Suicide Exposure and Its Negative Effects and Intervention

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Abstract

Suicide exposure—defined as an individual's contact with another person's suicidal behavior—can exert severe negative effects on vulnerable populations, including suicide-bereaved individuals, patients with mental disorders and those at risk of suicide, adolescents, and young adults. While previous research has emphasized the potential harms of suicide exposure, empirical investigations into identification methods for vulnerable populations exposed to suicide, mechanisms underlying negative impacts, and post-suicide intervention methods and their effectiveness remain extremely limited. This article reviews and delineates the concept of suicide exposure, summarizes the negative psychological reactions of vulnerable populations to suicide incidents along with corresponding trauma/grief maintenance mechanisms and suicide contagion mechanisms, and discusses existing post-suicide intervention methods, guidelines, their effectiveness and limitations, aiming to lay the groundwork for localized suicide exposure research and post-suicide intervention practice. Future research may employ qualitative studies, longitudinal quantitative analysis, and artificial intelligence approaches to explore classification systems for vulnerable populations and risk prediction models, and to conduct specialized evidence-based intervention studies based on clarified mechanisms of negative impact.

Full Text

Preamble

Suicide Exposure and Its Negative Impacts and Postvention

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Abstract

Suicide exposure—defined as exposure to others' suicidal behaviors (including completed suicide and attempted suicide)—can have severe negative impacts on vulnerable populations, including those bereaved by suicide, patients with mental disorders or suicide risk, as well as adolescents and young adults. Although prior studies have highlighted the potential harm of suicide exposure, empirical research examining methods for identifying vulnerable populations, mechanisms underlying negative impacts, and suicide postvention approaches and their effectiveness remains severely limited. With the aim of laying the groundwork for conducting localized suicide exposure research and suicide postvention practice, the present article systematically reviewed and redefined the concept of suicide exposure, summarized vulnerable populations' negative psychological reactions to suicide events along with corresponding trauma/grief maintenance mechanisms and suicide contagion mechanisms, and examined existing suicide postvention approaches as well as their effectiveness and limitations. Future research should employ qualitative inquiry, longitudinal analyses, and artificial intelligence to refine classification systems and risk prediction models for vulnerable populations. Subsequent studies may then develop evidence-based intervention protocols informed by a clearer understanding of the mechanisms underlying negative outcomes.

Keywords: suicide exposure, suicide postvention, suicide contagion, negative impacts, suicide bereaved

Suicide is a recognized major public health problem. Over 720,000 people die by suicide annually worldwide. Suicide events not only cause significant losses to families and society, but suicide exposure also triggers chain reactions among family members, friends, colleagues, communities, and society at large (WHO, 2025). According to statistics, each real-world suicide death exposes at least 135 people, with approximately 25 experiencing significant impacts (Cerel et al., 2019). Based on these figures, tens of millions of people are affected by suicide deaths each year, with even greater numbers affected by suicide attempts. With the increasing prevalence of new social media platforms, suicide exposure is no

longer limited to contact with the suicidal behaviors of relatives, friends, or acquaintances (Bell & Westoby, 2021). Some widely publicized real suicide events or fictional suicide stories have even broader impact, such as the suicide of high school student Hu Mouyu in Jiangxi, China, and the suicide storyline of the protagonist in Netflix's series *13 Reasons Why*, both of which triggered widespread public attention. Both experts and the general public worry that extensive dissemination of suicide events may induce strong negative impacts, such as triggering or exacerbating negative emotions among relatives, friends, or those aware of the event, and causing the extreme effect of suicide contagion.

Research on suicide exposure primarily originated from concerns about suicide bereaved groups and suicide contagion phenomena. Suicide bereaved groups are individuals who experience relationship loss due to the suicide death of relatives or friends, known as suicide bereaved. Related concepts include suicide survivors and suicide loss survivors. Mental health practitioners should pay attention to suicide bereaved individuals and provide support and help to those bearing the tragic consequences of suicide death (Cerel et al., 2014). Meta-analyses show that the proportion of the general population exposed to suicide death of family members or friends, or directly acquainted individuals, is 4.31% in the past year and 21.83% lifetime (Andriessen, Rahman, et al., 2017). The proportion of adolescents exposed to suicide death of relatives or friends is approximately 7%~17% (Swanson & Colman, 2013; Chan et al., 2018). In China, the proportion of adolescents exposed to suicide death of relatives or friends is 6.6% (Liu, Wang et al., 2020), while the proportion among college students exceeds 10% (Zhao et al., 2013). Compared with other bereaved individuals, suicide bereaved are more likely to experience psychological pain lasting for years or even lifelong (Kaur & Stedmon, 2022; Spillane et al., 2018). Suicide contagion refers to the process where a suicide event triggers subsequent suicidal behaviors in others within close temporal or spatial proximity. Related terms include Werther Effect, suicide cluster, suicide imitation, and suicide suggestion. Joiner (1999) summarized suicide clusters into two categories: mass clusters and point clusters. The former primarily involves widespread suicide clustering in close temporal proximity triggered by media dissemination of real or fictional suicide events, such as reporting on celebrity suicides or depictions of protagonist suicide in film and television. The latter primarily involves local suicide contagion in close geographical space triggered by real suicide events, such as suicide clusters within communities, schools, or families. Substantial evidence indicates that erroneous and repetitive media reporting on suicide is associated with staged increases in suicide rates (Niederkrotenthaler et al., 2020; Niederkrotenthaler et al., 2021). The World Health Organization has specifically developed media guidelines for suicide reporting, calling for appropriate ways to report suicide information (WHO, 2023). Suicide "point cluster" phenomena are also relatively common, as exemplified by Foxconn employee suicides in China and over 16 adolescent suicide deaths within 15 years in a small U.S. community (Abrutyn et al., 2020).

Both suicide bereavement and suicide contagion research highlight concerns

about the negative impacts of suicide exposure, particularly increased suicide risk. Numerous scholars have also listed suicide exposure as a risk factor for suicidal ideation and behavior, conducting extensive discussions on the association between suicide exposure and negative mental health outcomes, suicide contagion mechanisms, and postvention following suicide exposure. The World Health Organization and the International Association for Suicide Prevention have explicitly stated that suicide postvention for suicide-exposed individuals is equally important as suicide prevention and intervention before suicide events occur, representing an indispensable component of comprehensive suicide prevention systems (Andriessen, Krysinska & Grad, 2017). However, in mainland China, only a few scholars have investigated the association between suicide exposure and self-injurious behaviors, suicidal ideation and behavior, and the trauma/grief status of close relatives of suicide decedents (Li, 2013; Yao et al., 2022; Zhao et al., 2013; Liu, Wang, et al., 2020). Relevant workers in education, medical, and public health institutions have limited knowledge about suicide exposure and its negative impacts, with suicide postvention practice being almost nonexistent. Domestic scholars urgently need to strengthen academic research and practical accumulation in the field of suicide exposure to address this hidden yet significant public mental health challenge. This article reviews the concept and classification of suicide exposure, research findings on vulnerable populations and their negative impacts, discusses the current state and limitations of research on mechanisms underlying negative impacts and postvention methods, and provides a knowledge framework for domestic public and stakeholders to correctly understand and reasonably respond to suicide events and effectively mitigate the negative impacts of suicide exposure, offering research ideas for subsequent psychological education, identification of vulnerable individuals, and intervention.

1. Definition and Classification of Suicide Exposure

Early definitions of suicide exposure primarily referred to contact with information about others' suicide deaths in real life, but the definition was unclear and often used interchangeably with suicide bereaved. For example, Maple et al. (2017) viewed suicide-exposed individuals as those who had contact with others' suicide deaths, including relatives of the deceased. Andriessen, Rahman et al. (2017) defined suicide-exposed individuals as those who experienced suicide death of family members or friends, or personally knew someone who died by suicide (knowing about celebrity or online figures' suicides cannot be considered "personally" knowing the suicide decedent). Jang et al. (2020) defined suicide bereaved as victims who experienced suicide death of siblings, parents, spouses, or immediate family members living together. These definitions all treat suicide exposure as an objective phenomenon with a narrow definition limited to those who knew the suicide decedent. Cerel et al. (2014) further expanded the definition of suicide-exposed individuals by proposing the nested Continuum of Survivorship Model (CSM model), classifying suicide-exposed individuals based on the degree of impact from suicide events and relationship

