Clareus Scientific Science and Engineering
Volume 2 Issue 6 July 2025
ISSN: 3065-1182

Group Psychological Emergency Management after Suicide of Organization Members - A Practical Program from China

Citation: YuXin Du. "Group Psychological Emergency Management after Suicide of Organization Members - A Practical Program from China". Clareus Scientific Science and Engineering 2.6 (2025): 14-26.

Article Type: Review Article

Received: May 17, 2025

Published: July 12, 2025

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Abstract

Introduction: Globally, approximately 700,000 people die by suicide each year, and these people work and live in a wide range of social organizations, whose members' suicides can have an impact on family, friends, witnesses, other susceptible people and the organizations themselves. These effects include physical-psychological stress reactions, social influences and suicide contagion. Therefore, the suicide of an organization member should be regarded as a sudden crisis event of the organization, and the main body of the psychological emergency management for the suicide of an organization member should be the organization's decision-making and management personnel, and the target should be the other members of the organization.

Aims: To achieve the effect of curbing suicide contagion, reducing family disputes, restoring the group's mental health level, and reducing negative affect.

Method: Organizational members affected by different suicides were divided into four regions A, F, W, and O through the two dimensions of psychological distance, spatial distance and social distance, and psychological emergency management was carried out according to the characteristics of people in different regions.

Results: The methodology establishes a four-phase emergency management program - psychological prevention and preparedness phase that involves building psychological expectations, a non-punitive organizational culture, and a socially supportive organization; an emergency psychological response phase that involves determining the distribution of suicide-affected populations and blocking the spread of the effects of suicide in the media; an emergency psychological response phase that involves providing first aid through individual counseling, deconstructing social influences through Balint groups, and using the Satir model to enhance the mental resilience of the group; and a final phase that involves tracking the effects of the emergency psychological response and summarizing and improving the process.

Discussion: The following three questions were discussed: Do family members of suicides who are not part of an organization need intervention? How do the principles of emergency management and psychological intervention relate to each other? How do the subjects of emergency

management relate to the subjects of psychological intervention?

Implications for Practice: This paper serves as an emergency management plan that can be directly applied to all types of organizations in the event of an employee suicide.

Keywords: organization member suicide; suicide influence; psychological emergency management; psychological distance

Introduction

Background

The World Health Organization's 2019 State of Global Suicide report released in 2021 shows that approximately 703,000 people die by suicide each year globally, and the outbreak of the New Crown Pneumonia epidemic has shifted that number again. A meta-analysis from across the globe, across 54 research outcomes, and including 308,596 participants, showed that suicidal ideation, suicide attempts, and self-injurious behaviors rose by 10.81%, 4.68%, and 9.63%, respectively, during the epidemic (Dube et al., 2021). The impact of suicide is widespread and far-reaching, with survey data from the United States showing that 1 person's death by suicide can affect, on average, 5 family members, 15 extended family members, 20 friends, and 20 classmates or coworkers (Berman, 2011), while this number rose to 135 in Cerel's (2019) study, with some still experiencing intense emotional distress even 14 years later (Feigelman et al., 2018).

The crude all-age suicide rate in China in 2019 is 8.1 per 100,000 people (World Health Organization, 2021). A large organization with more than 10,000 employees should be self-conscious that the probability of one suicide within the organization in a year can be as high as 81%. This probability will increase in the event of a major infectious disease outbreak, and the severe negative impact of suicides makes emergency management essential. Relative to previous suicide research, this paper considers suicide as a crisis event in all types of organizations, and focuses intervention on the psychological impact of the group due to suicide.

China's emergency management theory and practice has developed to the fourth generation (Zhang, 2022), and psychological services as a part of emergency management have been improved, gradually forming the psychology of emergency management (Chen, 2022). The main body of traditional emergency management is the government, and the target is public emergencies, with the purpose of resolving the crisis and restoring order (Xue & Zhong, 2005). In contrast, the subject of emergency management for suicides is the decision-making management of the organization in which the suicidal person lives, and the target is the members of other organizations and friends and relatives affected by the suicide, with the purpose of eliminating the psychological impact of the group to the greatest extent possible.

