



The specificity of public stigma: A comparison of suicide and depression-related stigma



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ABSTRACT

Each year, approximately 1.3 million Americans survive a suicide attempt. While stigma has been reported by suicide attempt survivors, limited research has examined how suicide stigma may differ from the stigma of mental illness. U.S. adults ($n = 440$) completed an online survey in which they were randomly assigned to one of four vignettes. Vignettes depicted a target individual with either past depression, past suicide attempt, death by suicide, or no information on suicide or mental illness (control). Participants completed a general measure of stigma, a suicide-specific stigma measure, and were surveyed on the recovery potential of individuals with mental illness and suicide attempt. While the general stigma measure failed to distinguish between groups, significant differences on the suicide stigma scale (SSAS-44) emerged between participants assigned in the depression and suicide conditions, especially for stereotype and prejudice subscales. Across conditions, participants believed that recovery was more realistic for someone described as having a mental illness than it was for someone described as having attempted suicide. These findings suggest that individuals who have attempted suicide are subject to differential stigma content from those with depression. Implications are discussed for combating stigma for suicide attempt survivors.

1. Introduction

Globally, close to one million lives are lost to suicide each year (WHO, 2015). In the US alone, around 1.3 million individuals attempt to take their lives annually, but survive (CDC, 2013). For these individuals, stigma is a prominent concern. Suicide attempt survivors commonly feel ashamed about their suicide attempt (Tzeng and Lipson, 2004) and avoid talking about the attempt with others (Fulginiti et al., 2015). In some cases, family members may explicitly withdraw support from the attempt survivor, contributing to further social isolation (Frey et al., 2017). When individuals who attempt suicide avoid telling friends, family members, and acquaintances about the attempt, they are unable to fully benefit from informal support networks (Yakunina et al., 2010). Research indicates that stigma remains a critical barrier to help-seeking and full engagement in health services (Reynders et al., 2014; Calear et al., 2014; Chan et al., 2014; Gulliver et al., 2010). However, research on the stigma of suicide attempt has operated largely independently from that on stigma of mental illness and limited research has explored differences between the two.

Distinguishing between the stigma of suicide and mental illness is important for several reasons. First, research has found that stereotypes about individuals who attempt suicide fall outside the realm of

stereotypes about people with mental illness (Sheehan et al., 2016a; Batterham et al., 2013; Scocco et al., 2012). For example, those who attempt suicide are seen as attention-seeking, immoral, and potentially contagious. An understanding of how these suicide-specific stereotypes might impact their engagement in services, above and beyond mental illness stigma, is essential. Second, not everyone who attempts suicide has a diagnosable mental illness (Bertolote et al., 2004; Phillips, 2010). Thus, there is a subset of individuals who might be impacted uniquely by stigma of suicide. Third, while individuals can reduce or alleviate symptoms of mental illness, essentially removing themselves from the stigmatized category, a past suicide attempt remains an important part of the person's history, perhaps even in the form of visible scars. Finally, some individuals might perceive one type of stigma (e.g. suicide attempt stigma) as more salient or distressing for them. An ability to tease out differences between mental illness and suicide stigma could allow clinicians and anti-stigma programs to address needs specific to the individual.

Stigma is a complex construct that includes negative attitudes and behaviors directed at a particular group (Sheehan et al., 2016b). *Public stigma* occurs when members of a community or society hold negative beliefs about people (Corrigan and Watson, 2002). In contrast, *internalized stigma* occurs when an individual recognizes and applies public

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stigma to themselves, based on their membership in the stigmatized group (“Everyone else thinks I’m not capable, so I must not be”) (Watson et al., 2007). Self-stigma and public stigma have both been conceptualized through the social-cognitive model that includes three components: stereotypes, prejudice, and discrimination (Corrigan and Kosyluk, 2014). Stereotypes are the cognitions or beliefs that the public holds about members of the group (“People who attempt suicide are weak”). Prejudice is stereotype agreement and emotional reaction based on that group membership (“I’m afraid of that man because he tried to kill himself”), whereas discrimination is restriction of rights and opportunity.

