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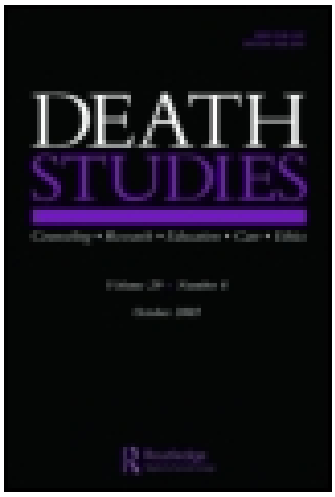

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Personal stigma in suicide attempters

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Abstract

The aim of this study was to explore suicide attempters' experiences of personal stigma. This qualitative study included a focus group of 7 experienced clinicians and semi-structured interviews with 8 suicide attempters. Thematic analysis of the data yielded four main themes: seriousness, care, "badness," and avoidance. Experiences of stigma pervaded all contexts, but were most emotionally upsetting to the participants in interpersonal relationships. The findings show the importance of evaluating stigma for suicide attempters during suicide risk assessment and the need for specifically tailored interventions to combat suicide stigma at the individual level.

KEYWORDS: suicide, stigmatisation, suicide prevention

Stigma has pervasive negative effects on those stigmatised (Major & O'Brien, 2005). However, there is lack of agreement on the precise definition of stigma, partly, as Link and Phelan (2001) observed, because stigma comprises a number of elements and only one or two of these are the focus of any particular project. They proposed an encompassing definition, which is adopted here, viz. '… stigma exists when elements of

labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them' (p. 377).

Mental illness stigma has attracted a good deal of research showing that it impacts the person's well-being, life opportunities and sense of self, and thus can hamper intervention and treatment (Brohan, Slade, Clement, & Thornicroft, 2010; Corrigan, Kerr, & Knudsen, 2005; Livingston & Boyd, 2010). Far less attention has been directed to the stigma of suicide and suicide attempts. Although the literature on mental illness stigma can be instructive when considering suicide stigma, there are reasons to examine the two types of stigma separately. First, suicide, although associated with mental illness, is not itself a mental illness but a behavioural act (De Leo, 2011), and the dynamics of the two are not necessarily the same. Second, efforts to de-stigmatise suicidal behaviour must be careful not to normalise (or even glorify) it, because doing so could lead to an increase rather than a decrease in the frequency of such behaviour (Joiner, 2011). Although social acceptance of mental health problems and more positive attitudes towards help seeking for mental illness are associated with lower rates of suicide (Reynders, Kerkhof, Molenberghs, & Audenhove, 2014), social acceptability of suicide is positively related to suicidality both at the individual level (Arnautovska & Grad, 2010; Chu, Goldblum, Floyd, & Bongar, 2010), and at the group level (Stack & Kposowa, 2008). Even though cause-and-effect have yet to be established in this relationship, careless attempts at reducing suicide stigma may have the effect of increasing social acceptability and with it the suicide rate, as it becomes a more acceptable option. Such associations between acceptability and rates have not been documented for mental illness and are an unlikely

concern in interventions combating the stigma of mental illness. These differences indicate the need for research specifically focusing on suicide stigma.

The existing literature on suicide stigma shows that negative attitudes towards those who attempt suicide are still pervasive (Lester & Walker, 2006). Stigma towards suicide and suicide attempts is present even in clinical settings, such as emergency departments (Pompili, Girardi, Ruberto, Kotzalidis, & Tatarelli, 2005), and can negatively impact the quality of medical care received (Zargoushi, Asghari, Zeraati, & Fotouhi, 2011). However, in addition to being limited in volume, current research and scales assessing suicide stigma have focused only on the public stigma (Batterham, Calear, & Christensen, 2013a; Scocco, Castriotta, Toffol, & Preti, 2012), the attitudes and actions directed by social groups towards individuals who are stigmatized (Corrigan et al., 2005). Researchers in mental illness stigma (e.g., Livingston & Boyd, 2010) have recognised the need to explore the individual level of stigma, which focuses on the experiences of the stigmatised person. Apart from references to stories of people who attempt suicide (e.g., Wiklander, Samuelsson, & Åsberg, 2003), the individual level of stigma in attempted suicide has not been systematically examined.

