Chapter 6
Understanding Suicide Bereavement, Contagion, and the Importance of Thoughtful Postvention in Schools

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Recent research estimates that one in five adolescents has been exposed to the suicide death of a family member, friend, or acquaintance during their lifetime (Andriessen et al., 2017). Understanding how youth cope with suicide loss is important since grieving early in the life course may come with unique challenges. In this review, we discuss the characteristics of adolescent suicide bereavement, research on the potential for suicide contagion, and recommended postvention practices in school settings, which can be crucial in addressing concerns about bereavement and contagion and thus help in future youth suicide prevention.

We begin by characterizing suicide loss along a continuum which contains three main categories (Cerel et al., 2014). Bereavement sits at one end of this continuum and applies to anyone who experiences long-term, significant psychological distress in response to the loss. Those affected by suicide but not bereaved may experience psychological distress, but typically less than bereaved youth. Finally, at the other end of the continuum are those who know or identify with a person who has died by suicide. The suicide loss may impact them meaningfully; however, their distress is noticeably less than those affected or bereaved. These definitions acknowledge the effects of suicide on individuals beyond the family unit, as well as variation in types of exposure and responses to suicide, and help in our understanding of appropriate assessment, support, and intervention for those who are grieving.

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Suicide Bereavement

Although clinical research identifies similarities between suicide bereavement and other types of grief, suicide bereavement nevertheless has unique characteristics. Specific features of suicide loss distinguish it from death by other means, including feelings of shock, abandonment, and anger at the deceased, which may depend upon the decedent's previous history of suicidality and the perceived preventability of the suicide (Andriessen et al., 2016). Those experiencing suicide bereavement often report both physical and psychological outcomes which can include depression, PTSD, complicated (protracted) grief, and subsequent suicidality (Bottomley et al., 2019). Compared with other bereaved groups, the suicide bereaved often feel painful social emotions like responsibility, guilt, and shame (Jordan, 2001). Additionally, studies show that they are more likely to drop out of work or school and may engage in high-risk coping behaviors such as substance misuse and self-harm (Cerel & Roberts, 2005).

The context in which suicide bereavement takes place is also important. A grieving individual's social relationships, their community's shared norms, the available support systems, and the frequent stigma surrounding suicide can make suicide bereavement especially difficult (Jordan, 2001). Stigma, both external and self-imposed, can create a "double whammy" effect for the suicide bereaved who may feel simultaneously grief stricken and socially marginalized (Schreiber et al., 2017). In turn, feelings of alienation can complicate recovery. This is particularly relevant for adolescents whose grief experience intersects with a developmental stage characterized by identity formation and heightened dependency on peer relationships and perceived social acceptance (Balk, 2014).

Finally, the process of suicide bereavement and healing after suicide differs from other types of grief. Unexpected death typically elicits acute shock, but suicide often compounds this with a further need to make sense of the decedent's intentions. This can elicit a cognitive process of meaning making in which the bereaved person attempts to create a story explaining the unknown aspects of suicide, particularly why a person ended their life (Currier et al., 2015). This can prolong the mourning process, though it can also result in post-traumatic growth as individuals (a) make sense of the loss, (b) find a "silver lining" in the experience, and (c) adopt a new identity, often that of "suicide loss survivor" (Sands et al., 2011).

Adolescent Suicide Bereavement

Adolescent suicide bereavement is unique in that aspects of this developmental stage, such as identity formation, may intersect with the grieving process. Adolescence is the time of life when mental health disorders are most likely to emerge. Additionally, this is a time during which their sense of self in relation to their social world is coalescing (Balk, 2014). Adolescents tend to value peer

relationships, but these relationships may become strained when an adolescent needs to process a suicide loss due to fears about stigma. Those bereaved by suicide may prefer peer support from others with similar experience in processing their grief, feeling that others who do not share their specific experience cannot appreciate their needs (Cerel et al., 2009). Informal support from peers or others with similar loss experiences may also reduce the awkwardness and stigma that can accompany suicide. However, peer support among youth raises some potential concerns; when peers support each other, they may engage in excessive and unproductive discussions of their personal challenges and mutually encourage negative talk. Such a process can increase feelings of closeness between the peers but also increase feelings of emotional distress (Andriessen et al., 2016). Peer relationships that appear outwardly supportive may mask these shared negative feelings and the peers' internalization of them, which can place adolescents at risk for adverse outcomes.

Factors That Can Impair or Facilitate Adolescent Suicide Bereavement

The mental health literacy of parents impacts how effectively parents access professional help for adolescents. Parents are often critical to getting bereaved youth professional mental health supports (Andriessen et al., 2019). When this connection is made, a trusting patient-clinician relationship is crucial for adolescents' engagement and continuation of treatment. Barriers to formal help-seeking include reliance on family, friends, or self, shame associated with mental health stigma, limited knowledge of services, and difficulty identifying symptoms of mental illness or perceiving symptoms as not meriting professional attention (Andriessen et al., 2019). Bereavement among adolescents is unique as it can leave youth vulnerable to contagion.

