

Qualitative Research  
**Insights into the processes of suicide contagion: Narratives from  
young people bereaved by suicide**

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Submitted to SOL: 6<sup>th</sup> March; accepted: 24<sup>th</sup> July; published: 18<sup>th</sup> March 2015

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**Abstract:** Death by suicide can have a profound and long lasting impact on the people left behind. Research has demonstrated that, in comparison to the general population, those bereaved by suicide, particularly young people, are at increased risk for suicide. However, the process of suicide contagion, as it has now become widely known, is poorly understood.

This paper examines the phenomenon of suicide contagion amongst young people who have been bereaved by suicide with data from research into student suicide in the UK (Stanley et al., 2007). It presents two in-depth case studies which draw upon participants' narratives of their experiences of suicide and their perceptions of suicide contagion. One explores the suicide of two close friends in succession and the subsequent belief among friends that this was contagious. The second explores another young person's own view of 'suicide as contagious', formed following the suicide of her best friend. Our analysis provides insights into the processes of suicide contagion and transmission not previously described, including identification, internalisation, and imitation and also Edwin Shneidman's assertion that suicide is the result of psychological pain.

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## Introduction

Suicide 'contagion' refers to the process by which one suicide facilitates the occurrence of another (Gould, Wallenstein, & Davidson 1989). The term contagion is often used in relation to media reporting (for example the Werther effect (Philips, 1974)). Other terms used include imitation, copy-cat, and transmission. Such terms can sometimes be used interchangeably in the literature.

The term suicide cluster has been used to refer to the factual occurrence of two or more attempted or completed suicides that are non-randomly bunched together in space or time. Clusters have been classified as either mass clusters or point clusters. Mass clusters involve suicides that cluster in time – irrespective of geography – and are often associated with media reports. Point clusters involve suicides that are close in time and / or space (Joiner, 1999).

However, suicide clusters are a rare and underresearched phenomenon (Niedzwiedz, Haw, Hawton & Platt, 2014) and evidence for why point clusters come about is generally lacking (Haw, Hawton, Niedzwiedz, & Platt, 2013). Suicide contagion – the social transmission of suicidality from one person to another – has been put forward as an explanation for suicide clusters following the 'infectious disease' model but has not been conceptually well developed or empirically well supported. For example, in the case of an infectious disease the agent of contagion and its mechanism of transmission are clearly specified. It is questionable whether applying the language of disease to suicide in this manner is accurate or constructive. The term 'contagion' depicts the individual who dies in the wake of another death as passive and strips them of agency in suggesting that suicide can be 'caught' like a virus. The use of this term also serves to reinforce the stigmatisation of suicide by likening it to an infectious disease. For suicide, no agent of contagion or transmission mechanism has been articulated. The one exception to this is behavioural imitation which borrows from a social learning model.

### **Social Learning Model**

The Social Learning Model (e.g., Bandura, 1977; Millar and Dollard, 1941) expresses the view that to some extent suicide has to be learned. According to this system, people can learn through observation. By observing significant others, one forms an idea of how new behaviours are performed.

On later occasions this coded information serves as a guide for action (imitation).

Internal mental states are also an essential part of this process. Human behaviour is regulated to a large extent by anticipated consequences of prospective actions. We need to be able to take into account what happens to other people when deciding whether or not to copy someone's actions. This is known as vicarious reinforcement. Bandura (1977) also stressed the role of memory as a major function involved in observational learning: a person needs to have a memory of an observed behaviour if he or she is to imitate it. Response patterns must be represented in memory in symbolic form (internalised) along with their functional value; that is their anticipated reinforcement / consequence.

According to this model then, we are more likely to imitate behaviour when: we identify in some way with the person being observed; we feel it is appropriate to ourselves and the circumstances we are in; it is performed by those who are similar to us, those who are powerful or influential, those who we aspire to be and those who are caring (Bandura, 1977).

Similar to this is the view that suicide contagion can be a culturally learned idea and behaviour. The *idea* of suicide as a cause of suicide was noted by Kral (1994) who draws upon the work of Emile Durkheim, Gabriel Tarde, and Edwin Shneidman to argue that suicide is a form of *social logic* – social logic and imitation are central to how ideas spread. Alfred North Whitehead (1933; 53) wrote that an idea 'has creative power, making possible its own approach to realization'. The person who dies communicates to those left behind the idea that this is a way of solving seemingly insoluble problems (Wertheimer, 2001) and so begins the internalization of the idea. Or, in the words of one anonymous bereaved individual, referred to by Alison Wertheimer 'it enters your bloodstream' (Wertheimer, 2001; 163).

