The Stigma of Suicide and How It Affects Survivors’ Healing

by William Feigelman, Ph.D.

This short article summarizes a longer work completed by two co-authors: Dr. Bernard S. Gorman and Dr. John R. Jordan and myself. Suiicidologists have long recognized how society stigmatizes those who complete suicide and their surviving relatives. Historical records show that during the Middle Ages suicide corpses were regularly mutilated to prevent the unearthing of evil spirits. Suicides were denied burial in church cemeteries. Afterwards, property of surviving kin was usually confiscated and families excommunicated for failing to pay the heavy taxes expected by the church.

Today analysts claim suicide stigma is more subtle with blame being cast upon survivors and survivors being subjected to informal isolation and shaming. Today it is often noted that stigmatization promotes more grief difficulties and mental health problems for survivors. Yet, we were surprised to find no one has verified whether these assertions about stigma are supported with systematic evidence.

Do survivors experiencing greater shaming have more grief difficulties than those that do not? How common is stigmatization among survivors? We also were wondering whether suicide survivors were exposed to more stigma than other survivors of traumatic deaths and natural deaths.

To investigate these questions we collected surveys from a sample of parents losing children to suicide (462 cases) and a contrast population of other parents who lost children to other traumatic deaths (i.e. auto accidents, drug overdoses, homicides, etc.) (58 cases) and natural deaths (24 cases). Our sample was drawn primarily from the ranks of members of suicide survivor support groups and from several chapters of The Compassionate Friends, a general bereavement support group open to parents who experienced untimely deaths of children.

We had no way of knowing whether our sample accurately represented the parent survivor population; only that it represented a diverse cross-section of survivors and it comprised the largest ever sample of parent suicide survivors. Most respondents (75%) were between ages 46-65. Most of their decedent children (80%) died between the ages of 16-35.

Respondents came from every state and community type, and were widely represented in terms of their socioeconomic and religious differences. In our support group-based sample we over-sampled women, Whites, and US born respondents.

In addition to asking respondents various standardized diagnostic questions about their grief difficulties, depression and suicidality, we developed a new stigmatization measure. The measure consisted of 22 questions asking respondents whether, following the loss of their child, they experienced harmful (instead of helpful) responses from various kin and non-kin, i.e., from parents, in-laws, children, siblings, other relatives, close and less close friends, neighbors, and coworkers.

Respondents also were asked whether relations with any of these groups had become more strained after their loss.

Our measure showed internal consistency. In addition, we asked respondents to write onto their survey forms any hurtful things said and done to them following their loss.

Our write-in questions yielded comments from over 80% of respondents. The overwhelming majority (80%) of these gave either negative or mixed negative comments. We grouped these comments into one of seven types: a) Avoidance (expressed most frequently) e.g., “People avoided me.” “Friends or family didn’t call me afterwards.” “People who I thought would be at the funeral or send a sympathy card didn’t show any acknowledgment of the death.” b) Unhelpful advice (expressed by a majority) e.g., “It’s time to move on.” “Are you still going to that support group, now?” “Have you grieved enough already?” “c) Absence of a caring interest (expressed by a majority) e.g., “No one asked me how I was feeling afterwards.” “If I started talking about my lost child, they quickly changed the subject.” “People just passed over my tragedy as if my child never existed.” d) Spiritual (expressed by a minority) e.g., “God called him.” “He’s in a better place now.” “It was meant to be.”

Although it might seem these remarks were helpful, respondents did not appear to take them that way. One male physician said, “If there was anything I found exasperating it was people saying ‘He’s with God now; How do they know I’m a Christian?’” An office manager said, “I was annoyed with people saying He’s with God. I wanted him here with me now, alive.” e) Blaming the victim (expressed by a minority) e.g., “That was a cowardly thing he did.”

“He was selfish,” “He was so reckless in how he lived.” f) Blaming the parent (expressed by a minority) e.g., “Didn’t you see it coming?” “Why didn’t you get him into therapy?” g) Other negative (expressed by a minority) e.g., “Well at least he didn’t kill anyone else when he died.” “At least you have other children.” and “He could have shot himself – I guess that would have been worse” (said to a parent whose child died by hanging).

