

iE: infoEXCHANGE

SUICIDE AND STIGMA

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The taint of the stigma associated with suicide is no simple metaphor for those who are stigmatized. Many victims suffer from very real psychological scars inflicted by the hurt and shame of attempting suicide or knowing someone who has died by suicide. Misunderstanding, ignorance, and fear are at the root of stigmatization, and these factors have inflicted immense suffering on those who are in any way perceived as “not normal”.

The people who are responsible for perpetuating suicidal stigma engage in behaviors such as **distrust, stereotyping, shunning**, and **avoidance** toward those affected by suicide (Cvinar, 2005).

We in the west have a long tradition of stigmatizing people who are associated in any way with suicide. Because the scope of such an account would far exceed the pages of this particular iE, I will not expand on this detailed history at this time. Suffice it to say that the very act of killing oneself used to be a crime in some countries, and that the criminal language associated with the suicidal act endures in the lexicon. Specifically, using the phrase “to ‘commit’ suicide” equates the act with homicide or fratricide, and suggests that it is akin to “self-murder”. The non-critical and non-thinking use of this phrase preserves the implied criminality of the act (see iE3: Language and Suicide- <http://suicideinfo.ca/LinkClick.aspx?fileticket=sNKET0k90VY%3d&tabid=554>).

The many myths associated with suicide have also contributed to the perseverance of stigma. Notions that people who kill themselves are “cowards” and “selfish” persist to this day, while attempters are often viewed as “attention seekers” who are not to be taken seriously. The idea that suicidality is hereditary can sometimes serve to further torture families who experience a suicidal death.

A major mandate of suicide prevention has been to dispel these myths and to educate and inform the public in an attempt to eliminate stigma.

Needless to say, this has been a long process. A cursory glimpse into the Centre for Suicide Prevention archives reveals a thirty-odd year history of pamphlets, posters, buttons, and other miscellany culled from local, national and international suicide prevention strategies. A common thread tying all of this material together is a strident call for an end to the stigma of suicide.

The International Association of Suicide Prevention (IASP) has deemed this year’s World Suicide Prevention Day: **Stigma: A Major Barrier** to suicide prevention. For more information, please check out: <http://www.iasp.info/wspd/index.php>.



Thus, our work continues and I do believe that we are making major headway. Before I comment on this progress, however, I will briefly highlight **two** specific groups directly associated with suicide who seem to feel the main brunt of stigmatization in order to illustrate how this stigma operates. These are the people who have lost loved ones to suicide who are commonly referred to as “**survivors of suicide**”, and those who have survived a suicide attempt, which, in the interest of clarity, we will refer to as “**suicide attempt survivors**”. It is very important to note that choosing these two groups by no means discounts all other possible groups affected by suicide.

Survivors of Suicide

According to one recent report, at least six people are directly affected by each suicide (Maple, 2010). These people might be family members, lovers, friends, or anyone else who is impacted by the death of a loved one. These survivors are often dumbfounded by the suicide and, in an unclear state of bereavement, might ask themselves if they could have done something to prevent the death. They may wonder if they may have contributed in some way to the actions of their deceased loved one, so deep are their feelings of guilt and self-blame.

I should emphasize here that suicide bereavement is very different from the mourning that occurs after the natural loss of life (Cvinar, 2005). The mourning process, which is already an overwhelmingly distressful time, is further upset by the presence of stigmatization. Survivors suffer greatly from the building of what Feigelman calls the “**wall of silence**” by family, friends and the community at large. Because of the nature of the death there may also be an **absence of caring and interest** or, conversely, an unwelcome shower of **unhelpful and awkward advice** (2009). The majority of us just do not know how to broach the subject of suicide with the bereaved - so we try not to.

In their fragile states of mourning, survivors may have real or imagined perceptions of what the rest of us are thinking. Are we judging them or, worse, blaming them for the death? These uncertain and self-doubting thoughts add even more stress to their predicaments, and might even feed the process of self-stigmatization.

Some survivors may choose to deal with this painful situation through **avoidance** or **denial**. This is sometimes done through suppression and outright refusal to accept that the death has occurred. In this case, although the death was obviously a suicide, it might never be accepted as such by the survivor (Cvinar, 2005). Other possible reactions include a “geographical solution, where remaining family members or other survivors may move to a new area to try and erase the memory of the death by starting life afresh.

Ultimately, if the grieving process in whatever form is not allowed to proceed, some survivors may inadvertently place themselves at risk for suicide. It is absolutely imperative that the bereaved seek out assistance if needed, but, unfortunately, the barrier of stigma can cause a reluctance to seek this vital help.

