of college students in response to a community that received considerable media coverage. They founds that many of these students described those in the community as uneducated, alcoholics, poor, isolated and gas-sniffers. The two most important sources of their information were newspapers and television.

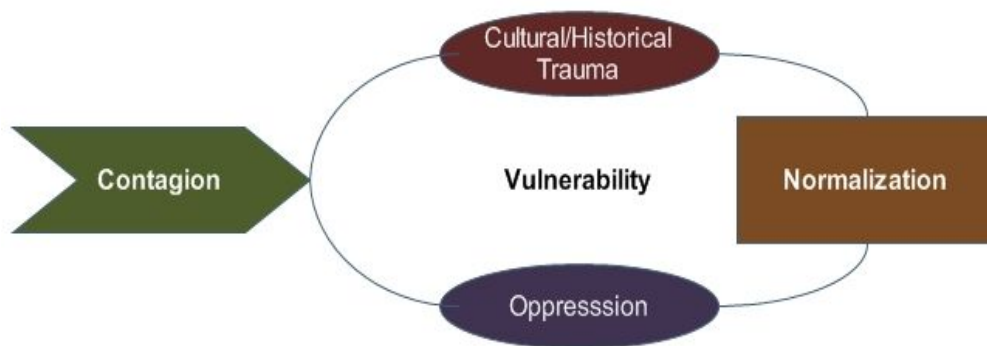
Finally, while suicide prevention campaign are designed to benefit communities, there is concern that depending on how they are developed, they may have unintended consequences. Public (including school based) suicide prevention campaigns have increased over the past two decades. However there has been little attention to how campaign messages are organized and presented. Recognizing this the U.S. Department of Health and Human Services and the Annenberg Foundation sponsored a workshop on the “science” of public messages for suicide prevention[140]. It was recognized that public service campaigns can drift from their intention by making an undesirable behavior appear more normative. Although people may believe that suicide is an undesirable outcome, talking about it may make it appear more normal. Broad based campaigns presenting general suicide prevention messages may not be sensitive to particular sub-groups and the fact that they have higher or lower suicide rates. For individuals at risk hearing that suicide is a frequent behavior, is occurring in epidemic proportions may increase its acceptance[140].



Once normalized, suicidal behavior fulfills many functions previously fulfilled in other ways either in the past or in different locations. It can provide a sense of identity, friendships and even community (e.g. internet chat rooms), social connectedness, a means of negotiating daily challenges, a rite of adolescent passage, a sense of control in addition to signaling overwhelming emotional pain. The normalization of suicidal behavior can also involve characterization through attitudes and beliefs by others that “suicidal behavior” is just another part of “those people”. Finally, the silence and lack of involvement in the life of children and youth on many levels (from individuals to government) can be the strongest reinforcement that not only what they are doing is normal, but also on some level expected. In this respect, these factors help to maintain suicidal behavior and ensure the continuation of suicidal clusters. As with any behavior, the more normal the more frequent.

## Discussion

The four processes (presented separately) interact within a complex framework. Over time, it is the establishment of this pattern rather than any one process that helps to understand how suicide clusters, at least within Indigenous communities develop.



**Figure 7: Development and Maintenance of Suicide Clusters**

Many of the characteristics of contagion can serve to introduce and reinforce ideas and behaviors in a population. These ideas and behaviors serve to “prime” individuals and communities. As Kral[16] has commented the idea of suicide is no different than how many fads, fashions and other social behaviors are adopted. The “potency” of messages is important and the influence of media on suicidal behavior has received considerable attention over the years. Phillips[87, 141] in particular has emphasized that many media stories can serve as advertisements for suicide. This possibility is also a concern with suicide

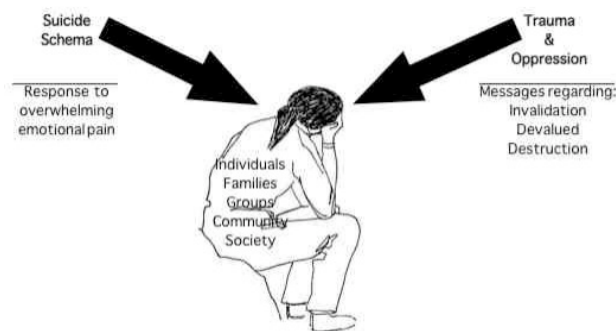
prevention campaigns in that how messages are crafted can create ambiguity at the least and in other situations can have unintended consequences in normalizing suicidal behavior[140].