Our numeric measure of stigma showed that 53% of survivors reported harmful responses from one or more family member groups following their loss and 32% reported harmful responses from at least one non-kin group. Also, about half of the respondents (55%) reported one or more strained family relationships after their loss and 47% reported one or more strained social relationships. These frequencies attest to the pervasiveness of stigma.

When we examined whether those gaining higher scores on our stigma scale had more grief difficulties, depression and suicidal thinking (compared to low scorers), our findings confirmed this. This hypothesis was even confirmed as we considered several potential confounders to the relationship: time since the death and the type of death (whether traumatic or not). A somewhat surprising result emerged when we compared stigma exposures among our three survivor subgroups: suicide, other traumatic deaths, and natural deaths. The results showed suicide survivors much like other traumatic death survivors in experiencing stigma, but showed more stigma exposures than parents of a child’s natural death.

These findings suggest most sudden deaths, whether by suicide, a fatal automobile accident, or drug overdoses evoke similar fear-based avoidance responses. People think “it could have happened to us,” and often evade survivors in terror and dread, rarely offering comfort to those on the front lines of grief. This puts suicide survivors in much the same boat as other traumatic death survivors in experiencing stigma.

Continued on page 2...
Continued from page 1.....

Survivors reading over this may not be very surprised with some of these results. Stigma experiences are part of their every day lives, as they strive to cope with loss and repair themselves. What makes these stigmatizing experiences so irksome to them are the expectations survivors have of gaining support and solace from these close family and social intimates. Who else should be able to readily understand their personal devastating tragedies?

Clinicians dealing with survivors may need to help them assess the kinds of supports that survivors may be gaining (or losing) after loss, for some associations may be impeding survivor healing. Survivors too, need to take stock of their supports (and interfering responses) gained from intimates after loss.

In some cases it will be necessary to avoid some significant others in the interests of promoting their own mental health. In other cases it may be necessary to impose a moratorium in association with others. And in still other cases, survivors may need to teach their significant others how to be more supportive to them. Future research should concentrate more on stigma, attempting to better understand its dynamics in survivor relationships, in efforts to promote better survivor mental health and healing.

About the Author

William Feigelman, Professor of Sociology at Nassau Community College, Garden City, New York, completed his doctorate at State University of New York at Stony Brook. Author or co-author of six books and more than 40 journal articles, he has researched and received grant support on a wide variety of subjects including: transracial adoptions, intergroup relations, problem gambling, youth alcohol and drug dependence, cigarette smoking and cessation. Since the suicide death of his son in 2002, he has turned his research focus toward youth suicide and suicide bereavement. Now he is completing a survey of more than 500 parents who lost children to suicide and all-other-death causes. For more information about this work, please visit the following website: http://www3.ncc.edu/faculty/soc/feigelb/survivor.htm

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A New Resource For Those Bereaved by Suicide

On the 6th November 2008, The DIPEX Charity will launch a new part of its unique, award-winning website, www.healthonline.org (formerly known as www.dipex.org). The aim is to help those bereaved by suicide by hearing about other people's experiences. This new part of the website also will be used for teaching health professionals, members of the police force, coroners' officers, counsellors, and others, helping them to understand the perspective of those bereaved by suicide. The website is free for anyone to use.

This new part of the website was funded by The Department of Health, and is based on high-quality research led by the DIPEX health experience research group at the University of Oxford. The site features summaries and extracts from narrative interviews with 40 people bereaved due to suicide.

The new part of the site, which can be found in a major section called "Living with Dying," will cover 29 topics each of which are illustrated with about 10 video, audio or written clips from the interviews. Each topic summarises what everyone said about why they thought the suicide took place, suicide notes, GPs and psychiatrists, finding out about the suicide, first reactions, changing emotions, seeing the body or not being able to do so, telling children and young people, other people's reactions, the press and other media involvement, police involvement, practical matters, the funeral or commemoration, the burial or cremation, the inquest, reactions to the verdict, informal support, help and support from professionals, help from Cruse Bereavement Care, self-help groups, finding help via the internet, support for young children, coping with grief and keeping memories alive, adjusting to life without the person who died, and anniversaries and other special occasions.
One of the Many People Bereaved by Suicide in Hong Kong
By Paul Wong, D.Psyc.

