

Point Cluster Suicide: Investigating PTSD and Quality of Life in The Community

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ABSTRACT

In 2018, a unique case of mass suicide came to limelight in Burari, Delhi. The mysterious deaths of 11 members of a family unsettled the NCT of Delhi and inflicted a sense of terror amongst the minds of the residents of Burari, and amongst others, the incident ignited curiosity. The general public identifies these deaths most commonly as the 'Burari Deaths'. Quite strangely, the psychological impact on the community experiencing the event was never formally studied. Therefore, the current study aims at exploring the interrelationship between experiencing a Point Cluster Suicide ('Burari Deaths'), Post Traumatic Stress Disorder (hereinafter 'PTSD'), and Quality of Life in the community of Sant Nagar, Burari. The sample included a group of exposed participants who resided in Sant Nagar where the incident took place (N = 60) and a group of non-exposed participants (N = 60) who were not exposed to such an event. The findings suggest that there is a negative correlation between PTSD and Quality of Life and a significant difference in Quality of Life between exposed and non-exposed participants. The study does not, however, suggest any significant difference in PTSD between the two groups. However, there is minimal to mild PTSD symptomology in the exposed population.

Keywords: *Suicide, Suicide Clusters, Point Cluster, Burari Deaths, PTSD, Quality of Life*

The World Health Organization describes suicide as a catastrophe that has a profound impact on those left behind and affects communities, families, and even nations. The term 'suicide' finds its roots in a Latin word 'suicidium' which roughly translates to meaning "the act of taking one's life." Suicide can also be referred to as an event in which a person physically attempts to inflict self-harm upon herself with the intent of killing herself, which, if committed, results in the death of the person.

The act of commission of suicide can be influenced by a number of factors, which, inter alia, include biological, social, psychological, economic, or even genetic factors. The interplay of these factors can encourage one to harm herself in a variety of situations across different cultures and geographical locations, using different methods of self-harm. As such, the magnitude of the act itself carries the propensity to affect individuals of all spheres of life irrespective of age, gender, socio-economic background, race etc. It is not only suicide

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attempts that contribute to a major public health concern but also ‘suicidal behaviours’ and ‘ideation’. (Ivey-Stephenson et al., 2020)

Incidentally, the unfortunate series of ‘Burari Deaths’ of 2018 at Sant Nagar, Delhi, comes across as a tragic, as well as, a unique case that India has ever experienced. A family of 11 members were found dead in the courtyard of their house, which also claimed the lives of two teenagers, among others.

For the sake of convenience, the author attempts to render brief explanations of the concepts of Point Cluster Suicide, PTSD and Quality of Life; provide a brief overview of the Burari deaths; and lay out necessary descriptions in the following sections.

Suicide Clusters: Understanding Point Clusters

The word ‘cluster’ is defined by the Centre for Disease Control and Prevention (hereinafter “CDC”) as one that develops when a "greater-than-expected" number of disease cases are reported in a particular location over the course of a few days or weeks. When numerous people attempt suicide or self-harm in a defined geographic area and over a defined time frame, a suicide cluster is formed. (Rezaemi, 2012; Too et al., 2017; CDC, 2022)

The CDC distinguishes three types of suicide clusters. The two most common types are the ‘Point Cluster’ (same geographical location and time period) and ‘Mass Cluster’ (geographically dispersed but same time period). The third type of suicide cluster is known as an ‘Echo Cluster’ suicide (indigenous suicide, same geographical location). (CDC, 2022; Mishra et al., 2014)

However, insofar as the current study is concerned, the subject of discussion is limited to ‘Point Cluster Suicide’ in light of the Burari Deaths. The CDC defines ‘Point Cluster’ as “a greater-than-expected number of suicides that occur within a time period in a specific location.” This phenomenon mostly occurs in small communities like schools, psychiatric wards and so on.