Once the idea of suicide is “primed” all other messages and behaviors function to increase the potency of the schema that is developed. The easier it becomes to access this schema the higher the risk of suicide, particularly in the absence of protective factors. One should not think of this schema in terms of individuals, but its application to groups (e.g. youth), communities or any level of organization.

As stated earlier the “idea” of suicide was rare if non-existent within Indigenous society before European contact. The first recorded incidents occurred with the devastation brought on by European diseases such as smallpox between 1517 and 1720[8]. European societies having a long history with suicide contributed to its introduction as well as many other behaviors into Indigenous society.

This schema settles and is easily transmitted in situations of increased vulnerability. With Indigenous communities, one has to look no further than the impact of trauma, both cultural/historical at the level of the society and complex/relational at the community, family and individual level. Embedded in this is the degree of oppression over many generations with the active and genocidal destruction of culture, identity and society; all the characteristics that provide a sense of cohesion, value, safety, emotional and physical protection. With trauma (relational, complex, cultural/historical) and oppression there is a profound message regarding the invalidation and destruction of the target population (individuals, groups, communities, societies). These external messages, now internalized, are associated with situations involving lateral violence.

Suicide as a response to overwhelming pain equally involves a profound message inherent in trauma and oppression that devalues and invalidates one’s existence (individual, family, group, community, society). Given the many dynamics involved with oppression for a number of youth it may also be as Tatz[47] comments, the only way of “fighting back”. Suicide clusters



are not necessarily an outcome of trauma (on many levels) as they are a self-reinforcing and vicious cycle.

This vulnerability is what Joiner[55] and Chotai[20] refer to when discussing assortative relating and assortative susceptibility, although it could more accurately be referred to as assortative vulnerability. Each additional suicide or other major loss continues to stress and distress this pattern. This pattern is the accumulation of profound loss, grief and trauma, historical and recent. However, instead of resolution through healing on many different levels (individual, family, community, etc.) and a return to health this pattern becomes “*normal*”.

Rather than asking the inevitable questions as to why suicide clusters exist or what contributes to them, a greater understanding is possible by asking their function and purpose they play in the lives of youth and the community. While suicide communicates overwhelming emotional pain, helplessness and hopelessness, once established and normalized it can serve to bring people together (e.g. funerals) negotiate daily challenges and disappointments, solicit attention and support, validate one’s existence (identity in death), express rage and anger at one’s circumstances and connect people. All aspects of life that were managed much differently when cultural and social ties were stronger.

Echo clusters in this respect represent a cohort effect in the life of the community as children grown into youth and become socialized into this pattern. While exposed, the difference will come down to the range of protective factors including cultural identity, positive relationships and skills (social, problem solving). supports and the perception of a future available to them.

## **Responding to Suicide Clusters**

Over the past few decades an increasing number of communities, both Indigenous and Western are actively working to reduce suicide and its impact. There is greater recognition that communities with comparatively fewer suicides and were able to lower suicide rates have knowledge that will benefit many. For example Chandler and Lalonde[5] in studying First Nations communities in British Columbia with high and low rates found that factors such as cultural continuity and community ownership were present in communities with lower rates. Kral and Idlout[49] report on one community in Nunavut where youth engaging other youth through positive activities (a youth group) reduced suicidal behavior. Once the youth group discontinued, suicidal behavior increased.

Masecar[142] in examining stories of communities where high suicide rates decreased found that a central theme involving increased “connectedness”. Connectedness to culture, positive youth activities, plus opportunities for support and healing helped to reduce suicide in one Northwestern Ontario remote First Nations community. Between 1989 and 1999 in a community of 350, there were approximately eighteen suicides. Between 2000 and 2007, that number decreased to one.

