

The efficacy of groups in preventing suicide: Is contagion a concern of the past?

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The efficacy and safety of including individuals at risk for suicide in groups is a polarizing topic that has been debated since the 1960s [1]. Often suicide has been viewed as a problematic factor in groups, specifically, researchers report suicidal individuals disturb the group process, and increase risk of harm [2,3]. Yalom wrote that suicidal patients do not benefit from groups because they, “do not receive the specialized attention they require” and the “threat of suicide is too taxing; too anxiety provoking for group members to manage” (p. 231). Additionally, some report that groups make it easier for suicidal individuals to conceal or evade [4]. However, one of the biggest concerns of suicide-focused groups is the effect of contagion (e.g., exposure to suicide leadings to one’s own suicide death) [5]. While some research regarding the development and efficacy of suicide groups was published in the 1960’s and 1970’s, there is a paucity of research in the past 50 years concerning the relationship between suicide risk and group therapy. Furthermore, the literature that does exist on this topic is contradictory with some fearing contagion related outcomes [6,7] and others noting the value of suicide prevention groups [8,9]. Therefore, this brief review aims to explore the use of groups in a population at risk for suicide and whether contagion is a concern within these groups.

Research suggests the concept of suicide contagion stemmed from psychoanalytic researchers who borrowed the concept from biology and applied it to feelings [6]. Goldberg [6] observed suicide contagion in groups. However, while some believe adults are at risk for contagion, evidence of suicide contagion has more often been reported with clusters of deaths amongst teenagers [7]. Therefore, some have argued that if contagion does exist amongst the suicidal population it may primarily effect adolescents due to an “imitation factor” [7]. However, these aforementioned studies are based in observation and clinical opinion, which may not adequately prove whether contagion does, or does not, exist. Therefore, researchers suggest that more data must be collected regarding this issue so that it can be properly statistically analyzed to see if criteria for suicide clustering, or contagion, is met [10]. For example, past research that is data driven has found that when someone famous dies, and many others seem to attempt suicide following their death, results do not meet statistical significance [10].

There have been reports of contagion in other treatment settings, such as inpatient units [11]. This research suggest that the response of staff is vital to prevent contagion as suicide survivors may feel empathy, identification or glorification of the deceased after the suicide, relating to possible attempts of the suicide survivors [11]. Within inpatient settings it has been reported that detailed information obtained about a suicidal act can suggest to other patients a previously unconsidered lethal means for ending one’s life [11]. However, this research is also based on clinical opinion rather than statistical data.

While some research herewith has observed contagion, other research suggests that contagion does not exist, or is not a concern [2]. Notably, some reports advocate that groups for suicidal individuals can be particularly helpful [8,12]. The first published article reporting clinical observations of a suicide focused group therapy reported no completed suicides, but groups leaders did report resistance from hospital staff due to their fear of contagion [1]. In another group therapy (N=105) that included those with a previous suicide attempt, there was only one death and a low reattempt rate of 4% in year one of the group [8]. Even amongst adolescent populations, which are thought to be at greater risk for suicide contagion, research suggests that group therapy with suicidal adolescents can be successful [4]. For example, Kaminer [7] suggests openly discussing suicidal behavior through group therapy. By pointing out the behavior, other group participants may be discouraged to imitate the method in fear of being labeled a follower or “copy-cat” by their peers, a mentality often observed in adolescents [7].

More recently, suicide prevention groups have been developed within the Veterans Health Administration (VHA). The VHA is America’s largest integrated health care system and often uses group therapy as a form of treatment. However, according to Johnson et al., [12] prior to 2009 no Veteran Affairs Medical Center (VAMC) had ever had a group in which suicidal ideation and behavior was the focus of the treatment sessions. While both groups were suicide- focused (N=141), one group investigated the impact and efficacy of the Suicide Status Form (SSF) for Veterans recently discharged from an inpatient psychiatry setting [12]. Although there was no significant difference between groups, all participants in the study experienced a significant reduction in suicidal ideation compare to the baseline assessment.

Another suicide-focused group being conducted within the VHA is Project Life Force (PLF), a 10-session, group intervention that combines social support, skills and psychoeducation, to maximize suicide safety planning development and implementation. In the open label pilot study, depression, hopelessness and suicidality all significantly improved [9]. There were also no suicide deaths or actual attempts throughout the study. Due to the success of the PLF intervention at the James J. Peters VAMC, the group is currently being implemented in several other VA hospital settings (e.g., Corporal Michael Crescenzo VAMC) and civilian community healthcare settings [9]. Additionally, PLF is currently being

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adapted for other populations [9]. To date, neither of these groups have reported contagion or suicide clusters.