Case Background: Burari Deaths

On July 01, 2018, a resident of Sant Nagar, Delhi, and neighbour to the deceased family members, discovered the bodies of 11 members of a family who hanged themselves at their residence at Sant Nagar, Burari, Delhi, India. As per the account of the other neighbouring residents, the family led a typical life and maintained positive social interactions with the other residents of the society. Even to suggest that they maintained any animosity with others was far from true. In fact, the family lived an ordinary life.

Initially, the neighbour who discovered the bodies informed one Mr. Rajeev Tomar, the Head Officer at the Burari Police Division (2017-2020) about the incident. Rajeev Tomar used to reside at Sant Nagar earlier before he shifted his residence elsewhere. At first, the case raised more concerns than it addressed because of the lack of any circumstantial evidences, like the absence of a suicide note and witnesses. Prima facie, the case appeared to be one suggesting a mass slaughter. Therefore, on the basis of suspicion and at the instance of the surviving family members of the deceased persons, an FIR came to be registered.

During the course of the investigation, any foul play was ruled out when the police obtained post-mortem reports of all the deceased family members. The cause of death was reported to be asphyxia caused due to hanging. Under these circumstances, from an objective

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application of the CDC's criteria for Point cluster suicide on the facts of the instant case, it appears that the said incident of death of 11 family members could be termed as a Point Cluster suicide. Unquestionably, all 11 family members hanged themselves to death in one geographical location, i.e., Sant Nagar Burari, and within the same time period.



Fig 2. A map of New Delhi and the location of the incident of a Point Cluster Suicide (Burari Deaths)

Exposure to Suicide Clusters, Post Traumatic Stress and Quality of Life

Post Traumatic Stress Disorder (hereinafter “PTSD”) is defined by the American Psychiatric Association as “a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events, or set of circumstances.” The core diagnostic criteria for the presence of PTSD are listed in the Diagnostic Manual of Mental Disorders (DSM-5-TR) as the type of exposure to the traumatic event, recurrent or repeated symptoms related to reliving the trauma, avoidance of the trauma (if any), and changes in mood and cognition. Suicide exposure is frequently a subject of great worry among members of the community, whether it be direct (such as via the loss of a loved one) or indirect (such as through media and social media). Suicide trauma and the effects of several suicide deaths on a community can result in perpetual grief, as well as, pervasive worry and anxiety, especially regarding the likelihood of other suicides. (Hill, 2022).

According to the World Health Organisation, "quality of life" (hereinafter “QOL”) is a person's perception of her own life, or the perspective from which she views it, in relation to her own objectives, successes, worries, expectations, ideals, and values, as well as her social and cultural frameworks. Witnessing a suicide can affect a person's QOL by compromising her sense of security and safety and by negatively affecting her psychological health. It can also lead to other issues like social withdrawal, impacting a person's interpersonal relationships and sense of belonging to her social environment. In fact, constant stress can also pose a serious detrimental effect on one's physical health.

Post Traumatic Stress and Quality of Life

Post Traumatic Stress Disorder is a standalone predictor of QOL impairment (Balayan et al., 2014). Psychological disorders like PTSD make it difficult to function on a daily basis and can prevent patients from leading regular lives. It can cause psychological dysfunction such as persistent nightmares, a lack of interest in activities, a certain degree of difficulty experiencing good emotions, and so on. It can also cause physiological arousal such as a racing heart, elevated blood pressure, headache, etc. When exposed to traumatic situations or events, PTSD symptoms may get reinforced. The effects may be gradual since trauma might

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endure for a longer period of time (Monson et al., 2017). When someone is diagnosed with PTSD, equal efforts should be undertaken to assist her in coping with all elements of life and not only her 'psychological well-being.'

Rationale

In relation to the 'Burari Deaths' in India, the study aims to dissect "Point Cluster Suicide" and its effects on the general population. This study's main objectives are to determine if PTSD symptoms correlate in a community that has recently witnessed a suicide cluster and to look into the community's current QOL.

