Research Trends

Social Modeling in the Transmission of Suicidality

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Abstract. Evidence from twin, adoption, and family studies suggests that there is strong aggregation of suicidal behaviors in some families. By comparison, the role of social modeling through peers has yet to be convincingly established. This paper uses data from four large studies (the WHO/EURO Multicentre Study on Suicidal Behaviour, the WHO/SUPRE-MISS, the CASE study, and the Queensland Suicide Register) to compare the effects of exposure to fatal and nonfatal suicidal behavior in family members and nonfamilial associates on the subsequent suicidal behavior of male and female respondents of different ages. Across all studies, we found that prior suicidal behaviors among respondents’ social groups were more important predictors of suicidal behavior in the respondents themselves than previous research had indicated. Community-based suicide attempters in the WHO SUPRE-MISS had higher rates of exposure to prior suicide in nonfamilial associates than in family members. In an adolescent population, exposure to prior fatal suicidal behavior did not predict deliberate self-harm when exposure to nonfatal suicidal behavior (both familial and social) were controlled for, but exposure to nonfatal suicidal behaviors in family and friends was predictive of deliberate self-harm and suicide ideation, even after controlling for exposure to fatal suicidal behavior. The potential impact of “containment” of information regarding suicidal behaviors as a prevention initiative is discussed, in light of information behavior principles of social marketing.

Keywords: suicide contagion, social modeling, suicide, attempted suicide, imitation, contagion, confidential death

Introduction

There is substantial evidence of suicides aggregating in some families from twin studies, adoption studies, and family studies (for a review see: Brent & Mann, 2005). In summary, biological relatives of suicidal adoptees have higher rates of suicide than adoptive relatives (Baldessarini & Hennen, 2004; Schulsinger, Kety, Rosenthal, & Wender, 1979; Wender et al., 1986); fatal and nonfatal suicidal behaviors are more common in monozygotic twins of index cases than in dizygotic twins (Roy & Segal, 2001); and completed (Qin, Agerbo, & Mortensen, 2002) and attempted suicide (Cheng, Chen, Chen, & Jenkins, 2000) are more prevalent in relatives of suicide victims than in the community generally. In combination with other risk factors, family history of suicide attempt increases the risk of suicidal behaviors (Brent & Mann, 2005). While the search for specific genes that may be implicated in fatal and nonfatal suicidal behaviors continues (for a review see: Baldessarini & Hennen, 2004), studies suggest that familial transmission of suicide is a complex interrelation of multiple biological and environmental factors (Correa et al., 2004).

Previous research has indicated that psychiatric disorders are transmitted familiarly (genetically) (Kendler, 2001; Merikangas & Low, 2004), so the well-established association between psychopathology and suicide (Arsenault-Lapierre, Kim, & Turecki, 2004) readily leads to the conclusion that both phenomena share the same pathway. However, research findings indicate that while there is an association between the two phenomena, independent pathways are involved (Brent et al., 2004; Brent & Mann, 2005; Goodwin, Beautrais, & Fergusson, 2004), particularly in mothers (Lieb, Bronisch, Höfler, Schreier, & Wittchen, 2005) and adolescents (Brent, Bridge, Johnson, & Connolly, 1996).

Social learning may be an important factor in both familial and nonfamilial transmission of suicidal behaviors (Agnew, 1998; Bandura, 1977). Theories of imitation have been postulated to explain clustering of suicides and nonfatal suicidal behavior. Suicide contagion is a concept from the infective disease model, and assumes that a suicidal behavior may facilitate the occurrence of subsequent, similar behaviors (Gould, 1990). Imitation refers to the process that explains the occurrence of contagion. Suicide contagion has been investigated primarily in adolescent and inpatient populations (Kreitman, Smith, & Tan, 1969, 1970; Taivainen, 1994).

Among secondary school students, suicide contagion was evident in schools where no crisis intervention was implemented following the suicide of a student (Poijula,
Adolescent suicides were seen to increase following a suicide by a teenager to a greater extent (6–7%) than adult suicides increase (2–3%) following a suicide by an adult (Phillips & Carstensen, 1986). Up to 5% of all adolescent suicides may be the result of suicide clustering (Velting & Gould, 1997). As is the case with completed suicides (Maris, 1997), attempted suicides tend to cluster, especially in adolescent age groups (Gould, Petrie, Kleinman, & Wallenstein, 1994).