types with the deceased. The outermost layer, "suicide-exposed individuals," includes all who know or confirm a suicide death occurred, including people in the deceased's domains (family, school, workplace, social circles), emergency responders, fans, netizens, etc. The second layer, "suicide-affected individuals," refers to those who suffer psychological pain due to suicide death events, including relatives and friends affected by significant others' suicides, strangers (such as witnesses, depressed adolescents in nearby communities), etc. The third layer, "short-term suicide bereaved," refers to those who feel psychological pain and have intimate/attachment relationships with suicide decedents, mostly family members, partners, close friends, and colleagues. A minority of short-term suicide bereaved develop into "long-term suicide bereaved" (innermost layer), who have attachment relationships with suicide decedents and struggle long-term with clinical symptoms caused by loss. Cerel et al.'s (2014) definition of long-term suicide bereaved is similar to Jordan and McIntosh's (2011) definition of suicide survivors—individuals who experience high levels of self-perceived psychological, physical, and/or social pain for considerable time after contact with others' suicide deaths. Both definitions focus on real suicide death events and combine objective indicators (whether experienced suicide death exposure) with psychological indicators (whether attachment relationships and long-term psychological pain exist) to define suicide-exposed individuals, acknowledging that practitioners frequently exposed to suicide events and even those unrelated to suicide decedents may be severely affected. To date, the CSM model is a widely recognized and cited definition model for suicide exposure, but it neglects some individuals who have no intimate relationship with suicide decedents yet still experience high levels of psychological pain. Bhullar et al. (2021) used latent profile analysis to test the CSM model and found a fifth group: those with low intimacy with suicide decedents but high impact, whose impact scores did not differ from short-term suicide bereaved but were lower than long-term suicide bereaved. Qualitative studies also found that individuals who did not know suicide decedents could still experience severe negative reactions and even implement suicidal behaviors (Sanford et al., 2023; Mirick & Berkowitz, 2023).

Additionally, besides limiting suicide exposure to contact with real individuals' suicide deaths, many researchers have focused on suicide contagion risks from fictional suicide stories in film, television, or literature (virtual exposure) (Bridge et al., 2020), or studied the impact of exposure to others' suicide attempts (Hill et al., 2020; Hvidkjær et al., 2021), or distinguished suicide exposure as direct versus indirect exposure based on whether contact with suicide decedents occurred in real life (Davidson et al., 1989; Haw et al., 2013). Wolford-Clevenger et al. (2019) included others' disclosure of suicidal ideation, preparation, and methods to individuals within the scope of suicide exposure, distinguishing direct exposure (such as witnessing others' suicidal behaviors) from indirect exposure (such as hearing about or seeing discussions and reports about others' suicidal behaviors in online media). However, their inclusion of participation in suicide information communication as suicide exposure is overly broad and risks losing research focus. To maintain research focus, this article follows most

research concerns by limiting suicide exposure to exposure to suicidal behaviors, while breaking through the CSM model's restriction to only include real suicide death exposure. We define suicide exposure as "contact with suicide death or suicide attempt behaviors of real or virtual figures, and knowledge of basic information including the suicide person, time and location, method, and outcome." We redefine "suicide-affected individuals" as "those who experience short-term or long-term psychological pain due to exposure to suicide death or suicide attempt behaviors of real or virtual figures." Psychological pain includes trauma and grief reactions, emotional contagion, and suicide contagion. The term "suicide bereaved" used hereafter is limited to those who have kinship or intimate/attachment relationships with suicide decedents and feel psychological pain due to relatives' or friends' suicide deaths, primarily referring to family members, romantic partners, or close friends. Suicide bereaved are subordinate to suicide-exposed individuals and suicide-affected individuals. Based on previous research, suicide exposure types can be partially subdivided according to exposure channels, content, objects, and event authenticity (Table 1):

Table 1 Types of Suicide Exposure

Exposure Channel	Direct Exposure	Indirect Exposure
	Direct contact with suicide decedents, including knowing the decedent, witnessing suicide scenes, etc.	Never contacted suicide decedents, indirectly learned about suicidal behaviors through intermediaries, such as through others' retelling, online information, news media, etc.
Exposure Content	Suicide Death Exposure	Exposure to suicide death behaviors of real or virtual figures
	Suicide Attempt Exposure	Exposure to suicide attempt behaviors of real or virtual figures
Exposure Object	Relative/Friend Suicide Exposure	Exposure to suicidal behaviors of relatives or other intimate contacts
	Non-relative/Stranger Suicide Exposure	Exposure to suicidal behaviors of acquaintances or strangers

Exposure Channel	Direct Exposure	Indirect Exposure
Event Authenticity	Real Figure Exposure	Exposure to suicidal behaviors of real figures, such as family, friends, community neighbors, netizens, public figures, etc.
	Virtual Character Exposure	Exposure to suicidal behaviors of virtual characters, such as characters in games, novels, film and television

2. Vulnerable Populations and Negative Impacts

Not all suicide-exposed individuals experience significant negative impacts. Due to practical and ethical considerations, it is difficult to directly manipulate independent variables to verify causal relationships between suicide exposure types, characteristics of suicide-exposed individuals, and negative reactions. Current research primarily uses quantitative studies to compare negative psychological indicators between suicide-exposed and non-exposed individuals (Andriessen et al., 2016; Beyraghi et al., 2023) and among suicide-exposed individuals with different characteristics (Maple et al., 2017; Bahamón et al., 2023), or uses correlation and regression analyses to infer negative impacts on suicide-exposed individuals (Hill et al., 2020; Feigelman et al., 2024; Pitman et al., 2024). Qualitative studies also collect cognitive and emotional reaction information from suicide-exposed individuals (Sanford et al., 2023; Mirick & Berkowitz, 2023). Among these, suicide bereaved, adolescents and young adults, individuals with mental disorders or suicide risk, and occupationally suicide-exposed individuals have received particular attention.

2.1 Suicide Bereaved

Suicide bereavement is a traumatic experience. The suddenness and violence of relatives' or friends' suicide deaths, along with the complex sociocultural meanings carried by suicidal behaviors themselves, place suicide bereaved individuals in multiple dilemmas. Among suicide bereaved individuals, 90% of immediate relatives, 88% of partners or spouses, 59% of non-immediate relatives, and 50% of friends and classmates report experiencing significant impacts (O'Connell et al., 2023), with higher incidence of psychiatric symptoms among immediate relatives (McDonnell et al., 2022). Cerel et al. (2016) argue that psychological intimacy with suicide decedents better predicts adverse mental health outcomes in suicide bereaved than kinship status, suggesting that focus should shift from relationship type to depth of emotional connection.

Like other bereaved individuals, suicide bereaved experience separation distress and traumatic distress caused by traumatic loss (Andriessen et al., 2020; O'Connell et al., 2023). However, suicide bereaved face more complex meaning-making and responsibility attribution dilemmas. Their fundamental cognitive frameworks regarding life value, interpersonal connections, and responsibility face major challenges, manifested in two aspects: first, persistent pursuit of "why"—suicide bereaved more intensely need to find reasonable explanations for the death (McGill et al., 2023; Kaur & Stedmon, 2022); second, excessive assumption of "responsibility"—believing they bear significant responsibility for relatives' or friends' suicide deaths (Cerel & Sanford, 2018; Kaur & Stedmon, 2022), or interpreting suicidal behaviors as accusations or abandonment by suicide decedents (Spillane et al., 2018; Goulah-Pabst, 2023), and feeling fear about their responsibility (Kõlves et al., 2020). Therefore, the core experience of suicide bereaved is guilt and blame (self-blame, blaming others, and feeling blamed) (Shields et al., 2017). Immediate relatives or partners of suicide decedents also experience high levels of shame and anger (Andriessen et al., 2020), with high comorbidity rates of post-traumatic stress disorder (PTSD) and prolonged grief disorder (PGD). Substantial evidence also shows increased rates of depression, anxiety symptoms, suicidal ideation, and behaviors among suicide bereaved (Cerel et al., 2016; O'Connell et al., 2023; McDonnell et al., 2022). A study of relatives of suicide decedents in Germany found that 12.4% had complex PTSD (CPTSD), 5.0% had PTSD, 22.0% had PGD, and 41.6% had moderate or higher levels of depressive symptoms (Hofmann & Wagner, 2024). Among relatives of suicide decedents in rural China, 22.4% had PTSD, mostly parents and female spouses of suicide decedents (Li, 2013). After controlling for baseline characteristics, bereaved individuals whose partners died by suicide had twice the suicide death risk of other bereaved individuals, and suicide bereaved with depression had four times the suicide death risk of other bereaved individuals (Pitman et al., 2024). Mothers bereaved by child suicide and suicide bereaved under age 25 show more prominent mental health and suicide risk (McDonnell et al., 2022). Mothers of suicide decedents reported suicidal ideation, suicide plans, and suicide attempts at rates of 60%, 24%, and 5%, respectively (Westerlund et al., 2020). Children of suicide decedents show higher rates of suicidal behaviors than children of those who died from other causes, and younger children at the time of parental suicide have greater odds of subsequent suicide death, suicide attempts, and hospitalization (Andriessen et al., 2016). This further demonstrates that stronger intimate/attachment relationships with suicide decedents are more likely to develop into "long-term suicide bereaved."