Group impact of suicides

Xu Yan(2020) classified the stress reactions triggered by emergencies into physical-psychological stress reactions and social influence. For suicidal events there is also the possibility of triggering suicide contagion. These three types of impacts are alternately overlapping and differently distributed in organizational groups and need to be discussed separately.

Physical-psychological stress reactions

Hospitals are a high prevalence area for suicidal events, and studies addressing the impact of suicide have focused on the nurse population. In Belgium, 73% of nurses in psychiatric hospitals experienced at least 1 acute event, with suicide accounting for 64% (Martens et al., 2016), while 55.0% of nurses in Japanese psychiatric hospitals experienced a patient suicide, with 13.7% experiencing post traumatic stress disorder (Takahashi et al., 2011). A meta-analysis of 63 studies (Wang et al., 2022) showed that nurses experienced significant physiological, psychological, and behavioral changes after experiencing patient suicide. Physiological responses included headache, increased heart rate, sleep disturbances (Zheng et al., 2019), hallucinations (Matandela & Matlakala, 2016), de-

creased appetite (Hu et al., 2014), and gastrointestinal distress. Psychological reactions include shock, fear, grief, guilt, nervousness, anxiety (Joyce & Wallbridge, 2003), and even depressive symptoms (Matandela & Matlakala, 2016). In terms of behavior, difficulties in concentration, hyper vigilance, over protectiveness (Liu, 2010), and avoidance (Zheng et al., 2019) are observed. Similar reactions also occurred in other groups, for example, in the early morning of October 22, 2015, after a freshman female student in a university died by suicide by taking poison and falling from a building, five other students in the dormitory experienced emotional and behavioral reactions that night, such as crying, being afraid, not being able to sleep, each wearing a lot of clothes, and papering the dormitory's windows (Qin et al., 2016).

Social influence

Those most affected by suicide are the friends and family of the deceased. Studies from the UK (Pitman, Khrisna Putri, et al., 2018) and Australia (Ross et al., 2021) have shown that cold numbness and avoidance from coworkers has led to those bereaved by suicide to experience more stigma and social isolation in the workplace, and as a result, have more strained relationships with coworkers (Feigelman et al., 2009). This significantly impairs their social functioning, reduces job performance, and leads to more separations and dropouts (Pitman et al., 2016). This effect does not only stop at family and friends, but also spreads to the periphery.After a fifth-grade girl in a city committed suicide and died by jumping from the window of her room on April 22, 2018 (Hu et al., 2019), her best friend and her boyfriend both took leave from school to stay home because they could not continue their studies, and some of their classmates cried in class as well, making it impossible for the class to function normally. Nurses who experienced the patient's death (Zeng Li & Hu Deying, 2015) also experienced a general sense of burnout and affected other nurses in the same ward, resulting in low overall morale. In turn, low group morale can be a major trigger for suicidal ideation and behavior (Costanza et al., 2022).

Suicide contagion

The biggest impact of suicide is suicide contagion, a process that is fueled by the media.Phillips (1974) found that the suicide rate in the United States between 1947 and 1968 had a strong correlation with suicide news coverage. Six suicides occurred at Foxconn between January and April 2010, and began to attract a lot of media attention in May, with a flurry of coverage. In May alone, there were seven consecutive suicides in January, all of which involved jumping from a building. The contagion effect is even more pronounced in the case of celebrity suicides (Stack, 2000). A meta-analysis of 98 celebrity suicides found a 0.26 change in the local suicide rate in the month following a celebrity suicide. The increase was even greater in the case of entertainment stars, at 0.64 in North America, 0.68 in Europe, and 0.58 in Asia (Niederkrotenthaler et al., 2012).Following the suicide of the Japanese singer, Okada Yukiko, on April 8, 1986, Japan's suicide rate was 44% higher than at the same time in 1985 (Lu Pengcheng, 2005), and on April 1, 2003 After the death of Hong Kong movie star Leslie Cheung by suicide, the suicide rate in Hong Kong increased by 32% in April compared to March (Ma Huiying, 2006), which was also related to the two person from the leftover information of the deceased. In addition to entertainment stars, if suicides involve special groups or professions, such as officials (Meng & Deng, 2015) and police officers (Pi, 2015), the effects will also spread to the occupational groups in which they are located, and even lead to greater social turmoil.