There have been inconsistent findings pertaining to suicide clustering in psychiatric settings. Among persons with mental illness in the UK, imitation was believed to account for about 10% of all suicides (McKenzie et al., 2005). However, earlier research suggested that inpatient suicides are random (Taiminen & Helenius, 1994) and an infrequent problem among adolescent inpatients (King et al., 1995). In this case, series of suicides may not be related through contagion (Haw, 1994). Contrarily, adolescent inpatients’ nonfatal suicidal behavior was highly clustered (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998).

The effect of imitation depends on similarities between the stimulus and the potential imitators (Schmidtke, Bille-Brahe, De Leo, Kerkhof, 2004). The characteristics that assist in determining imitation include age (with younger people and the elderly apparently most susceptible; Stack, 2000), gender, self-esteem, and ethnicity (Molock, Williams, Lacy, & Kimborough, 1994; Stack, 1996). However, social modeling of suicidal behavior through peers still appears to be a largely unresearched topic, although there are indications of its significance from related studies (Hanson et al., 2002; Schmidtke, Bille-Brahe et al., 2004).

This paper considers the role of social sources in the development of suicidal behavior, specifically focusing on possible transmission from stimuli originating outside the family.

Methods

In this document, the terms “attempted suicide,” “deliberate self-harm,” and “nonfatal suicidal behavior” are used interchangeably, although the authors prefer the term nonfatal suicidal behavior (De Leo, Burgis, Bertolote, Kerkhof, Bille-Brahe, 2006), particularly in those cases where the intention to die is not reported/detected. Fatal and nonfatal suicidal behavior are examined and discussed individually, without any implicit assumption that the two types of phenomena may belong to the same process, i.e., a continuum of suicidality (De Leo, Cerin, Spathonis, & Burgis, 2005; Wyder & De Leo, 2007).

The paper considers data from four large studies: (1) the WHO/EURO Multicentre Study on Suicidal Behaviour, (2) the Child and Adolescent Self-harm in Europe (CASE) study, (3) the World Health Organization (WHO) Suicide Prevention – Multisite Intervention Study of Suicide (SU-PRE-MISS), and (4) the Queensland Suicide Register (QSR).

Results from the Studies

WHO/EURO Multicentre Study on Suicidal Behaviour

The Repetition-Prediction part of the WHO/EURO Multicentre Study, which involved 15 European centers and 1,866 patients with 731 reinterviewed 1 year later, included a series of questions related to social modeling of suicidal behaviors (Schmidtke, Lohr, & De Leo, 2004). More than half of all suicide attempters (54%) reported at least one suicidal model (either completed or attempted suicide), with 4% of the sample reporting four or five models (Schmidtke, Lohr et al., 2004).

In 86% of cases the respondent’s suicide attempt occurred more than 12 months after the suicidal behavior in the respondent’s associate. Only in 1% of cases did the respondent’s attempt occur within 1 week of the associates’ suicidal behavior (Schmidtke, Lohr et al., 2004). In the majority of instances, the most recent reported suicidal behavior was in someone from the respondents’ social group (either friend or colleague). Forty-three percent of males and 37% of females had a lifetime exposure to suicidal behaviors by a friend. The next largest model group was that of “other relatives” (i.e., members of extended family).

In more than 25% of cases the respondent had made contact with the suicidal associate at a treatment facility. Approximately one quarter of suicide attempters were physically present, in telephone contact, or contacted immediately prior to or after the suicidal behavior of the associate. The choice of method of the suicide attempt by the respondent was unrelated to the method used by the model (Schmidtke, Lohr et al., 2004).

The suicidal act of male respondents’ associates was more often fatal whereas that of female respondents’ associates was more often nonfatal, particularly for women under 35 (Schmidtke, Lohr et al., 2004).

Child and Adolescent Self-Harm in Europe (CASE)

The Child and Adolescent Self-Harm in Europe (CASE) study is a multicountry investigation of deliberate self-harm (DSH) in school-aged adolescents. Australia was the only non-European country involved in this project. On the Gold Coast in Queensland, 3,757 high-school students completed a self-report questionnaire, answering questions relating to personal history of DSH and suicidal ideation, as well as a number of potentially important life events, including exposure to suicidal behaviors in friends and...
family (De Leo & Heller, 2004b). In the 12 months preceding the interview, 233 participants reported DSH that matched the study criteria. Females (n = 200, 85.8%) were more likely to report DSH than males (n = 33, 14.2%). In a multivariate logistic regression of the entire sample, exposure to self-harm by friends was the most important factor associated with subject’s DSH (odds ratio [OR] = 4.07, 95% confidence interval [CI] 2.64–6.26), superseding self-harm by family members (OR = 3.22; 95% CI 2.17–4.78).

