Psychiatria Danubina, 2017; Vol. 29, Suppl. 5, pp S895-899 *Conference paper*

STIGMA AND SUICIDE

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SUMMARY

Suicide is one of the major mental health problems in the world. It is estimated that one million suicide are committed per year and that after every suicide six people from the surrounding suffer or develop major life changes. After suicide survivors are at higher risk of developing major psychological changes and suicidal ideations as well. They go through the complicated process of grief which is specifically characterized by the felling of guilt, shame, denial and anger. The griefing process, more often than in other causes of death, doesn't integrate but is complicated with prolonged grief. This represents a very favorable state for perceiving stigma. Stigma is most often defined as a mark of disgrace or infamy; a stain or reproach, as on one's reputation. In suicide we talk about public and self stigma. Both forms of stigma can separately cause social isolation, demoralization, the felling of hopelessness and other consequences that interfere with the previous functioning. Because of the high incidence of psychological changes after stigma it is crucial for the bereaved to have close mental health services. But stigma is a barrier to treatment seeking. After suicide most survivors fell stigmatized but it is not yet known which factors modify the perception of stigma. Other causes of death like natural death are less related to stigma. On the other side traumatic death like an accident or homicide seem to be related to perception of stigma in the same way survivors perceive after suicide. Suicide and stigma are related in a two way direction meaning that suicide can cause stigma but stigma can lead to suicidal thoughts as well. Even suicide attempters fell stigmatized by colleagues, medical staff and their closest surrounding. There is a need for interventions. The effect of broad anti-stigma campaigns and targeted programs still have to be examines. In clinical settings, interventions that reduce self stigma, stigma-stress and shame might successfully reduce suicidality.

Key words: *suicide – stigma – grief - survivors*

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Introduction

Suicide is one of the major mental health problems in the world. If you look at the number of a million suicide per year, you can see how big the burden is. It is estimated that after every suicide six people suffer and then we come to a number of 6 million people suffering from someone's suicide. It is estimated that 85% of the American society will be in contact with someone who will commit suicide. Death due to suicide is one of the top ten causes of death in all age groups.

Grief reactions and its characteristics

Grief is a universal, instinctive and adaptive reaction to a loss of loved ones. We can divide it to acute grief which actually is the initial answer to a loss; then integrated grief which represents the behavior that appears after the adaptation to the death and finally complicated grief which is usually defined as prolonged or traumatic grief. Complicated grief references acute grief that remains persistent and intense and does not transition into integrated grief. In grief after suicide we more often see feeling of guilt, denial, shame and anger. People usually refuse to talk or admit that their loved ones have committed suicide.

Acute grief

After the death of a loved one, regardless of the cause of death, bereaved individuals experience intense and distressing emotions. Immediately following the death, bereaved individuals often experience feelings of shock and denial. This denial is adaptive for some individuals as it provides a brief respite from the pain, allowing time to accept the death. But, for most, it may not be until days, weeks or even months following the death that the reality is fully comprehended, both cognitively and emotionally, and the intense feelings of sadness, longing, and emptiness may not peak until after that recognition sets in (Zisook 2009). Indeed, grief has been described as one of the most painful experiences an individual ever faces. For most bereaved persons, these feelings gradually diminish in intensity, allowing the individual to accept the loss and re-establish emotional balance.

Integrated grief

Under most circumstances, acute grief instinctively transitions to integrated grief within several months. However, this period may be substantially extended for those who have lost a loved one to suicide.

The hallmarks of "healing" from the death of a loved one are the ability of the bereaved to recognize that they have grieved, to be able to think of the deceased with equanimity, to return to work, to re-experience pleasure, and to be able to seek the companionship and love of others. However, a small percentage of individuals are not able to come to such a resolution and go on to develop a "complicated grief" reaction (Zisook 2010).