The choice of terms and the precise definition of stigma at the level of the individual have been a source of debate (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). In the present study, following Brohan et al. (2010), we use the term personal stigma to refer to (a) perceived stigma, the individual's beliefs about public attitudes to suicidal behaviour, (b) experienced stigma, the individual's experiences of actual discrimination and

prejudice, and (c) self-stigma, which is the person's own internalisation of public stigma, the process of accepting and applying the negative evaluations to oneself, leading to self-discrimination. Personal stigma thus consists of the elements identified by Link and Phelan (2001) as seen from the vantage point of the individual stigmatised. There have been other uses of the term personal stigma, for example, Griffiths and her collaborators (2008) have used the term personal stigma for what Corrigan et al. (2005) term public stigma. In addition, some authors (e.g., Corrigan et al., 2005) argue that only self-stigma should be included in discussion of stigma at the individual level. However, they acknowledge that self-stigma is influenced and closely related to the perceptions and experiences of public stigma (Corrigan & Watson, 2002), which are the other two components of the Brohan et al (2010) definition of personal stigma. Given that stigma in suicide attempters has been investigated only in terms of prevailing public attitudes (e.g., Batterham, Calear, & Christensen, 2013b), it is both necessary and appropriate to investigate all three domains, perceived, experienced, and self-stigma, which constitute personal stigma.

In the absence of knowledge on the individual level of suicide stigma, the present study was exploratory in nature and aimed to describe in-depth the experiences of personal stigma that suicide attempters face in their everyday lives across different contexts. The study examined experiences and perceptions of labelling, stereotyping and discrimination in interpersonal relationships, health care settings, at work, and in the community, and the negative attitudes suicide attempters had about themselves.

METHOD

Participants And Settings

We conducted the study at an outpatient clinic, which specialises in treatment of suicidal individuals and every week sees approximately 60 patients with varying levels of suicidality. The first stage involved a focus group with experienced clinicians about their perceptions of where and how patients face stigma in their everyday lives. We used these data to inform the areas to be examined in interviews with suicide attempters, conducted in the second stage of the study. Themes from the focus group were used in the final analysis only if they were confirmed by the patients in the interviews.

Clinicians. Seven members of the treatment team participated in the focus group on experiences of stigma reported by their clients. The clinic team includes 10 clinicians with various backgrounds (psychiatry, mental health nursing, psychology), but three clinicians (psychiatrists), holding part-time appointments, were not included in the study due to their limited availability. The seven participating clinicians had from 2 to 12 years' experience in treating suicidal behaviours.

Suicide attempters (patients). Eight adults (6 women, 2 men; aged 27-55 years, *M* = 46.88 years) who were being treated in the clinic for suicidality and had made at least one suicide attempt (number of lifetime attempts varied from 1 to more than 10) were interviewed. To capture a wide range of experiences and ensure maximum variation in the sample (Liamputtong & Ezzy, 2005), we asked the clinicians to identify current patients from all age groups who had a history of at least one suicide attempt but were not

acutely suicidal. Altogether, 21 patients were identified as suitable for the study. Of these, 6 refused to participate in the interviews, 5 were not contactable, and 2 who had agreed to participant did not present for interview.

Procedure

All interviews and the focus group were conducted in a semi-structured way by one of the authors (J.R.), who has a Master's degree in clinical psychology and experience in qualitative interviewing. Clinical supervision of the interviews was provided by another author (J.H.), who is a registered clinical supervisor and has extensive background in working with suicidal persons. Informed consent was obtained from all participants and no monetary incentive was offered for participation. The study received ethical clearance from Griffith University Ethics Committee.

Focus group. We asked the clinicians to recall specific examples from different contexts where their patients' encountered stigma and discussion was facilitated about the differences in the patients' experiences. Patient anonymity was preserved by asking clinicians not to provide details that could identify the person in any way. We used the information from the focus group to build the framework for interviews with patients.