The effect of exposure to fatal and nonfatal suicidal behavior on subsequent DSH was independently evaluated using univariate and multivariate methods. Adolescents with DSH were more likely to know someone who had completed suicide (33.9%) than those without DSH (11.8%); χ²(1) = 93.26, p < .001. Exposure to a completed suicide predicted suicidal ideation and DSH in the sample (Table 1). When exposure to nonfatal suicidal behaviors in family and friends was controlled for, exposure to a completed suicide predicted suicide ideation but not DSH in the adolescent cohort (Table 1).

Given the much larger number of respondents exposed to family members or associates with nonfatal suicidal behavior (because attempts are much more common that completed suicides) it was possible to compare the relative importance of exposure to nonfatal suicidal behavior in a family member versus that in an associate. A greater proportion of self-harmers reported exposure to DSH by friends than by family members. Over one-quarter of all respondents had friends who had a history of DSH (n = 1062; 28.3%) compared to less than one-sixth having a family member with DSH history (n = 589; 15.7%). Self-harmers were significantly more likely to know friends who had also self-harmed than nonharmers (79.8% vs. 24.9%), χ²(1) = 324.84, p < .001. History of self-harm in the family similarly differentiated self-harmers from nonharmers; however, the proportions were lower, 54.5% vs. 13.2%, χ²(1) = 285.92, p < .001 (cf. Table 2).

Where there was no family history of self-harm (n = 104), 75.0% of self-harmers had a friend with a history of DSH. In cases where the self-harmer did not have exposure to friends’ DSH behaviors (n = 47), less than half had familial history of DSH (n = 21; 44.7%). Therefore, where self-harmers were not exposed to DSH behaviors by their friends, a higher proportion reported no exposure to the suicidal behaviors of others (55.3%) than exposure to suicidal behavior in family members (44.7%). This difference was, however, nonsignificant, χ²(1) < 1, p = .466, ns.

More females (41.8%) than males (15.9%) had a close friend in the general school population who had deliberately self-harmed, χ²(1) = 307.79, p < .001, but among self-harmers there was no gender difference in the proportion who had a friend who had self-harmed (Males: 27 of 32; 84.4%; Females: 158 of 200; 79.0%), χ²(1) < 1, p = .482. More females (21.3%) than males (10.7%) from the entire sample had a family member who had self-harmed, χ²(1) = 78.37, p < .001.

After controlling for exposure to fatal suicidal behavior in family or friends in a logistic regression model, males who had been exposed to nonfatal suicidal behavior among their friends were 21.3 times (95% CI = 7.7–58.5) more likely to have experienced suicide ideation than males who had not been exposed to suicidal behavior in their friends (Table 2).

Table 1. Univariate and multivariate logistic regression models of completed suicide by family or friends as predictors of own suicidal behaviors (3,757 schoolchildren investigated)

<table>
<thead>
<tr>
<th></th>
<th>Univariate</th>
<th>Multivariate</th>
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</thead>
<tbody>
<tr>
<td><strong>History of family or friends completing suicide</strong></td>
<td><strong>Odds ratio (95% CI)</strong></td>
<td><strong>Odds ratio (95% CI)</strong></td>
</tr>
<tr>
<td>Suicide ideation</td>
<td>3.20 (2.61–3.92)</td>
<td>1.64 (1.30–2.07)</td>
</tr>
<tr>
<td>Deliberate self-harm</td>
<td>3.83 (2.87–5.12)</td>
<td>1.32 (0.95–1.83)</td>
</tr>
</tbody>
</table>

See De Leo & Heller, 2004, for further details.