Method

Theory and Modeling

Individuals' judgments and responses to critical events are moderated by psychological distance (Li et al., 2020), which has four dimensions: temporal distance, spatial distance, social distance, and probability distance (Trope & Liberman, 2010). Temporal distance measures the time interval between the event and the individual, and Probability distance measures the probability that the event meets the individual (Chen & He, 2014). The probabilistic distance for the case where the suicide has already occurred, the P=1. Its temporal distance is equal for all individuals in the organization. Then the impact of the suicide event on the individual is only regulated by the two dimensions of spatial distance (distance from the suicide site) and social distance (social relationship with the deceased), and the farther the spatial distance and social distance are the less impacted. For a more intuitive and concise representation, let the impact of suicide be Φ, then:

$$\Phi \propto \frac{1}{Sp * So} \qquad (1)$$

Due to individual difference (Individual difference, Id) in cognitive judgment, personality traits, suicide susceptibility, psychiatric history, etc., even with the same spatial and social distance, individuals are not affected in the same way. For example, in the case of a college freshman girl who committed suicide by jumping off a building and taking poison, there were two students from the same dormitory building who did not know the deceased, and there was a certain distance from the scene of the crime, but due to the traumatic experience they had had, this suicide event also triggered their stress reaction.

Introducing individual differences as correction constants in Eq. (1) is:

$$\Phi \propto \frac{Id}{Sp * So} \qquad (2)$$

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

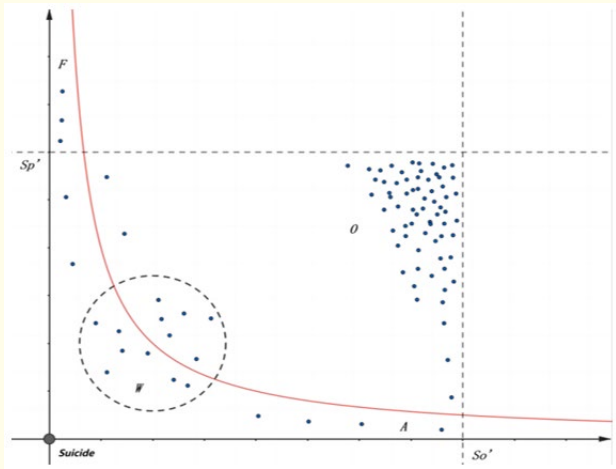

Figure 1: Distribution of organization members affected by suicide.

Explanation and Usage

The horizontal axis represents social distance, the vertical axis represents spatial distance, and the red line indicates that the physical-psychological stress caused by the effects of suicide has reached a level $\boldsymbol{\Phi_0}$ that requires rapid intervention, and the individuals under the red line are those who require urgent intervention. Area ***A*** near the horizontal axis indicates Audience, with large social distance and small spatial distance; Area ***F*** near the vertical axis indicates Family members and Friends , with large spatial distance and small social distance ('outside the dots indicate family members and friends who are not in the organization); Area ***W*** inside the circle indicates the people in the organization who are acquainted with the suicidal person, mostly the other Worker of the same team, the social distance and spatial distance are closer than others; ***O*** area indicates Other members of the organization who do not know the suicide victim , the social distance is far and the spatial distance is scattered.

Below red line Φ_0 that, zones F, A and part of W are the main influence zones of physical and psychological stress reactions, while zone W indicates the main range of social influences, and the risk of suicide contagion is more insidious and has a wider distribution, and all four zones of AFWO need to be included in it.