Long-term suicide bereaved face long-term challenges of psychological reconstruction and social adaptation. This complex and turbulent process damages their mental health and increases suicide risk while inevitably reducing their quality of life. Suicide death triggers reconstruction of bereaved individuals' family and social relationships, with common family communication barriers, conflicts, and intimate relationship ruptures (Kaur & Stedmon, 2022). They

both desire connection and fear further loss (Azorina et al., 2019; McGill et al., 2023), which exacerbates social isolation, psychological pain, and social adaptation difficulties (Andriessen et al., 2016). Suicide bereaved individuals show increased risks of high-risk behaviors (smoking, alcohol use, substance abuse), unemployment and economic difficulties (Erlangsen et al., 2017; McDonnell et al., 2022; Feigelman et al., 2024), and increased morbidity and mortality risks for diseases including hypertension, diabetes, and cancer (Erlangsen et al., 2017; Spillane et al., 2018). Therefore, helping suicide bereaved cope with real-life crises is also crucial.

2.2 Adolescents and Young Adults

Adolescents and young adults (aged 10-24), due to their immature psychosocial functioning, high impulsivity, high sensitivity, and susceptibility to peer influence on behaviors and values, have long been considered vulnerable populations for suicide contagion (Abrutyn & Mueller, 2014; del Carpio et al., 2021). Research confirms that suicide contagion primarily occurs among adolescents and young adults, with suicide contagion incidence rates 2-4 times higher in the 15-24 age group than other age groups, while rates are very low among those over 24 (Gould et al., 1990). Conservative estimates suggest approximately 10% of adolescent suicide deaths or attempts are attributable to suicide exposure and contagion (Hawton et al., 2020). Adolescents and young adults have diverse pathways of suicide exposure, potentially having direct contact with relatives' or friends' suicidal behaviors while also easily accessing indirect exposure to others' suicidal behaviors and related audio-visual content through offline social networks and online social media (Kline et al., 2022).

Like suicide bereaved mentioned above, young suicide bereaved individuals show increased risks of new-onset mental disorders, social adaptation difficulties, externalizing behaviors, and suicide (Andriessen et al., 2016). However, their psychosocial developmental level limits the meaning-making process, making it more challenging to address the question of "why" (Cerel & Sanford, 2018; Mirick & Berkowitz, 2023), requiring more intervention and guidance. Nevertheless, unlike suicide bereaved who suffer psychological pain based on emotional connections, adolescents and young adults' exposure to peers' or same-age individuals' suicidal behaviors does not require emotional connection as a necessary condition. Simply "knowing about peers' or same-age individuals' suicide" itself can trigger emotional, suicidal ideation, and behavioral contagion (Mueller & Abrutyn, 2015), even better predicting their future suicidal behaviors than "personally knowing suicide decedents" (Swanson & Colman, 2013; Abrutyn & Mueller, 2014). Moreover, this emotional and suicide contagion has sustained and cumulative effects: after controlling for a series of risk factors, exposure to same-age individuals' suicide attempts still predicts adolescents' suicidal ideation and behaviors two years later (Abrutyn & Mueller, 2014); adolescents with multiple exposures to relatives' and friends' suicidal behaviors have higher suicide risk (Liu, Wang, et al., 2020). Similar results have been obtained in studies on virtual

suicide exposure (Bridge et al., 2020). Therefore, research on this population should not only focus on negative impacts of suicide bereavement but also pay special attention to multiple suicide exposure risks in their offline social networks and online social media, and emphasize analyzing interactions between cognitive and emotional regulation abilities, developmental characteristics, interpersonal patterns, and digital media use with suicide exposure.

Currently, differences in impacts between suicide death exposure and suicide attempt exposure on adolescents and young adults remain unclear. Although exposure to family members' or peers' suicide deaths or attempts is associated with increased suicide risk among adolescents and young adults (Kline et al., 2022; Mitchell et al., 2019), some studies indicate that adolescents who experienced relatives' or friends' suicide attempts have higher suicide behavior risks than those exposed to suicide deaths (Liu, Wang et al., 2020; Ho et al., 2000). Peers of suicide attempters show higher levels of psychiatric symptoms and suicidal ideation than peers of suicide decedents, with higher externalizing problem risks, while peers of suicide decedents show higher internalizing problem risks (Ho et al., 2000). This shows that young suicide-exposed individuals have differentiated psychological reactions when facing different suicide behavior outcomes, and future research needs to systematically examine the psychological processes and impacts involved.

2.3 Individuals with Mental Disorders or Suicide Risk

Individuals with mental disorders or suicide risk have higher rates of suicide exposure than those without mental disorders (Yao et al., 2022; Athey et al., 2022). Due to impaired psychological functioning and coping styles, as well as vulnerabilities in social support systems and neurobiology, they are prone to pathological reaction patterns to suicide exposure. However, because their mental disorders and clinical symptoms differ, their reaction types and intensities also show significant individual variation.

First, suicide exposure has different impacts on their clinical symptoms. Research confirms that when depressed patients contact online suicide information, it activates their inherent negative cognitive triad about self, world, and future, exacerbating helplessness and hopelessness (Voros et al., 2022). Hospitalized psychiatric patients who learn about fellow patients' (including unfamiliar fellow patients') suicides experience grief and guilt reactions similar to suicide bereaved, and may also exacerbate somatization, intrusive flashbacks, dissociative episodes, increased psychological arousal, hypervigilance, and sleep disorders, or increase needs for care and medication use. Patients with prominent positive symptoms may also develop delusions, such as believing they bear responsibility for the suicide or have close connections with suicide decedents (Beyraghi et al., 2023; Seeman, 2015). Individuals with high emotional reactivity and high dissociation tendencies are more severely affected (Pouliot et al., 2011).

Second, suicide exposure has complex impacts on suicide attitudes, ideation, and

behaviors. Some patients may experience increased suicidal ideation due to real or virtual suicide exposure (developing wishes to imitate suicide decedents), or even develop suicidal impulses and adopt the same methods as suicide decedents (Beyraghi et al., 2023; Pouliot et al., 2011; Zahl & Hawton, 2004). Some patients may feel anxious about their own suicidal thoughts and worry about imitating suicide (Beyraghi et al., 2023; Pouliot et al., 2011). Other patients may reject the choice of suicide, contemplate other feasible methods, or disclose their own suicide attempt experiences to close others (Zahl & Hawton, 2004). For this population, suicide exposure does not trigger single emotional contagion and suicide imitation behaviors but also triggers cognitive reappraisal processes—reweighing pros and cons of suicidal behaviors or making decisions about suicide.

Joiner (1999) explicitly stated that suicide contagion is most likely to occur in individuals who already have high suicide risk. Adolescents who end their lives in suicide cluster events are more likely to come from dysfunctional family environments, and most have histories of suicide preparation, threats, or attempts, and have been hospitalized for mental disorders or substance abuse problems (Davidson et al., 1989). Mental disorders play a moderating role between adolescent suicide exposure and subsequent suicide attempts (Kline et al., 2022). Another piece of evidence comes from sexual and gender minority (SGM) populations, whose baseline mental disorder prevalence and suicide risk are higher than the general population (Lynch et al., 2020). Their probability of experiencing severe emotional distress due to suicide exposure is more than three times that of heterosexual individuals (Clark et al., 2023). Moreover, approximately one-quarter of SGM individuals have been exposed to SGM peers' suicidal behaviors, which more easily generates empathy and emotional contagion, increasing their suicide ideation and behavior risks (Canetto et al., 2021; Cerel et al., 2021). This also demonstrates that suicide contagion among individuals with mental disorders and suicide risk has systematic characteristics, requiring additional attention to these high-risk individuals after suicide events. Clinical intervention also needs to shift from single individual treatment models to ecological systems intervention models, conducting both cognitive and emotional correction for high-risk individuals and studying suicide contagion blocking mechanisms in homogeneous groups.

2.4 Occupationally Suicide-Exposed Individuals

Practitioners in certain special occupations contact others' suicidal behaviors in work environments, characterized by high frequency, strong impact, and inevitability. Representative groups include first responders (including firefighters, ambulance workers, police) and mental health practitioners (MHP, primarily referring to counselors or therapists, psychiatrists and nurses, and social workers), most of whom experience multiple suicide exposures throughout their careers (Witczak-Błoszyk et al., 2022; Stanley et al., 2015).