Table 2. Proportion of adolescents with exposure to suicidal behaviors (case study in Australia)

<table>
<thead>
<tr>
<th></th>
<th>Personal suicidality</th>
<th>Suicidal ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliberate self-harm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes (n = 233)</td>
<td>No (n = 3518)</td>
</tr>
<tr>
<td>DSH by friends</td>
<td>186 (79.8%)</td>
<td>876 (24.9%)</td>
</tr>
<tr>
<td>DSH by family</td>
<td>127 (54.5%)</td>
<td>462 (12.2%)</td>
</tr>
<tr>
<td>Family or friend suicide</td>
<td>79 (33.9%)</td>
<td>415 (11.8%)</td>
</tr>
<tr>
<td></td>
<td>414 (57.3%)</td>
<td>242 (33.7%)</td>
</tr>
<tr>
<td></td>
<td>633 (21.3%)</td>
<td>336 (11.3%)</td>
</tr>
<tr>
<td></td>
<td>299 (10.1%)</td>
<td></td>
</tr>
</tbody>
</table>

DSH = Deliberate self-harm. See De Leo & Heller, 2004, for further details.

Table 3. Univariate and multivariate logistic regression models of suicidal behaviors of friends as predictor of own suicidal behavior by gender (case study in Australia)

<table>
<thead>
<tr>
<th></th>
<th>Univariate</th>
<th>Multivariate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History of friend(s)</strong></td>
<td><strong>Odds ratio (95% CI)</strong></td>
<td><strong>Odds ratio (95% CI)</strong></td>
</tr>
<tr>
<td>Male</td>
<td>4.85 (3.50–6.71)</td>
<td>3.12 (2.18–4.49)</td>
</tr>
<tr>
<td>Suicide ideation</td>
<td>4.31 (2.76–4.22)</td>
<td>2.74 (2.20–6.40)</td>
</tr>
<tr>
<td>Deliberate self-harm</td>
<td>31.25 (11.93–81.82)</td>
<td>21.25 (7.72–58.52)</td>
</tr>
<tr>
<td>Female</td>
<td>31.25 (11.93–81.82)</td>
<td>21.25 (7.72–58.52)</td>
</tr>
<tr>
<td>Suicide ideation</td>
<td>6.38 (4.47–9.09)</td>
<td>4.41 (3.05–6.40)</td>
</tr>
</tbody>
</table>

See De Leo & Heller, 2004, for further details.
likely to engage in self-harming behavior than males with no exposure to a friend who self-harmed and females with friends who had nonfatal suicidal behavior were 4.4 times (CI = 3.1–6.4) more likely to self-harm than those with no exposure to a friend who self-harmed (Table 3).

A similar procedure was utilized to determine the predictive power of exposure to nonfatal suicidal behavior in family members. Univariate and multivariate logistic regression models indicated that exposure to nonfatal suicidal behavior in family members predicted suicidal ideation and DSH in both male and female adolescents; these relationships remained significant after adjusting for exposure to fatal suicidal behavior in family members and friends. (see Table 4).

World Health Organization (WHO) Suicide Prevention – Multisite Intervention Study on Suicide (SUPRE-MISS)

The WHO SUPRE-MISS is an international program that includes a community survey and an intervention study. In Australia, the survey included randomized telephone interviews (n = 11,572) that evaluated lifetime prevalence of suicidal ideation and attempts, and corresponding sociodemographic and cultural characteristics of the respondents. A subsequent postal survey sent to consenting individuals who reported lifetime suicide ideation/attempt (n = 1,311) assessed prior exposure to suicidal behavior, together with possible development of suicidal behavior along a continuum, psychiatric and psychological factors, and help-seeking and service utilization (De Leo et al., 2005).

Having personally known someone who had attempted suicide was associated with increased probability of suicidal ideation and suicide attempts (De Leo et al., 2005). Attempters were more likely than ideators to know someone who had died by suicide in the past, and reported that this loss had affected them strongly.

Among a subsample of suicide attempters who were recontacted by telephone (n = 48), 22.9% reported that at the time of their own attempt they had known someone who had attempted suicide, and 27.1% had known someone who had died by suicide. More of the respondents exposed to nonfatal suicidal behavior had been exposed to nonfatal suicidal behavior in nonfamilial associates than in family members (90.9% vs. 9.1%), \( \chi^2(1) = 7.36, p < .01 \). Similarly, more of the respondents exposed to fatal suicidal behavior had been exposed to fatal suicidal behavior in nonfamilial associates than in family members (76.9% vs. 23.1%), \( \chi^2(1) = 3.77, p = .052, ns \).