Edwin Shneidman (1993; 1996) used the term psychache to refer to the psychological pain and mental anguish which is the common stimulus in suicide. There is some suggestion that those bereaved by suicide can inherit this pain. This can be explained by empathy. For example, individuals who are bereaved by suicide are often tormented with questions about the reasons for the death and with searching for meaning for the death. In order to answer these questions the person has to try to imagine the state of mind of the deceased – to put themselves in the shoes of the person who died, or, rather in the mind of the person who died. This activity requires empathy. So, the more a person is able to recognise and identify with the emotional

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state of the deceased person; that is, the more they are able to feel their *psychache* and suffering, the more likely they are then to think about how they themselves could end up there.

This explanation suggests that individuals are more likely to internalise the idea of suicide if they are able to identify and empathise with the deceased. Shneidman refers to the importance of the 'interior dialogue', a point we will return to later. This explanation is also consistent with the behavioural imitation paradigm; if, in the search for meaning of the suicide death, individuals find details to identify and empathise with, the more likely they may be to internalise the idea of suicide and imitate the behaviour.

According to Hollander (2001), the strong reactions and extreme grief of those bereaved by suicide make them more at risk of taking their own lives in the wake of a suicide of a close person. An act of suicide forces those surrounding it to face huge questions about what life means, about how to be in it, about what keeps pain from overwhelming us, and many other questions that go to the very centre of the human condition. Thus those who are bereaved by suicide are likely to experience additional challenges, including shock, stigma, blame, guilt and anger (Jordan and McIntosh, 2011; Ratnarajah and Maple, 2011; Bell, Stanley, Mallon, & Manthorpe, 2012) and are forced to endure complicated and traumatic grief (Jacobs and Prigerson, 2011).

Despite widespread recognition and acknowledgment of this phenomenon, social modelling of suicidal behaviour through peers still appears to be a largely un-researched topic (De Leo and Heller, 2008). This could be partly due to the methodological constraints of quantitative research, which limits substantive understanding of the complexity of suicide. Kral, Links, and Bergmans (2012) argue that research in suicidology has been restricted by such constraints. Very little emphasis has been given to qualitative research or people's subjective experiences. However, recent calls to add qualitative research to this arena have increased in intensity (Lakeman and Fitzgerald, 2008; Krall et al., 2012) with recognition that the lived experiences of those with suicidal feelings represents important knowledge (Webb, 2010).

To our knowledge there is no research to date which has reported on the processes for identification and imitation and how it is experienced by those whose lives have been touched by suicide. Based on a national study into student suicide in the UK, we seek to demonstrate insight into the *processes* of contagion shown in the narratives of participants. In this study we found evidence of transmission in four out of twenty cases of student suicide. This paper reports on two of these case

studies, chosen for their diversity, depth and level of insight into this subject matter.

## Method

The data presented here were derived from a UK study of 20 completed student suicides (see Stanley, Mallon, Bell, and Manthorpe, 2007). The research took place between 2004 and 2006 and focused on suicides of students attending Higher Education Institutions (HEIs) between May 2000 and June 2005. In order to achieve a detailed understanding of the psychological circumstances contributing to the suicides, we employed a modified version of the psychological autopsy approach to studying suicide (Shneidman, 1981; Beskow, Runeson, & Asgard, 1990). This involved qualitative interviews with relatives and significant others, and reviews of various documents relating those who had died by suicide.

The research drew together a range of accounts of the death and its impact on the bereaved. Several data sources were collected for each case, including interviews with people bereaved (parents, friends, siblings, and academic and student support staff from HEIs who knew the student well), coroners' records, medical records and other information from health professionals, letters and suicide notes. Interviews were also undertaken with parents whose child had taken their own life whilst a student, those whose friends had taken their own lives whilst a student, and staff from HEI support services who had experience of responding to a student suicide.