Individual interviews. We used semi-structured interviews to collect data from patients. The interviewer began by explaining that the purpose of the study was to examine the impact previous suicide attempts had on their life. The initial questions focused on experiences related to participants' suicide attempts across different contexts: healthcare

and work settings, relationships with friends and family, or legal problems experienced. The interviewer asked how the participant perceived the attitudes of others towards those who attempt suicide in these different contexts, and whether the participants hide their suicide attempt history from anyone and why. In addition, participants were asked how they viewed other suicide attempters and how their view of themselves changed after the suicide attempt. We selected these interview topics based on studies of mental health stigma (Dinos, Stevens, Serfaty, Weich, & King, 2004) and the focus group with the clinicians. Consistent with the approach of Dinos et al. (2004), we specifically avoided using the word "stigma" so as not to lead the participant. The interviews were scheduled in such a way that participants had clinical appointments on the same or the following day with their treating clinician to ensure timely follow-up of any negative experiences or increase of suicide risk arising from participation in the study.

Analysis

All interviews and the focus group discussion were audio-recorded and transcribed verbatim. The text was analysed line by line using thematic analysis, as described by Braun and Clarke (2006). An inductive approach was used in selecting the themes and the themes were allowed to emerge from the data as opposed to using previously existing knowledge to create a set of themes (Braun & Clarke, 2006). The NVivo 10 software package was used to manage the analysis. Initial coding was undertaken by one researcher (J.R.) and then reviewed by the second (J.H.). These initial codes, which closely reflected each data segment coded, were separately grouped by two researchers (J.R. & J.H.) into themes. Then all disparities in the coding structure were discussed by

the two researchers and a collaborative approach (Krefting, 1991) was used to arrive at the final theme structure.

RESULTS

Four broad themes emerged from data analysis: seriousness, care, "badness" and avoidance. Quotes in the text are presented verbatim and <…> represents omissions from the original transcripts. Quotes are marked cl. if they represent quotes from clinicians' transcripts and p if the quotes are from patients' transcripts. List of themes, subthemes and examples for each of them are available upon request from the first author.

Seriousness

The seriousness theme included overgeneralised ideas about the severity of "illness" the attempt represented. On the one hand, the person may be perceived as chronically compromised by the suicide attempt, as *"once suicidal, always suicidal"*. There is a hopelessness about the possibility of functioning at the same level as others and was most frequent in self-stigma: *"I can see the recovery that I've made but am I ever going to be normal again?"* Such perceptions that those who attempt suicide would not recover from suicidality can also be present in health care professionals:

> *They may be unwell only temporarily, but the decisions become "forever" for fear it may happen again. (cl)*

On the other hand, there is the attitude that *"suicide attempts are not serious"*. In the community, treatment settings, and interpersonal relationships participants described hearing that suicide attempts were a form of manipulation "*to get attention"*; that they

were *"not seriously wanting to die".* Importantly, beliefs that suicide attempts were just *"attention seeking"* were stated as one of the reasons to deny mental health treatment.

> *I got hold of my medical records and in there was my husband saying: "She just does this for attention seeking and the best thing to do is to not give her any attention at all." (p)*

Care

Descriptions of care experiences that felt discriminating were either related to care that was perceived as inadequate (too limited) or as disempowering (too intrusive). Lack of care was most frequently related to treatment settings, when the participants perceived the doctors were *"not interested*" in suicide attempters, only interested in *"serious patients"*, that is, patients with medical complaints. Some patients saw clinicians as having a *"do not care attitude*" and described receiving insufficient help after their suicide attempt. These participants were visibly upset and angry when talking about the situations where the care felt inadequate. However, some patients described receiving insufficient care in a less emotional way and did not experience it as discrimination. These participants related limited care to lack of resources, or they recognised they came to hospital in a vulnerable state when *"5 min sounds like an hour"*. These patients mentioned getting upset about the level of care, but were more forgiving to those providing it.

Lack of care was also experienced from family members and friends in the form of comments of the sort "*you don't need treatment".* In some cases, this was expressed as

pressure to stop treatment, not to take medication or advice, or not to seek additional help, because family members did not perceive suicide attempts as a real issue. One person described needing to make a difficult choice between adhering to treatment and seeing her grandchildren because of the pressure from the family:

> *He's always telling me get off that shit, excuse the language. The medication, get off the medication he said you're like a zombie. He said you should be able to deal with it without medication. <…> they want me to look after the kids but they want me off my medication before they do it. (p)*

Disempowering care involved patients feeling their basic rights to freedom were being threatened because the care was far more intrusive and controlling than the situation warranted. Such disempowering care occurred in treatment settings, through actual behaviours of staff, such as putting the person in physical restraints.