There have been several efforts to conceptualize suicide stigma. Earlier work, such as the Suicide Opinion Questionnaire (Domino and Groth, 1997) focused more generally on the public’s beliefs about suicide. Recent work by Batterham et al. (2013) resulted in a scale (Stigma of Suicide Scale; SOSS) to measure the public stigma directed at those who have died by suicide. Scocco et al. (2017) have also created the stigma of suicide-survivor subscale (STOSSS) and the stigma of suicide subscale (STOSS), which measure perceived stigma of individuals bereaved by suicide (i.e. suicide loss survivors) and perceived stigma of suicide, respectively. Another measure, the Stigma of Suicide Attempt (STOSA) scale (Scocco et al., 2012) was designed to capture public stigma directed specifically towards suicide attempt survivors. The STOSA, however, is limited to the assessment of behavioral intentions. The Suicide Stigma Assessment Scale (SSAS-44; Corrigan et al., 2017), in accordance with the social-cognitive model, includes factors for public stereotypes, prejudices, and discrimination, directed at individuals who have attempted suicide. The SSAS-44 was developed from qualitative research with suicide stakeholders (Sheehan et al., 2016a) and refined in a large quantitative study (Corrigan et al., 2017).

Given the body of research, we wondered how public suicide stigma might differentiate from that of mental illness. Suicide can be viewed as the “end game” of mental illness in the sense that mental illness is seen as leading to suicide attempts and attempts lead to ultimate death by suicide. Thus, our first hypothesis was that public stigma would increase with perceived progression of illness, such that a person who died by suicide would be most stigmatized, suicide attempter, person with depression, and person without depression or suicide history. For those with mental illness, content and degree of stigma has been found to vary by diagnosis (Leach et al., 2008; Sheehan et al., 2016b). For example, people with schizophrenia are viewed by the public as more dangerous and incompetent than those with depression (Angermeyer and Matschinger, 2003). Therefore, it was important to choose a specific mental health diagnosis to compare with suicide stigma. We chose depression as this would seem the most logical progression to suicide. As the SSAS-44 contains subscales corresponding with stereotypes, prejudice and discrimination, this allowed us to compare how these might differentiate suicide stigma from depression stigma. Our second hypothesis, based on the findings that stereotype and prejudice content vary by diagnosis (Angermeyer and Matschinger, 2003), was that stereotypes and prejudice would show differentiation between a target who had attempted suicide and one who had been seriously depressed, whereas discrimination would not vary. We expected to see differences on a scale designed specifically to measure suicide attempt stigma, however we also wondered whether a more general measure of stigma (i.e. Difference scale) would differentiate between depression and suicide. Due to the nature of measure as an omnibus measure of public perception of difference, we expected it to distinguish a target with no depression or suicide history from a target with mental illness or suicide.

Finally, scholars have emphasized the importance of considering affirming attitudes in addition to stigma. They have argued that although it is essential to eliminate the negative attitudes and behaviors, it is just as important to replace these with more positive thoughts and actions (Corrigan et al., 2014b). One validated measure of affirmation towards people with mental illness is the public’s belief in recovery

Table 1

Demographic characteristics of participants (N = 440).

Variable	n	Percentage; M (SD)
Age		
Years	440	36.1 (10.60)
Range (in years)		20–77
Gender		
Male	232	52.7
Female	207	47.0
Other	1	0.2
Race/Ethnicity		
Caucasian/White	367	83.4
Black/African	32	7.3
Asian	35	8.0
Latino/Hispanic	25	5.7
Other	26	5.9
Sexual Orientation		
Heterosexual/Straight	397	90.2
Lesbian/Gay	15	3.4
Bisexual	22	5.0
Other/No Answer	6	1.4
Marital Status		
Single/Never Married	149	33.9
Married	167	38.0
Long-Term Relationship	90	20.5
Divorced/Widowed	34	7.8
Educational Level		
High School Diploma or less	57	12.9
Some College	164	37.3
Bachelor’s Degree	151	34.3
Graduate Degree	165	37.5
Employment Status		
Full-Time	280	63.6
Part-Time	61	13.9
Other	107	24.3
Household Income		
\$0–\$25,000	99	22.5
\$25,001–\$49,999	153	34.8
\$50,000–\$74,999	95	21.6
\$75,000 +	49	11.2

potential; however, similar research has not focused on suicide attempt survivors. In the current study, we included a measure of recovery, which we expected to be negatively correlated with our measure of suicide attempt stigma. We explored whether this affirming measure would distinguish between suicide and depression targets.