Complicated grief (CG)

Complicated grief is a reaction in which acute grief is prolonged, causing distress and interfering with

functioning. The bereaved may feel longing and yearning that does not substantially abate with time and may experience difficulty re-establishing a meaningful life without the person who died. Symptoms include recurrent and intense grief and a preoccupation with the person who died mixed with avoidance of reminders of the loss. The bereaved may have recurrent intrusive images of the death, while positive memories may be blocked or interpreted as sad. Alternatively, the pain from the loss may be so intense that their own death may feel like the only possible outlet of relief.

Some reports suggest that as many as 10% to 20% of bereaved individuals develop this form of grief (Prigerson 2011). Notably, survivors of suicide loss are at higher risk of developing CG (Shear 2011). CG is associated with poor functional, psychological and physical outcomes. Individuals with CG often have impairments in their daily functioning, occupational and social functioning (Lannen 2008). They have increased rates of psychiatric comorbidity, including higher rates of comorbid major depression and posttraumatic stress disorder (PTSD) (Newson 2011). Furthermore, individuals with CG are at higher risk for suicidal ideation and behavior (Dell'osso 2011). Overall, untreated CG results in suffering, impairment, and poor health outcomes, and will persist indefinitely without treatment.

Suicide survivors often face unique challenges that differ from those who have been bereaved by other types of death. In addition to the inevitable grief, sadness, and disbelief typical of all grief, overwhelming guilt, confusion, rejection, shame, and anger are also often prominent. These painful experiences may be further complicated by the effects of stigma and trauma (Feigelman 2009). For these reasons, grief experienced by suicide survivors may be qualitatively different than grief after other causes of death. In one study, Sveen and Walby found no significant differences in rates of comorbid psychiatric disorders and suicidality among suicide bereaved individuals compared with other bereaved individuals across 41 studies, they did find higher incidences of rejection, blaming, shame, stigma, and the need to conceal the cause of death among those bereaved by suicide as compared with other causes of death (Sveen 2008).

Children of parents who died by suicide or in an accident had higher rates of current and incident depression, alcohol or substance abuse up to 21 months after the death than the non-bereaved and children of parents who died by sudden natural death (Brent 2009). Siblings of suicide victims, particularly adolescents, experienced depression, anxiety, post-traumatic and grief reactions. However, the aftermath of suicide is not limited to mental health problems (Dyregrov 2005). A wide variety of psycho-social needs of suicide survivors should be underlined as well. These include difficulties related to the disruption of family relations and routines, functional impairments in daily activities, difficulties with social and familial relationships, spiritual struggles as well as financial and juridical problems. In addition, the mechanisms of identification with the deceased, social modelling, punishment for perceived self-blame as well as genetic factors might be accountable for the increased risk of suicidal ideation and behaviour, and at-risk behaviours observed among some of the survivors (Krysinska 2003). Such increased risk of suicidality has been observed in both adolescent and adult samples of survivors (Cerel 2005).

Types of stigma related to suicide

The most often used definition of stigma in english literature is the one given by Webster. He defined stigma as "a mark of disgrace or infamy; a stain or reproach, as on one's reputation."

In suicide we usually see two kinds of stigma:

- *Public stigma* – in which people from the surrounding develop negative stereotypes and discriminate persons suffering from a psychiatric disorder. A typical consequence of this kind of stigma is social isolation and damage of social interactions. This kind of stigma can lead to unemployment and can affect education and household. Stigma and discrimination are often viewed as a social debacle which can contribute to suicidality (Taylor 2011). Some social regulations can systematically neglect psychiatric patients and this is called structural discrimination, a term that is often mentioned in terms of psychiatry and stigma. For example, smaller financing of mental health care compared to other branches of medicine can lead to lower quality and reduce the approachment to mental health services.
- *Self stigma* is refered to negative stereotypes that the person develops by itself. This can lead to shame, social withdrawal and demoralization. As a consequence of self stigma persons with a psychiatric disorder can fell worthless or uncapable for daily life events (Corrigan 2009).