As shown in Table 1, participants connected to the 20 cases comprised 29 family members; 12 student friends; 17 HEI staff; records from 15 Coroners and Procurators Fiscal. Additional interviews included 9 parents; 4 students; 10 staff from HEI support services. Interviews were recorded with permission and followed a semi-structured style (described by Cooper, 1999). Each interview began by asking questions about the circumstances of the death. Following this, interviews sought to establish the chronological sequence of events and development of any perceived problems to provide information on the suicidal process (Hawton et al., 1998). Details covered included family background, childhood, significant life-events and difficulties, relationships, social and personality factors, physical and mental health, exposure to suicidal behaviour, academic progress, social support, reaction to the death, aftermath, coping and help-seeking. The development of our schedules was influenced initially by those used by Houston, Hawton, and Shepperd (2001) on previous psychological autopsy work on young

Research Participants	Case Studies	Parents' Perspectives	Students' Perspectives	Positive Practice	Total
Family Members	29	9			38
Students Friends	12		4		16
HEI Staff	17			10	27
Coroners and Procurators Fiscal Records	15				15

**Table 1 – Total number of research participants and data collection.**

people<sup>1</sup>. Emphasis was placed on encouraging the informant to talk freely about the person who died and to 'tell the story' of the suicide as they perceived it (Owens, Lambert, Lloyd, & Donovan, 2008).

Data were analysed thematically using a Grounded Theory Approach (Ritchie and Spencer, 1994; Strauss and Corbin, 1990). Themes across and within data sources were compared and contrasted by all four researchers who are experienced in qualitative research with backgrounds in Social Work, Psychology and Sociology. Inter-rater reliability was addressed by cross checking analysis to ensure consistency in interpretation of data.

Following the interview, participants were given the opportunity to comment and amend the transcripts. In line with good practice in suicide research (Hawton and Simkin, 2003), interviewees were offered a 'bereavement pack' containing details of sources of help and support (Hill, Hawton, Malmberg, & Simkin, 1997). All were contacted shortly after the interview to check their responses to the experiences of participating in the study. Participants were assured of anonymity and identities and locations are disguised here. The research received ethical approvals from the NHS Multi-Region Research Ethics Committee and from the University of Central Lancashire's Research Ethics Committee.

## Results

In this section, we present analyses of two case studies which draw upon participants' narratives of their experiences of suicide and their perceptions of suicide contagion. The first of these case studies gathered interview data from parent, University tutor, and girlfriend (Lisa) of the student (James) who died by suicide. The second draws on data gathered from three close friends (one female and two male) of the student who died. We start by outlining the background to each case and follow by presenting data on **contagion** from respondents.

### Case 1 - James: Background

James was one of a group of friends of another student (Adam) who took his own life. James was described as popular, laid back (on the surface), sporty, bright, and gentle with a good sense of humour. He had no psychiatric history. He was living in a shared house with other students. One morning, after enjoying a night out with the housemates, one of them discovered that another (Adam) had taken his own life. He was found in his room.

Adam's death came as a complete shock to everyone. No one was aware of anything wrong in his life. James played a major responding and supporting role in the immediate aftermath of Adam's death. He also received support from University staff in the months that followed. Shortly before the anniversary of Adam's death James very rapidly became depressed and anxious (his parent confirmed he was prescribed anti-depressant medication by his GP). His girlfriend, Lisa, described him as 'morbidly obsessed' with his death. Within the space of a few days he took his own life using the same method as Adam.

### Contagion

The tutor described his own perception of the factors that led to James's suicide. In his narrative he clearly sees James's suicide as directly linked to Adam's and acknowledges this from the very start:

*The whole group and James included were totally baffled as to why Adam had killed himself, there was no obvious reason...there wasn't any sign of any significant mental health problem, there wasn't any sign of anything particularly going wrong in this life, his academic work was all fine, he seemed to be pretty successful, he had plans for the future, so he didn't fit the profile at all. So, I think... the complete lack of any reason... that anyone else could make sense of for Adam's death was one of the things that, ...James just couldn't get rid of that. That kept coming back to him.*

<sup>1</sup> We acknowledge here their kind permission.

