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Group Psychological Emergency Management after Suicide-related Death of Organization Members

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Abstract: The occurrence of member suicide in various types of organizations can have adverse effects including physical and psychological stress reactions, social impact, and suicide contagion. The study considers organizational member suicide as an unexpected crisis event in organizations, and divides organizational members affected by different suicides Φ into four regions A, F, W, and O through two dimensions of spatial distance and social distance of psychological distance, and through four stages of emergency management work: prevention-response-disposal-assessment, to achieve the goals of curbing suicide contagion, restore the mental health level of the group, and reduce the negative impact.

Keywords: Organization member suicide; Suicide influence; Psychological emergency management; Psychological distance

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1. Introduction

The impact of suicide is widespread and far-reaching, with survey data from the United States showing that 1 person's death by suicide can affect, on average, 5 family members, 15 extended family members, 20 friends, and 20 classmates or coworkers, with some still experiencing intense emotional distress even 14 years later [1–2]. The rough all-age suicide rate in China in 2019 was 8.1 per 100,000 people (World Health Organization, 2021). A large organization with more than 10,000 employees should be self-conscious that the probability of one suicide within the organization in a year can be as high as 81%. This probability will increase in the event of a major infectious disease outbreak, and the severe negative impact of suicides makes emergency management essential. Relative to previous suicide research, this paper considers suicide as a crisis event in all types of organizations and focuses intervention on the psychological impact of the group due to suicide.

Suicide has an impact on groups. Hospitals are a high-prevalence area for suicidal events, and studies addressing

the impact of suicide have focused on the nurse population. In Belgium, 73% of nurses in psychiatric hospitals experienced at least 1 acute event, with suicide accounting for 64%, while 55% of nurses in Japanese psychiatric hospitals experienced a patient suicide, with 13.7% experiencing post-traumatic stress disorder [3]. A meta-analysis of 63 studies showed that nurses experienced significant physiological, psychological, and behavioral changes after experiencing patient suicide [4]. Physiological responses included headache, increased heart rate, sleep disturbances, hallucinations, decreased appetite, and gastrointestinal distress. Psychological reactions include shock, fear, grief, guilt, nervousness, anxiety, and even depressive symptoms. In terms of behavior, difficulties in concentration, hypervigilance, over-protectiveness, and avoidance are observed.

Those most affected by suicide are the friends and family of the deceased. Studies from the UK and Australia have shown that cold numbness and avoidance from coworkers have led those bereaved by suicide to experience more stigma and social isolation in the workplace, and as a result, have more strained relationships with coworkers [5–6]. This significantly impairs their social functioning, reduces job performance, and leads to more separations and dropouts. This effect does not only stop at family and friends but also spreads to the periphery. After a fifth-grade girl in a city committed suicide and died by jumping from the window of her room on April 22, 2018, her best friend and her boyfriend both took leave from school to stay home because they could not continue their studies, and some of their classmates cried in class as well, making it impossible for the class to function normally [7].

The biggest impact of suicide is suicide contagion, six suicides occurred at Foxconn between January and April 2010 and began to attract a lot of media attention in May, with a flurry of coverage. In May alone, there were seven consecutive suicides in January, all of which involved jumping from a building. The contagion effect is even more pronounced in the case of celebrity suicides [8]. A meta-analysis of 98 celebrity suicides found a 0.26 change in the local suicide rate in the month following a celebrity suicide. The increase was even greater in the case of entertainment stars, at 0.64 in North America, 0.68 in Europe, and 0.58 in Asia [9]. Following the suicide of the Japanese singer, Okada Yukiko, on April 8, 1986, Japan's suicide rate was 44% higher than at the same time in 1985.

2. Method

Individuals' judgments and responses to critical events are moderated by psychological distance, which has four dimensions: temporal distance, spatial distance, social distance, and probability distance [10]. Temporal distance measures the time interval between the event and the individual, and probability distance measures the probability that the event meets the individual. The probabilistic distance for the case where the suicide has already occurred was the same. Its temporal distance is equal for all individuals in the organization. Then the impact of the suicide event on the individual is only regulated by the two dimensions of spatial distance (distance from the suicide site) and social distance (social relationship with the deceased), and the farther the spatial distance and social distance are the less impacted. For a more intuitive and concise representation, let the impact of suicide be Φ, then:

$$\Phi \propto \frac{1}{\mathrm{Sp}*\mathrm{So}} \tag{1}$$

Due to individual differences (Individual difference, Id) in cognitive judgment, personality traits, suicide susceptibility, psychiatric history, etc., even with the same spatial and social distance, individuals are not affected in the same way. Introducing individual differences as correction constants in **Equation 1** is:

$$\Phi \propto \frac{\mathrm{Id}}{\mathrm{Sp}*\mathrm{So}} \tag{2}$$

In the same organization, both spatial and social distances have their qualifying values, and here the maximum spatial distance is set as the general spatial boundary of the organization's activities and the maximum social distance is the shared organizational membership. Taking the suicidal person as the origin, the distribution of other people affected in the case of a member's suicide can be represented in **Figure 1** below.