Two other consequences of stigma are important as well. The first one is the felling of hopelessness and the cognitive approach of stigma as a stresor or the perception of stigma as a threat which then becomes a personal defence mechanism. Higher levels of stress as a cosequence of stigma are related to social anxiety, shame and hopelessness. Finally, any form of stigma can be a barrier for treatment seeking (Rusch 2009, Clement 2014). The most often used words for describing people who have comitted suicide are: arogant, attention seeking, pathetic, weak, selfish (Batterham 2013). People with a suicidal past tend to seek less professional support and all this seems to be related to high levels of shame and self stigma (Reynders 2015). In a study that evaluated attitudes toward suicide, participants reported that they believe that it is more realistic to recover from a severe mental health disorder than it is for a person after a suicide attempt. These findings suggest that individuals who have attempted suicide are subject to differential stigma content from those with depression (Sheehan 2017).

Many cosequences of stigma and discrimination are related to suicidal behavior (Pompili 2011, Wray 2011). Two conceptualizations of suicide models are important for stigma. First, the interpersonal theory which defines suicidality as a combination of social isolation, loss of sense of belonging and the perception that the person is „a burden“ to others. This is a consistent finding in stigma as a risk factor for suicide (van Orden 2010).

Second, the stress model of suicidality which defines that biological, psychological vulnerability in correlation with psychosocial stressors can lead to suicidality. Stigma is a stressor with negative consequences that are present during risky phases of a mental disorder. The stress related to stigma can lead to hopelessness and precipitate suicidal behavior according to the stress model.

Stigma in suicide survivors

In one quantitative study 31% od respondents reported general stigma which has been related to their status as suicide survivor (Solomon 1983). One other quantitative study found that 87% od suicide survivors reported some kind of stigma, from which 23% reported very high scores (Parker 2008). This differences in numbers are probably due to the lack of adequate instruments for stigma evaluation. Available data suggest as that this is the most prominent obstacle for proper research in the field of stigma.

Crosby and Sacks have reported that persons whose family member or someone close committed suicide during the last year had 1.6 times higher risk of suicidal thinking, 2.9 times higher risk of developing a suicidal plan and 3.6 times higher risk of a suicide attempt (Crosby 2002). Results of qualitative studies show that stigma was related to a deep felling of shame (Gall 2014). It has been shown that social skills are damaged. This additionally complicates the griefing process and the coping with all the consequences of suicide. Most respondents have reported rejection and avoidance by others (Biddle 2003). Family members, friends and even colleagues often fell guilty for the suicide and this is usually the cosequence of behaviors of people in the surrounding and survivors usually perceive this as stigmatising. 15-35% of respondents reported that they have tried to hide or not talk about their loss (Tzeng 2010). Evidence confirmed that the fear of stigma development did lead to avoidance and damage of social interaction (Tzeng 2010). Females are more exposed to stigma (Scocco 2012). Younger people perceived more stigma (Feigelman, 2011, Wojtkowiak 2012).

Children and spouses are specifically exposed to the perception of stigma, and in this sutdy, interestingly, parents felt less stigmatised (Feigelman 2011). If we compare stigma after suicide versus stigma after natural death in most studies we see that those who have lost their loved ones due to suicide reported higher levels of stigma. Barrett and Scott showed that levels of stigma have been shaped by the fact if a death was expected or not (Barrett 1989).

In one study, Cleiren and his associates have evaluated stigma levels in family members who have lost someone due to suicide and due to a chronic disease. They did a follow-up after 4 and 14 months. They didnt see any differences between this two groups in no point of evaluation. This probably suggests that taking care of someone with a chronic disease can harm social interactions and lead to stigma perception in the same way that suicide leads to it (Cleiren 1994). Two publications have evaluated parents after suicide and parents after death of a child due to a traumatic event (for example accident, homicide). They didnt see any differences in stigma levels (Feigelman 2009). However, one other study showed that surivors after suicide felt more stigmatized than relatives after the death of a loved one after an accident or homicide (Pitman 2017). These results actually confirm most study findings which concluded that grief after suicide and traumatic death cause similar grief reactions. It is assumed that both forms of death cause similar reactions meaning fear, avoidance and wrong experience of their own responsibility because survivors in both cases have to deal with their own inability to control fundamental questions of life and death (Jordan 2011). Additional absence of obvious social norms in coping with suicide and traumatic death can contribute to the same mechanism of insensitivity towards those groups and this can be perceived as stigma by survivors.