In this extract we see the first clues that something had taken hold of James following Adam's suicide, which the tutor senses but struggles to articulate. What is clear however is that his inability to understand Adam's death troubled him deeply. He expands:

*I sometimes wonder whether one part of why James killed himself was a, some kind of curiosity...curiosity doesn't sound strong enough to be a reason to kill yourself and I'm sure it wasn't enough in itself, but I suspect there was a component of it.... I think it was probably part of what was going on and beyond that I don't know. What was it about Adam's death that it awoke in him? I don't mean about the loss, I mean it was as if it awoke something, this sort of depression that.... it was like it was there sometimes and you could kind of feel it sometimes but he couldn't articulate it....*

In this extract, he refers again to an underlying depression (psychache), this time suggesting that it was awakened by Adam's death – something that grew to engulf him around the anniversary but something that he couldn't put into words.

He relates some of things that James was able to put into words:

*....well he was asking questions, he was certainly asking questions about death. And beyond and you know what happens... what the meaning of it is, what the nature of it is.*

All three interviewees pointed to the importance of religion in their perceptions of the factors that led to James's suicide. Lisa recalls:

*.... I remember.... he prayed so hard.... it was quite intense*

From James's parent there was some sense that Adam's death corresponded with a disconnection from God for James. His parent remembers him saying 'God let me down' in relation to his feelings about Adam's death. Narratives from both Lisa and the tutor hint strongly at an existential crisis of sorts: his 'morbid obsession' with Adam's death; his 'curiosity' and questioning of the nature and meaning of death; his 'intense praying', 'puzzlement', 'underlying depression', and uncertainty about God.

According to Lakeman and Fitzgerald (2008) a disconnection from others, culture or God appears to be a common feature of the suicidal experience; for Joiner (2005), this feature is fundamental – one of three factors that mark those most at risk for death. For Joiner, a secure sense of belongingness or

connectedness (to family, community, faith or religion) is an essential ingredient of the will to live – an ingredient that gives meaning to life. Those who lose these connections over a period of time may come to view death in peculiarly positive ways. So in the sense that connection with God gave meaning to life for James, having that connection thwarted may have brought about an existential crisis from which he may have begun to form connections to the idea of death.

### **Lisa's story**

Lisa was one of the housemates who lived with James and Adam and was at the house when Adam died. She was also James's girlfriend. So within the space of a year Lisa had experienced the suicide of two close people. She talked about her inability to understand the factors that led to Adam's death:

*I honestly have not got a clue.... I couldn't even begin to tell you, I mean it just, the whole, that just seemed totally bizarre,... I don't know.... I just have not got a clue....*

Lisa also attributed James's suicide directly to Adam's death and talked about the speed with which his mental state deteriorated in the run up to the anniversary:

*I think just 'cos of the dates and everything and.... I mean literally James just started to go down the week before [the anniversary of] Adam's death. ....It was only a really short space of time. He literally switched kind of overnight almost.*

Whilst she had an explanation for James's death, Lisa talked about areas that were still confusing for her:

*....I'm confident that it was because.... he was affected by what Adam did, and that had.... obviously some sort of traumatic, traumatic effect on him, but at the same time, there was kind of another nine people in that friendship group that didn't react how he did so I guess you wonder why it affects somebody enough that they cannot live with it...*

### **Contagion**

After James's death, concern that others in the friendship group might be susceptible to suicide spread rapidly. The spotlight turned on Lisa; her parents, the University tutor and her close friends all worried that she would be next. The tutor was candid about his concerns:

*I mean frankly I was terrified about Lisa, because.... she'd been a really close friend of Adam's. And she was James's girlfriend. So I*

*was very, very concerned for her.*

Lisa was clear that she did not ever feel suicidal herself in the aftermath of either Adam's or James's death. She hinted quite strongly nonetheless at an increased feeling of vulnerability to suicide:

*No, I ... used to get worried, because with James and Adam they seemed so fine, I used to think... well what if one day I feel kind of, but I never actually felt like that. But I used to think well if... a normal lad of nineteen or twenty can just wake up one morning and do that when he seemed reasonably fine, what if I woke up one morning.... Yeah, that's how I felt. But I never, that was just a, kind of ridiculous paranoia.*

In this extract she testifies to having had the *idea* of suicide running through her mind. It seems to be represented as some kind of terrifying force that could come and get her or something that could happen to her without warning (*what if I woke up one morning...*), something invisible, unpredictable and without logic. Despite Lisa's acknowledgement that this was a 'ridiculous paranoia', the fear of contagion – the belief that it could happen again and to Lisa in particular – persisted and dominated the thoughts of those close to her:

*...one of the hardest things since that I've had to deal with is my parents worrying about me doing it. My dad would ring me every morning to make sure I was alive. But I guess that's how you would get, 'cos no-one ever thought you know, two people in the friendship would do it, so why not a third? And I've found out since, that... girls that I lived with used to always be terrified of going up to my room in the morning, 'cos they'd ... God if she's done something and so it does.... I think because it happened twice, you start thinking well who's next?*

There is no logic to this idea, but in the absence of any logic in the other two deaths, logic is irrelevant as a way of furnishing an explanation. This finding is also supported by Higgins and Range (1996) and Kaltreider (1990). For example, Kaltreider (1990) reported on the impact of a medical student's suicide and found that students' own sense of identification and vulnerability was increased because of the seeming randomness of the event. Similarly, Adam's death was seemingly random. There was nothing wrong in his life: no mental illness, no major problems, nothing that marked him out as different in any way. This is the part that others identify with and the part that makes them feel vulnerable. We see this in Lisa's narrative: 'if a normal lad of nineteen or twenty can just wake up one morning and do that when he seemed reasonably fine' she reaches the conclusion that this can happen to anyone. And if this

is the case, it would beg the question 'who's next?'

### **Case 2 - Tara: Background**

Tara was described variously by those who were interviewed as a deep thinking intellectual person who was gentle, caring, fun-loving, loyal, charming, generous, bright, friendly, energetic, ambitious, stropky, arrogant, temperamental, beautiful, strong, eccentric, and impulsive. Tara also suffered from depression, and was engaging in suicidal behaviour which increased with severity and intensity as the academic year progressed. She was very reluctant to seek professional help. Eventually the situation reached crisis point towards the end of the academic year when she eventually took her own life.

### **Sophie's story**

Sophie met Tara at University where they quickly became firm friends. Sophie described how she was attracted initially to Tara's charismatic personality. She recalls the time when she first found out about Tara's suicidal tendencies:

*....and I thought she was just being silly and then she said 'no, actually I was trying to kill myself'. And that was the first I heard of it and it was just a complete blow, I had no idea it was coming and I never experienced anything like that before. I just didn't know what to do and that was when it first started and literally from there it just got worse and worse and worse, more and more episodes and more and more disruptive behavior.*

Prior to University and meeting Tara, the idea, even the notion, of suicide was alien to Sophie. She was not prepared for it, nor was she equipped to deal with Tara's problems and behaviour. She reiterated this a number of times:

*I was a supremely sheltered child as well and I had absolutely no concept of these things like when she first cut herself I just was flabbergasted, I didn't even know this kind of thing existed, it just absolutely blew my world away, I just didn't have a clue about what it was all about....*

Latterly, Tara became heavily dependent upon Sophie for support:

*... and she just needed constant looking after,... you ...never knew what she would do or what would happen, and it was a huge stress... and I just thought it was my responsibility to help her....*

In this narrative we see how she became increasingly entangled in Tara's problems and how,

over time, this took its toll on Sophie. She undertook the role (*it was my responsibility*) and their interdependence intensified.

So, ultimately, when news of Tara's death came, it changed everything:

*...it was an absolutely life altering moment the day that... I found out that she'd killed herself.... if I could say there was one day that changed my life forever it would be that one....*

### Contagion

In talking about the immediate aftermath of Tara's death and her own reaction to it, Sophie quickly turned the topic of conversation to contagion:

*No, I think it is contagious, I mean I tried to kill myself.... I thought about killing myself after Tara did, and I have not got any of these problems.*

Here Sophie expresses the view that suicide is contagious and that her thoughts about killing herself had been acquired through direct experience of Tara's situation. There was nothing else in her life that would account for why she would think about killing herself (*I have not got any of these problems*).