One night in May 2004, when Tiger got home from work, he found both of his parents lying dead in their bed and there was a small barbecue grill next to the bed. He then shockingly realized that his parents took their own lives by charcoal burning. (This suicide means first appeared in Hong Kong in 1997 and its medical cause of death is carbon monoxide poisoning. Charcoal-burning has now become the second most common means of suicide in Hong Kong that accounts for about 25% (200 to 300 deaths) of all suicide deaths in Hong Kong.)

Below is a letter that Tiger wrote to his parents two years after the incident. This letter first appeared in a book titled, The Belated Dialogues Between the Suicides and their Families published by the HKJC Centre for Suicide Research and Prevention and the Breakthrough Ltd, which aims to enhance the public awareness of suicide survivorship in Chinese societies. Tiger is one of the very few people bereaved by suicide in Hong Kong who is willing to share his stories (using his real name) with the society and with the hope that both the grieving individuals and the suicides can learn from his painful experience.

Cover of the book:

Dear Mom and Dad,

I am writing this letter to you to tell you how I have been doing and how much I miss you.

Mom, you had always been kind to me. We went along very well. The first thing I remember about you was your dementia. When you were suffering from dementia after you retired, you became very forgetful, for once, when I answered your question, you would ask me the same question again a few minutes later, it was funny, I think. After all, I think you always had a “happy mind.”

Dad, do you know you were such a typical traditional Chinese man?! You never talked much about yourself and your problems. You know what? Though brother and I both sensed that your graphic design company was not doing well, we had never thought that it was such a big problem to you. We had no idea that that your company could end up owing so much money to the suppliers.

Do you want to know why we couldn’t get along? I was tired of listening to your lecturing. Do you remember how many times you told me what I SHOULD DO and SHOULD NOT DO? When I have grown, I told myself that I had enough of you and why SHOULD I listen to your advises.” So, I had chosen to stay away from you. I chose not to have dinner with you and mom anymore — No more dinners with you after work, and no more gatherings with you on weekends. Family gathering was out of my to-do-list.

Let me tell you how I felt when I last saw you (or your body, literally). I was shocked, and felt that I must be dreaming or something. I couldn’t believe that my parents could have done something like that. I was so lost, I couldn’t sleep. I had lost my appetite for a long time. Moreover, I was overwhelmed by the numerous questions about your death from your friends and colleagues — “How would that happen?,” “Why did they do that?,” “Do you think it was a mutual agreement that they killed themselves?” etc. I found those questions non-sense. The most annoying questions were “Didn’t you talk to them before? How an earth you did not notice anything?” Well…… people, it wouldn’t had happened if I knew about it. These questions made me furious. They made me think that what you did was very wrong. You and mom were very wrong because you didn’t tell us anything. More, now that you are gone, and you had left us nothing but sadness and problems to deal with.

However, those sadness and anger have gone. Time passes by and I have started to look at the whole thing from many different perspectives. Now I regret that I had never spent any quality time to get to know you. I was very wrong to have chosen to stay away from you just to avoid arguments with you. It was a very selfish act. I am SORRY! Can you come back and give me some advice, some time?

I guess it is just a human nature that we all take things for granted - when you have something you don’t think they are necessary, but when they disappear, you suddenly realize that those are the things you need most. Sometimes when we keep our heads down and keep looking for the things ahead of us, and we pass by the present. There is a question which fits well - Is it about the Destination or the Journey?

Tiger
2/3/2006
People Bereaved by Suicide in Hong Kong

The World Health Organization estimates that about one million people die by suicide per year and more than 60% of the world suicides occur in Asia (Beautrais, 2006). Based on Dr. Edwin Shneidman's estimation that one suicide affects six to 10 people, there may be at least 3.6 million people affected by suicides per year in Asia alone.

Unfortunately, empirical studies on people bereaved by suicide in the Asia region are almost non-existent. Hong Kong is of no exception. Through our psychological autopsy study conducted in 2003-2004, we asked 150 relatives and friends of the suicides to fill out a questionnaire about their perspectives on suicide, stigmatization, and psychological, social, and physical adjustments during their grieving processes. As far as we know, this is the first empirical study on people bereaved by suicide in Hong Kong.