2. Methods

2.1. Participants

U.S. MTurk participants who were 18 years of age and older responded to the survey. Of the 535 initial respondents, 37 dropped out of the survey prior to completion or had missing data on questionnaires. An additional two participants did not enter a completion code for payment and nine failed one or more of the questions designed to detect insufficient effort responses. Data from these participants were excluded from analyses, as were 47 participants who completed the survey in less than six minutes, which was, based on pilot testing, an insufficient amount of time to thoroughly read and respond to all items. A total of 440 participant responses were analyzed.

Table 1 summarizes the demographic composition of the sample. Participants were fairly evenly split on gender (female; 47%) and were an average of 36.1 years old (SD = 10.6). Participants roughly approximated a representative sample of U.S. ethnic population, with White (83.4%), African-American/Black (7.3%), Asian (8.0%) and other (5.9%). Most participants (90.2%) identified as heterosexual.

Nearly two-thirds (63.6%) were employed full time and the majority of participants had household incomes between \$25,000 and \$75,000.

2.2. Procedure

The institutional review board at the Illinois Institute of Technology approved the study protocol and data was collected in April of 2016. Research participants responded to a solicitation on Amazon Mechanical Turk (MTurk) to complete an academic survey about perceptions of mental illness and suicide. MTurk is an online platform where workers complete tasks, including surveys, for pay. MTurk workers participating in survey tasks have demographic characteristics that approximate those of the U.S. population (Paolacci et al., 2010). While valid concerns have been raised about reliability of MTurk samples, careful data collection and screening practices can reduce this risk (Goodman et al., 2013). Participants gave informed consent, spent about 15 min completing the online survey, and were compensated through MTurk after submitting a completion code. Three quality-control questions were embedded within the survey in order to detect participants who did not read the questions thoroughly. For example, one quality-control question read: “Please choose answer choice three to continue.”

After giving informed consent, participants completed the demographic questionnaire and were randomly assigned to one of four vignettes. Vignettes were adapted from an existing measure of mental illness stigma, the Attribution Questionnaire (AQ-27; Corrigan et al., 2003) and were presented to a small sample ($n = 8$) for feedback. Minor revisions were made based on feedback. Vignettes stated that the target individual, Harry, had either a) been hospitalized due to depression six months ago, b) attempted suicide six months ago c) died by suicide six months ago or d) not struggled with depression or suicide at all. For example, the vignette condition depicting a suicide attempt read: “Harry is a 30 year-old single man who lives alone in an apartment and works as a clerk at a large law firm. About six months ago, Harry attempted suicide.” After reading the assigned vignette, participants completed scales measuring stigma specific to suicide, general stigma of difference, and recovery attitudes about people who attempt suicide. The assigned vignette was visible at the top of the screen at all times for participants to review as needed.

2.3. Measures

2.3.1. Suicide Stigma Assessment Scale (SSAS-44)

The SSAS-44 is a newly developed measure designed to capture three components of public suicide stigma: stereotypes, prejudice, and discrimination (Corrigan et al., 2017). This scale is used in conjunction with a vignette about Harry and includes items such as “How cowardly would you feel Harry is?” and “I would think Harry is looking for attention.” The format of this measure allows for easy manipulation of the vignette in order to compare and contrast stigma endorsement across different conditions for the social-cognitive components of public stigma. Items are scored on a 9-point scale, with scores ranging from 56 to 337. Subscales for stereotypes, prejudice and discrimination were derived using exploratory factor analysis (Corrigan et al., 2017). Three subscales (weak, crazy, and distressed) describe stereotypes about suicide, two subscales (fear/distrust and anger) describe prejudices and three (avoidance, disdain, and coercion) describe discrimination. Higher overall and subscale score indicate greater levels of stigma. Cronbach's alpha for the overall scale was 0.94 in this sample.