Sophie reflected both on how she was affected emotionally by Tara's death (horror, shock, trauma) and how the idea of suicide and self-harm first emerged in her consciousness:

*my reaction to the death was absolutely... I can't even begin to quantify what happened to me as a result of it. It turned my world literally upside down and inside out for a very long time.... Like I said, I thought about killing myself in the aftermath but there were various times where I'd been upset in that sort of timeframe and something really upset me, I thought maybe I should cut myself, you know I just caught myself thinking it. What a stupid thing to say, I mean you know it's just, I mean now it sounds ludicrous to me but then it was horrible you know, if you're feeling bad cut yourself, if you're feeling really bad kill yourself, you know, it's just stupid.*

Tarde's (1904) metaphor of a mental imprint becomes useful here in explaining Sophie's thoughts. Having been exposed to suicide, the idea of suicide is planted – Tara leaves a 'mental imprint', a model of behaviour for Sophie to copy (*maybe I should cut myself?*). Sophie inherits the idea of suicide as a solution to seemingly insoluble problems from Tara (*I just caught myself thinking it... if you're feeling bad cut yourself, if you're feeling really bad kill yourself*). The learned aspect of Sophie's suicidality is even more clearly articulated in the following account of

her near suicide attempt. She had reached crisis point. Here we see how she went from fleetingly thinking about it to, based on what Tara did, seeing this as the only solution:

*when I thought about killing myself, I was feeling the most excruciating pain you could possibly imagine and I thought the way out of this is to kill myself, how will I do it? Oh I'll [kill myself], that's what Tara did....*

Sophie then went on to describe how she took steps to end her own life adopting the same method used by Tara. She explains:

*...I.... wanted to stop feeling the pain. That was the most important thing to me and sleeping wasn't doing it, I was dreaming about her, being awake wasn't doing it, it was killing me, you know inside. So the only way out was to kill myself, as far as I could tell, that's what she did it, it worked....*

In this account Sophie describes her *psychache* (*the most excruciating pain you could possibly imagine... killing me inside*) which was brought about by Tara's death. Her solution to this pain is explained by the social learning model and vicarious reinforcement (*I thought the way out is to kill myself, how will I do it? Oh [states means of death] – that's what Tara did' ... so the only way out was to kill myself, as far as I could tell, that's what she did, it worked*). This narrative also offers some insight into Sophie's internal mental state in this process. It emphasises how the memory of what Tara did was internalised, along with its functional value and anticipated consequence.

Sophie's examination of her own feelings, thoughts, and motives also correspond strikingly with Shneidman's (1996) important proposal that suicide is the result of an interior dialogue. He suggested, at the point of intolerable pain and despair, 'the mind scans its options; the topic of suicide comes up (*maybe I should cut myself*), the mind rejects it (*what a stupid thing to say*), scans again; there is suicide (*if you're feeling really bad kill yourself*), it is rejected again (*sounds ludicrous; just stupid*).... then finally the mind accepts suicide as a solution' (*the only way out was to kill myself, as far as I could tell, that's what she did, it worked*) (Shneidman, 1996, p. 15).

Interestingly, Sophie then goes on to explain how she thought herself out of it as the stark reality of what she was doing entered her consciousness:

*... and I suddenly thought if I do this I'm going to die and it wasn't the fact I was, you know it, that suddenly made that connection and the*

*thing that actually stopped me doing it was I thought, I imagined the look on my dad's face if he found me and I couldn't do it. I just didn't do it and I never, I've never even thought about it since and that's what stopped me, it was actually being able to make that final step and saying I'm going to kill myself but the thing that stopped me was the consequences, the knowing what it meant, the actual being able to put that ... into lucid rational kind of form.*

Although Sophie did not ultimately take her life, she was nonetheless very clear that experiencing the death of her best friend changed her forever:

*Surviving the suicide of your best friend is an entirely different thing and living with it has been the most awful thing.... I feel like it's a cross I have to bear, no matter what happens, no matter how I try and get rid of it, because it happened to me at such a vulnerable age, it's there now....And that's completely changed me.*

Interviews with two others (George and Marcus) from the friendship group at University revealed how others, who were close to Tara, also suffered:

*George: everybody who was in that group didn't do as well as they ought to have done...*

George talked about another friend who suffered a breakdown and spent some time in a psychiatric unit following Tara's death: *absolutely nuts, she went nuts...*

Marcus also reflected upon this and how Tara's death had affected him:

*...she went into an institution....I... visited her and yeah that was kind of, it kind of meant that the memory really stayed.... Certainly I kind of suffered quite a lot, I think, personally because like all our friendship...kind of... just kind of fell apart.... I think I had less ideals and less kind of, you know the world wasn't rosy anymore, you know it's not like all promising and wow the world is much more cold and...people are much more... sinister kind of self-absorbed, including myself of course.... I think that was really... fortified by that experience.*