Hunter et al[143] report on one community in Australia (Yarrabah) which experienced 3 to 4 suicides per year. Community ownership and control was key to reducing suicide. This involved democratic, community controlled decision making, a social-historical understanding of health, a primary health care approach, a focus on community rather than individual risk, culturally appropriate interventions and the development of knowledge and skills over time[144]. Community ownership and decision making was key with external resources (e.g. government) playing a supportive role.

Given the historical record of destruction, building upon and rebuilding culture and identity are central to reducing high rates of suicide and the presence of suicide clusters. Among First Nations and Inuit communities, there is growing attention to the approach used. Based on the wisdom of Elders many groups are now referring to suicide prevention in terms of promoting life. For example in Nunavut their suicide prevention association is the “Embrace Life Council”. In Alberta the provincial National Aboriginal Youth Suicide Prevention Strategy is referred to as the “Life is Valued Network”. In a similar way the Alberta Aboriginal Youth Suicide Prevention Strategy has been renamed as the “Honoring Life: Aboriginal Youth & Communities Empowerment Strategy”. Additionally many strategies are now emphasizing, “suicide is not our way of life”.

The above represents change over the long term. There is no doubt that building healthier communities, increasing positive connections, culture and identity will help to reduce suicide and other problems. Many communities are concerned about more immediate measures and the following can help in this regard. Following these suggestions are ones that address Canada.

The following recommendations are based on as White comments[145] moving ahead with imperfect knowledge. Given the challenges identified earlier in

identifying suicide clusters, much of what forms recommendations come from experience, some research and common sense. Over time with greater study, our knowledge will increase and this will lead to more specific recommendations and actions.

### Community

O'Carroll[6] has cautioned that suicide contagion can occur within a highly charged emotional atmosphere. While intense feelings of trauma and grief are normal after a suicide(s) his caution should be a primary concern in that a community's response to any suicide or suicide cluster can play a role in subsequent suicidal behavior. There is a substantial difference between intense feelings of grief and trauma due to suicide(s) and a highly charged emotional atmosphere because of a lack of planning, resources and inappropriate responses. As with suicide the goal is to reduce the impact of suicide clusters in order to support normal grief processes for individuals and communities.

Well-developed postvention responses (one part of a community suicide prevention strategy) can help reduce the frequency of suicidal behavior and its impact. Within the appendices, the reader will find examples of postvention responses through a list of web sites. The Centers for Disease Control has provided a set of recommendations for containing suicide and suicide clusters (in the appendices with a web link to the original document). However in keeping with many of the concerns discussed above, it needs to be recognized that many communities with suicide clusters are experiencing intense traumatic grief and complex trauma. Additional supports and resources are often required.

*Establishing the presence of suicide clusters.*

Communities should examine data from as far back as possible in order to identify the possibility of additional clusters. A tool to help with this is located within the appendices. Caregivers and service providers should consider mapping relationships between deceased and family friendship networks in order to help identify those at potential risk. As Hazell[24] observed, the greater the number of networks of the deceased one is involved in, the higher the risk. Continued support and involvement with these networks can help to lower the long-term risk and increase wellness.

*Responding*

Overall, training in suicide intervention and bereavement skills is necessary. However, the timing around presentations on suicide intervention is one consideration. In the author's experience, presentations on prevention and intervention too close to the death can stir up feelings of guilt. Participants can often feel that they were somehow responsible for failing to recognize warning signs and intervening. Efforts at supporting individual, family and community trauma and grief reactions represent an important first phase.

Triaging and engaging those at risk is important to prevent additional suicides[146]. There is no doubt that youth peers present an additional risk category and their safety must be taken into consideration in the short and long term. Engaging youth in general on many levels should also happen during non-crisis times to prevent the perception that the only time someone pays attention is when I am suicidal.

Psychological debriefing after crises and particularly in situations involving complex trauma requires caution. There is no evidence that psychological debriefing is effective in situations involving complex trauma in addition to questions regarding its effectiveness after a traumatic event[147, 148]. In some situations, psychological debriefing may make the situation worse and interfere with the normal recovery process. It can provide a false sense that one has adjusted minimizing the time needed to recover. Secondly with complex trauma short term efforts at recalling traumatic events can serve to de-stabilize individuals as they often struggle to manage daily stresses. In a number of

communities, a suicide may be just one more event in a long list of traumatic events.