2.3.2. Difference

Participants were administered a 3-item semantic differential scale of difference (Corrigan et al., 2015) in order to rate Harry on three levels of difference (i.e. unlike me or like me; not similar to me or similar to me; and not comparable to me or comparable to me). This measure provides a general assessment of stigma that allows for

comparisons across disparate conditions, rather than focusing on specific stigma content. The Difference scale is designed to be less susceptible to effects of social desirability (survey takers may feel more comfortable agreeing that they are different from a target than rating the person as highly incompetent, for example) (Corrigan et al., 2015). The measure also promises greater sensitivity to detect stigmatizing attitudes. Each item was scored on a 9-point visual analogue scale and internal consistency for the current study was high ($\alpha = 0.98$). Difference scores ranged from 3 to 27 with lower scores indicating a greater level of difference.

2.3.3. Recovery Scale

The Recovery Scale (RS; Corrigan et al., 2004) is a measure of public beliefs about the recovery of people with mental illness. Three items from the original RS were selected that, based on past research, loaded highest onto the three factors of personal confidence and hope; goal and success orientation; and no dominance by symptoms (Corrigan et al., 2016). The RS items are framed to refer to people with mental illness in general (rather than about the target character in the vignette specifically or about a person with a specific diagnosis). The scale was scored on a 9-point strongly agree to strongly disagree scale with higher scores indicating greater belief in recovery. RS scores ranged from 3 to 27, with Cronbach's alpha of 0.60. An example item is “People with mental illness are hopeful about their future.”

2.3.4. Recovery Scale-Suicide Attempt

The RS-SA was adapted directly from the RS, with items changed from “people with mental illness” to “people who attempt suicide.” The RS-SA scores ranged from 3 to 27 and had a Cronbach's alpha of 0.54 in the current sample.

2.4. Analytic procedure

All analyses were performed in SPSS 22. Questionnaires with missing responses were not included in the analyses. Due to a protocol in the online survey platform which reminded participants to complete questions which might have been inadvertently skipped, missing data were minimal. A preliminary examination of the data failed to find any significant differences between the four experimental groups on age, gender, or race/ethnicity. Bivariate correlations were computed between study measures and a series of one-way ANOVAs were conducted to determine whether significant differences existed between outcome responses for the four vignette conditions. Tukey post-hoc tests were performed when F -tests were significant at $p < 0.004$. The Bonferroni correction ($0.05/12 = 0.004$) ameliorated concerns about Type 1 error resulting from multiple comparisons of total scores and subscales. ANOVAs were performed for total scores on the SSAS-44, Difference, and Recovery Scales. ANOVAs were also performed for the eight subscales on SSAS-44.

3. Results

Table 2 presents correlations between study measures as a validation of the survey instruments. Affirming and stigmatizing scales were

Table 2
Bivariate correlations.

Variable	1	2	3
1. SSAS Total			
2. Difference Total	−0.31**		
3. RS Total	−0.36**	0.15**	
4. RS-SA Total	−0.21**	0.22**	0.46**

Note: SSAS = Suicide Stigma Assessment Scale.

RS = Recovery Scale, RS-SA = Recovery Scale for Suicide.

** $p < 0.01$.

Table 3
Means, standard deviations and ANOVA results by measure and subscales (N = 440).

