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Coping planning to reduce stigma and support coping after suicide

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Bereavement after a death by suicide can be complicated by stigma. Stigma can result from conceptualising suicide and the causes of suicide, as a personal and/or familial fault, flaw, or deficiency. This stigma can cause negative thoughts about the person who died, engender blame, and result in real or perceived judgment or ostracism. To effectively decrease the stigma surrounding suicide, we need to change the narrative surrounding it and its causes. A coping planning framework conceptualises suicide as the final strategy to reduce overwhelming distress, when a person has no other effective strategies. Within this paradigm, bereavement counselling following suicide involves supporting people to cope with the loss of a loved one rather than the cause of death. Reframing suicide using a coping paradigm has the potential to eliminate the stigma that can complicate bereavement. It also has the potential to contribute to better coping in people experiencing bereavement.

Keywords: *bereavement; coping; stigma; suicide; survivor*

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Bereavement is the combination of the physiological, psychological, behavioral, and social response patterns experienced following the loss of a significant person (Dunne et al., 1987). It is typically characterized by a period of mourning followed by eventual adaptation to life without the deceased person. Adaptation following the death of another varies substantially (Maercker et al., 2017). While many experience distress and grief in response to a significant loss, others experience more severe or protracted grief, which is associated with poorer adjustment and is sometimes described as complicated or prolonged grief (Cutcliffe, 1998). There are a number of risk factors for complicated grief, including low levels of social support, dissatisfaction with information provided regarding the death, attachment style, and being a parent or spouse of the deceased (Burke & Neimeyer, 2012; Maercker et al., 2017). Furthermore, there is evidence that traumatic or violent deaths are associated with more intensive or prolonged grieving (Kaltman & Bonanno, 2003; Nakajima et al., 2012).

Of the factors that complicate bereavement, poor social support, traumatic death, and a lack of information may be particularly relevant for those grieving a death by suicide. In particular, those who find it difficult to make sense of the loss are also more likely to experience complicated grief than those who find meaning in their experience (Burke & Neimeyer, 2012). It can be particularly difficult for friends and family to make sense of death by suicide. Their search for causes can lead to them to believe the stigma that often surrounds suicide, and experience blame and shame as a result. Along with other potentially relevant factors—such as lack of support, a violent or traumatic death— this may increase risk for complicated or traumatic grief responses and even suicidality during bereavement (Currier et al., 2006; Jordan, 2017; Pitman et al., 2014).

Stigma and suicide

Stigma is a mark of disapproval by most people in a society toward a particular circumstance, quality, or person (Link & Phelan, 2001). It is “manifested by bias, distrust, stereotyping, fear, embarrassment, and/or avoidance” of the stigmatized individual or group (U.S. Department of Health and Human Services, 1999, p.18). The stigma towards people who have attempted or died by suicide developed through both religion and then criminalization (Tadros & Jolley, 2001). However, despite decriminalization, stigma remains pervasive. People who experience suicidality may be subject to a sort of ‘double stigma’, one of incompetence and danger assumed due to mental illness,

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and another of being immoral for the attempt of ending one's own life (Sheehan et al., 2017). As a result, people who have attempted suicide are frequently stigmatized as being selfish, incompetent, crazy, untrustworthy, immoral, and hopeless (Sheehan et al., 2017). One study for example, found that almost a quarter of the general population would not purchase a house next door to someone who had attempted suicide (Lester & Walker, 2006).

Stigma extends beyond the person who attempted or died by suicide to include those who are close to the individual—parents, spouses/partners, children, and close friends—due to their close ties with the person (Sheehan et al., 2018). Named 'courtesy stigma' (Goffman, 1963), this extension of stigma results directly from the person's relationship with the stigmatized individual, such as through presumed responsibility for the suicide genetically and/or socially (e.g., not acting to prevent the death and being negligent). Those who grieve an individual who has died by suicide have noted the tremendous impact of stigma on them as a result of their loved one's cause of death, including the beliefs of others that they caused the suicide through abuse, lack of love, failure to act, or shared flawed genetic vulnerabilities (Sheehan et al., 2017). They also report the withdrawal of social support from their family and community (Feigelman et al., 2009) and describe feeling blamed and pitied, and being subject to discrimination, such as through shunning, shaming, and impatience (Feigelman et al., 2009; Sheehan et al., 2017).