Another area to monitor is media involvement. While media stories can help to educate far too often reporters wander through communities and engage in sensationalistic reporting that contributes to a highly charged atmosphere. There are a number of recommendations within the appendices for media reporting. Communities and schools can appoint spokespersons where media can ask questions and receive information.

In the long-term efforts to build and re-build, community relationships should receive just as much attention as crisis times. It is important that the community and those who live in the community feel that they receive attention during non-suicidal and suicidal periods. Suicide prevention should be part of the bigger picture of increasing the overall health of the community.

As discussed earlier, all suicide prevention campaigns should recognize that even the best intentions can have unintended consequences. The reader is referred to Chambers et al[140]<sup>5</sup> discussion of the public messages in many suicide prevention campaigns that can unintentionally become ineffective, or have the opposite effect.

### National

- All levels of governments and national, provincial, territorial suicide prevention associations, representatives from health, coroner's, researchers, etc. develop a national dialogue on suicide clusters for the purpose of:
  - Clarifying definitions and criteria for identification of suicide clusters.
  - Identifying and establishing surveillance systems for gathering information on clusters according to established criteria.
  - Developing research agendas into suicide clusters.
  - Facilitating linkages between interested parties.
- Build upon knowledge sources and developing community-specific training regarding identification and responding to suicide clusters. This

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<sup>5</sup> The Science of Public Messages for Suicide Prevention: A Workshop Summary. Suicide and Life-Threatening Behavior, 35(2). April 2005.





training should include postvention responses, media awareness and training community representatives on working with media.

Recommendations regarding media coverage of suicide is included in the appendices.

- A systematic review of the practice of psychological debriefing and concerns regarding its use take place. Debriefing should not be confused with overall supports and resources necessary after a death by suicide or any other traumatic event in the life of the community.
- Research on communities that reduced the frequency of suicidal behaviour and its impact. Specifically communities that experienced high rates/clusters and the actions they took to reduce this frequency.



## Appendices

-  Determining a Suicide Cluster
-  CDC<sup>6</sup> Recommendations for A Community Plan for the Prevention and Containment of Suicide Clusters
-  Media Guidelines for Reporting on Suicide
-  Suicide Prevention Resources

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<sup>6</sup> Centers for Disease Control

## Determining a Suicide Cluster

An official procedure for identifying a suicide cluster does not exist. Many procedures have used statistical methods, or proposed criteria (e.g. two or three above what would expected). This form represents one means of identifying a possible cluster.

While this form provides a table, software programs such as Word and Excel are also helpful allow the user to make charts.

### Steps:

- ✚ Collect data on suicide deaths, non-fatal attempts and hospitalizations for as far back as possible. Construct a timeline by determining a starting point (as far back as the data goes) and an end point (the most recent set of data). When collecting this data it is good if you can begin with a period of years in which there were no suicides.
- ✚ To quickly identify potential clusters shade the boxes to the right indicating the number of suicides and/or non-fatal attempts for that year. Episodes involving serious ideation that required hospitalization can also be included. The example provided below contains only suicide deaths. A blank form that can be copied is provided also.
- ✚ Add up the number of suicides that have taken place within the timeline and divide by the number of years. This will allow for a comparison average. However a comparison average should not be interpreted as a baseline.
- ✚ Identify those time periods in which the frequency of suicides was two or more above the comparison.

### Further Clarification:

- ✚ It is worthwhile to examine the frequency of other traumatic deaths during your timeline, for example homicides and accidents.
- ✚ Similar to the work by Bechtold and Wilkie et al, it helps to *map* the relationships between those who died by suicide, made non-fatal attempts and present with suicidal ideation and furthermore to map as much as possible their relationships with family, friends, etc. This can help to indicate the highest risk group and need for intervention, postvention resources and supports.
- ✚ Apart from identifying when clusters developed, discuss with others in the community possible contributing factors to these clusters, and importantly what do you think made the difference in years in which there were fewer or no suicides.