> *I was put in restraints in Hong Kong. You are not allowed to do that here. It's very upsetting. They just tie your arms and your legs so you couldn't move. (p)*

In some cases the care lacked sensitivity and was perceived as unhelpful, disappointing or even humiliating.

> *I was locked in this room like you know with a little door that people were poking and looking in to see if I was alright and stuff. And umm yeah I suppose I just felt like I was embarrassed. (p)*

However, in most cases the person did not directly experience such discrimination, but was afraid of it, if he or she were to disclose suicidality. These participants talked about the fear of being put into hospital against their will, being *"locked-up"*. Patients

mentioned that such fears influenced how much they were willing to share with the clinicians.

I lied the whole time I was in that room just so that I could get out of the hospital. (p)

In interpersonal relationships, the participants described disempowering care as rigid control, for example, monitoring even minor expenditures or requiring that the person account for their whereabouts every hour of the day; or as excessive caution, as one patient put it "*they are afraid of doing or saying something in the family to set me off"*. Such disempowering care was seen as related to the attitudes of the significant other, who saw the suicide attempter as unable to care for themselves or extremely fragile and was described with sadness, anger, and some level of hopelessness.

"Badness"

Participants described themes relating to characteristics of "badness" attributed to the person who attempted suicide (potential threat to others, unreliable, a less admirable person, a burden) or to stigmatising behaviours, such as blaming and direct violence, as if the person was "bad" for attempting suicide. Some of the patients reported being perceived as potentially harming others. These attitudes arose when a suicide attempt was seen as direct *"emotional abuse"* of another person. The act was taken *"personally",* as if the suicide attempter was directly damaging another person:

The immediate reaction is: "How dare you do something to me when we are trying so hard to help you?" (p)

The most severe form of such stigma was experienced by one of the patients, who mentioned that it was possible for her partner to obtain a domestic violence order against her because she attempted suicide. In court the patient received the following explanation: "*cutting myself in self-harm was an act of violence that I've created against him."* Alternatively, some patients mentioned that others perceived them as capable of physical violence towards others, because they can harm themselves. One of the participants reported that he was not able to visit his niece, because after the suicide attempt her mother was afraid he could hurt the girl.

In areas of child care and work, patients described being perceived as unreliable. This belief was related to the theme "once suicidal, always suicidal", because their unreliability was perceived as permanent and not as a temporary feature.

> *Every presentation will limit the person's ability to care. They may be unwell only temporarily, but the decisions become "forever" for fear it may happen again. (cl)*

Burdensomeness, a subtheme of "badness", was prominent across all contexts; however it was mostly mentioned in close interpersonal relationships and in relation to self-stigma. Suicide attempters reported that they are seen as abusers of time and resources, *"demanding too much", "just causing trouble"*. Feeling like a burden was very painful to the participants: *"I just feel like nobody wants me, my own mother doesn't want me."* Participants mentioned they sensed that having made a suicide attempt made them a less admirable person in the eyes of others. They saw the suicide attempt as something that signifies "*selfish", "crazy", "silly", "weak",* or *"soft in the head"*. Comments

representing this theme were also present in relation to self-stigma*: "that's where I feel I belong, in the toilet."* Such negative comments related to self-stigma were only present when patients talked about specific contexts – treatment settings, family, friends, work, but not when they were directly asked about their attitudes towards themselves or people who attempted suicide in general.

Two types of discriminative behaviour emerged in relation to negative attitudes under the "badness" theme. The first was blaming, when others or the participants considered themselves guilty for the suicide attempt *("I felt that I was going to get into trouble. For umm…. you know, putting everyone through the stress").* In such cases the person could become a scapegoat for everything that happens in the family.

> *She [mother] blamed my marriage failure on my suicide attempt. You know she said what do you expect? Meaning you know my husband has left me because I tried to suicide and I should have expected that response. (p)*

Second, some participants experienced direct violence, which was verbal or even physical. It was not a frequent occurrence, but was present when difficulties existed in the relationship before the suicide attempt.