One source of psychological trauma for first responders is witnessing suicide scenes. As first-arriving workers at suicide scenes, firefighters suffer strong

impacts from witnessing suicide deaths, especially those of children and adolescents, but must suppress strong negative feelings due to occupational role constraints (Nelson et al., 2020; McDonnell et al., 2022). Nearly half of ambulance workers also report distress from workplace suicide exposure (Witczak-Błoszyk et al., 2022). MHPs develop emotional connections with suicide decedents through deep psychological involvement in helping and treating them. After clients' suicide deaths, MHPs experience trauma/grief reactions similar to suicide bereaved, with most believing it negatively impacts their personal lives (Sanford et al., 2021; Lyra et al., 2021). Occupational suicide exposure effects also extend to practitioners' occupational competence and stability of helping workforces. High levels of suicide exposure are associated with high levels of occupational burnout, low occupational efficacy, and deteriorated interpersonal relationships among first responders (Witczak-Błoszyk et al., 2022; Stanley et al., 2015). MHPs face more prominent professional efficacy crises and occupational behavior changes after experiencing client suicides. They easily develop self-doubt and frustration, feel less confident about professional learning, affecting subsequent professional practice. Some MHPs become more cautious when working with suicide-risk individuals, more worried about legal liability, and even refuse to work with suicide-risk individuals or consider career changes or early retirement (Sanford et al., 2021; Lyra et al., 2021). Moreover, occupational suicide exposure shows obvious cumulative effects on practitioners' suicide risk: suicide exposure frequency positively correlates with firefighters' own suicide attempts, with firefighters exposed 12 or more times more likely to be screened as having suicide behavior risk (Kimbrel et al., 2016). Thus, occupational suicide exposure impacts on practitioners may be no less than those on suicide bereaved, and they equally need suicide postvention.

In summary, substantial evidence and data confirm that suicide exposure causes severe psychological trauma to suicide bereaved and occupationally suicide-exposed individuals, stimulates mental disorder patients or suicide-risk individuals to worsen symptoms, and leads to suicide contagion among adolescents and young adults and other populations. It can be inferred that cross-populations among these vulnerable groups have higher probabilities of experiencing significant negative impacts. This shares common ground with Palmer et al.'s (2018) vulnerability model, which posits that suicide-exposed individuals who simultaneously satisfy geographical proximity, psychosocial proximity, and belonging to risk populations are high-risk groups vulnerable to impacts. However, current research still has limitations. First, sample bias: most study samples are adolescents and young adults, with even fewer studies on populations beyond these four groups, making it impossible to determine whether other populations are also vulnerable to suicide exposure. Second, unclear differences in negative impacts across different suicide exposure types. A meta-analysis examined different impacts of suicide attempt versus suicide death exposure, showing that suicide death exposure increased individuals' suicide death risk by 3.23 times and suicide attempt risk by 2.91 times, but showed no significant association with suicidal ideation; suicide attempt exposure increased individuals' suicide

attempt risk by 3.53 times, with no significant association with suicide death risk (Hill et al., 2020). However, the practical significance of these results remains unclear. Most studies do not distinguish suicide exposure types or only study one type, failing to specify differences in negative impacts across different suicide exposure types on vulnerable groups. Third, lack of core negative reaction measurement indicators for non-bereaved suicide-exposed individuals, with limited screening methods. For suicide bereaved, potential high-risk individuals can be screened by measuring core symptoms of PTSD and PGD, but actual screening accuracy for non-bereaved suicide-exposed individuals is low.

3. Mechanisms of Negative Impact from Suicide Exposure

Current research on mechanisms underlying negative impacts of suicide exposure primarily involves trauma/grief maintenance mechanisms in suicide bereaved and suicide contagion mechanisms following suicide exposure. However, most are based on traditional theories with empirical explanations or deductive speculation, with few high-quality empirical studies.

3.1 Trauma/Grief Maintenance Mechanisms in Suicide Bereaved

The Dual Process Model of grief and the Two-track Model of Bereavement (Kustanti et al., 2024) indicate that suicide bereaved often oscillate repeatedly between loss-oriented and restoration-oriented states, struggling to balance processing loss and restoring personal functioning. The causal systems perspective on mental disorders provides a framework for understanding this difficult process. This perspective suggests that mental disorder symptoms are often interacting and reinforcing elements within the same complex network, with causal relationships and meaningful connections among them. Symptoms themselves are causes that maintain diseases and other symptoms (McNally et al., 2015), with certain core symptoms potentially causing overall symptoms to be difficult to alleviate. For example, experiential avoidance is considered a primary cause of trauma/grief maintenance (Nam, 2016). This suggests researchers can identify core symptoms that hinder recovery from trauma/grief to explain symptom maintenance mechanisms.

The core experiences of suicide bereaved (guilt and blame) and shame and stigma perception are primary variables maintaining trauma/grief. Research confirms that guilt or self-blame and stigma perception are significantly positively correlated with PGD, PTSD, depression, suicidal ideation, and other indicators (Feigelman & Cerel, 2020), and also lead to low levels of posttraumatic growth (PTG) (Pitman et al., 2017; Oexle et al., 2020). Specifically, guilt, self-blame, shame, and stigma perception cause suicide bereaved to neglect and hide their painful feelings, limit their ability to talk about suicide events with others, and increase social avoidance, which is extremely detrimental to alleviating bereavement pain (Azorina et al., 2019; McGill et al., 2023; Westerlund et al., 2020). Consequently, individuals who worry that disclosing suicide bereavement experiences will incur shame and embarrassment report more PGD and

mental health problems (Feigelman et al., 2018). Perceived social support is negatively associated with suicide bereaved individuals' suicide behaviors (Bahamón et al., 2023). Conversely, self-forgiveness, secure attachment, sense of belonging, perceived social support, and self-disclosure behaviors buffer psychological pain in suicide bereaved. Self-forgiveness includes accepting one's faults, letting go of self-resentment, and cultivating positive self-cognition, serving as a protective factor against depression and suicide in suicide bereaved and promoting adaptive coping strategies and PTG (Levi-Belz & Gilo, 2020; Gilo et al., 2022). Perceived social support and self-disclosure play chain mediating roles between secure attachment and PTG (Levi-Belz & Lev-Ari, 2019; Levi-Belz et al., 2021). Securely attached suicide bereaved hold positive beliefs about self and others, have higher interpersonal belonging, and are more willing to interact with others, all of which help them integrate traumatic experiences and form complete narratives (Levi-Belz et al., 2021; Levi-Belz & Rotem, 2022; Feigelman et al., 2018).

Thus, clinical workers should actively address guilt and blame in suicide bereaved to alleviate responsibility attribution dilemmas, reduce experiential avoidance to promote integration of traumatic memories and meaning-making, decrease shame and stigma perception to promote psychological help-seeking, and encourage interpersonal communication to obtain emotional support. Scholars need to continue examining dynamic associations between suicide bereaved individuals' specific negative reactions and experiential avoidance, promoting clinical transformation from experiential to evidence-based practice. For example, network analysis methods can be used to construct network models among multiple variables to identify key "bridge symptoms" and predict pathways of symptom deterioration or alleviation, providing targets for suicide bereaved intervention.

3.2 Suicide Contagion Mechanisms Following Suicide Exposure

Joiner (1999) argued that spatiotemporal clustering phenomena of suicide events are collections of independent suicide events in high suicide-risk, homogeneous groups, with no imitation or contagion involved. Suicide decedents are more likely to become friends with other high suicide-risk individuals (assortative relating), with similar family environments and shared life stressors as risk factors being core explanations for suicide contagion. In contrast, Mueller and Abrutyn (2015) confirmed that the key to suicide contagion is "knowing" about others' suicidal behaviors. If peers have suicidal ideation and behaviors but adolescents are unaware, suicide contagion will not occur. Currently, scholars primarily use the Contagion Model, Symbolic Interactionist Theory (SIT), Social Cognitive Theory (SCT), the Interpersonal Theory of Suicide (IPTS), and the Integrated Motivational-Volitional Model of Suicidal Behavior (IMV) to explain suicide contagion phenomena.