The 'Burari Deaths' are an unusual instance of a mass suicide that affected the general populace in India. The psychological effects of witnessing a colleague commit suicide who had positive correlates of PTSD symptoms were investigated in a study (Brent et al., 1996). Therefore, the instant study intends to further the discourse on exploring how a single-point cluster suicide affects the psychological well-being of the community where the incident took place. Furthermore, in the Indian context, no studies have been conducted in relation to the above variables, nor have there been studies in relation to the specific variables of the study, i.e., Point Cluster Suicide, PTSD, and QOL. There has been no significant research conducted in relation to exposure to Point Cluster suicide and PTSD or exposure to Point Cluster suicide and QOL.

METHODOLOGY

Aim

To explore the relationship between experiencing a Point Cluster Suicide, PTSD, and Quality of Life in the community of Burari, Delhi.

Objectives

1. To study the relationship between post traumatic stress disorder and quality of life in the exposed group.
2. To measure P.TSD symptomatology in the exposed population.
3. To study the significant difference in PTSD between exposed and non-exposed group.
4. To study the significant difference in quality of life between non exposed and exposed group.
5. To study the relationship between PTSD and Quality of Life.

Hypothesis

Null Hypothesis: There is no significant correlation between Point Suicide Cluster and PTSD.

Alternative Hypothesis:

- There will be a significant relationship between post traumatic stress and quality of life of the exposed group.
- There will be a significant difference between the quality of life of people exposed and non-exposed to trauma.

Description of the sample

The study employed Judgement/Purposive sampling, a type of non-probability sampling. In non-probability sampling, units of the population are selected on a 'subjective basis' as per the requirement or according to the objective of the study undertaken which is non-random

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in nature. The study obtained data from two groups - one group that has been exposed to a Point Suicide Cluster (Burari Deaths) and another from a neighbourhood with no exposure to Point Suicide Cluster.

Sample Size

The total number of sample in the study is 120 individuals i.e for the exposed group : 60 Individuals; and for the non-exposed Group: 60 Individual

Inclusion Criteria:

- a. Age: 18 and above
- b. Exposed Group: Sant Nagar, Burari
- c. Non-Exposed Group: Delhi NCR
- d. Gender: Both males and females
- e. Proficient in English (able to answer at least 3 questions in English)

Exclusion Criteria:

- a. Families or Individuals who have moved into the area after 1st July 2018
- b. Individuals who are not proficient enough in English to attempt selected questionnaires.
- c. People who have been exposed to suicide in their social circle (direct contact) will be excluded from the Non-Exposed Group participation.

Research Design

The study adopted a descriptive approach to achieve the goals of the study and was implemented in the form of a PTSD diagnostic scale and QOL questionnaire. The research employed an ex-post facto research design where the effect of 'Point Cluster Suicide' on levels of PTSD and QOL were measured on groups of population that had already experienced the phenomenon. The study also included a comparative study between two groups i.e. Exposed (who was directly exposed to a Point Cluster Suicide) and Non-Exposed (randomly selected; not exposed to a Point Cluster Suicide). The study design examined the relationship between the two variables by using correlation and understanding the difference between the two groups by conducting a comparative analysis.

Variables

- a. Exposure to Point Cluster Suicide;
- b. PTSD; and
- c. Quality of Life.

Description of the Tools Used

1. **The Posttraumatic Stress Diagnostic Scale – Self-Report Version for DSM-5 (PDS-5) - 2013:** The scale is a self-reported version of the 'PTSD Symptom Scale - Interview for DSM-5 (PSS-I-5)'. The scale is employed to provide an estimate of the intensity of a respondent's PTSD symptoms, which was supplemented with the PDS-5 self-report measure. Respondents are required to relate their symptoms to a single recognized "target" trauma when completing the PDS-5.
2. **World Health Organization Quality of Life Brief Version (WHOQOL-BREF) - 1998:** The study employed the WHOQOL-BREF which consists of 26 items; a shorter version of the 100-item. It consists of 4 domains: psychological health consisting of 7 items; physical health consisting of 7 items; environmental health

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consisting of 8 items and; social relationship consisting of 3 items. It can be administered both individually and in groups.