Measure	Subscale	Depressed		Attempted Suicide		Died by Suicide		Control		F	p	Partial eta
		n = 109		n = 116		n = 110		n = 105				
		Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)			
Difference	Total	12.18	(6.52)	11.30	(7.02)	10.78	(6.53)	13.05	(5.95)	2.52	n.s.	0.02
SSAS												
Stereotypes												
	Weak	20.20 ^a	(8.34)	30.44 ^b	(10.62)	30.80 ^b	(10.73)	16.71 ^c	(6.80)	64.56	0.000	0.31
	Crazy	9.79 ^a	(4.79)	15.41 ^b	(5.19)	14.95 ^b	(5.03)	9.56 ^{a,c}	(3.54)	50.64	0.000	0.26
	Distressed	30.39 ^a	(5.47)	32.44 ^b	(4.31)	32.40 ^b	(5.01)	13.09 ^c	(7.26)	301.60	0.000	0.68
Prejudice												
	Fear/Distrust	7.05 ^a	(3.16)	8.34 ^b	(3.33)	8.17 ^b	(3.23)	6.41 ^{a,c}	(2.52)	9.73	0.000	0.06
	Anger	7.78 ^a	(5.03)	12.96 ^b	(8.49)	14.45 ^b	(8.01)	6.59 ^{a,c}	(4.24)	35.30	0.000	0.20
Discrimination												
	Avoidance	39.41 ^a	(11.69)	39.99 ^a	(10.93)	42.96 ^a	(12.79)	34.70 ^b	(9.92)	9.66	0.000	0.06
	Disdain	14.13 ^a	(6.01)	14.96 ^a	(5.74)	15.67 ^a	(6.14)	10.92 ^b	(4.27)	14.94	0.000	0.09
	Coercion	17.76 ^a	(6.99)	19.98 ^a	(7.65)	23.70 ^b	(7.56)	10.16 ^c	(5.52)	71.20	0.000	0.33
SSAS												
	Total	146.51 ^a	(38.14)	174.52 ^b	(41.17)	183.12 ^b	(43.81)	108.14 ^c	(36.35)	76.76	0.000	0.35
RS												
	Total	16.96 ^a	(4.51)	16.03 ^a	(4.33)	15.37 ^a	(4.84)	18.21 ^b	(4.63)	7.78	0.000	0.05
RS-SA												
	Total	11.32 ^a	(4.91)	12.79 ^a	(5.00)	10.85 ^a	(4.39)	11.86 ^b	(5.13)	3.31	0.020	0.02

Note: SSAS = Suicide Stigma Assessment Scale, RS = Recovery Scale, RS-SA = Recovery Scale for Suicide

Post-hoc tests are indicated by superscripts. Within each row, means with different superscripts (^{a,b,c}) differ significantly ($p < 0.05$). For example in the “Weak” row, 20.20^a differs significantly from 30.44^b, while 30.44^b does not differ significantly from 30.80^b

correlated in the expected direction. The SSAS-44 and Difference measure were moderately correlated ($r = 0.31$) indicating that, across vignettes, participants endorsing more stigmatizing attitudes on the SSAS-44 rated themselves as more different from the target person. The RS-SA was negatively correlated with the SSAS-44 ($r = -0.21$) such that participants with more positive views of suicide recovery scored higher on suicide stigma. The RS-SA was positively correlated with RS ($r = 0.46$), meaning that individuals who believe in recovery of people with mental illness are more likely to also believe that individuals can recover from a suicide attempt.

Table 3 displays means, standard deviations, ANOVA results, and post-hoc tests for study measures. Contrary to our hypothesis that an omnibus stigma scale would differentiate stigmatized conditions from the control conditions, an F -test on the Difference scale failed to reach significance. Although means for the control conditions were greater than the suicide and depression conditions, participants were statistically no more likely to rate the target (Harry) as different when they read the suicide vignettes versus when they read the depression vignette or the control vignette.

In support of our first hypothesis, an ANOVA on the SSAS-44 was significant. On the SSAS-44, the depression and suicide vignettes differed significantly from the control condition. More importantly, and in partial support of our second hypothesis, the SSAS-44 distinguished depression stigma from that of suicide, especially in regards to stereotypes and prejudice subscales. Post-hoc tests revealed scores for the depression vignette that were significantly different from the attempted and died by stigma vignettes. Significantly lower scores also occurred when participants read the control condition (i.e. no mention of Harry having either depression or suicide attempt) than any of the other conditions. SSAS-44 scores were highest when Harry was depicted as dying by suicide, however these scores were not significantly different from those viewing Harry as having attempted suicide. Participants assigned the depression vignette had significantly lower SSAS-44 scores than those assigned to the suicide vignettes. We also compared SSAS-44

total score between participants who reported a past suicide attempt ($n = 34$) and those who did not. SSAS-44 scores did not vary significantly by suicide attempt status.