The interviews were carried out at an average of 7.3 (SD=4.0) months after the incidents. The interviews lasted from 1.5 hours to 6 hours (M=3.4 hours). The majority of the informants were the spouses (n=37, 24.7%), parents (n=31, 20.7%), and siblings (n=44, 29.3%) of the deceased; 21 (14.7%) were children, and 17 (11.3%) were others including friends, relatives, and co-workers. We found that the reactions of suicide survivors in Hong Kong are somewhat similar to what has been reported in other countries. Our subjects reported typical suicide bereavement reactions such as cognitive disorganized, dysphoric, somatic distress, and social and occupational disruptions, feelings of guilt, taking the responsibility for the death, preoccupation with an "agonizing questioning" about why the death occurred, feeling rejected or abandoned by the deceased, feeling shameful, embarrassed, and social isolation etc.

Nevertheless, some different and interesting findings are noteworthy. For instance, we found that more than 80% of our survivors reported to have better relationships within the family in a way that they got along better and became more empathic and supportive towards other family members and nearly half of the survivors found the suicide was a relief for the deceased (Wong, Chan, & Beh. 2007). These findings may have provided us a basic understanding of the reactions of people bereaved by suicide in Hong Kong; however, there still are many voids to be filled in this unexplored area.

Stigma of Mental Illness and Suicide in Chinese Culture

It is beyond the scope of this short article to discuss in detail about the extent of stigma of mental illness and suicide in Chinese culture that relates to suicide survivorship; however, a brief discussion on this topic seems to be a necessity because without this discussion, it would be difficult to comprehend the subtle differences of suicide survivorship in Chinese societies.

The Chinese perspective on mental illness - Despite the issues of modernization and westernisation in contemporary Chinese societies, the traditional beliefs about mental illness and suicide still play a vital role in the understanding of psychopathology and suicide in our society. Because Chinese cultural norms hold the family as responsible for the individual's behaviour and welfare, the "atypical" behaviour of a person who suffers from mental illness bring extreme shame and guilt to the family. The shame for the individual's behaviour even extends to the ancestors. Thus, when a person suffers from mental illness or dying by suicide, non-family members might have shown sympathy toward the individual, but they also would have indicated that either the person's family or ancestors had done something immoral or his/her family is responsible for the "problem/illness" in some ways.

Families with members who are mentally disordered or died by suicide may fear being ridiculed and "losing face" and therefore they are reluctant to disclose or even deny that a family member of their own has mental illness and died by suicide (Kleinman & Li, 1981). Thus, there is a short but memorable Chinese adage that "problems within the family should not be discussed outside the family." This may also shed light on reasons for the limited empirical studies on suicide bereavement have been conducted in Hong Kong.

The usual way of expressing emotions amongst the Chinese - Contrary to the Greek and European tradition which highly stresses the therapeutic value of emotional catharsis when facing life adversities, any excess and incongruence of emotions (i.e., happiness, anger, worry, desire, sadness, fear, and fright) is considered as pathogenic in the Chinese tradition. This belief probably has its root from the fundamental principle of the Chinese philosophy that "balance and harmony" are the tao or ways of living.

Also, Confucianism teaches that maintaining harmony in familial and other social relationships require inhibition and avoidance of emotional expression. These Chinese philosophical traditions work together to reinforce the quality of equanimity among Chinese and to legitimate the suppression of excess emotions as a way to cope with stressful events (Bond, 1991). This tends to hinder the urge of survivors to talk about their painful experiences and reinforce the expectation of survivors to "get on with their lives."
Postvention Research and Intervention in Hong Kong

In 2006, a local entrepreneur, Mr. Peter Lee, whose friend died by suicide, approached the HKJC Centre for Suicide Research and Prevention at the University of Hong Kong, to develop a research-intervention program for people bereaved by suicide in Hong Kong. This three-year pilot multi-disciplinary project aims to develop, study, and evaluate a yet-to-be-developed evidence-based quality care to both understand the needs and to identify the best practice to help survivors of suicide in Hong Kong.

This program was developed based on local and international experiences that not all suicide survivors develop complicated grief or suicidal risk, but those who are at risk do not generally seek professional help. Thus, we established a program that cares people bereaved by suicide at all level of needs. And we categorize the proposed research-intervention activities into the universal, selective, and indicated levels using their suicide risk as an anchor. The aims and the details of the three-levelled activities are described below:

**Universal** — aim to provide some informational support and immediate help proactively at the early phase of suicide bereavement for survivors of suicide as a stress management strategy. Activities include approaching survivors of suicide at public mortuaries to enhance their help-seeking behaviour when necessary, distributing informational materials at the mortuaries, developing a website on suicide survivorship, and evaluating all proposed activities.