The Australian component of the WHO SUPRE-MISS study also found that exposure to fatal or nonfatal suicidal behavior was more common in suicide attempters under 45 years of age than in those over 45 years of age, \( \chi^2(1) = 4.77, p < .05 \), suggesting that the importance of exposure to suicidal behavior in others as a predictor of suicidal behavior in oneself decreases with age.

Queensland Suicide Register (QSR)

The QSR stores information on all suicide deaths in Queensland from 1990 to the present. Data for each case is obtained from police investigations, postmortem and toxicology reports, and a psychological autopsy. There are between 450 and 650 suicides in Queensland each year, and these are classified in the QSR on three levels: beyond reasonable doubt, probable, and possible (see De Leo & Heller, 2004a). For research purposes, possible suicides are excluded from analysis.

Between the years 1994 and 2001, there were 4,262 deaths reported in the QSR, with exposure to completed suicide in the victims’ social group recorded for 348 cases (8.2%). Of these cases, 59.8% had a family member who had died by suicide, whereas 20.4% had a friend who had died by suicide. Unfortunately, for the years considered, the QSR did not record exposure to nonfatal suicidal behavior in a reliable manner.

From the QSR, there was no difference in the reporting of exposure to completed suicide in the victim’s social group between genders, \( \chi^2(1) < 1, ns \), however males were more likely than females to have a friend who had suicided (23% vs. 7.2%), whereas females (18.8%) were more likely than males to have a spouse who had died by suicide (18.8% vs 2.9%), \( \chi^2(4) = 34.199, p < .001 \).

Exposure to a completed suicide among suicide victims was most common in the youngest age group considered and generally decreased with age (Figure 1), suggesting that suicide victims are less likely to be influenced by suicide in their social and familial groups as their age increases.

Stratification of the results by age (Figure 2) shows that in all age groups more suicide victims were exposed to the
suicide of a family member than that of nonfamilial associates, but the proportion of decedents who had been exposed to the suicide of a friend was highest in the 25–34-year age group (28.2%) and then gradually decreased only to rise again (to 12.5%) in the oldest age group. When spouse was included as part of the victim’s “social group,” the proportion of suicide decedents exposed to suicides in their social associates increased to 31.7% in the 15–24-year age group, 31.7% in the 25–34-year age group, and about 25% in those over 65.

Discussion

In psychological autopsy studies, the reporting of the decedent’s exposure to prior suicidal behavior in associates may be underestimated because the proxy is unfamiliar with all the deceased’s social groups, and is subject to potential recall bias (Lieb et al., 2005). In contrast, the proxy/next-of-kin is presumably more likely to be aware of family members who had enacted both fatal and nonfatal suicidal behaviors (Pouliot & De Leo, 2006). The results described here from self-report surveys in both adolescent and adult samples provide a perspective on this issue that is not subject to these biases.

Most previous studies that considered the relationship or prior exposure to suicidal behavior in nonfamilial associates have focused on adolescents and psychiatric patients. Both of these subgroups are samples of convenience, easier to monitor than a general adult population in terms of identifying their potential contacts. As most adults belong to multiple social groups (e.g., work, family, friends, acquaintances), the effect of suicide imitation on them may be more difficult to observe. However, the results from the studies presented here indicate that the effect of suicidal behaviors...
by nonfamilial associates may be influential, and warrant further investigation.

The datasets considered in this report come from investigations that were different in targets and sample characteristics. The WHO/Euro Study was mainly meant to monitor suicide attempters (all ages) at the health facility level in Europe, the CASE study targeted schoolchildren aged 14–17 (mostly 15–16 years old), the WHO/SUPRE-MISS study was a transcultural comparison of treatment of suicide attempters that included a community survey in each of the participating centers, and the Queensland Suicide Register contains all deaths by suicide recorded in that part of Australia. Notwithstanding different aims and methodologies, it was possible to obtain information on respondents’ exposure to suicidal behavior in associates from all of the datasets (although only on exposure to fatal suicidal behavior in the case of the QSR). The absence of a standardized cross-study method of obtaining this information is a significant limitation, but this is counterbalanced by the size and (apart from the QSR) cross-national characteristics of the samples. Despite these caveats about the comparability and generalizability of the results, the similarity of the findings in the different studies convincingly demonstrates that exposure to suicidal behavior in nonfamilial associates is a risk factor for suicidal behavior in oneself. Importantly, these data cannot address the question of whether or not the observed association is causal. For a review of methodological problems involved in studies dealing with suicide contagion, see, for example, Gould, 1990; Maris, Berman, & Silverman, 2000; and Schmidtke & Schaller, 1998).