The Contagion Model borrows from public health infectious disease research, summarizing factors causing suicide contagion into five categories: (1) Host

Susceptibility (whether individuals are born with genetic-physiological predispositions to mental disorders); (2) Modes of Transmission (such as direct transmission—person-to-person direct contact with suicide decedents; or indirect transmission—learning about suicides through friends or media); (3) Degree of Virulence (such as celebrity suicides having stronger contagion than criminal suicides); (4) Susceptibility to Contagion (primarily referring to whether individuals already have mental disorders or psychological distress); and (5) Dose Dependency (higher frequency or number of contacts with suicide events leads to greater impacts) (Haw et al., 2013). The Contagion Model assumes that others' suicidal behaviors do not have uniform or similar impacts on suicide-exposed individuals, which can explain why individuals with pre-existing suicide risk and those experiencing negative life events have increased suicide risk after suicide exposure, and why suicides by individuals with higher socioeconomic status easily trigger suicide contagion (Ma-Kellams et al., 2018; Hawton et al., 2020). The Contagion Model analogizes suicide contagion to virus transmission. Although it does not emphasize human psychological complexity and subjective agency, it enlightens scholars to construct suicide contagion risk assessment models by analyzing factors such as transmission modes, virulence strength, contagion susceptibility, and toxic dose, developing corresponding "isolation strategies" and "immunity enhancement strategies." It also guides relevant departments to timely deploy prevention resources after suicide events while protecting vulnerable populations and avoiding excessive information restriction and reducing direct exposure of high-risk groups.

SIT and SCT place greater emphasis on internal psychological processes and both focus on the key role of "identification" with suicide decedents in suicide contagion. SIT originates from sociological research on group culture and meaning-making, believing that human behavior is not mechanical but accompanied by processes of interpretation, understanding, and meaning-making. These processes are built upon symbolic systems and easily influenced by social interaction and cultural environments (Abrutyn et al., 2020). People communicate or disseminate suicide behavior information through various symbolic systems, forming cultural scripts or meaning constructions about suicide during group narrative processes (Abrutyn et al., 2020). For example, if media reports focus on depicting suicide decedents' emotional struggles, family dilemmas, and post-suicide outcomes, or construct suicide as a symbolic behavior expressing extreme pain, despair, or anomie, these symbolic meanings may be processed and adopted by audiences. Some individuals may identify with suicide decedents obtaining some kind of "relief" and view suicide as a problem-solving method (Abrutyn et al., 2020). SIT can also jointly explain suicide contagion with Social Integration and Regulation Theory, suggesting that in closed communities with high social cohesion (including online communities), symbolic transmission and cultural script formation occur faster and are more easily adopted by individuals (Hawton et al., 2020). Therefore, media workers and clinical practitioners should understand both mainstream cultural group narrative characteristics and sensitively perceive special symbolic systems in subcultural groups, guiding

groups to avoid simplistic attribution of suicidal behaviors to specific pressures or falling into romanticized or ritualized narrative patterns. They should also strive to construct positive cultural transmission paradigms—publicizing successful crisis coping cases, positive help-seeking behaviors, and hopeful recovery prospects—to exert effective social psychological protective effects.

SCT focuses on cognitive processes, emphasizing that behavior, individual factors, and environmental factors interact and jointly influence individuals' social cognition and behavioral learning. Individuals initiate and maintain new behaviors not only through observational learning reinforced by outcomes but also by forming internal cognitive models through some symbolic representations to recall, interpret, and even predict behavioral outcomes (Bandura, 2009). Among these, embodied simulation and abstract inferences are two main pathways of social cognition. The former involves understanding others through automatic representation of others' emotions and behaviors via the mirror neuron system, while the latter involves actively constructing theory of mind (ToM) about others from observation, reasoning, and instruction, and explaining or predicting others' mental states and behavioral patterns (Alcalá-López et al., 2019). When individuals experience suicide exposure, they may automatically activate brain mirror neuron systems to produce unconscious "mirror reactions," enabling observers to personally experience suicide decedents' mental and behavioral states. They may also activate abstract reasoning systems, enabling cognitive inference and interpretation of suicide decedents' intentions, motivations, and suicidal behaviors, evaluating the feasibility of suicide as a problem-solving method. Social cognitive processes are influenced by individual factors. If suicide-exposed individuals have deficits in mentalization ability, they will have difficulty distinguishing between self and others' mental states (self-other distinction, SOD) (Luyten et al., 2020). They may be unable to effectively regulate embodied experiences generated by mirror neuron systems, producing pathological identification with suicide decedents, or project their own mental states onto suicide decedents, producing projective identification, leading to excessive emotional reactions or imitation of suicidal behaviors (Haw et al., 2013; Gauld et al., 2019) (see Figure 1

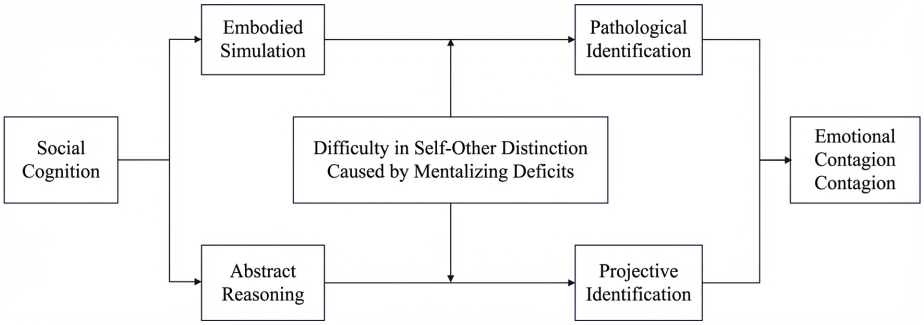

Figure 1: Figure 1

). Research provides evidence for the role of identification in suicide contagion: Hong et al. (2019) found that young people who experienced increased negative emotions when watching suicide web dramas were more likely to identify with suicidal protagonists and believed the drama increased their own suicide risk. Till et al. (2015) used an experimental method of watching suicide films and found that individuals who identified with protagonists and had higher baseline suicide risk perceived protagonists as more attractive, realistic, and relevant to their own lives, and reported stronger suicidal ideation after watching the film. In summary, suicide contagion is not simple behavioral imitation but a complex process involving multiple levels including neural, cognitive, emotional, and social dimensions. Although the SCT theoretical framework is relatively abstract and empirical research on core variables such as symbolic representation, embodied simulation, mentalization, self-other distinction, identification, and empathic responses remains insufficient, it has important implications for suicide contagion prevention. Researchers can start with cognitive intervention, adjusting suicide-exposed individuals' cognitive reasoning and belief systems about suicidal behaviors and improving their mentalization abilities related to self-other distinction to reduce risks of maladaptive identification and decrease chances of emotional and suicide contagion.

Additionally, some scholars explain suicide contagion based on IPTS and IMV theories. Both believe suicide exposure plays an important role in individuals' transition from suicidal ideation to action. Suicide exposure can increase accessibility of suicidal ideation, suicide capability (reduced fear of death perception, increased fearlessness about death), and change individuals' attitudes toward suicide (such as believing suicide is inevitable, unpreventable, or optional) (MaKellams et al., 2018; Soberay et al., 2021; Lee et al., 2022). IPTS and IMV also view suicide mental imagery as a factor in the ideation-action transition. Suicide exposure triggers individuals to generate mental imagery approaching suicide, such as intrusive images causing loss of mental control, cognitive flashbacks of suicide as a solution, images of unfulfilled ideals, and imagination of suicide processes and outcomes, thereby activating and intensifying trapped experiences in high-distress individuals and increasing thwarted belongingness or perceived burdensomeness (Nilsson et al., 2023). Individuals with mental disorders or suicide risk process suicide exposure information more deeply, projecting themselves into suicide decedents' story contexts through imaginative involvement. This process also reinforces suicidal ideation, even beautifies suicide, reduces fear of death perception, and accelerates the transition from ideation to action (Liu, Huang, et al., 2020). This again demonstrates that suicide contagion results from interactions between individual vulnerability and environmental factors, requiring multi-dimensional defense networks formed through cognitive intervention, social support, and environmental regulation.

The above theoretical explanations of suicide contagion mechanisms have cross-population and cross-situational applicability, capable of explaining suicide contagion phenomena in different populations and exposure types, providing important conceptual frameworks and practical bases for understanding suicide conta-

gion processes and suicide postvention. Future researchers can deepen theoretical verification from multiple aspects: regarding the Contagion Model, examine individual susceptibility factors, hazard differences between direct/indirect exposure, virulence strength of different suicide events, and whether toxic dose effects exist; for SIT, use natural language processing technology to analyze meaning generation processes and transmission trajectories of suicide-related symbols in subcultural groups; for SCT, find proxy indicators for core variables such as cognitive reasoning, embodied simulation, and mentalization, compare differences between vulnerable and non-vulnerable groups, or use neuroimaging technology to monitor associations between mirror neuron system reaction characteristics and psychological reactions in suicide-exposed individuals. Additionally, using qualitative research to collect exposed individuals' psychological reaction processes and narrative materials can provide bases for integrating theoretical mechanisms, thereby constructing more complete theoretical systems of suicide contagion mechanisms.