Social Contagion

Following a suicide, there is concern that exposure to suicide through both traditional and new media (social media and use of the internet) (Marchant et al., 2017; Ortiz & Khin Khin, 2018) or through personal role models (Abrutyn & Mueller, 2014; Maple et al., 2017; Cerel et al., 2016) puts youth at increased risk of suicidal ideation or attempt. These social influences, collectively referred to as contagion, can occur from one person to another or through a social environment, as in the case of suicide clusters or successive suicides (two or more) that occur in delimited geographic and temporal space (Haw et al., 2013; Poland et al., 2019).

Contagion research has largely focused on traditional media exposure, with recent retrospective studies suggesting that media coverage of suicides can facilitate

the emergence of youth suicide clusters (Gould et al., 2014). Questions remain about how much traditional media youth consume. One recent study in Japan, for instance, found traditional media coverage following celebrity suicides was not associated with population suicide rates, though Twitter coverage was (Ueda et al., 2017). The role of social media in youth suicide is an important emerging field of research; however, studies examining the impact of exposure to suicide through social media on youth or the connection between social media and youth suicide contagion or clustering are extremely limited (Robertson et al., 2012; Ortiz & Khin Khin, 2018). One rare study of a high school suicide cluster found that youth who were posting suicide cluster-related content to their social media had a significantly higher risk of suicidal ideation (1.7 times more likely than their non-posting peers) and attempts (1.7 times) (Swedo et al., 2020); however, the study used cross-sectional data making it impossible to determine whether the observed association between posting and suicidality was because more distressed or impacted youth were more likely to post to social media or whether the posting (and ostensibly reading others' posts) generated or exacerbated youth's risk (or both). Given the importance of social media and technology to youth's lives and connections, more research is necessary to unpack the influence social media has on youth suicide bereavement as well as contagion and clustering.

Far more is known about exposure to suicide and suicide attempts through personal role models. Several decades of research using a variety of methodologies has confirmed that youth are at higher risk of suicidality after experiencing the suicide attempt or death of a friend or family member (Hawton et al., 2012; Cerel et al., 2016; Maple et al., 2017). Some hypothesize that this pattern is due to similarities in pre-existing risk factors for suicide, shared between friends or family, a phenomenon otherwise known as "homophily" or "assortative relating" (Joiner, 2007). However, multiple longitudinal studies using a variety of causal modeling strategies suggest that shared pre-existing risk factors do not fully explain this dyadic form of contagion (Baller & Richardson, 2009; Fletcher, 2017; Randall et al., 2015). In one study, researchers found that youth who had no previous suicidal history and who were exposed to a friend or family member's suicide attempt or death in the past 12 months were significantly more likely to report suicidal ideation 1 year later (Abrutyn & Mueller, 2014). Though the mechanisms through which exposure to suicide translates into increased risk of suicide are still an important area of research, studies have shown that (1) social learning, where knowledge of a friends' suicide attempt or death makes suicide more of an "option" for coping with particular forms of distress, and (2) emotional contagion contribute to suicide contagion. However, it is also worth noting that experiencing suicide loss does not always translate into increased risk of suicide; some studies show evidence of inoculation effects, where losing someone to suicide makes a person less vulnerable to suicide (Brent et al., 1993; Miklin et al., 2019). Given implications for bereaved youth, investment in additional research is justified.

Youth Suicide in Schools

Studies underscore the vulnerability of youth to suicide exposure: vulnerability that is amplified by their stage of cognitive and emotional development, which makes them especially sensitive to other's influence (Giordano, 2003). Not surprisingly, then, schools (Haw et al., 2013) and youth (Gould et al., 1989) are disproportionately susceptible to suicide clusters. Importantly, preventing suicide contagion and suicide clusters requires identifying and intervening in environmental risk factors. School contexts are important environments where youth form protective social relationships that offer youth support and meaning. However, school environments can also increase risk of suicide if they house a toxic, high-pressure culture, stigmatize mental health help-seeking, or offer few opportunities for building positive relationships with trusted adults (Mueller & Abrutyn, 2016; Pisani et al., 2012; Wyman et al., 2019). In addition, environments in which a suicide has occurred may develop a new cultural script about suicide—that is, shared beliefs about why people die by suicide, who we expect to die by suicide, and, in some cases, where, when, and how. This script can render suicide a more normative option for exposed youth, particularly if schools do not engage in adequate postvention.