Stigma is also prevalent amongst health professionals. From the perspective of suicide attempt survivors, interactions with health professionals are often seen as either over-reactive or, at the other end of the spectrum, dismissive, with health professionals assuming that those who attempt suicide are dangerous, hopeless, and/or perplexing (Sheehan et al., 2016). This treatment extends to the treatment of family members. One study found that despite international suicide prevention strategies recommending the provision of support to families bereaved by suicide, next-of-kin of patients who had comorbid unhealthy coping strategies or problematic psychosocial histories prior to their death by suicide (e.g. forensic history, unemployment, and primary diagnosis of alcohol or drug dependence or misuse) were significantly less likely to be contacted by psychiatric professionals following a death by suicide (Pitman et al., 2017).

As a member of a culture that stigmatizes death by suicide, the bereaved people also have their own beliefs about the deceased and suicide as a cause of death. This stigma can include feelings of rejection, isolation, shame and blame towards the person who died and they may subsequently conceal the cause of death (Sveen & Walby, 2008). This appears to be greater following an unexpected death by suicide, compared with those where both the deceased and/or family members had experienced significant difficulties and worry in the lead up to the death, which is more likely to result in relief for those bereaved (Sveen & Walby, 2008). Stigma experienced by those bereaved after a death by suicide is therefore a combination of their own negative self-talk (Jordan, 2001) and the perceived or actual stigma from others (Dunne et al., 1987).

The bereaved person may also experience 'self-stigma,' which is the term used to describe the individual accepting the stigma as legitimate, and thus seeing themselves in the same stigmatized way as others do (Corrigan & Watson, 2002). For people who are stigmatized due to mental illness, self-stigma is particularly harmful, resulting in diminished self-esteem, self-efficacy, and social connectedness (Corrigan & Rao, 2012; Corrigan et al., 2006; Watson et al., 2007; Yen et al., 2005). Although there is little research available on the topic, emerging research and self-reports on self-stigma experienced by those bereaving the loss of a loved one due to suicide indicate that this is an additional source of pain (Sheehan et al., 2017; Sudak et al., 2008). Qualitative research has recently noted the extreme feelings of contamination, self -blame and shame, followed by extreme social avoidance to avoid triggering the feelings (Sudak et al., 2008). One professional and author, for example, disclosed, "Eventually I went to a different bank, food store, gas station, etc., so I would not be recognized as the mother of a young man who took his life" (Sudak et al., 2008; p.140). These reports have resulted in calls for approaches to suicide that reduce stigma, and to support bereaved families in ways that are free of stigma (Maple et al., 2014; Sheehan et al., 2017; Sudak et al., 2008). Given that perceptions of stigma are affect seeking and receiving social support amongst those bereaved due to their loved one's suicide (de Groot et al., 2006), addressing this topic is an urgent matter.

Coping paradigm

The coping paradigm is part of a biopsychosocial approach to suicide prevention that is person- and strengths-focused (Stallman, 2018). This framework, illustrated in the Coping Continuum (Figure 1), is stigma-free because distress is conceptualized as a normal human experience (Stallman, 2017). Subsequent to distress, everyone will attempt to feel better by using conscious and unconscious strategies to cope. With the goal of survival, people will firstly draw on healthy coping strategies. These include self-soothing activities (e.g. deep breathing, coping self-talk, and mindfulness), distracting or relaxing activities, and gaining support from family and friends. Healthy coping also includes accessing professional support when personal strategies are not effective. When people do not have adequate healthy coping strategies, their mind will still try to find ways to reduce their distress. It does this by drawing on unhealthy coping strategies. These strategies may reduce distress momentarily, but they are unhealthy because they are likely to result in adverse consequences and can weaken the natural survival instinct. Unhealthy coping strategies can include negative self-talk, activities (e.g., emotional eating, aggression towards self or others, alcohol and drug use), social isolation, and suicidality. Suicidal ideation can become habitual and, in the absence of other strategies to reduce distress, can lead to the thought that the only option to stop the distress is suicide. From a coping perspective, suicide is the result of an absence of coping skills.