The horizontal axis represents social distance, the vertical axis represents spatial distance, and the red line indicates that the physical-psychological stress caused by the effects of suicide has reached a level Φ_0 that requires rapid intervention, and the individuals under the red line are those who require urgent intervention. Area A near the horizontal axis indicates audience, with a large social distance and small spatial distance; Area F near the vertical axis indicates family members and friends, with a large spatial distance and small social distance (outside the dots indicate family members and friends who are not in the organization); Area W inside the circle indicates the people in the organization who are acquainted with the suicidal person, mostly the other worker of the same team, the social distance and spatial distance are closer than others; O area indicates other members of the organization who do not know the suicide victim, the social distance is far and the spatial distance is scattered. Below red line Φ_0, zones F, A and part of W are the main influence zones of physical and psychological stress reactions, while zone W indicates the main range of social influences, and the risk of suicide contagion is more insidious and has a wider distribution, and all four zones of AFWO need to be included in it.

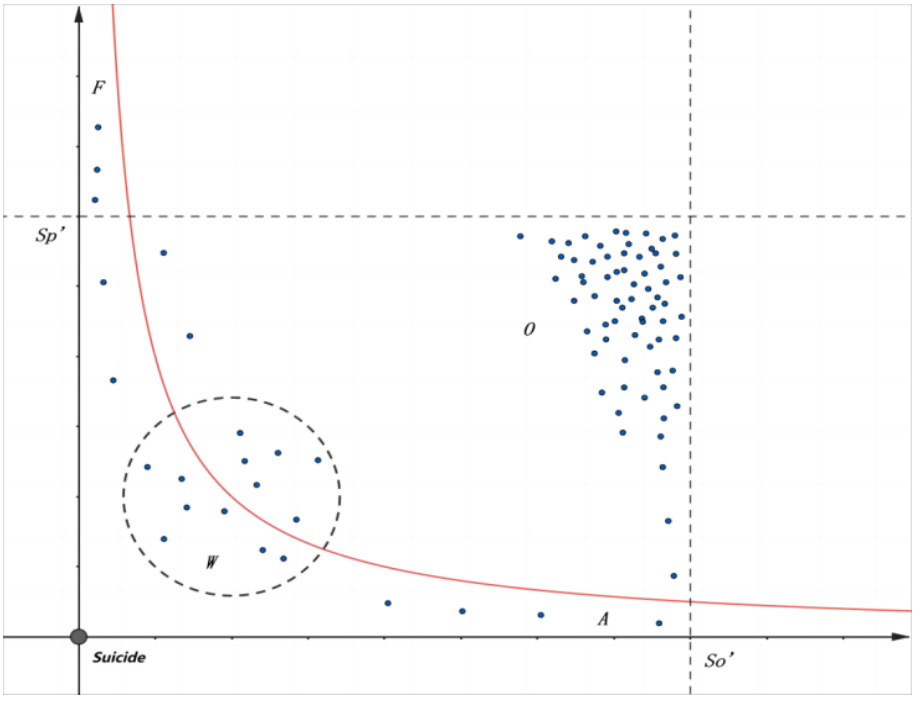

Figure 1. Distribution of organization members affected by suicide

3. Result: Emergency program

The Emergency Response Law of the People's Republic of China divides emergency management into four phases: prevention and preparedness, monitoring and early warning, emergency response and rescue, and post-event recovery and reconstruction. The psychological emergency management of groups affected by suicide is carried out under this system.

3.1. Phase 1: Prevention

3.1.1. Building psychological expectations

An anonymous survey involving 1120 people in India showed that people who had more awareness of the symptoms of COVID-19 were aware of nearby hospitals with emergency phone numbers, and paid regular attention to reports of COVID-19 had higher levels of mental health [11]. This reflects that mental preparation for possible emergencies is effective and necessary. Suicide prevention campaigns can be conducted within the organization to raise awareness of suicide among its members, equip them with certain methods of emotional processing and stress coping, and build up psychological expectations in advance.

3.1.2. Non-punitive organizational culture

The culture of "accountability" in an organization after suicide will undoubtedly increase the psychological burden of the responsible individuals, and the resulting blame-shifting and avoidance will lead to a breakdown in organizational trust. A survey of 731 nurses who experienced patient suicide in eight hospitals in Hubei Province found that the highest scores on support needs came not from family and friends, but from leaders, and were consistent both at home and abroad [12]. This shows that the establishment of a non-punitive organizational culture is then important, and may even to a certain extent play a role in suicide prevention.