Amongst studies that have found suicide prevention groups to be efficacious [13], literature agrees that group leaders need to be effective in their leadership and have proper clinical training [2]. It is hypothesized that these groups are helpful due to their social nature promoting a decreased isolation, and that group members can help each other identify coping strategies [2]. Frederick, et al. [14] were the first to note the importance of group cohesion, in suicide focused groups, arguing group psychotherapy “provides very real support from those who have had a similar experience,” (p.111). Both Johnson et al. [12] and Goodman [9] report the importance of group cohesion in suicide-focused groups. Johnson et al.’s [12] results indicate that higher group cohesion scores at one month were significantly associated with less thwarted belongingness. However, conflicting research notes that if group members model suicidal behaviors instead of these positive coping strategies, this is when contagion can become a concern [11].

While many of these recent suicide focused groups seem to have promising data driven results, guidelines for how to run the group and reduce suicide risk differs greatly. There have been conflicting reports regarding the selection of group members, whether they need to be carefully selected [14,15], or if all with suicidal tendencies are welcome to participate [13]. Additionally, reports of interactions outside of the group have been contradictory with some researchers reporting no interaction should be carried out outside of the group [1] and others reporting their interpersonal relationships to be helpful [9,13]. Lastly, while some groups may not allow discussion of suicide means for fear of glorification [11], Goodman reports openly discussing means within the PLF group to debunk any possible means that could be used [9].

Overall, despite early reports of effective suicide prevention groups, published papers on this topic over the past 50 years convey fears of contagion within this population [5,10]. However, recent literature, particularly amongst adults, suggest this fear may be unwarranted [2,12]. Moreover, emerging data is highlighting the clinical benefits of discussing suicidal symptoms in a group setting.

References

1. Indin BM (1966) The crisis club: A group experience for suicidal patients. *Ment Hyg* 50: 280-290. [[Crossref](#)]
2. Fournier R (2005) Group therapy and suicide. Assessment, treatment, and prevention of suicidal behavior: John Wiley & Sons, Hoboken, NJ, pp: 313-332.
3. Richman J, Eyman JR (1990) Psychotherapy of suicide: individual, group, and family approaches: In D. Lester. Current concepts of suicide, Charles Press, Philadelphia, pp. 139-158.
4. Horwitz L (1976) Indications and contraindications for group psychotherapy: Bulletin of the Menninger Clinic.
5. Stack S (2015) Crisis phones-suicide prevention versus suggestion/contagion effects. *Crisis* 36: 220-224. [[Crossref](#)]
6. Goldberg JG (1985) The contagion of death. *Modern Psychoanalysis* 10: 13-30.
7. Kaminer Y (1986) Suicidal behavior and contagion among hospitalized adolescents. *N Engl J Med* 315: 1030
8. Comstock BS, McDermott M (1975) Group therapy for patients who attempt suicide. *Int J Group Psychother* 25: 44-49. [[Crossref](#)]
9. Marin L, Sullivan S, Spears A P, Goodman M (2019) “Project Life Force-Geriatric”: A novel suicide safety planning group treatment. *Am J Geriatr Psychiatry* 27: 72-S173.
10. Manson R, Lester D, Gunn III, J F, Yeh C (2013). Do suicides cluster? *OMEGA-Journal of death and dying* 67: 393-403.
11. Seeman MV (2015) The impact of suicide on co-patients. *Psychiatr Q* 86: 449-457. [[Crossref](#)]
12. Johnson LL, O’Connor SS, Kaminer B, Gutierrez P M, Carney E, et al. (2019). Evaluation of Structured Assessment and Mediating Factors of Suicide-Focused Group Therapy for Veterans Recently Discharged from Inpatient Psychiatry. *Arch Suicide Res* 23: 15-33. [[Crossref](#)]
13. Billings JH, Rosen DH, Asimos C, Motto JA (1974) Observations on Long-Term Group Therapy with Suicidal and Depressed Persons. *Suicide Life Threat Behav* 4: 160-170.
14. Frederick CJ, Farberow N L (1970) Group psychotherapy with suicidal persons: A comparison with standard group methods. *Int J Soc Psychiatry* 16: 103-111. [[Crossref](#)]
15. Hipple J (1982) Group treatment of suicidal clients. *Journal for Specialists in Group Work* 7: 245-250.