> *After the suicide attempt he actually treated me really badly. I was in a domestic violence situation and so that escalated to be… he was nastier than ever to me. (p)*

voidance

Avoidance was the most frequently reported discriminatory behaviour that varied in severity from minimizing the experiences related to suicide to complete distancing from

the person. Minimizing occurred in treatment settings as well as interpersonal relationships.

> *There is also: "but you have a wonderful family. Good job, boyfriend". At times people will be: "but what are you doing? I have more problems than you." (cl)*

In the stronger form of avoidance, distancing from the person occurred. The patients perceived that because of their suicide attempt history some people were trying to limit or cut off contact with them. Distancing was extremely painful in close interpersonal relationships. For example, one of the participants became overwhelmed with emotions and could not stop crying when recalling how the partner did not allow the children to visit after the suicide attempt. In other cases the patients felt their relationship with their partner broke down specifically because of the suicide attempt.

> *They did not want me in the family. And they did not want me to do anything with her. They told her that I was crazy. And that I've been in hospital. Anyway, that was the end of it. That was the end. She told me to go and not come back. And I did not understand why it changed all of the sudden. It was ages before I worked it out. (p)*

In some cases patients hid their experiences of suicidality for fear of stigma. This was most prominent in workplace settings, but was present in close relationships as well.

> *It's burning and hurting inside but I don't want to let that out because I think that it will just make the situation worse. Other people will withdraw from me. If I stay with a happier face or a mask, that's what I normally call them, masks, then I will have a better interaction with them. (p)*

Patients and clinicians commented that minimising, ignoring or distancing can occur in families because the suicide topic seemed too confronting for the family members and this created attitudes that suicide is a taboo topic. The relatives were not sure how to talk about suicidality and ignoring the topic seemed for them the easier solution.

If we don't talk about it well it's not an issue. If we talk about it well then it is an issue and we'll have to deal with it. (p)

However, in such cases the person still feels stigmatised, as if they are *"not being heard".* Also, there are fewer opportunities to prevent future suicide attempts, as the person cannot ask for help.

> *Where I've had two uncles an aunty and a cousin that have committed suicide and on one side of the family and they don't want to talk about that either. And I say, well, you know, I think you need to talk about it to understand where certain people are coming from to commit suicide. It gets so bad that they take their own lives and just to brush it under the carpet and not want to talk about it, as far as I'm concerned, it's not addressing the situation and the respect that talking about it may stop another one from doing it. (p)*

DISCUSSION

We found that the personal stigma of suicide attempts can be described in four broad themes: "badness", avoidance, care, and seriousness, which were recognisable in all contexts, but which were especially painful in interpersonal relationships. The theme "badness" represented attitudes that suicide attempters are a threat to others, unreliable, a

burden and a less admirable person because of the suicide attempt, together with blaming and violent behaviour towards them. Avoidance indicated discriminatory behaviours related to distancing, secrecy, ignoring, and the minimising of experiences. Care and seriousness contained opposing subthemes. Both lack of care and too rigid care were considered to be stigmatizing. In the same way suicide attempters were described as "not really sick" and "sick for life", with both views being experienced as damaging. The themes showed a close relationship between perceived stigma (perceived attitudes of others) and experienced stigma (encounters with discriminatory behaviour), which implies that assessment of one of these dimensions is difficult to separate from the other.

The study indicated specific aspects of personal stigma in suicide attempters that have not been described in mental illness stigma or at the public level of suicide stigma. Polarity of stigmatising themes found in attitudes about the seriousness of the suicide attempter's condition and the discriminatory behaviour related to care has not been delineated in stigma of mental illness (Brohan et al., 2010; King et al., 2007). In addition, scales assessing suicide stigma at the public level omit the care theme (Batterham et al., 2013a; Scocco et al., 2012) and only minimally reflect the seriousness theme by including only the "attention seeking" subtheme (Batterham et al., 2013a), but not the "once suicidal, always suicidal" subtheme. This indicates that the scales capturing the public level of suicide stigma or mental illness stigma do not reflect the full spectrum of personal suicide stigma experiences and specific tools are necessary to assess it. Further research is needed to explore whether the polarity of stigmatising attitudes is present only in personal stigma or is part of public stigma as well. Nevertheless, caution may be needed

when using educational strategies found to be effective in combating mental illness stigma (e.g., Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Corrigan & Penn, 1999) to inform suicide stigma prevention campaigns. Specifically in the suicide stigma area the anti-stigma messages and actions need to be balanced in terms of the opposing views about seriousness and care.