Result- Emergency program

The Emergency Response Law of the People's Republic of China divides emergency management into four phases: prevention and preparedness, monitoring and early warning, emergency response and rescue, and post-event recovery and reconstruction. Chen (2022) argues that as China's emergency management system enters the fourth generation, emergency psychological services should also build a corresponding whole-process management system. The psychological emergency management of groups affected by suicide is carried out under this system.

Phase 1- Prevention

Building psychological expectations

An anonymous survey involving 1120 people in India (Agarwal et al., 2020) showed that people who had more awareness of the symptoms of COVID-19, were aware of nearby hospitals with emergency phone numbers, and paid regular attention to reports of COVID-19 had higher levels of mental health. This reflects that mental preparation for possible emergencies is effective and necessary. Suicide prevention campaigns can be conducted within the organization to raise awareness of suicide among its members, equip them with certain methods of emotional processing and stress coping, and build up psychological expectations in advance.

Non-punitive organizational culture

The culture of "accountability" in an organization after a suicide will undoubtedly increase the psychological burden of the responsible individuals, and the resulting blame-shifting and avoidance will lead to a breakdown in organizational trust. A survey of 731 nurses who experienced patient suicide in eight hospitals in Hubei Province (Tan et al., 2020) found that the highest scores on support needs came not from family and friends, but from leaders, and were consistent both at home and abroad (Wang et al., 2022). This shows that the establishment of a non-punitive organizational culture is then important, and may even to a certain extent may play a role in suicide prevention (Quillivan et al., 2016).

Building socially supportive organizations

Social support is a protective factor for group mental health (Ortiz-Calvo et al., 2022). Interview surveys from the UK (Pitman, De Souza, et al., 2018; Wainwright et al., 2020) and Australia (Ross et al., 2021) have demonstrated that social support has an important role to play in the recovery of the mental health of secondary victims of suicide, but due to feelings of guilt, self-blame, and the stigmatization of suicide, these individuals are path to seeking social support is fraught with obstacles. Employers show less sympathy when it comes to suicide than other difficulties (Pitman, Khrisna Putri, et al., 2018),and most people also choose to avoid the topic in all types of work and social situations, resulting in more mistrust, social isolation, and withdrawal. In order to cope with this situation, an open and inclusive organizational culture, a cordial and honest communication environment, an internal atmosphere of solidarity and mutual support should be constructed to promote a common organizational social identity, which in turn leads to the formation of social group psychological resilience in all kinds of emergencies (Drury et al., 2019).

Phase 2 - Response

Emergency psychological response following a suicide of an organization member involves at least two tasks - first, quickly identifying those affected by the suicide, i.e., AFWO district personnel, to prepare for the next step in the intervention; and second, controlling public opinion, preventing the impact from spreading further, and blocking the risk of contagion of the suicide.

Determining the distribution of people affected by suicide

The first step in zoning the population affected by suicide within an organization is to delimit Φ_0, for which it is necessary to carry out a comprehensive psychological screening within the organization, looking for individuals who have already experienced intense physical and psychological stress and others who are at risk of suicide. On this basis, zones F and A are identified on the basis of the dimensions of social and spatial distance, zone W is identified in relation to the deceased's work and social network within the organization, and zone O is identified for the rest of the population. Three screening tools are recommended here

1. The Patient Health Questionnaire Item (PHQ-9) adapted by Spitzer (1999). This scale is commonly used for the identification of suicidal ideation in patients in medical settings, with a sensitivity of 87.6% and specificity of 66.1% (Na et al., 2018), and has been used for many years, with the advantage of simplicity and ease of administration, and avoiding sensitive words such as suicide, which has the dual roles of both psychological status census and screening for suicidal ideation.
2. The Columbia Suicide Severity Rating Scale (C-SSRS) developed by Columbia University in the United States is mostly used as a professional suicide screening tool, with the advantage of good reliability and validity, high specificity (95%) and sensitivity (95%) (Viguera et al., 2015). However, the entries are compiled in blunt and straightforward language and need to be used with caution.
3. The suicidal behavior screening questionnaire developed by Tianjin University (Yang et al., 2021), with a specificity of 73.77% and a sensitivity of 73.68%, has the advantage of being localized and avoiding sensitive words, so it can be used with caution.