4. Postvention Following Suicide Exposure

Shneidman first proposed the term postvention, emphasizing the importance of supporting and intervening with suicide bereaved, and viewing postvention as a direct form of preventing future suicide (cited in Bell & Westoby, 2022). As defined by Andriessen, Krysinska, and Hill et al. (2019), postvention is "activities developed for suicide bereaved by suicide bereaved or together with suicide bereaved, aimed at promoting recovery after suicide and preventing adverse consequences including suicidal behaviors." In recent years, expanding postvention to include all individuals affected by suicide exposure has become a basic consensus. Cook et al. (2015) pointed out that postvention objects should be expanded, providing a more comprehensive definition of postvention as "organized responses after suicide events that promote healing from grief and pain for suicide bereaved, mitigate other negative impacts on suicide-exposed individuals, and prevent suicide among high-risk groups after suicide exposure in a comprehensive, balanced, and effective manner." However, current postvention practice still focuses on suicide bereaved, with postvention for numerous suicide-exposed individuals difficult to implement, insufficient to alleviate large-scale negative impacts triggered by suicide events.

4.1 Postvention for Suicide Bereaved

Current intervention methods for suicide bereaved mainly include individual intervention, peer support groups, group intervention, community intervention, and online resource use, with slightly more detailed discussion of peer support groups, group intervention, and community intervention.

Individual intervention refers to psychological counseling and therapy. Jordan (2020) pointed out that psychological intervention for suicide bereaved should focus on relieving trauma, integrating loss, and reconciling with suicide experiences as core goals, including key tasks such as restoring safety and control,

repairing cognitive and belief systems, constructing psychological buffer space, improving social regulation abilities, repairing connections with the deceased, reconstructing life narratives of the deceased, and regaining life meaning. Therapists need to provide stable supportive relationships and positive psychoeducation, helping suicide bereaved rationally understand suicide causes and accept their own psychological pain, thereby promoting adaptive coping. Structured 16-week cognitive grief therapy borrowed from interventions for other bereaved populations can also improve medication adherence and reduce suicidal ideation incidence and PGD symptoms in suicide bereaved (Zisook et al., 2018). Individual intervention can focus on processing trauma and grief symptoms and is very necessary for long-term suicide bereaved, with active help-seeking encouraged. Clinical psychologists should receive systematic specialized training in suicide bereavement therapy before providing services.

Peer support groups developed earlier and have been most discussed, initially initiated autonomously by suicide bereaved, usually as open rolling groups where members achieve mutual help through experience sharing, coping strategy learning, psychoeducation, and emotional support. This is an intermediate form between non-professional and professional helping. Its main advantage is that homogeneous experiences among members can effectively alleviate suicide bereaved individuals' isolation and stigma perception (O'Connell et al., 2024). However, non-professional leaders may be unable to properly handle crisis situations due to lack of clinical training, leading to excessive focus on traumatic experiences within groups and causing excessive emotional activation among suicide bereaved (Westerlund, 2020). Bartone et al. (2018) pointed out that effective peer support programs need to meet basic requirements such as accessibility, confidentiality, and professionalism, establish collaborative mechanisms with professional institutions, strictly screen and train leaders, and provide continuous supervision for leaders. Optimized peer support groups are usually led by trained suicide bereaved individuals alone or co-led with MHP professionals (McIntosh, 2017; Ali & Lucock, 2020) in semi-structured ways (Griffin et al., 2022). Although some participants report that peer support groups help understand and cope with psychological pain and obtain emotional support and resource information, individual differences among members may weaken the universality of homogeneous support, limiting benefits for some participants (Ali & Lucock, 2020). In contrast, MHP-led group interventions, though similar in form to peer support groups, have higher safety and more diverse intervention methods. Examples include CBT-oriented group psychoeducation groups (Berardelli et al., 2020) and online groups (Wagner et al., 2022), mindfulness weekend retreats for adults (Scocco et al., 2022), grief support weekends or camps for children and adolescents bereaved by parental suicide (Krysinska et al., 2024), and art group interventions (Strouse et al., 2021), all showing significant intervention effects. Group interventions usually use structured or semi-structured protocols to systematically explain typical reactions to suicide bereavement, grief processes, and suicide behavior mechanisms, strengthening group emotional connections and promoting individual emotional expression and

narrative reconstruction through psychoeducation, reading and writing, artistic creation, physical exercises, and mindfulness training to alleviate psychological pain. However, applicability standards for these two types of interventions remain unclear and need future research to specify. Additionally, online support groups, memorial websites, or forums initiated autonomously by suicide bereaved, and online resources provided by non-profit organizations can serve as extensions of traditional peer support groups and group interventions. Their advantage is providing freer discussion space and improving mental health satisfaction for some participants (Carlon et al., 2025). However, unsupervised online interactions may exacerbate rumination tendencies in some individuals (Westerlund, 2020). Suicide bereaved should use online support communities cautiously, preferably in conjunction with offline professional interventions.

Community intervention is represented by active outreach support, where volunteers (suicide bereaved, MHPs, emergency responders, etc.) provide supportive assistance at suicide scenes or conduct home/phone visits to provide practical help, resource information, and referral services for suicide bereaved (McIntosh et al., 2017). Representative programs include the U.S. Local Outreach to Suicide Survivors (LOSS) (Abbate et al., 2022), Australia's national postvention service StandBy (Maple et al., 2019), and the Primary Care Navigator Model (Hill et al., 2022). Their core value lies in immediate response after events, proactively contacting suicide bereaved, establishing psychological service docking mechanisms, and implementing rapid referrals. This can overcome geographical limitations, stigma, and insufficient help-seeking motivation in traditional psychological interventions, achieving forward intervention shifts. Evidence indeed shows that active outreach services can effectively shorten time intervals between suicide exposure and help-seeking for suicide bereaved (Abbate et al., 2022), with individuals receiving services showing significantly lower suicide risk, social support deficiency, and loneliness than those not receiving services (Gehrmann et al., 2020). However, such interventions require cooperation among different institutions and demand high policy support and human and material resources.

Recent reviews and meta-analyses show that intervention studies for suicide bereaved have obvious heterogeneity in intervention methods, participant screening, control group settings, and outcome measurement, making it difficult to integrate results across studies (Ramamurthy et al., 2025). Some evidence supports that the above intervention methods can effectively relieve trauma/grief symptoms, psychological pain, and suicidal ideation in suicide bereaved, with the most effective mechanism being helping suicide bereaved establish supportive connections and obtain understanding and belonging in empathic community environments (Andriessen, Krysinska, Hill, et al., 2019; Gehrmann et al., 2020; Abbate et al., 2022). Psychological support for suicide bereaved can also save costs across a series of socioeconomic indicators including medical care, work, mental health, and life expectancy, with good cost-effectiveness (Comans et al., 2013). However, evidence for long-term efficacy of these intervention methods is insufficient, with participants' PTSD and PGD outcomes not signif-

icantly improved at follow-up (Andriessen, Krysinska, Hill, et al., 2019; Strouse et al., 2021). A key reason may be structural deficits in professional service systems for suicide bereaved: intervention resources provided by MHP professionals are scarce, evidence-based intervention protocols and practical training in postvention for MHPs are lacking. Many suicide bereaved report insufficient professional support due to lack of help-seeking channels (Ligier et al., 2020). Therefore, relevant experts and scholars need to accelerate research on evidence-based intervention methods, actively construct specialized service systems, conduct professional training and supervision in suicide bereavement intervention, and strengthen technological innovation and digital transformation, using artificial intelligence-assisted diagnosis and mobile health intervention programs to provide scientific and accessible services for suicide bereaved.

4.2 Systematic Postvention Guidelines

To mitigate negative impacts of suicide events on numerous suicide-exposed individuals, relevant departments or institutions should implement a series of intervention measures after suicide events to improve psychological distress among suicide-exposed individuals, prevent public mental health deterioration, and prevent suicide contagion. Industry associations or official mental health departments in some countries and regions have released "Suicide Postvention Guidelines" or "Suicide Cluster Response Frameworks" (collectively referred to as guidelines below) (Andriessen, Krysinska, Kõlves, et al., 2019; Palmer et al., 2018), calling for creation and maintenance of necessary resources, facilities, and service systems to effectively respond to suicide events and guide stakeholders to take organized and targeted intervention measures (Cook et al., 2015). Most guidelines focus on schools, residential communities, or specific workplaces (such as fire departments, psychiatric inpatient wards), with some guidelines specifically mentioning special populations such as ethnic minorities or sexual minorities (Gulliver et al., 2016; Beyraghi et al., 2023; Andriessen, Krysinska, Kõlves, et al., 2019; Ramamurthy et al., 2025), emphasizing multi-stakeholder collaboration (Hill & Robinson, 2022).