3.1.3. Building socially supportive organizations

Social support is a protective factor for group mental health [13]. Interview surveys from the UK and Australia have demonstrated that social support has an important role in the recovery of the mental health of secondary victims of suicide, but due to feelings of guilt, self-blame, and the stigmatization of suicide, seeking social support is fraught with obstacles [14]. Employers show less sympathy when it comes to suicide than other difficulties, and most people also choose to avoid the topic in all types of work and social situations, resulting in more mistrust, social isolation, and withdrawal. To cope with this situation, an open and inclusive organizational culture, a cordial and honest communication environment, and an internal atmosphere of solidarity and mutual support should be constructed to promote a common organizational social identity, which in turn leads to the formation of social group psychological resilience in all kinds of emergencies [15].

3.2. Phase 2: Response

3.2.1. Reveal the distribution of people affected by suicide

The first step is to delimit Φ_0 the population affected by suicide within an organization, for which it is necessary to carry out a comprehensive psychological screening within the organization, looking for individuals who have already experienced intense physical and psychological stress and others who are at risk of suicide. On this basis, zones F and A are identified based on the dimensions of social and spatial distance, zone W is identified in relation to the deceased's work and social network within the organization, and zone O is identified for the rest of the population. Three screening tools are recommended as follows: The Patient Health Questionnaire Item (PHQ-9) adapted by Spitzer [16]. The Columbia Suicide Severity Rating Scale (C-SSRS) developed by Columbia University [17]. The suicidal behavior screening questionnaire developed by Tianjin University [18].

3.2.2. Blocking the media from spreading the effects of suicide

He and Qin examined 9,922 suicide reports on Weibo and found that these reports violated 9 of the 12 principles in the World Health Organization's Responsible Reporting of Suicide: A Quick Reference Guide [19]. As the main body

of emergency management, the organization of the suicidal person has the most truthful and accurate information and has the authority of the "official media" in suicide reporting. Concealment and shirking of responsibility is a breeding ground for rumors, and the best way to stop the fermentation of public opinion is for organizations to take the initiative to report suicide incidents in a truthful and responsible manner.

3.3. Phase 3: Disposition

3.3.1. Psychological first aid with individual counseling

After the psychological screening and delineation Φ_0, organizations can basically target the people who need emergency intervention, and the specific counseling or treatment plan needs to be formulated according to the specific situation of the interviewees, and here this study only recommends three commonly used methods of post-disaster psychological crisis intervention.

Post-disaster psychological first aid that is derived from the U.S. "Psychological First Aid Field Operation Guide." The content is comprehensive and systematic, highly structured, and has been used in emergencies such as the 9/11 incident in the United States as well as many terrorist attacks, hurricane disasters, and the Wenchuan earthquake in China, with remarkable results [20].

Eye movement desensitization reprocessing. It can effectively alleviate the effects of traumatic memories in a short period of time without the aid of medication and also has good efficacy in bereavement PTSD [21].

Cognitive behavioral therapy. Compared to eye-movement desensitization reprocessing, cognitive behavioral therapy has a lower rate of exposure to traumatic memories and a lower rate of shedding in interviewees [22].

3.3.2. Mitigating social influence adopt the Balint group

To reduce the impact of the suicide on the group (W-zone) in which the suicide is committed and to resume normal organizational activities as soon as possible, group psychological interventions are also needed after dealing with the physical and psychological stress of the second victim of suicide. The social effects of suicide are commonly manifested in the form of avoidance, stigmatization, impaired interpersonal communication and trust, and low team morale, which can be addressed by Balint groups. Founded in the 1950s by Hungarian psychiatrist Michael Balint, Balint's group was originally designed to train physicians to deal with the doctor-patient relationship and has been generalized to various group domains because of its clear steps and effectiveness.

The Balint group provides an outlet that allows people who are psychologically close to the suicidal person to open up about the deceased, express their emotions, answer their doubts, and bridge the gap, a process in which social support and empathy continue to derive, helping the team to get through and even further improve cohesion.

3.3.3. Enhancing group mental toughness with the Satir model

The negative impact of employee suicide on a large organization is huge, not only does it destroy the working atmosphere and performance of the deceased's team, but it is also a big blow to organizational morale. On the other hand, focusing only on localized areas (A, F, and W) does not eliminate the risk of suicide contagion. For example, in the Foxconn serial jumping incident, the suicides were relatively far from each other in terms of spatial and social distances, but the serial suicides still occurred. Therefore, attention should also be exerted on all team members including Zone O. The Satir model of group counseling can provide a solution.

The Satir Model of Therapy is a humanistic approach to family therapy founded by American psychotherapist Virginia Satir. Its most important feature is that it focuses on improving the individual's self-esteem and communication

rather than just eliminating the symptoms, and the ultimate goal of the treatment is for the individual to achieve "integration of mind and body, internal and external congruence" [23]. The Satir model can enhance members' sense of self-worth and self-esteem, which can not only reduce the impact of suicide among members of the organization, but also improve the psychological resilience of the group, playing a role in treating both symptoms and root causes, and can be used in group psychological emergency management to further reduce the risk of suicide contagion, or even play a role in preventing suicide.