**Name of Community: Example**  
**Population: 1800**

Year	#	1	2	3	4	5	6	7	8	9+
2009	5									
2008	1									
2007	0									
2006	0									
2005	0									
2004	2									
2003	1									
2002	0									
2001	0									
2000	0									
1999	0									
1998	4									
1997	2									
1996	1									
1995	2									
1994	0									
1993	0									
1992	0									
1991	3									
1990	3									
1989	2									
1988	1									
1987	0									
1986	0									
1985	2									
1984	0									
1983	1									
1982	0									
1981	0									
1980	0									
1979	0									
1978	0									

Comparison Average: # of suicides (30) divided by years (32) = .9375 or 1. If the average involves a decimal, round up to the nearest number.

In the above example, using the criteria of 2 or more, clusters are identified in 1990, 91, 98 and 2009 if one goes by years. However, one can also consider “blocks” of years (2 or more years). Clusters for the years 1988-1991, 1995 to 1998, 2003 to 2004 and 2008 to 2009 exist. If there were no other clusters before 1988 to 1991, then the remaining clusters are “echo clusters”.

Population:

Comparison Average (# of suicides divided by years) = \_\_\_\_\_

## **CDC<sup>7</sup> Recommendations for A Community Plan for the Prevention and Containment of Suicide Clusters**

1. A community should review these recommendations and develop its own response before the onset of a suicide cluster.
2. The response to the crisis should involve all concerned sectors of the community and should be coordinated by:
  - a. Coordinating Committee, which manages the day-to-day response to the crisis, and
  - b. Host Agency, whose responsibilities would include "housing" the plan, monitoring the incidence of suicide, and calling meetings of the Coordinating Committee when necessary.
3. The relevant community resources should be identified.
4. The response plan should be implemented under either of the following two conditions:
  - a. When a suicide cluster occurs in the community, or
  - b. When one or more deaths from trauma occur in the community, especially among adolescents or young adults, which may potentially influence others to attempt or complete suicide.
5. If the response plan is to be implemented, the first step should be to contact and prepare those groups who will play key roles in the first days of the response.
6. The response should be conducted in a manner that avoids glorification of the suicide victims and minimizes sensationalism.
7. Persons who may be at high risk of suicide should be identified and have at least one screening interview with a trained counsellor; these persons should be referred for further counselling or other services as needed.
8. A timely flow of accurate, appropriate information should be provided to the media.
9. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.
10. Long-term issues suggested by the nature of the suicide cluster should be addressed.

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<sup>7</sup> Centers for Disease Control

## Media Guidelines for Reporting on Suicide

The following are a summary of a number of guidelines provided by the Centre for Suicide Prevention[149]. For a more in-depth discussion, you can access a number of guidelines on-line (see below).

- ✚ **Avoid presenting simplistic explanations for suicide.**
  - *Suicide usually results from a complex set of circumstances and is seldom the result of a single event such as the loss of a job or the end of a relationship.*
- ✚ **Do not engage in repetitive, prominent, or excessive reporting of suicide.**
  - *This may promote and maintain a preoccupation with suicide among at-risk individuals. For example, suicide reports should be located on an inside page of a newspaper, never as a front page headline.*
- ✚ **Be careful not to sensationalize coverage.**
  - *Sensational news coverage of a suicide tends to heighten the general public's preoccupation with suicide, particularly when a celebrity is involved. For example, sensational coverage can be minimized by avoiding the use of dramatic photographs.*
- ✚ **Avoid “how-to” descriptions of suicide.**
  - *It is also thought that the technical details about the method of suicide used in a particular incidence may provide a vulnerable person with the knowledge they need to imitate the actions of the victim.*
- ✚ **Do not position a suicide as a means to solve a problem.**
  - *Presenting suicide as a means of dealing with personal problems may suggest that suicide is an acceptable coping strategy.*
- ✚ **Avoid glorifying the incident or the victim.**
  - *Prominent coverage of community expressions of grief (e.g. eulogies, memorials, flags at half-mast) may suggest that society is honouring the suicidal behaviour of the victim, rather than mourning the person's death.*
- ✚ **Avoid overemphasizing the victim's positive characteristics.**
  - *It is important to note the victim's problems in addition to the positive aspects of his or her life in order to decrease the attractiveness of the suicidal behaviour, especially for individuals who rarely receive positive reinforcement.*
- ✚ **Treat survivors with sensitivity and respect their privacy.**
  - *Immediately following a death by suicide, grieving family members and friends are in shock, have difficulty understanding what happened, and may be at risk of suicide themselves. Care and consideration should always be shown when interviewing a close family and friends of the victim.*
- ✚ **Provide information that increases public awareness.**
  - *Enhancing general public awareness about suicide risk factors, warning signs, and possible actions to assist a suicidal person can help friends and family members recognize suicidal risk in a vulnerable person.*
- ✚ **List available community resources.**
  - *Information on available resources (help lines, crisis services, and clinical services) with up-to-date contact information should always be included in media stories dealing with suicide.*
- ✚ **Feature stories about people who adopted life-affirming options.**
  - *Stories that present positive ways of coping and positive role models can help prevent further suicide attempts.*