School Postvention: Best Practices

Schools are critical locations for suicide postvention (see Ayer et al., this volume). While more research is needed to empirically establish the efficacy of various postvention practices, two key resources provide guidance on best practices: *After a Suicide: A Toolkit for Schools* (AFSP, 2018) and *Suicide in Schools* (Erbacher et al., 2015). These resources suggest that it is important that schools solidify a plan for postvention and establish a crisis response team long before a crisis occurs. To be effective, these plans should encompass the following four areas:

1. Community Relationships

Schools should work to build community relationships, because while every school should have postvention practices in place, schools should never engage in postvention efforts alone. Establishing memoranda of understanding with community health officials, crisis centers, local counselors, and others who are trained in grief support and/or crisis response and can be ready to enter the school and provide extra support contributes to a more effective postvention response. Plans to draw support from the school district when possible is also advised (some districts have complementary crisis response teams). When a crisis event does occur, it is helpful to have open lines of communication with trusted community and district partners who may be able to provide extra support or interventions; for example, community partners may be able to provide trainings to school staff that highlight the typical

and atypical responses in grieving and bereaved adolescents or risk factors for suicide (Erbacher et al., 2015).

2. Clear Plan of Communication

Schools should create a clear plan of communication to speak early and clearly with school staff, as well as parents and students, to help ensure that the news is delivered responsibly and sensitively (and not through informal means, like social media). Sample communications are available (see AFSP, 2018). Phone trees for staff can be useful, as can a crisis response team coordinator. Often, the first 24 hours are critical; the school should notify key personnel, while remembering that students may be hearing things before many staff due to the information flow on social media. Schools should follow guidelines for talking about suicide in all communications (AFSP, 2018, pp. 55–59). It is a school's responsibility to verify the facts of the death. Schools should be clear with all staff about what may be shared publicly (with parents) and what should not be shared. In making these decisions, it is important to respect the family's wishes regarding disclosures of details. However, if rumors are circulating among students, it may be appropriate for a trusted staff member to talk to the decedent's family and explain that talking about suicide with students can help to keep them safe (Erbacher et al., 2015).

On the first morning back at school following the loss of a student to suicide, the school should hold a meeting to provide staff with a death announcement to read to their classes. How youth hear about a death can have a profound effect on ways in which the individual responds (Hart, 2012). As such, anyone known to be very close to a deceased youth should be notified individually if possible, while the rest of the students can be told in class. The death announcement is not counseling or therapy, but a space where teachers can provide facts, dispel rumors, answer questions and normalize student reactions, and triage students following a three-tier model of crisis prevention (see Erbacher et al., 2015). Schools should also facilitate students self-referring for additional support. Staff may also be grieving and in need of support; thus, school should have substitutes or mental health professionals available to support staff.

3. Clear and Consistent Policies and Trainings

Ideally, schools will have clear and consistent policies and trainings. These policies should outline the process of recognizing and memorializing student deaths and supporting bereaved parents and impacted students and staff. School-related memorials for a suicide are a challenging issue as they can sometimes be interpreted as glorifying suicide. A standardized school policy that treats all causes of death similarly can be helpful, though this policy should be developed with all causes of death in mind to avoid stigmatizing some deaths (Gilliam, 1994; Vidal, 1989). For more details on memorializing suicide losses, we recommend reviewing *After a Suicide: A Toolkit for Schools* (AFSP, 2018, p. 60). In addition to postvention policies, strong prevention policies are also necessary. Notably, routine mental health training for school staff helps prepare staff in the event of a suicide loss. Trainings should include information on suicide and suicide myths, normalize talking about mental

health and suicide, include information on cultural differences within the student body, and identify strategies to overcome potential barriers for students' access to out-of-school mental health help (e.g., language concerns, cultural beliefs about mental health, financial limitations, etc.). Trainings should address the pervasive myth that talking about suicide encourages suicide (also known as iatrogenic risk). This is not true (Joiner, 2011). This myth can be very salient during postvention as fears that a suicide may trigger contagion are common, but it is important that the community have fact-based conversations around suicide. After a suicide, such conversations are safe and necessary and likely mitigate suicide contagion.

4. Creating Space for Suicide Bereavement

Finally, schools should plan out a space within a school that, if needed, grieving students can go to, receive support, and feel safe (Erbacher et al., 2015). It is appropriate for impacted students to be invited into these spaces; however, students should be encouraged to self-refer and refer their friends as well. Scheduling meetings with vulnerable students (alone or in small groups) is another recommended approach. Collectively, these postvention strategies can help ensure a more effective suicide postvention experience.

Conclusions and Future Directions

Many youth and schools are impacted by suicide losses. Current research and practice recommendations provide sound guidance for schools to develop thoughtful postvention protocols that in turn serve as an important form of suicide *prevention*. Of course, more research is needed—particularly as new forms of communication and connection emerge—to understand the complexities of exposure to suicide during vulnerable developmental stages and to maximize the efficacy of postvention strategies. Additionally, research on suicide postvention and bereavement would benefit from a more significant emphasis on equity and strategies for postvention in contexts of resource scarcity.

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