Most guidelines are developed based on crisis intervention models and expert consensus experience, focusing on immediate intervention in the proximal period after suicide events. Main contents include: establishing postvention teams and emergency plans, initial emergency response (confirming information, issuing announcements, coordinating resources), safe suicide discussion (guiding media, family members, individuals, and groups to communicate and disseminate suicide information appropriately), supporting suicide-exposed individuals, preventing suicide contagion (screening high-risk/vulnerable groups, implementing crisis intervention), and other follow-up matters (recommendations for memorial activities, restoring order, long-term psychological assistance, future suicide prevention education programs) (Aluri et al., 2023). Among these, psychological support strategies for suicide-exposed individuals can refer to the Public Health Model, providing corresponding intervention measures based on the de-

gree of impact on suicide-exposed individuals (Andriessen, Krysinska, Kõlves, et al., 2019): providing informal social support and psychoeducation for all suicide-exposed individuals (Universal Strategies), providing individual counseling, group intervention, and mutual aid groups for mildly affected individuals (Selective Strategies), and referring highly distressed and/or high mental disorder risk individuals to hospital psychiatric or psychotherapy institutions (Indicated Strategies) (see Figure 2

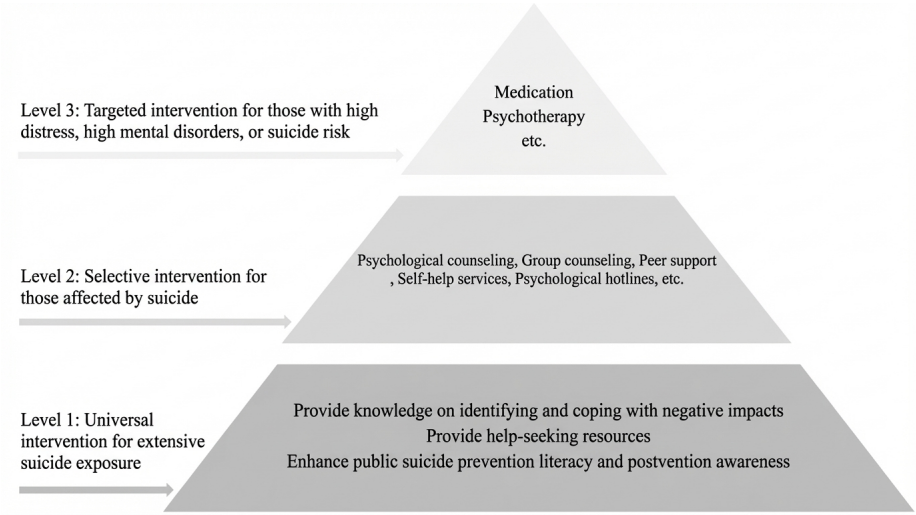

Figure 2: Figure 2

). In postvention, valuing psychological pain in suicide-exposed individuals, breaking suicide topic taboos and encouraging discussion of feelings, and using this as an opportunity to conduct suicide prevention education are all very important (Mueller & Abrutyn, 2024). Suicide cluster response frameworks also focus on routine monitoring and cluster detection of suicide deaths and attempts for timely warning and intervention (Hill & Robinson, 2022).

Figure 2 Public Health Model of Suicide Postvention

Existing guidelines provide important guiding frameworks for postvention practice, covering comprehensive intervention systems from individual to community levels. However, only a few studies have reported practice effects: suicide rates significantly decreased five years after implementing systematic postvention programs in a Hong Kong community (three control communities showed no such trend) (Lai et al., 2020); PTSD, PGD, anxiety, and depression symptoms significantly decreased five months after a school in South Korea implemented postvention according to guidelines (Cha et al., 2018); four schools in Slovenia also reported that guidelines helped improve schools' crisis response effectiveness, enabling rapid access to local mental health resources and effective long-term professional support for affected students and parents (Podlogar et al.,

2022). These limited but consistent evidence indicate that systematic postvention has good clinical value and practical significance, and all stakeholders need to learn and implement postvention guidelines.

Of course, existing postvention guidelines also have many limitations. First, limited application scope. Guidelines are mainly based on geographically concentrated settings such as schools and communities, focusing on preventing "point cluster" phenomena, with limited guidance for postvention in online media and certain online communities, and less attention to intervention for virtual exposure. Second, insufficient effectiveness evidence, with no evidence-based postvention guidelines established. Ideally, longitudinal data should be used to evaluate feasibility and effectiveness of guidelines. However, due to practical difficulties such as ethical approval, participant recruitment, and control group monitoring, research capturing and measuring impacts of postvention on rare phenomena such as suicide clusters is costly and difficult to implement. Currently, there are no research reports on feasibility and effectiveness of specific measures such as issuing suicide announcements, safe suicide discussion, and memorial activities. Third, multiple barriers exist between theoretical recommendations and practice transformation, including uneven resource allocation, shortage of professional personnel, and cultural stigma challenges. Guidelines mainly provide programmatic recommendations with limited descriptions of relevant training programs, specific operation methods, and tools (Williams et al., 2022). Most professional personnel or school psychologists mentioned in guidelines report lacking knowledge and skills in postvention and have not received relevant training (Tiatia-Seath et al., 2019; O'Neill et al., 2020). Some stakeholders who have implemented postvention programs report not knowing responsible or leading departments, feeling difficulties and insufficient experience in identifying high-risk suicide-exposed individuals, monitoring and guiding public opinion, and human resource shortages in MHP professional teams also limit sustainable postvention activities (Hill & Robinson, 2022). More critically, many organizational institutions do not understand or accept postvention, with some officials holding stigmatized attitudes toward suicide, refusing to conduct postvention work and avoiding any suicide-related activities (Lai et al., 2020). Fourth, cultural applicability needs verification. Existing guidelines inadequately consider applicability to different ethnic and socioeconomic cultural backgrounds, requiring adaptation and verification in Eastern cultural contexts. Future research and practice need to focus on breaking through these systematic barriers, promoting cross-sector collaboration, localized adaptation, and technological innovation, and gradually establishing sustainable postvention service systems.

5. Summary and Future Directions

Existing research on suicide exposure and its negative impacts and interventions responds to public psychological concerns but still has many limitations. First, research focus is biased toward suicide bereaved, with postvention methods and effectiveness studies primarily focusing on relatives and friends of suicide dece-

dents. Second, classification and identification of vulnerable populations are imprecise. Although suicide bereaved, adolescents and young adults, individuals with mental disorders or suicide risk are known to be vulnerable populations, this is limited in identifying significantly affected individuals among broad suicide-exposed populations. Third, empirical research on negative impact mechanisms is not in-depth. Exploration of trauma/grief maintenance mechanisms in suicide bereaved is mostly limited to mediation or moderation analyses among few variables, while discussions of suicide contagion mechanisms remain at the level of empirical explanations or deductive speculation of traditional theories, lacking empirical analysis and verification of intrapersonal cognitive, emotional, and behavioral impact pathways. Fourth, obvious shortcomings exist in postvention systems, with insufficient specialized service provision for suicide bereaved and lack of research on intervention methods and effectiveness for non-bereaved suicide-exposed individuals. Coupled with methodological limitations and practical constraints, the evidence base for current postvention guidelines is weak. Future research directions are as follows.

5.1 Expand Research Subjects and Update Survey Tools

Future researchers urgently need to advance high-quality empirical exploration among non-bereaved suicide-exposed individuals, focusing on emotional, cognitive, and behavioral reactions and their temporal characteristics in vulnerable populations such as adolescents and young adults and individuals with mental disorders or suicide tendencies. Simultaneously, researchers should attach great importance to negative impacts of suicide behavior information disseminated through social media, especially the multiple harms caused by exponential diffusion and information iteration of suicide events by online users to suicide-exposed individuals.

Moreover, suicide exposure is an individual's life experience rather than a psychological trait. Many studies use a simple question to ask respondents whether they know anyone who has died by suicide (only assessing presence/absence of suicide exposure), with some studies only including samples exposed to suicidal behaviors within the past year. This cannot clarify differences in negative impacts between single and multiple exposures or different exposure types. Lack of standardized survey tools makes it difficult to compare and integrate results across studies. Future research needs to design more detailed suicide exposure questionnaires, quantifying characteristics of suicide exposure by collecting information on timing, type, frequency, and relationship with suicide decedents. Based on this, high-quality cohort or longitudinal studies can be conducted to explore impacts of different suicide exposure situations on different populations and their similarities and differences. In quantitative research on negative impacts of suicide exposure, scholars should also change the current research status of only using traditional psychological indicators (PTSD, PGD, depression, anxiety, suicidal ideation and behavior) to assess impacts on suicide-exposed individuals. Future research needs to add qualitative or phenomenological methods

to comprehensively capture complex psychological reactions after suicide exposure, develop negative impact scales for suicide exposure or select more specific measurement tools to assess dimensions and degrees of negative impacts from suicide exposure, laying a solid foundation for subsequent identification and classification of at-risk populations.