Procedure

The study was conducted in the academic year of 2023. For the data collection, the community of Burari was visited, and a survey on 60 individuals was conducted. The inclusion and exclusion criteria were checked in order to ensure the smooth functioning of the study and its continuation thereto. The self-reported assessment was taken using the PDS-5 and the WHOBREF-QOL. The other 60 participants were approached on a random basis who resided in Delhi, NCR. These participants were part of the control group who were not exposed to suicide or suicide clusters in their social environment. The data collected was manually entered and scored in MS Excel.

Statistical Analysis

Pearson's correlation in statistical terms can be understood as an assessment tool to measure or investigate a linear relationship between two continuous variables. Researchers often use Pearson's correlation to predict a relationship between two variables. The defined relationship is denoted by 'r' and it ranges from -1 to 1. It helps researchers to measure the cause-effect relationship between two variables. For example, Pearson's correlation can be used to measure the effectiveness of a medication on a clinical population. Pearson's correlation is widely used in research and has proven to be an effective statistical tool. In the current study, Pearson's correlation was employed to define the relationship between PTSD and QOL.

A t-test is a statistical measure that helps us compare and identify the means of two groups. The test is mostly used to test a hypothesis where a cause-effect relationship is assessed between two groups of the population. These groups can be both randomized and non-randomized depending on the requirements of the study. A type of t-test known as the independent t-test or independent sample t-test compares the mean scores of two groups in order to understand if there is a significant difference between the two groups of the study. The study employed an independent t-test to define the relationship between the exposed and non-exposed groups with respect to PTSD and QOL.

RESULTS

Table 1.1 Correlation matrix of post-traumatic stress and quality of life among the group exposed to trauma

		Correlations	
		VAR00005	VAR00006
VAR00005	Pearson Correlation	1	-.624**
	Sig. (2-tailed)		.000
	N	60	60
VAR00006	Pearson Correlation	-.624**	1
	Sig. (2-tailed)	.000	
	N	60	60

** . Correlation is significant at the 0.01 level (2-tailed).

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The above table shows a negative correlation between post traumatic stress and quality of life among the group exposed to trauma (-.624**) at 0.01 level.

Table 1.2 Group statistics of quality of life among exposed and non-exposed groups of people

		Group Statistics			
Groups		N	Mean	Std. Deviation	Std. Error Mean
QOL	N-EXP	60	82.7333	8.24799	1.06481
	EXP	60	88.2667	9.81501	1.26711

The above table shows N, Mean and Standard Deviation of quality of life among exposed and non-exposed groups of people.

Table 1.3 t-value, df and Sig. (2-tailed) of quality of life among exposed and non-exposed groups of people. (N=60)

Quality Of Life	t	df	Sig. (2-tailed)
	-3.343	118	0.001

The above table shows a significant difference in the quality of life among exposed and non-exposed groups of people, ($p < 0.01$).

Table 1.4 Group statistics of PTSD among exposed and non-exposed group of people

Groups	N	Mean	Std. Deviation	Std. Error Mean
PTSD N-EXP	60	7.867	5.1006	.6585
EXP	60	8.117	5.2046	.6719

The above table shows N, Mean and Standard Deviation of PTSD among exposed and non-exposed groups of people.

Table 1.5 t-value, df and Sig. (2-tailed) of PTSD among exposed and non-exposed group of people. (N=60)

PTSD	t	df	Sig. (2-tailed)
	-.266	118	0.791

The above table shows no significant difference in the PTSD among exposed and non-exposed groups of people, ($p > 0.791$).

DISCUSSION

The aim of the study is to explore the relationship between experiencing point cluster suicide, PTSD and QOL in the community of Burari, Delhi and further, to evaluate the impact of the unfortunate event of death of 11 members of a family in Burari upon a randomly selected sample size population of Delhi, NCR. The sample size encompasses a total of 120 individuals wherein, 60 participants constitute as the exposed group and the other 60 participants constitute as the non-exposed group.