Blocking the media from spreading the effects of suicide

He and Qin(2022) examined 9,922 suicide reports on Weibo and found that these reports violated 9 of the 12 principles in the World Health Organization's Responsible Reporting of Suicide: A Quick Reference Guide (see Tab.1). As the main body of emergency management, the organization of the suicidal person has the most truthful and accurate information, and has the authority of the "official media" in suicide reporting. Concealment and shirking of responsibility is a breeding ground for rumors, and the best way to stop the fermentation of public opinion is for organizations to take the initiative to report suicide incidents in a truthful and responsible manner.

Phase 3 - Disposition

Psychological first aid with individual counseling

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

1. Post-disaster psychological first aid. Derived from the U.S. "Psychological First Aid Field Operation Guide", including contact and input, safety and comfort, stabilization of emotions, provision of relevant information, provision of practical help, contact social support, provision of coping information, and contacting assistive service agencies for eight action links. The content is comprehensive and systematic, highly structured, and has been used in emergencies such as the 9.11 incident in the United States as well as many terrorist attacks, hurricane disasters, and the Wenchuan earthquake in China, with remarkable results (Luo & Guo , 2015).
2. Eye movement desensitization reprocessing. Containing the stages of examining history, preparation, assessment, sensitization decrement, implantation, viewing, conclusion, and evaluation, it can effectively alleviate the effects of traumatic memories in a short period of time without the aid of medication (Qian, 2009), and also has good efficacy in bereavement PTSD (Chen et al., 2015).
3. Cognitive behavioral therapy. Cognitive-behavioral therapy and eye movement desensitization and reprocessing are the same preferred therapies for coping with PTSD, with similar efficacy and respective advantages. Compared to eye-movement desensitization reprocessing, cognitive behavioral therapy has a lower rate of exposure to traumatic memories and a lower rate of shedding in interviewees (Wang Xinyan et al., 2017).

The "Six Keys" principle	*The "Six Don'ts" principle*
(1) To provide accurate information about seeking help;	(1) Do not prominently feature stories about suicide or overly repeat such stories;
(2) To teach the public about suicide and suicide prevention without spreading suicide-related rumors;	(2) Do not use language that sensationalizes or normalizes suicide or describes suicide as a constructive solution for individuals facing problems;
(3) To report on how to cope with life stress or suicidal thoughts and how to get help;	(3) Do not describe in detail the methods used in suicide;
(4) To report on celebrity suicides with particular caution and care;	(4) Do not provide detailed information about the place/location of the suicide;
(5) To be careful about interviewing family members or friends of suicides;	(5) Do not use sensationalized news headlines;
(6) To realize that media workers themselves may be affected by the suicides they report.	(6) Do not use photos, live footage or social media links.

Table 1: Responsible Reporting of Suicide: A Quick Reference Guide.

Mitigating Social influence with the Balint group

In order to reduce the impact of the suicide on the group (W-zone) in which the suicide is committed and to resume normal organizational activities as soon as possible, group psychological interventions are also needed after dealing with the physical and psychological stress of the second victim of suicide. The social effects of suicide are commonly manifested in the form of avoidance, stigmatization, impaired interpersonal communication and trust, and low team morale, which can be addressed by Balint groups.

Founded in the 1950s by Hungarian psychiatrist Michael Balint, Balint's group was originally designed to train physicians to deal with the doctor-patient relationship, and has been generalized to various group domains because of its clear steps and effectiveness. Balint groups usually consist of 8 to 12 people and unfold in a safe and private environment, with the following basic steps (Ling et al., 2020):

1. Form a circle and group members enter the circle to give a narrative;
2. Other group members ask relevant questions;
3. The reporter exits the circle and other group members discuss;
4. The reporter returns to the circle to discuss and summarize;
5. The reporter is thanked for her presentation, which Closing the discussion.