ANOVAs on the seven subscales of the SSAS-44 are also displayed in Table 3. All subscales showed significant group differences by vignette. The three subscales for stereotypes (weak, crazy, and distressed) and the two subscales for prejudice (fear/distrust, anger) had significant differences in scores between the depressed condition and the two suicide conditions. On 5 of the 8 subscales (weak, distressed, avoidance, disdain, and coercion), the control group scored significantly lower on the SSAS-44 than all three other vignette groups. In the “crazy”, “fear/distrust”, and “anger” subscales, a pattern emerged whereby the suicide conditions scored significantly higher than the depressed and control conditions. For two of the three discrimination subscales (avoidance and disdain), depression vignettes were not significantly different from the suicide-related vignettes. Only one of the eight subscales (coercion) showed a differentiation in scores between the two suicide conditions (attempted and died by suicide). Effect sizes for subscales (partial eta-squared) ranged from 0.06 to 0.68, with the distressed subscale resulting in the largest effect size.

Omnibus tests on the RS and RS-SA revealed significant differences between vignettes for RS-3, but not for RS-SA, as portrayed in Table 3. Post-hoc analysis for the RS found that the control group was most positive about recovery of people with mental illness and had significantly higher scores than the two suicide conditions. There were no significant differences between control and depressed vignette in terms of mental illness recovery. Interestingly, the group means for RS were much higher (ranging 15.37–18.2) than those on the RS-SA (ranging 10.86–12.79). A one-way within subjects ANOVA found that these differences were significant, $F(1334) = 294.63$, $p < 0.001$.

4. Discussion

Consistent with our first hypothesis, the SSAS-44 was able to

distinguish between people with history of depression and those with suicidal histories for total scale scores and for 6 of the 8 subscales. Most of these differences occurred on subscales describing stereotypes and prejudice, which was consistent with our second hypothesis, whereas discriminations were similar for depression and suicide. This appears consistent with findings that stereotype content varies by group. Stereotype and prejudice content vary for family members of mental illness (Corrigan and Miller, 2004) and for people with different diagnoses (Angermeyer and Matschinger, 2003; Sheehan et al., 2016b). Discriminatory behaviors however, seem to be more consistent across health conditions, perhaps because of the limited amount of distinct negative behaviors.

Despite past research indicating that suicide attempt survivors are more likely to endorse suicide-related stigma (Scocco et al., 2016), in the present study there were no differences in endorsement of public stigma directed at suicide attempt survivors between participants who had attempted suicide and those who had not. These contradictory findings might be attributed to differences in the stigma measures. The STOSA scale used by Scocco et al. (2016) asks participants to respond to items about how likely the members of the public (“most people”) are to engage in various social relationships with someone who has attempted suicide. Thus, the STOSA might capture an awareness of public suicide attempt stigma, which suicide attempters are more acutely sensitive to, rather than an endorsement of public stigma per se. Further research could examine how stigma is internalized by suicide attempt survivors and the role of psychological distress in the internalization process (Scocco et al., 2016).

In this sample, although we predicted that the public would view individuals who die by suicide as a more severe case of suicide, few significant distinctions emerged between stigma of people who die by suicide and stigma of those who attempt suicide. High scores on coercion for those who died by suicide may indicate the public's belief that more coercive strategies could have prevented the person from taking his/her life. Future research using different methodologies should seek to validate and expand on these findings. Additionally, the more global measure of difference (Hypothesis 3) failed to distinguish between the suicide and mental illness conditions. In fact, participants endorsed only insignificant differences between themselves and a person with history of depression or suicide behavior as compared with the control condition.

Recovery beliefs are viewed in the mental health stigma literature as the counterpoint to stigma (Corrigan et al., 2004). Scholars argue that while reducing stigma is a valuable goal, the enhancement of positive attitudes and behaviors is equally essential. Therefore, we included a measure of belief in recovery scale, adapted from the mental health literature. Across conditions, belief in recovery was higher for a person with depression than for a person who attempted suicide. Belief in recovery from mental illness and suicide attempt were inversely correlated with the stigma measures (Difference and SSAS-44), meaning that participants with more affirming attitudes towards suicide and mental health recovery are also less likely to express stigmatizing attitudes. While significant, these correlations were relatively small, suggesting that affirming and stigmatizing measures are capturing distinct aspects of participant attitudes. Participants who read vignettes about Harry attempting or dying by suicide, had less belief in recovery of mental illness than the control condition. This suggests that exposure to stories emphasizing suicidal behavior may impact belief in recovery from mental illness. These findings support the idea that suicide is seen as an extreme case of mental illness and underlines public beliefs that recovery is unlikely. Future research could explore aspects of recovery stories that might produce more positive aspects of recovery. For the recovery scales, it is important to note that the RS and RS-SA were not presented to participants as specific to the target person, Harry. Rather the two recovery scales were presented to all participants, regardless of vignette condition, and measured general prognosis of recovery for each specific group. Furthermore, interpretation of recovery scale

findings is questionable, given poor internal consistency of these measures in the current sample.