<b>Media Guidelines – On-line</b>	
Suicide Prevention Resource Centre	<a href="http://www.suicidepreventionlifeline.org/pdf/at_a_glance.pdf">http://www.suicidepreventionlifeline.org/pdf/at_a_glance.pdf</a>
Centre for Suicide Prevention	<a href="http://www.suicideinfo.ca/">http://www.suicideinfo.ca/</a>
Media Influences on Suicide	<a href="http://www.suicideinfo.ca/csp/assets/alert58.pdf">http://www.suicideinfo.ca/csp/assets/alert58.pdf</a>
Samaritan Media Guidelines	<a href="http://www.samaritans.org/pdf/SamaritansMediaGuidelines-UK2005.pdf">http://www.samaritans.org/pdf/SamaritansMediaGuidelines-UK2005.pdf</a>
National Institute on Mental Health	<a href="http://www.nimh.nih.gov/health/topics/suicide-prevention/reporting-on-suicide-recommendations-for-the-media.shtml">http://www.nimh.nih.gov/health/topics/suicide-prevention/reporting-on-suicide-recommendations-for-the-media.shtml</a>
Reporting on Suicide: Recommendations for the Media American Foundation for Suicide Prevention American Association of Suicidology Annenberg Public Policy Center	<a href="http://www.suicidology.org/associations/1045/files/MediaRecommendations.pdf">http://www.suicidology.org/associations/1045/files/MediaRecommendations.pdf</a>
MindFrame – A resource for media professionals	<a href="http://www.mindframe-media.info/site/index.cfm?CFID=8917455&amp;CF_TOKEN=53997291">http://www.mindframe-media.info/site/index.cfm?CFID=8917455&amp;CF_TOKEN=53997291</a>
Reporting on Suicide: Recommendations for the Media	<a href="http://www.sprc.org/library/sreporting.pdf">http://www.sprc.org/library/sreporting.pdf</a>
Suicide Prevention Resource Centre	<a href="http://library.sprc.org/browse.php?catid=1512">http://library.sprc.org/browse.php?catid=1512</a>
Media Wise – Suicide and the Media	<a href="http://www.presswise.org.uk/display_page.php?id=166">http://www.presswise.org.uk/display_page.php?id=166</a>

## **Suicide Prevention Resources**

Honoring Life Website: [www.honouringlife.ca](http://www.honouringlife.ca)

Aboriginal Healing Foundation: [www.ahf.ca/about-us](http://www.ahf.ca/about-us)

Turtle Island: [www.turtleisland.org/healing/healing-suicide.htm](http://www.turtleisland.org/healing/healing-suicide.htm)

Indian Health Service Suicide Prevention Site:  
[www.ihs.gov/NonMedicalPrograms/nspn/](http://www.ihs.gov/NonMedicalPrograms/nspn/)

Centre for Suicide Prevention (formally the Suicide Information and Education Centre) Calgary, Alberta: [www.suicideinfo.ca](http://www.suicideinfo.ca)

Centre for Research in Suicide and Euthenasia (CRISE) (University du Quebec a Montreal): [www.crise.ca](http://www.crise.ca)

CARMHA - Center for Research into Mental Health and Addictions:  
[www.carmha.ca/publications/index.cfm?topic=13](http://www.carmha.ca/publications/index.cfm?topic=13)



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