In alleviating the depression and anxiety problems of nurses experiencing patient suicide, the effectiveness of Balint groups was significantly better than that of conventional intervention methods (Cheng et al., 2020). Not only that, their burnout was alleviated, and their interpersonal communication and empathy skills were enhanced (Chai, et al., 2014; Ren, & Pang, 2018).

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

Enhancing Group Mental Toughness with the Satir Model

The negative impact of employee suicide on a large organization is huge, not only does it destroy the working atmosphere and performance of the deceased's team, but it is also a big blow to organizational morale. On the other hand, focusing only on localized areas (A, F, and W) does not eliminate the risk of suicide contagion. For example, in the Foxconn serial jumping incident, the suicides were

relatively far from each other in terms of spatial and social distances, but the serial suicides still occurred. Therefore, attention should also be exerted on all team members including Zone O. The Satir model of group counseling can provide a solution.

The Satir Model of Therapy is a humanistic approach to family therapy founded by American psychotherapist Virginia Satir. This model starts from the system of the individual, family, and society, and deals with psychological problems through techniques such as iceberg theory, sculpture, family remodeling, weather reporting, and breathing therapy, etc. Its most important feature is that it focuses on improving the individual's self-esteem and communication rather than just eliminating the symptoms, and the ultimate goal of the treatment is for the individual to achieve "integration of mind and body, internal and external congruence" (Virginia, 2007). Compared to the Balint group, the Satir model of group psychological intervention is more lenient in terms of the number of participants, with 40 (Chen et al., 2022) and 60 (Dai et al., 2021), and has already been applied to enhance the sense of meaning in the lives of college students (Chen et al., 2022) and to improve coping styles (Hu et al., 2022), and has been used in the improvement of negative mood (Bao et al., 2022). In addition, efficacy has been found in improving negative emotions in adolescents with depressive disorders (Bao et al., 2022) as well as reducing loneliness in older adults (Ye et al., 2019), and both were accompanied by increased levels of self-esteem. Not only that, the Satir model is also helpful in enhancing the sense of occupational benefit (Dai et al., 2021) and interpersonal relationships (Li, 2020).

The Satir model can enhance members' sense of self-worth and self-esteem, which can not only reduce the impact of suicide among members of the organization, but also improve the psychological resilience of the group, playing the role of both symptoms and root causes, and can be used in group psychological emergency management to further reduce the risk of suicide contagion, or even play a role in preventing suicide.

Phase 4 - Assessment

Tracking and evaluation of the effectiveness of Disposition

Individual counseling and group interventions have a certain period of time, and a period of follow-up assessment is needed after the end of emergency psychological treatment. Cheng(2020) surveyed nurses who experienced a patient's suicide 1 month and 3 months after the end of a group intervention using Balint; Dai (2020) also re-tested the sense of occupational benefit of nurses who participated in Satir training 6 months later. After emergency psychological treatment, there is no guarantee that the effects of suicide can be completely eliminated, and regular follow-up is needed in at least three other areas:First, regular visits to those who are more seriously affected by suicide to observe whether their physical and psychological stress reactions have been eliminated and whether their social functioning has recovered; Second, to observe and determine whether the mental health and work performance of the suicide victim's team have been restored; and third, to follow up to determine whether the overall morale of the organization is no lower than before the suicide incident.

Summarize the psychological emergency management process

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

Discussion

Intervention with families of suicide victims

Does group psychosocial emergency management for suicides of members of an organization need to include the families of the deceased? It is recommended that families should be included. There are two reasons for this: first, when it comes to the suicide of the deceased, the organization needs to deal with many aftermath issues with the family, which may have secondary effects if disputes arise. For example, after the death of a freshman female student in a university who committed suicide by taking poisons and jumping

off a building (Qin et al., 2016), the family members pulled banners and burned paper money in front of the school, which aggravated and expanded the impact of the suicide, and then there were students in the same dormitory building waking up, losing sleep, and shouting due to fear that same night. After intervening in the family's stress reaction, maintaining a state of calm and understanding is more conducive to communication between the two parties. Secondly, family members, as the group of people who are socially closest to the deceased, are the most deeply affected and have the strongest need for intervention. Ou(2008) and others, in investigating suicidal ideation among college students at a medical university in Fujian, found that the risk of suicidal ideation among family members and friends who had a history of suicide was twice as high as that of the general population, and Cero and Witte (2020), who examined 64 million tweets from Twitter's 17 million users, found that if a user posted suicide-related words, their friends and family and the friends of friends were more likely to post words with similar content, even if some had never met in person. If a suicide contagion event occurs in a family member of a deceased person, it is also a secondary harm to the organization.