4.1. Clinical implications

Given the higher endorsement of stereotypes and prejudice for suicide attempt (as compared with depression) in this study, clinicians should be aware that individuals who attempt suicide might be subject to stigma of a greater magnitude and should be prepared to assist patients in processing experienced or perceived stigma from friends and family members. Stereotypes and prejudice might be perpetrated, even unintentionally, by friends, family, or faith communities. Clinicians can help patients recognize and address real or perceived stigma within their social sphere. If individuals who have attempted suicide fail to disclose their attempt or thoughts to helping professionals for fear of stigma, this can reduce the support available to a person already in significant distress. Furthermore, this public stigma could be internalized in the process of self-stigma, causing patients to see themselves as weak, crazy or deserving of anger from others. Physical and mental health providers themselves are not immune to stigma (Corrigan et al., 2014a), and even subtle prejudice can influence a suicide attempt survivor's experience with care. For example, a therapist with implicit mistrust of the client might struggle to develop rapport and ultimately discourage the client from continuing the relationship. To counteract this bias, clinicians can engage in a process of identifying and monitoring potential bias in their professional relationships (White and Stubblefield-Tave, 2016). Results of this study can provide a framework for examining bias specific to suicide attempt survivors.

4.2. Limitations

The use of Mturk workers for academic research has been criticized due to concerns with reliability of data and attention to task (Goodman et al., 2013). To address these concerns, we included quality control checks in the survey, and excluded data from participants who completed the survey too quickly. However, we cannot be sure that professional survey-takers recruited through Mturk were completely attentive. Selection bias might threaten generalizability; that is, participants responding to the solicitation may have had a particular interest in this research topic and not represent the diversity of possible responses. Critics have also questioned the representativeness of Mturk samples (Buhrmester et al., 2011). While our sample showed diversity in terms of age, ethnic minorities were underrepresented. Past research finds cultural differences in attitudes towards suicide, so results might have been different if research was conducted in another culture or with a more diverse sample (Domino, 2005). In the “depression” version of the vignette, the target individual, Harry, was described as having been hospitalized because of depression. Had the vignette described Harry with a different psychiatric condition (e.g. schizophrenia or bipolar disorder) there may have been quite different patterns between groups on the outcome measures. For example, given that people with schizophrenia are seen as dangerous and unpredictable, the scores for the SSAS-44 subscale of fear might have been higher for a vignette in which Harry had schizophrenia.

The outcome measures used in this study were not able to measure actual behavior towards people who have attempted suicide. Rather, our methodology was limited to self-report about attitudes and expected behavior towards the target in the vignette. Future studies should look at implicit attitudes towards suicide and actual acts of microaggressions towards people who attempt suicide. It would be especially important to look at possible stigma perpetrated by family members and healthcare providers, who have frequent contact with people who attempt suicide (Rimkeviciene et al., 2015) and the unique influences of internalized mental illness and suicide-related stigma.

Research can be undertaken to develop and refine anti-stigma programs specific to suicide. A comprehensive understanding of the most

salient public beliefs and attitudes in the form of stereotypes and prejudice will be essential to designing anti-stigma programs. Contact with people who share stories of suicide and/or challenge the myths of suicide stigma might be helpful as it has been shown in the case of mental illness (Corrigan et al., 2012). Identification of discriminatory behaviors that apply both to people with mental illness and those who attempt suicide should guide public and organizational policies of suicide prevention and care.

This study demonstrates the ability of the SSAS-44 measure to differentiate people who have attempted suicide from those with depression (i.e. discriminate validity). These results suggest that while the subgroup of people who display suicidal behaviors are subject to different stereotypes and prejudices than people with depression alone, discriminatory behavior directed at the two groups is very similar. Anti-stigma programs that recognize and address both the similarities and differences between the suicide stigma and mental illness stigma may better meet the needs of individuals who have experiences with both.

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