Researchers have suggested that assortive friendships may explain the contagion of suicidal behaviors among adolescents (Joiner, 2003), but this theory hasn’t been developed to explain linkages between suicides in adult social groups. Do vulnerable adults associate with others who are vulnerable to suicide or have a history of suicidal behaviors? This could be the case, for instance, among separated males who are at increased risk of suicide and attempted suicide (Kposowa, 2003). Some separated males congregate regularly in special “men’s groups” and this, besides providing support, could also provide the stimulus for transmitting suicidal behaviors among this high-risk cohort.

The results reported here from four separate studies imply that the influence of suicidal transmission through nonfamilial social sources may be more significant across the lifespan than previously believed. As people mature, the influence of family tends to decrease as the actor creates lifespan than previously believed. As people mature, the influence of family tends to decrease as the actor creates a latent effect of exposure to suicidal behavior, for example by increasing the acceptability of this type of response to social stress.

Borrowing from social identity theory (Tajfel & Turner, 1979), an individual’s identity is a combination of their personal identity and their social identity, i.e., part of the self-concept that derives from membership in social groups, which extends to race, community involvement, friendship groups, workmates, sporting teams, and family membership. When an individual identifies with a group, s/he adopts cognitions and behaviors that are characteristic of that group. Therefore, when suicidal behaviors occur within a social group, this behavior, be it fatal or nonfatal, may become a characteristic behavior of that group, and lead to subsequent suicidal acts.

Likewise, theories of suicide imitation suggest that suicides increase among people who are similar to the stimulus suicide (Schmidtke, Bille-Brahe et al., 2004). This is exemplified by excesses in white male suicide rates following a high-profile suicide by a white male, but no increases in suicidality among women and black males in the USA (Stack, 1987). Likewise, other characteristics; including age, marital problems, and mental health; may be relevant in the view of vulnerable people when comparing themselves to a stimulus suicide (Stack, 1987).

Information behavior principles from social marketing may play an important role in preventing suicide. Social marketing has been utilized in health promotion fields such as quitting smoking (Lowry, Hardy, Jordan, & Wayman, 2004) and treating sexual abuse (Boehm & Itzhaky, 2004), and has been recommended for improving mental health in men (Rochlen & Hoyer, 2005) and adolescents (Andreasen, 2004). By containing information about suicidal behaviors, and enlisting social marketing strategies such as market segmentation, product concept development and testing, and exchange theory (Lowry et al., 2004), a population-level approach to reducing fatal and nonfatal suicidal behaviors may be achievable.

The concept of “confidential death” as a suicide prevention initiative may be pertinent, and has been suggested elsewhere (Leonard, 2001). This notion would see that any and all suicide deaths are kept confidential, and not reported in the popular media. More controversially, this could become an active postvention strategy within schools and organizations in the event of a suicide. However, this seems to be rather impractical and difficult to control, particularly in schools and other public environments, and likely to end by magnifying the stigma associated with suicidal behavior.

Notwithstanding, victims of suicide should not be heralded or celebrated, as this may glorify the suicidal act, and render it as an attractive option to vulnerable people experiencing similar situations.

This paper has not explored the possible role of media.
on suicidal behaviors. With the advent of sophisticated technology that enables many people to instantaneously access information from all over the world, the potential transmission of suicidal behaviors beyond people in the immediate vicinity is troublesome. The matter of suicide imitation through media sources is described elsewhere (Stack, 2002, 2005).

Conclusions

The relationship between exposures to suicidal behavior in others to individuals’ suicidal behavior is long established, particularly through familial sources. Yet, there is compelling evidence to suggest that nonfamilial social sources may be as prominent, if not more so, as family. The adage of “you can choose your friends, but not your family” may be relevant in explaining how the social ties of an individual impact on their suicidal behavior development. Familial exposure may be unavoidable, yet highly important; whereas the people that we associate with outside of family circles are usually acquaintances or friends by choice. Levels of impact of various suicidal thoughts and behaviors need to be investigated using a variety of potential sources, to ascertain the relevance of each model in predicting future suicidality, with a view to incorporating them in future postvention and bereavement programs. As inferred from the present study, postvention activities should have targets that go well beyond the immediate family circle, but encompass all emotionally affected proxies/peers of the deceased person.

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References


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