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The traumatic event in the study is 'witnessing a point-cluster suicide' and the aftermath it leaves on the community. An individual's QOL is severely compromised in PTSD populations, which can include veterans, refugees, terrorist attack survivors, victims of natural disasters, rescue workers, and victims of violence (Balayan et al., 2014). According to the aforementioned research, PTSD is a unique predictor of quality of life impairment, and a variety of psychotherapy and pharmaceutical treatment approaches may help PTSD patients' QOL (Balayan et al. 2014). One of the objectives of the present study is to measure PTSD symptomology, if there exist any, in the exposed population. Similar to the previous studies undertaken on PTSD and QOL, the current study also endeavors to explore the relationship between the two variables in the exposed group to provide more empirical evidence of the existence of a cause-effect relationship, which can help furthering specific strategies and techniques to improve the QOL of an individual diagnosed with PTSD.

The study employed the WHOQOL-BREF questionnaire to quantify the QOL in both the exposed and unexposed groups and explore a comparative analysis by using group statistics from both groups. The Posttraumatic Stress Diagnostic Scale Self-Report Version (PDS-5) was employed to measure PTSD symptoms.

The statistical findings in the present study show that there is a negative correlation between PTSD and QOL in the exposed group [$(-.624^{**})$ at the 0.01 level]. This shows that when PTSD symptoms are high, people will generally have low QOL, or vice versa. On the other hand, when PTSD symptoms are low or nonexistent, QOL will be significantly higher. In an exploratory study that investigated the relationship between PTSD, depression, anxiety, and QOL in individuals after a traffic injury, it was revealed that PTSD is negatively correlated with an individual's QOL (Wang et al., 2005). Secondly, the mean scores for QOL of the exposed and non-exposed groups are 82.7333 and 88.2667 respectively; and the standard deviations of both the exposed and non-exposed groups are 5.1006 and 5.2046 respectively. There is a significant difference ($p < 0.01$) in QOL among the exposed and non-exposed groups to trauma. Therefore, the study accepts the alternative hypothesis that signifies the existence of a significant difference between the QOL of the non-exposed and exposed groups and that there exists a significant relationship between PTSD and QOL.

The PDS-5 states that if the total score of an individual falls between 28 and 80, there is a probable diagnosis of PTSD. However, the maximum score obtained (individual scoring) is 21. This signifies that there is no diagnosis of PTSD in the exposed population. Additionally, there are minimal (0–10) to mild (11–23) symptoms of PTSD.

Inasmuch as the PTSD symptoms are concerned, the statistical findings do not reflect any significant difference between the exposed and non-exposed groups ($p > 0.791$). Therefore, we accept the null hypothesis. Both groups exhibited certain levels of PTSD symptoms; however, there is no diagnosis in relation to the recorded data. Therefore, contrary to previous studies, in the aftermath of a traumatic event, an exposed population did not exhibit any symptoms that fulfilled the diagnostic criteria of Post Traumatic Stress Disorder.

These findings, from the study concerning the lack of significance between the two groups in terms of PTSD, may be explained by the duration of time since the occurrence of the event as participants of the exposed group reported that the event initially (during the first month) affected them. After having a considered view of the survey, it may be correct to state that the 'Burari Deaths' tragedy did not have a long-lasting impact on the exposed populace. The effects on the community were, in fact, negligible, and it can be concluded

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that the span of time between the event and the study's implementation is a significant determinant in terms of the exposed group having neither moderate nor severe PTSD symptoms.

Another possible reason is the place of occurrence. Burari is situated in the northwest region of Delhi, which is also one of the major hotspots for criminal activities (Gupta, 2020). Under certain circumstances, continuing exposure to violence may deter the likelihood of a future PTSD diagnosis (Harden, 2018). Individuals with constant exposure to traumatic events or violence equip themselves with coping techniques like compartmentalization or repression, which can allow them to cope, and eventually, these traumatic memories may become latent in nature (Warren, 2015). Therefore, when people are exposed to crime frequently, they may get used to experiencing trauma, which essentially may make them averse to the trauma; and the feeling may subside over time as more crimes happen.