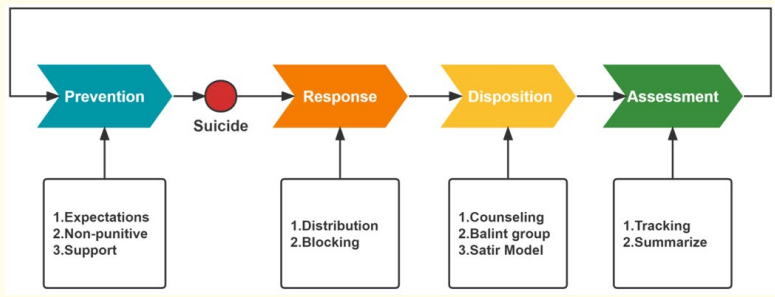

Figure 2: Flowchart for psychosocial emergency management of groups affected by suicide.

Relationship between emergency management and the principles of psychological intervention

How to deal with the relationship between emergency management and the principles of psychological intervention? While the targets of emergency management can basically be identified through psychological screening and AFWO zoning, the method used for psychological emergency management is psychological intervention or group counseling, which requires adherence to basic psychological counseling and treatment principles, such as voluntariness, confidentiality, and informed consent. On the other hand, the three types of effects of suicide may be overlapping in different populations, and some members of Zones A, F, and W may need to receive more than one type of intervention, while many members of Zone O may not need intervention. In light of this, it is recommended that individual psychotherapy be delivered in an unsolicited manner, Balint groups be established by issuing invitations, and Satir group psychosocial interventions be conducted by open recruitment. Members of the organization affected by suicide can choose to accept or decline participation in one or more activities, and can be informed about the process and content of the intervention and other members of the group intervention.

Who's going to enforce it?

The main body of the group psychological emergency management of the suicide of the organization's members is the decision-making management of the organization, but the main body does not have the qualification and conditions for the implementation of emergency psychological treatment. Then, in the whole psychological emergency management process, there is a need for an executive body with the qualification of psychological intervention, and the executive body will carry out various activities. For large organizations, they should set up institutions or departments similar to psychological counseling centers to establish the main body of the organization's implementation. For general organizations, they can set up psychological work teams or positions that are adapted to the size of the organization, and establish channels of contact and cooperation with qualified psychological intervention agencies in

the market, so as to ensure a rapid response to suicides.

Conclusion

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

Funding information

National Social Science Foundation of China under the General Program of "Research on Psychosocial Emergency Management Strategies and Plans for Major Epidemics" (No. 20BGL262).

Accessible Summary

What is Known on the Subject?

- Globally, approximately 700,000 people die by suicide each year, and these people work and live in a wide range of social organizations, whose members' suicides can have an impact on family, friends, witnesses, other susceptible people and the organizations themselves.
- These effects include physical-psychological stress reactions, social influences and suicide contagion.

What the Paper Adds to Existing Knowledge?

- Focus suicide interventions on those affected by suicidal events within the organization.
- Distinguish the distribution of people affected by suicide using the dimensions of spatial and social distance.
- Emergency psychological services within the framework of emergency management theory.

What is the Implication for Practice?

- Through the four phases of emergency management, namely, psychological prevention and preparation, emergency psychological response, emergency psychological treatment, and psychological tracking and assessment and summarization and improvement, we can achieve the effect of curbing suicide contagion, restoring the level of mental health of the group, and reducing the negative impact.

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