Language and stigma

The narrative around deaths by suicide perpetuates stigma (Stallman & Ohan, 2018) . Society does not stigmatize the death of people who die from physical illnesses, even those with significant lifestyle causal factors (e.g. heart disease and diabetes) by saying "s/he killed him/herself", "committed suicide", "were selfish not to consider the impact on their family", "they chose to die", or "some people just weren't meant to live". Yet, this stigma is prevalent in discussions about those who die by suicide. Similarly, terms such as 'suicide survivor' to refer to a bereaved person implies difference, as it would not be equally applicable to physical illnesses for example, 'heart failure

survivor' or 'pneumonia survivor'. Language that chains those experiencing bereavement to the cause of death, that is suicide, perpetuates the focus on the cause of death, rather than the grief process related to the loss of a significant person in their lives. The coping paradigm aligns language about psychological problems with that used for physical illnesses (Stallman, 2018). Suicide, almost without exception, occurs as a result of an absence of alternative coping strategies. Stigma disappears when the narrative about deaths by suicide are comparable with other causes of death. It destigmatizes the deaths of people who die as a result of suicide, by changing language to 'died by suicide' similar to 'died from heart failure', 'died from a stroke', or 'died from pneumonia'.

Coping after the death of a loved one by suicide

As with other distressing events, the initial task following the death of a loved one is coping. Events do not cause emotions. Emotions arise subsequent to individual thoughts about an event (see Beck & Haigh, 2014). Emotions, therefore, drive distress. Distress drives coping. Unhealthy coping strategies, including suicidal ideation and suicide, are more common in family, friends and colleagues following a death by suicide than other causes of death (Brent et al., 2009; de Groot & Kollen, 2013; Hedstrom et al., 2008). This suggests differences in the way suicide is thought about. As shown in Table 1, thoughts that use a coping paradigm explanation of death by suicide result in emotions that focus on the loss of a loved one, rather than the cause of death. Stroebe and Schut's (1999) dual process model of coping with bereavement purports that coping involves confronting grief through loss oriented processes as well as focusing on restorative processes that allows both distraction from grief and investment in new identities, tasks and relationships. Similarly, the coping paradigm presented here allows the bereaved people to focus on their loss and grief (loss-oriented coping) as opposed to the cause of death and to engage in healthy coping strategies such as connecting with others and engaging in distracting activities (restoration-oriented coping).

Professional support after the death of a loved one by suicide

The needs of family, friends, and colleagues after a death by suicide is like any death—to cope with their grief and loss. It is important that professionals who have contact with the bereaved have the knowledge and skills to counter the prevailing stigma. There are four steps to a strengths- and person-focused approach to supporting people during bereavement following the death of a loved one by suicide:

1. Cause of death. To be able to assist those bereaved from a death by suicide, health professionals and others who communicate causes of death (e.g. coroners, police officers) need to: a) understand the coping paradigm of suicide; and b) communicate it to the next of kin. This provides the loved ones with a stigma-free narrative to be able to confidently communicate the cause of death with family and friends. This aids connection with social support during their grieving and minimizes social isolation caused by stigma.
2. Access to professional support. Professional support is an important part of everyone's coping continuum, to assist when personal supports are no longer sufficient. Support services should also use non-stigmatizing language—that is, language that would be equally applicable to a person bereaved by a loved one dying from a physical illness or suicide.
3. Support that is strengths- and person-focused and uses a coping paradigm. The Care · Collaborate · Connect format of supporting people who are distressed involves attending to their distress (listening), exploring their coping strategies (asking how they are coping), and connecting them with more intensive professional support people, as needed (working with them to identify and support their needs) (Stallman, 2017, 2018).
4. Tailored interventions. Psychotherapy may be useful for people experiencing complicated grief. Within a strengths-focus, the key tasks are promoting healthy coping and challenging dysfunctional beliefs about suicide and the person who died. People with complicated grief may also have comorbid psychiatric illnesses that warrant assessment and evidence-based treatment—Major Depressive Disorder and Post-Traumatic Stress Disorder are particularly prevalent in this population (Robinaugh et al., 2012).