The good news is that if they do reach out for help, survivors have some of the most developed and connected support networks in existence today. For example, in Calgary, the Canadian Mental Health Association (CMHA) runs ongoing suicide bereavement support groups, and also put on an outstanding annual event called Survivors of Suicide Day (SOS) day: http://calgary.cmha.ca/programs_services/survivors-of-suicide-day/. It is a safe, supportive, and informative forum where survivors can connect and share their experiences with one another. It is a truly inspiring annual event.

Similar support networks exist throughout North America and the world. These groups often serve to provide a crucial lifeline for survivors – one which allows them to deal with both the death and the ensuing stigma that many of them face.



Suicide Attempt Survivors

Even those of us who work in suicide prevention/postvention are sometimes confused by the distinction between those who attempt suicide and survive, and the aforementioned "survivor of suicide". They are both "survivors," but this ambiguity can cause stigma in its own way because of this misunderstanding.

Suicide Prevention Australia (SPA) has tried to clarify this difference by describing those who attempt but survive as "suicide attempt survivors". This terminology is far from universal but we will use their definition for clarification purposes.

Suicide attempt survivors often face extreme stigmatization and are not taken seriously because they are viewed as simply "crying wolf". Further, the fact that they survived the attempt suggests to many that they are not really sincere in their intent to die. In actuality, the attempter is trying to stop the psychological pain brought on by depression or other mental health issues. If their distress is not addressed after their first attempt, then there is a very strong chance that they will attempt again. This cyclical repetition of behavior might help explain why attempters are often wrongfully perceived as "seeking attention" (Witte, p.612, 2010). One statistic suggests that, with youth in particular, there may be 200+ attempts for every single suicide, but that the ultimate predictor for future suicide is a previous attempt. The fact that the best predictor of future behavior is past behavior thus speaks to the importance of taking every attempt very seriously (Marcus, 1996).

A report by Suicide Prevention Australia states that dismissive attitudes are sometimes expressed by health care professionals - including emergency care personnel, physicians and nursing staff - toward patients who attempt suicide. Although adequate attention was paid to the physical consequences of the attempt, there was a near-complete failure to meet the patient's emotional and psychological needs (Suicide Prevention Australia, 2009). Nearly all patients were given perfunctory care, but they did not receive either the true "care," or referrals for future counselling that their tenuous state required.

Attempters need to be psychologically assessed and urged to seek follow-up help after they are discharged from hospital. The underlying causes of the attempt - undiagnosed depression, for example - need to be addressed in a timely manner. The same report indicated that only "A small proportion of suicide attempters seek formal help" (SPA, p.8, 2009). There must be stronger efforts made to get suicide attempt survivors assistance as soon as possible, and to reach out to them before they make successive attempts.

Curiously, attempters can also suffer the effects of stigma from others affected by suicide. In other words, even within the suicide prevention/postvention world, they can be marginalized and even shunned. To some they may symbolize a living reminder of a lost loved one, while to others, they may seem like a constant, potential death just around the corner. Others may see them as representing utter, contemptible failure.

The SPA offers some useful suggestions for how the stigmatization of these suicide attempt survivors might be obviated. Most notably, they recommend that attempters be given a much stronger voice in the "Development of treatments for suicide attempt survivors" (p.11, 2008). You can read the complete document at <http://suicidepreventionaust.org/wp-content/uploads/2012/01/SPA-SuicideAttemptSurvivors-PositionStatement.pdf>.



Progress

As I mentioned previously, I believe wholeheartedly that the stigma of suicide is lessening. I believe that this is happening because of an increase in information, education, understanding, and awareness about suicide. Similar positive progress can be seen throughout history. For example, there was a major stigma surrounding cancer up until the mid-twentieth century, and people with AIDS faced unprecedented stigmatization in the 1980s. With the widespread communication of accurate information to the public comes a “normalizing” effect on these illnesses in the sense that anyone – even you or someone very close to you – could be afflicted.

Similar strides have been made in the field of suicide and suicide prevention, where a dialogue is emerging that is reducing the barrier of stigma on its victims.

Empirical evidence now exists that this stigma is lessening, and an increasing number of studies are also reflecting this conclusion. One encouraging study by Witte, Smith, and Joiner showed that replicating experiments and questionnaires from an earlier era in a current setting showed that attitudes toward suicide have indeed changed for the better (2010). Still, they are “cautiously optimistic” about the continued reduction of stigma.

I do not believe that suicide should be accepted or condoned, but I most certainly think that its prevalence and seriousness should be acknowledged. The more information and resources we have regarding suicide and the more openly we talk about it, the better. Hosting a larger and much more supportive conversation about suicide might prove to be an inviting forum for people who are at-risk to seek the assistance they need without fear of stigmatization. It might also make victims less fearful of the reception they will receive once they find the courage to get help, and also give them a renewed sense of hope that their “not so abnormal” needs will be met.

We are on the right track, but it goes without saying, of course, that there is much more work to do.

WHAT DO YOU THINK ABOUT THE STIGMATIZATION OF SUICIDE?

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