## Discussion

This paper has attempted to understand the phenomenon of suicide contagion or transmission from the point of view of the individual who is affected, recognising lived experience and first person accounts as important sources of information. In doing so, it provides insights into these processes not previously described. Our data expands the concept of contagion described by others to further

illuminate the processes by which that comes about. We are not aware of any other qualitative studies which explore this. Our data have been interpreted and analysed in terms of infectious disease model, social learning model and suicide contagion or transmission as a cultural phenomenon. It has linked the processes of identification, internalisation, and imitation with Shneidman's concept of psychache to provide a model for the transmission of suicide.

What gets transmitted is the *idea of suicide*. The case studies presented in this paper illustrate how suicide as an *idea* is planted and emphasises the 'power of ideas' (how the unthinkable can become thinkable). It has explored what happens when people are metaphorically 'infected' with the *idea* of suicide and what is transmitted to others when a death by suicide occurs.

Suicide is something that disrupts the narrative of individual lives. There was evidence that James felt significantly guilty about Adam's death. But James's psychache was also existentially driven. The idea that death by suicide raises crucial issues about the meaningfulness and rationality of life is supported by other research (e.g., Dunne, 1987). Our analysis suggests that the experience of losing a friend to suicide triggered a form of existential pain in James. It provoked introspection about the foundations of his beliefs and his sense of reality and mortality (puzzlement, lack of reason, meaninglessness). Did James identify with Adam? Was this a result of his empathy with Adam? Did he internalise the idea of suicide? Did he inherit his pain?

Sophie was able to describe the psychological pain brought about by Tara's suicide in some detail. Sophie's narrative also portrayed a strong sense that she had been in some way contaminated by the suicide of her best friend and that this is still in her *bloodstream* (*no matter how I try to get rid of it... it's there now*). Like Sophie, Lisa had never thought about this before, subsequent to Tara's death she felt that it could happen to anyone. Lisa's friends, parents and the university tutor were terrified it would happen again – to her. For them, the concept of contagion was the best way of explaining how it affected them, what it did to them and how they experienced it phenomenologically: like an external force; something they could catch from each other – a kind of referred pain.

Our analysis explored how this type of thinking translates into action (empathy, identification, internalisation, imitation). Sophie's suicide attempt can be explained by processes of imitation outlined in the social learning model and vicarious reinforcement. Her narrative shows us how the *idea* of suicide as a way of escaping from intolerable pain spread into her consciousness as a result of prolonged exposure to Tara's suicidality. It

is an account of how a person went from feeling supremely sheltered and having no concept of these things, to being something she briefly caught herself thinking, to reaching the conclusion that suicide is the only solution. This analysis suggests that imitation may be more likely in combination with traumatic grief and in those of a vulnerable age or stage of development who may have a limited repertoire for solving difficulties in life.

This paper has shown that in-depth interviews using qualitative methods can provide new knowledge and understanding about suicidal behaviour. Our findings are based on an in-depth exploration of two case studies. We make no claim that these findings can be generalised to others who have been touched by suicide; not everyone who has been devastated by the loss of someone by suicide goes on to take their own lives. Everyone's experience of suicide is unique and each suicidal person's story has to be understood in terms of the dynamics in the relationship between the individual and his or her specific socio-cultural context. It has been noted that the term 'suicide contagion' and the use of the language of disease is problematic in relation to suicide. More research is needed to critically examine this concept. More research is also needed to contribute to knowledge that can be used to inform and postvention strategies and a fuller understanding of the suicidal process.

#### Disclaimer and Funding

The views expressed in this article are those of the authors alone. The research was funded by The Big Lottery

#### Acknowledgements

Many thanks to all family members, friends, and higher education institution staff who participated in this study. We are also grateful to PAPYRUS (Prevention of Young Suicide, UK), SOBS (Survivors of Bereavement by Suicide, UK), and Compassionate Friends UK, Coroners, Procurators Fiscal and their staff, the Project's Advisory Group members and many individuals and groups within the higher education sector in the United Kingdom who assisted in the project from which this article was drawn.

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