More and more studies focus on the effects of stigma on suicidality. In some population studies shame and self stigma have been less reported in regions with a lower suicide rate compared to regions with higher suicide rates (De Wall 2013). Less access to mental health services actually is a index of structural discrimination. We often see that psychiatry is a branch of medicine which is financed les than other parts. Stigma actually is a barrier to treatment seeking (Clement 2014). Actually, we can talk about a two-way relationshiop between suicide and stigma. This means that suicide can cause stigma but stigma can facilitate suicide tendencies as well.

A study from Turkey showed that 80% of medicine students who have attempted suicide show a tendency to social isolation (Emul 2011). One other study from the United States has shown that 50% of respondents who have attempted suicide had an impression that the emergency room staff didnt take their state serious. Moreover, 50% felt stigmatized (Suokas 2009). Half of american student have reported that they would not date with a person who had a past suicide attempt. Stigma ,that has its roots in social network, has shaped the severity of depressive symptoms in suicide attempters. If we compare people without a suicidal past, persons who have attempted suicide were less likely to seek for professional help, perceive more stigma and self stigma (especially men), fell ashamed if they seek for help (especially woman). Previous suicide attempts have been linked to higher self stigmatizing attitudes towards suicidal behavior (Scocco 2016). Among people who have tried to attempt suicide the psychopathological

distress especially leads to higher stigma perception (Scocco 2016).

Wojtkowiak and his colleagues showed that higher scores of stigma in survivors has been linked to complicated grief and specific aspects of grief after suicide which include the feel of shame, guilt and the search for answers.

There is a higher risk of autodestructive behavior and somatic reactions, as well (Wojtkowiak 2012). Higher stigma was related to depression and to suicide ideations as well (Feigelman 2008, 2009).

Conclusion

Searching through the literature we found only a small number of studies that focused on this topic. Most of the studies were methodologically incomplete, they used different instruments which makes any evaluation or comparation more complicated. The results of most studies have shown that stigma is a serious problem for most family members. Very little is known about the factors that impact the perception of stigma. It is known and studies confirmed that family members after suicide have problems with complicated grief, suffer from depression and somatic symptoms more often. Moreover, stigma can contribute to a higher suicide risk in relatives after suicide. Studies have confirmed that a death due to suicide often says hiden and unspoken, people less engage in social interactions and supress their fellings. Stigma has the potential to cause shame and silence in survivors. It can lead to social isolation which then causes complicated grief and other psychological distresses.

There is a need for adequate interventions. Education of psychological changes after suicide in schools, institutions and in work enviroments has shaped the attitudes towards suicide attempters (Robinson 2013). In terms of research we need longitudinal studies to have concrete evidences about the hypothesizes link between stigma variables and suicide. This studies should be based on the mentioned interpersonal theory or the stress related model of suicidality. The link between stigma and suicidality would have important implications for psychiatric practice and policies. Initial evidence about efficacy of interventions show that they reduce public and self stigma, as well as the stress related to stigma (Corrigan 2012, Mittal 2012, Rusch 2014). It is unclear whether interventions cosequently reduce suicidality as well.

The effect of broad anti-stigma campaigns and targeted programms still have to be examines. In clinical settings, interventions that reduce self stigma, stigma-stress and shame might successfully reduce suicidality. There is an ongoing discussion that social media could be a potential target to help to increase social inclusion and emphasize the effects of stigma on suicidality. We already have evidence to speculate about stigma as a risk factor for suicide. Unlike other factors, stigma and discrimination are modifiable risk factors which makes them an important target for interventions.

Acknowledgements: None.

Conflict of interest: None to declare.

Contribution of individual authors:

Both authors have significantly contributed to the design, literature research and writing of the article.

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