5.2 Identify Vulnerable Populations and Strengthen Mechanism Research

First, emphasize classification and screening of suicide-exposed individuals. Future researchers need to conduct large-scale cross-sectional and longitudinal surveys based on comprehensive mastery of complex psychological reaction measurement indicators for suicide-exposed individuals, using latent profile analysis, taxometric analysis, or transition analysis to explore categories and classification criteria for mildly versus severely affected individuals. Second, researchers can attempt to use network analysis, machine learning, and other methods to analyze predictive effects of suicide-exposed individuals' demographic variables, psychological characteristics, and suicide exposure features on negative impacts, identifying protective factors, risk factors, and their relational pathways and key nodes for suicide exposure, selecting key variables with good predictive efficacy to construct risk stratification models for suicide contagion. For online suicide exposure, researchers can also use natural language processing technology to conduct in-depth analysis of relevant individuals' online speech information to identify internal cognitive patterns, emotional states, and explicit behavioral tendency characteristics, thereby screening high-risk groups for suicide contagion and providing bases for subsequent personalized postvention measures.

Second, strengthen mechanism research to identify intervention targets. Other factors causing meaning-making and responsibility attribution dilemmas in suicide bereaved, such as relationship rupture with suicide decedents, family conflict or suicide communication taboos, and excessive family cohesion, may all hinder recovery from trauma/grief (Jordan, 2020; Chen, 2023). Future researchers can explore impacts of these variables on psychological pain in suicide bereaved. Regarding suicide contagion, researchers can, on one hand, use qualitative research to interview individuals with suicidal ideation or behaviors, exploring processes of how suicide exposure affects their emotional reactions and suicidal ideation or behaviors to identify key variables triggering emotional or suicide contagion for theoretical integration. On the other hand, quantitative research using cohort studies, controlled trials, and cognitive neuroscience methods is needed to verify emotional and suicide contagion mechanisms based on SCT, SIT, IPTS, and IMV theoretical frameworks, examining key roles of factors such as group meaning-making, social cognition, suicide capability, and suicide mental imagery between suicide exposure and negative impacts, thereby identifying intervention targets. For example, researchers can design multi-version experimental materials of group attribution for suicidal behaviors, implement reading interventions for suicide-exposed individuals, and subsequently examine

between-group differences in participants' attribution methods for others' suicidal behaviors to verify impacts of group meaning-making on suicide-exposed individuals. Alternatively, use questionnaire surveys to test mechanism paths such as "mentalization deficits → pathological identification/projective identification → emotional contagion/suicide contagion" to measure potential value of improving suicide-exposed individuals' mentalization abilities in blocking emotional and suicide contagion chains.

5.3 Strengthen Postvention Research and Build Evidence-Based Guidelines

Relevant experts and scholars should emphasize practice and effectiveness testing of suicide bereaved interventions to compensate for shortcomings in specialized interventions. Tang et al.'s (2025) meta-analysis found that networked interventions primarily based on CBT orientation for general suicide bereaved have good effects, with better treatment effects when intervention sessions exceed 10 and include treatment feedback. Networked Acceptance and Commitment Therapy (ACT) intervention programs also show positive prospects for improving grief symptoms in bereaved individuals (Willi et al., 2024). Future researchers can design networked intervention programs based on CBT, ACT, mindfulness, or narrative therapies to provide more accessible psychological services for suicide bereaved. Intervention programs should also highly align with the intertwined dilemma of trauma and grief symptoms in suicide bereaved, focusing on processing negative cognitions and emotions such as guilt, blame, and shame, and meaning-making dilemmas, and embedding formal effectiveness feedback including PTSD, PGD, or other outcome measures as part of intervention (She et al., 2021). For long-term suicide bereaved, therapists also need to intervene in other risk factors maintaining trauma/grief symptoms, such as exploring individual treatment plans and their effectiveness for improving family relationships or conflicts, or providing psychological support for their families (such as CBT-oriented family psychoeducation) or even family therapy.

For suicide-exposed individuals in schools or communities, relevant experts and scholars should follow the three-tier framework of the public health model to develop differentiated intervention schemes for different risk levels and test their effectiveness. For example, at the universal intervention level, design psychoeducation content with core goals of improving suicide prevention literacy and mental health literacy, using reading interventions, online or offline course interventions to help suicide-exposed individuals understand suicidal behaviors and their own reactions, reduce suicide stigma, and improve knowledge and awareness of psychological helping and self-help. At the selective intervention level, design group interventions or self-help intervention programs with core goals of alleviating negative cognitions and reducing emotional contagion, helping suicide-exposed individuals face their negative cognitions and emotional reactions, learn coping skills, and improve mentalization levels centered on self-other distinction ability. At the indicated intervention level, the goal is improving clinical symp-

toms in high-risk individuals and preventing suicide contagion, with relevant workers needing to actively conduct crisis intervention work such as referring high-risk individuals and coordinating family and community resources for practical support. When conducting effectiveness research, researchers should adopt experimental or quasi-experimental methods as much as possible, corresponding intervention goals with "core outcome indicator sets" to improve reliability and comparability of results. For other components of postvention guidelines, such as recommendations for issuing suicide event announcements, safe suicide discussion, and conducting memorial activities, research should also be conducted to understand psychological needs of suicide-exposed individuals, balancing contradictions between satisfying public psychological needs and excessive exposure. In summary, evidence-based postvention guidelines should clarify which measures are appropriate and effective for which suicide-exposed individuals and for which improvement goals.

For online suicide exposure or virtual exposure, universal intervention should be dominant, conducting online psychoeducation research. For example, in social media interventions, pushing psychoeducation content to online communities helps guide users to safely discuss suicide topics and promote mutual support behaviors, with the Chatsafe project developed by Robinson's team being a positive attempt (La Sala et al., 2023). Additionally, professional scholars should advise social media platforms to improve content review mechanisms, optimize push algorithms and ethical standards, reduce suicide information push for vulnerable users, and increase mental health service resources and positive information push.

5.4 Reduce Barriers to Intervention and Help-Seeking and Develop Localized Practices

Due to lack of corresponding theories, policies, and professional guidance, shortage of MHP professionals, and insufficient postvention competence, postvention practice foundations in mainland China are very weak. Moreover, China's traditional "suicide stigma" and "death taboo" culture are also key factors hindering establishment of specialized postvention systems and help-seeking by suicide-exposed individuals. Suicide events cause loss of group "face," leading families or schools of suicide decedents to conceal suicide events due to fear of damaging family/school reputations (Zou et al., 2022), with some communities refusing any postvention practice (Lai et al., 2020). At the individual level, most suicide bereaved individuals, especially men, choose to hide grief and avoid mentioning suicide events due to family care responsibilities and grief communication taboos (Li et al., 2024; Chan & Cheung, 2022), deliberately keeping distance from others and becoming "invisible groups" (Chan & Cheung, 2022). Those suicide-exposed individuals who resonate with suicide decedents or view them as similar also feel hurt or self-doubt due to negative evaluations and alienation of suicide decedents by media or others (Lai et al., 2021; Zou et al., 2022), and have concerns about help-seeking behaviors.

Therefore, the primary future task is strengthening MHP professional training, incorporating basic knowledge and skills training on suicide exposure, suicide contagion, and postvention into suicide prevention and crisis intervention courses in clinical and counseling psychology master's programs or MHP continuing education programs, to improve professionals' awareness of suicide exposure, vigilance for suicide contagion, and postvention competence. Second, streamline postvention programs and conduct postvention training and practice. Currently, Chinese government policy support for school mental health education is continuously increasing, providing favorable conditions for conducting school postvention training and practice. However, postvention programs still need to be streamlined to reduce implementation difficulty and resistance, focusing mainly on issuing suicide announcements and safe suicide discussion initiatives, implementing three-tier intervention frameworks, and complying with school class culture systems by training homeroom teachers or counselors for universal intervention, training psychological teachers for selective and indicated interventions, and reminding parents to pay attention to psychological changes in suicide-exposed students. Third, continuously improve suicide stigma and death taboo phenomena in Chinese culture. Relevant experts and scholars should actively seek policy support and funding, conduct extensive public suicide prevention education and gatekeeper training to help the public understand suicide phenomena and causes, clarify multi-factorial nature, treatability, and help-seeking effectiveness of suicidal behaviors, improve public suicide prevention literacy and mental health literacy, reduce prejudice and discrimination against suicide decedents and suicide bereaved, and increase public acceptance of suicide research and intervention programs. Additionally, mainstream media can be advised to encourage affected suicide-exposed individuals to seek help while following suicide reporting guidelines.

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