

SUICIDE PACTS

Introduction

A *suicide pact* is defined as an agreement between two or more people to commit suicide together, usually at a given place, usually at the same time and usually employing the same method. However, the recent emergence of *cyber-based suicide pacts* in which individual pact members agree to die by suicide at about the same time, but not necessarily at the same place, means that a more liberal definition may need to be borne in mind to take these current trends into account.

While tragic, suicide pacts are very rare and there is very little literature about how best to treat those involved in pacts, as individuals and/or as a pair or a group, in a failed, revealed or threatened suicide pact. There are no substantive findings about any approaches or programmes about treating and managing suicide pacts. Parallel literatures in two related areas: *folie à deux* (where two people share similar delusional beliefs), and *suicide clusters*, provide some guidance.

Deaths by suicide pacts have traditionally usually involved two people (to the extent that alternative, though less common, terms are “double suicide” or “dyadic suicide”) and have been very rare events (estimated to account for <1% of all suicides). However, there is an emerging trend for cyber-based internet-facilitated suicide pacts which increasingly involve more than two people. Often these pacts develop amongst strangers who meet on the internet and share similar world views. For example, a series of suicide pact deaths in Japan in recent years has been attributed to the growing use of the internet for people to “*seek companions to die with*”. These pacts have attracted disproportionate and extensive attention from the media, being described with phrases such as “*Japan's chilling Internet suicide pacts*” and “*Lives burn out in embers of online suicide pacts*”. This media coverage is likely to have contributed to the rise in such pacts.

Features of Suicide Pacts

The features of suicide pacts that make them different from single suicides reside in the nature of the relationship between, or amongst, pact members. Older research (from studies conducted last century) suggested that suicide pact victims were likely to have *mental or medical illnesses*. Most suicide pact victims were aged 50-60. Pacts tended to involve people well known to each other, and in most cases occurred in people who were married or in relationships. Most often this was a pathologically exclusive relationship in which the couple was intensely interdependent, socially isolated and without a socially healthy support system. Usually one individual was dominant and coercive while the second was extremely dependent. Often, the dominant member had an antisocial personality disorder or traits and the submissive member had borderline traits. When this relationship was threatened with dissolution a plan was put forward, usually by the powerful partner, for a suicide pact. Often the suicide plans made by the pair were so secretive and meticulous that few suicide pact victims survived. Some researchers have commented on similarities between *folie à deux* and suicide pacts, suggesting that pacts may develop from *folie à deux*. *Folie à deux* is a psychotic disorder between two individuals who have an enmeshed and socially isolated relationship, in which one individual is usually dominant and imposes the delusion upon the other.

However, the recent emergence of internet-based websites detailing methods of suicide and including suicide chatrooms may encourage suicide pacts with features which are different from the traditional picture. These websites may encourage suicidal behaviour among vulnerable people, particularly adolescents and young adults, by providing opportunities for isolated individuals to meet, via the internet, other people with similar life views and psychopathology including, in particular, depression. Unlike traditional suicide pacts, web-generated suicide pacts involve people who were not previously known to each other, and may involve more than two people.

Recent examples of cyber-suicide have come from Japan, the country which appears to have the highest suicide pact rate in the world, a fact which has been attributed to the Japanese belief in collective orientation and group cohesion and a cultural tendency for suicide to have been glorified. On November 28, 2004 four men died in a suicide pact in Tokyo and the following day a further four individuals died together, with police believing the two groups met via the internet. On December 2 there was another pact in which seven people died in one location and two more people died a few miles away. Media publicity about these pacts has tended to be dramatic and extensive, and may contribute to the behaviour.

Adolescent Suicide Pacts

Historically, adolescent suicide pacts have been relatively uncommon, with a study in England and Wales finding that only 6% of suicide pacts in the period 1988-1992 were aged between 15 and 24. However, this figure may rise if cyber-based suicides, which tend to involve younger rather than older individuals, increase.

Adolescent suicide pacts have tended to differ from adult suicide pacts. They have similar features and risk factors to a *suicide cluster*. Further, they tend to involve platonic relationships rather than marital or family relationships. These features are clearly apparent in recent cyber suicide pacts, and imply that the identification and management of potential pacts, and management of those who threaten involvement in suicide pacts or survive such pacts should draw upon best practice recommendations for managing suicide clusters (see attachment).

Identifying and Managing Suicide Pacts

The emergence of internet sites suggests it is now prudent for clinicians to ask routinely if young people have been accessing internet sites, obtaining suicide information from such sites and talking in suicide chat rooms.

Warning signs for suicide pacts may include the formation of isolated, small groups of individuals who may have depression, substance abuse or borderline or antisocial personality traits and a history of exposure to suicide. Particularly for older couples (but not exclusively) the concurrence of depression and medical illness in an isolated, closely connected couple should provoke an enquiry about joint suicidal intent, providing an opportunity to intervene.

After any suicide attempt or death it is important to question whether anyone else knew about these plans to try to determine if there is any kind of a pact. Lukonis and colleagues¹ suggest that it is important for clinicians to identify all of the individuals involved in the pact. It is difficult to predict the extent of risk for each person in the pact. The clinician needs to assess the personal meaning the suicide has for each individual in the pact and to tailor treatment to individual needs¹.

Treatment and management of individuals involved in pacts focuses on treating mental disorders they may have including depression and substance abuse.

The two papers below provide examples of identifying and managing young people involved in suicide pacts^{1,2}. For information about suicide clusters: www.chmeds.ac.nz/research/suicide/topics.htm.

References

1. Lukonis CJ, Lustig SL, Brant R, Goldman SJ, Vaughan BL. Suicide, substances, and stories: Treating a teenager in trouble. *Harvard Review of Psychiatry* 2001;9(6):302-309.
2. Ryabik B, Schreiner M, Elam SM. Triple suicide pact. *Journal of the American Academy of Child & Adolescent Psychiatry* 1995;34(9):1121-1122.