Conclusion

Suicide prevention involves many factors, including healthy environments, responsive parenting, healthy behaviors, belonging, coping, resilience, and treatment of mental illness (Stallman, 2018). In the absence of alternative coping skills, some people die by suicide. Coping can then be particularly challenging for those bereaved following the death by suicide because of the prevailing community and self-stigma associated with suicide. This may result in unhealthy coping strategies, including social isolation, suicidal ideation, and suicide. The coping paradigm provides a non-stigmatizing explanation for the cause of death, tasks for those who are bereaved and a strengths- and person-focused approach to supporting people during bereavement. This approach removes stigma and promotes healthy grieving. Changing the narrative around the cause of death and connecting people with complicated grief with appropriate professional support and treatment may contribute to a decrease in stigma and a reduction in suicide in those bereaved following the deaths by suicide of family, friends or colleagues.

Footnotes

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Situation	Thoughts	Emotion	Behaviour
Death of a loved one by suicide	Stigma framework Self-stigma Actual social stigma Perceived social stigma	Distress	Unhealthy coping strategies
Death of a loved one by suicide	Coping planning framework Suicide results from coping skill deficits	Grief	Healthy coping strategies

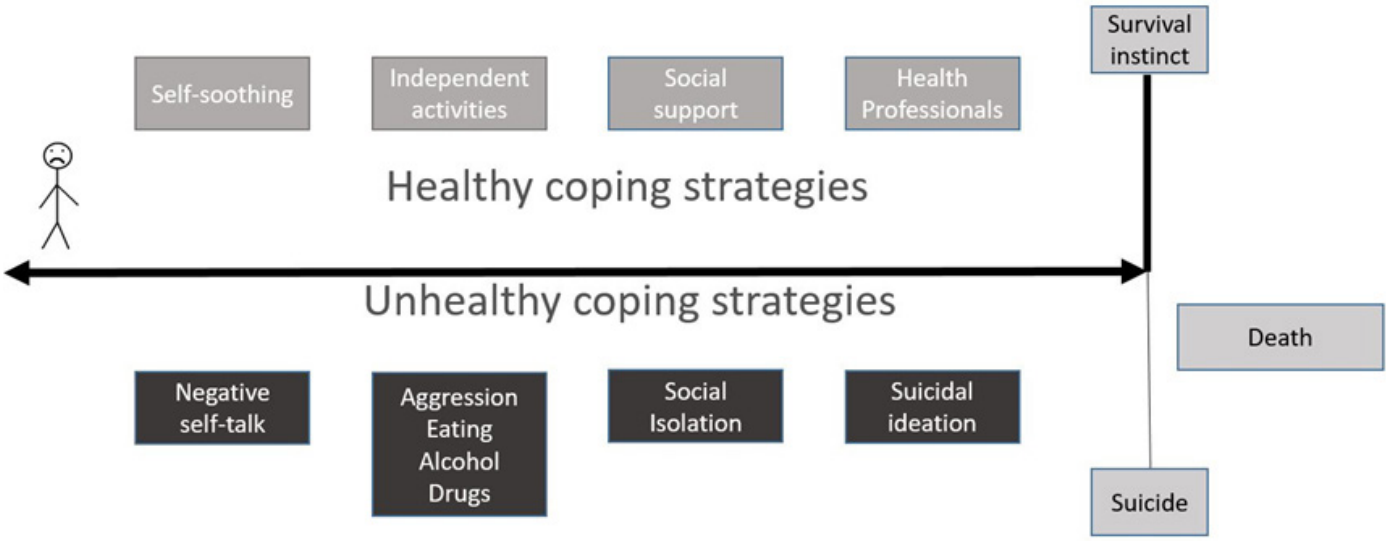

Figure 1
Coping Continuum (Stallman, 2017)