One of the participants in the exposed group shared that the incident of suicides were restricted within the limited confines of the residence of the deceased family, and therefore, the community at large did not experience a long-term impact. According to the participant, a gruesome crime took place in Sant Nagar where a woman was stabbed multiple times with a knife in broad daylight. They continue to find the event traumatizing as they witnessed 'harm towards another individual' but found themselves unable to prevent it.

Seemingly, suicides raise major public health concerns, and therefore, it is important to approach the issue of suicide and the clustering of suicides using strategic techniques in order to prevent their occurrence. (Brent et al., 1992, 1993, 1995; Elklit et al. 2008; Abbot 2012; Balayan et al. 2014; Pitman et al. 2014; Cerel et al. 2016)

CONCLUSION

This study investigates the relationship between 'witnessing a point cluster suicide', 'PTSD' and 'QOL.' The cornerstones of this study are the two independent samples formed: the "exposed group" and the "non-exposed group." The research is aimed at studying whether there is a significant difference in PTSD levels and QOL between the exposed and non-exposed populations, as well as if there exists a significant relationship between QOL and PTSD. The study employed a judgmental/purposive sampling method that included a survey of 120 individuals (exposed group: 60 individuals, non-exposed group: 60 individuals).

The research identified a significant difference in QOL between the exposed and non-exposed groups of the population. The study found that there was no diagnosis of PTSD symptoms; however, the clinical population showed symptoms ranging from minimal to mild. These symptoms were not sufficient to fulfil the diagnostic criteria for posttraumatic stress disorder. On the basis of the findings of the study, there exists a negative correlation between QOL and PTSD in the exposed population, which suggests that an increase in PTSD symptomatology leads to a decrease in QOL. However, the study could not identify any significant difference in PTSD between the exposed and the non-exposed groups. Further research can evaluate the risk factors involved in the clustering of suicides in India, as it has seen a slight increase in cases of cluster formation. It is also important to address coping strategies in the initial months after witnessing or experiencing a suicide cluster, as many studies have provided evidence of the negative impact on the psychological well-being of people connected to the suicide victims.

Limitations

The involvement of uncontrollable extraneous variables specifically in measuring QOL between both the groups such as living in a more developed area, financially strong backgrounds, gender, sustainability, easy access to medical facilities etc. may have impacted the result. Participants were acquiesce to be a part of the study as they were already exposed to extensive questioning from media outlets, police forces, medical officers and so on. The field study carried out on the exposed group took a long time due to an ostensible lack of interest in answering the questions. A resistance was witnessed as this issue was addressed again after a long time, and they did not understand the relevance of the study immediately. Another important limitation to the study was the language barrier, as on certain occasions questions were translated to Hindi for a better understanding of the subject by reading the English Manual for PDS-5.

Future Implications

By using these assessments, an individual can examine her own state of psychological well-being after being directly or indirectly exposed to traumatic events or circumstances. Whether being directly or indirectly exposed to trauma, it can even show minimal symptoms in an individual, and therefore, it is important to address such onset through counselling and therapy, because the manifestation of such minimal symptoms and constant exposure to trauma may result in developing severe symptoms that can impact one's functionality. Suicide at an individual level or in the form of a cluster can impact the community as a whole. Therefore, it is important to develop interventions and coping strategies to prevent and foster a consequent aftermath of such an event. This study can provide insight into how to manage the effects of clusters as soon as feasible. Understanding the complexity of one particular culture that may be distinct from many others might be aided by research on the risk factors associated with the formation of suicide clusters in the Indian setting. Due to the collectivist nature of Indian society, the effects of being close to a suicide cluster's victims can be researched, and comparative analysis can be used to understand how a suicide cluster differs between cultures.

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Conflict of Interest

The author(s) declared no conflict of interest.

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