The results also illustrate the need to assess stigma in suicide attempters because of its potential impact on suicide risk. The participants voiced feelings of burdensomeness as part of stigma as well as discriminatory behaviours where others distance and ignore the person, which leads to ruptures in social ties with others. According to Interpersonal-Psychological Theory of Suicide (Van Orden et al., 2010), perceived burdensomeness and thwarted belongingness are two main states that lead to suicidal ideation. Stigmatising attitudes that portray the suicide attempter as a burden or discriminate against them through avoidance may further perpetuate suicidal thoughts in individuals who, because of their previous suicidal behaviour, are already at a higher risk of suicide (e.g., Brown, Beck, Steer, & Grisham, 2000). Some of the participants also directly noted that they felt stigma in the form of others avoiding the suicide topic increased their suicide risk, because it made them less likely to seek help and openly address problems in the family that contribute to their suicidality. The present findings imply that burdensomeness and avoidance domains of stigma may be especially important in assessing suicide risk in suicide attempters.

Self-stigma was most difficult to capture in this study. When asked directly, participants tended to make positive or neutral comments about their perceptions of themselves or

suicide attempters in general. However, clear indications of self-stigma were present when the participants talked about the different contexts in which they experienced stigma and here they referred to themselves negatively. Lack of direct reporting of self-stigma is not surprising, because self-stigma is proposed to arise from internalized beliefs of others that the person endorses (Corrigan & Watson, 2002), some of which can be outside conscious awareness (Rüsch, Corrigan, Todd, & Bodenhausen, 2010). It indicates, however, that self-stigma effects should not be overlooked, even when the person is not expressing them when directly asked. Further, lack of direct reporting indicates that assessment of self-stigma in suicide attempters is best done in the context of the overall assessment of personal stigma, the approach taken in assessing mental illness stigma (Brohan et al., 2010). Interventions that first teach the person to be more aware and mindful of their negative beliefs and self-stigmatising behaviour were found to be effective to combat stigma in mental illness (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012) and may be of value for suicide attempters as well.

The study found that suicide stigma in interpersonal relationships can have intense emotional impact and may have potential detrimental effects on treatment adherence. The stigmatising attitudes of family members may discourage the person from seeking or continuing to receive help. Although some research on suicide stigma in health care professionals and the general public has been conducted (e.g., Batterham, Calear, & Christensen, 2013b; Wallin & Runeson, 2003), the stigma suicide attempters face in close relationships has received limited attention to date and there are no systematically evaluated intervention strategies for it (Reavely & Jorm, 2013). Further research is

needed to close this gap, but emerging initiatives on the psychoeducation of the next of kin (e.g., Hunter Institute of Mental Health, 2014) may prove to be of use.

Finally, the limitations of the present study must be acknowledged. Present attempters were undergoing therapy for suicidality. Whether stigma experienced by those not presenting for treatment is more intense or possibly even of a different kind cannot be determined from present data. That said, the sample studied is one that is typically difficult to access because of the strict ethical guidelines applied to this area of research (Lakeman & FitzGerald, 2009; Sutton, Erlen, Glad, & Siminoff, 2003) and because of the high prevalence of complex patient conditions affecting their willingness and ability to attend for interview (Gibbons, Stirman, Brown, & Beck, 2010). The data thus provide some insight into the experience of stigma by those who have attempted suicide and who have sought professional help. There is a further limitation in that initially only 50% of patients agreed to participate and there was a further 20% attrition before interview, which limited the sample size. Nevertheless, no new main themes appeared after two initial interviews and no new subthemes appeared in the final interview, which is in line with prior studies showing that all themes are present as early as the sixth interview (Guest, Bunce, & Johnson, 2006). Further clarification of the relationship between themes and accessing the group missed by the interview approach, unavoidable in this phase of the research program, may be possible when, as planned, the data reported here are used to develop questionnaires that can be completed anonymously by participants.

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