**Selective** — aim to help bereaved persons who are deemed to be likely to experience a complicated form of grief or suicide risk. Activities include developing close-ended and structured psycho-educational groups; and telephone following up distressed survivors at least three times in the first six months.

**Indicated** — aim to help people who are experiencing complications in their grieving process or expressing suicide risk. Activities include providing brief-psychotherapy by clinical psychologist; and referring very high-risk survivors for timely psychiatric services.

As Arnold Toynbee (1889-1975), a British historian, states that “the capital fact about the relation between living and dying is that there are two parties to the suffering that death inflicts; and, in the apportionment of this suffering, the survivor takes the brunt.” We hope that this local pioneering project can stimulate more caring societal responses in our community for those who have lost their loved ones and the sufferings of people bereaved by suicide may be lessened or even dispelled.

References


Biography of Paul Wong

Paul Wong received his D.Psyc. (Clinical) from Bond University in Australia.

He is a registered psychologist in Queensland, Australia, and Hong Kong and a member of the Australian Psychological Society College of Clinical Psychologists. He was given an opportunity to study suicide prevention at University of Rochester Medical Center, Department of Psychiatry, New York in 2004. His present title is Clinical Psychologist, HKJC Centre for Suicide Research and Prevention, University of Hong Kong. He is a member of the International Association of Suicide Prevention Postvention Taskforce.

He has consulted with suicidal persons and families of suicide, and has been teaching courses on suicide prevention and mental health at the university.

In addition, he has conducted seminars and workshops on suicide prevention for front-line professionals and the general public, and published articles on psychological autopsy study, community-based suicide prevention program, youth suicide, suicide notes, suicide survivorship, and homicide and suicide. He can be emailed at: paulw@hku.hk
The IASP Postvention Task Force Needs Your Help

The IASP Postvention Task Force is looking for help in several areas. Membership support is crucial with these items so that the Task Force and its initiatives may move forward.

New Editor Sought for the Postvention Newsletter

Following the December 2008 issue, a new editor will be needed for the postvention newsletter. Responsibilities include working with the chairs to ensure articles are secured for each issue, working with the writers to make sure the articles are submitted in a timely manner, editing the articles for content, and proofreading. Currently, the Task Force puts out six issues a year but this will be cut to four issues in 2009. If you are interested, please email Michelle Linn-Gust at michelle@chellehead.com

Articles Sought for Newsletter

The newsletter needs postvention content. While the issues are full through the December 2008 issue, articles are needed beginning with the March 2009 issue. Please email articles and article ideas to Seán McCarthy at sean.mccarthy@console.ie

Materials Needed for Web Site

Since IASP launched its new website www.iasp.info the postvention section needs materials from members and about people bereaved by suicide. If you have an article, a link, or another resource you would like to contribute, please email it to Karl Andriessen at karl.andriessen@pandora.be

Abstracts Needed for IASP Montevideo, Uruguay Congress

The 2009 IASP Congress, set to take place October 27-29, 2009, in Montevideo, Uruguay, should include postvention presentations and workshops. Without membership submissions, there will be no postvention track. Please consider submitting an abstract and attending the conference. Members are encouraged to email the task force co-chairs for help and/or discussion about ideas. Please consult the congress website, www.iasp2009.org for more information about submitting abstracts as well as deadlines.

“How to Start a Survivors’ Group” Booklet Updated and Available

The WHO document, “How to Start a Survivors’ Group” has been updated and is available for distribution. If you would like to receive printed copies, please contact Karl Andriessen at karl.andriessen@pandora.be and indicate number of copies requested and full postal/mailing address. WHO/IASP encourages the translation of the document in various languages for domestic use. Please contact Karl if you would intend to translate the booklet.

Link to Postvention Task Force Meeting Minutes

The Postvention Task Force meeting minutes are available on the IASP web site by following this link: http://www.iasp.info/postvention.php
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Upcoming Events

November 1-4, 2008: 3rd Asia Pacific Regional Conference of Suicide Prevention, Hong Kong, csrp.hku.hk/iasp2008


May 21-23, 2009: 2nd Australian Postvention Conference, Melbourne, Australia.