3.4. Phase 4: Assessment

3.4.1. Tracking and evaluation of the effectiveness of disposition

Individual counseling and group interventions have a certain period of time, and a period of follow-up assessment is needed after the end of emergency psychological treatment [24]. After emergency psychological treatment, there is no guarantee that the effects of suicide can be completely eliminated, and regular follow-up is needed in at least three other areas: First, regular visits to those who are more seriously affected by suicide to observe whether their physical and psychological stress reactions have been eliminated and whether their social functioning has recovered; Second, to observe and determine whether the mental health and work performance of the suicide victim's team have been restored; and third, to follow up to determine whether the overall morale of the organization is no lower than before the suicide incident.

3.4.2. Summarize the psychological emergency management process

Finally, a review should be conducted to look for the reasons why members of the organization committed suicide, make targeted adjustments to the organization's construction, and strengthen prevention and preparedness. In addition, it is necessary to summarize and evaluate the emergency management of the incident, accumulate experience, improve the unit's emergency plan, and enhance the organization's ability to deal with similar emergencies. The entire psychological emergency management process is shown in **Figure 2**.

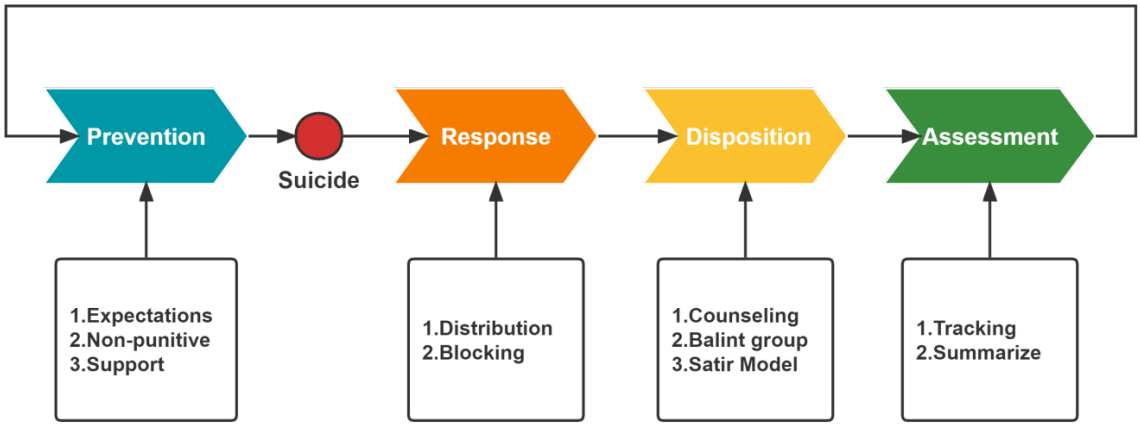

Figure 2. Flowchart for psychosocial emergency management of groups affected by suicide

4. Discussion

Does group psychosocial emergency management for suicides of members of an organization need to include the

families of the deceased? It is recommended that families should be included. There are two reasons for this: first, when it comes to the suicide of the deceased, the organization needs to deal with many aftermath issues with the family, which may have secondary effects if disputes arise. Secondly, family members, as the group of people who are socially closest to the deceased, are the most deeply affected and have the strongest need for intervention.

The three types of effects of suicide may overlap in different populations, and some members of Zones A, F, and W may need to receive more than one type of intervention, while many members of Zone O may not need intervention. In light of this, it is recommended that individual psychotherapy be delivered in an unsolicited manner, Balint groups be established by issuing invitations, and Satir group psychosocial interventions be conducted by open recruitment. Members of the organization affected by suicide can choose to accept or decline participation in one or more activities and can be informed about the process and content of the intervention and other members of the group intervention.

The main body of the group psychological emergency management of the suicide of the organization's members is the decision-making manager of the organization, but the main body does not have the qualifications and conditions for the implementation of emergency psychological treatment. In the whole psychological emergency management process, there is a need for an executive body with the qualification of psychological intervention to carry out various activities.

5. Conclusion

Member suicide is a major blow to any organization. If not handled well, it can damage the organization's image, undermine team trust, lower organizational morale, interfere with work performance, and lead to member turnover. However, if handled well, it can not only reduce the impact of suicide, but also provide social support to each other for other members who share the death of a teammate, improve personal empathy, self-esteem, and a sense of the meaning of life, and thus play a role in preventing suicide. Therefore, group psychological contingency management for organizational suicide is valuable and necessary.

Disclosure statement

The author declares no conflict of interest.

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