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Published online: 28 Nov 2017.

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The Dialectics of Stigma, Silence, and Misunderstanding in Suicidality Survival Narratives

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ABSTRACT

Modern suicidologists have noted a dearth of qualitative research on suicide. The first author conducted 20 in-depth interviews with formerly suicidal adults to understand how they accounted for their experiences contemplating or attempting suicide. According to participants, *stigma* necessitated impression management, which contributed to the production of *silence* and *misunderstanding*. Silence and misunderstanding reinforced stigma. This complex, dialectical, belief system about stigma yields insight into the interpretive culture of surviving suicidal ideation or a suicide attempt. These beliefs about suicide may serve as a barrier to individuals seeking help, recovering from suicidality, and larger social change regarding attitudes toward suicide.

People [researchers] don't take risks because we're too busy being sanitized, and talking about quantitative research instead of qualitative research. I mean, people are convinced that everything has to be nice and tidy and "we can't talk about anything bad." I mean, I want to talk about the taste of the gun barrel between my teeth. –Gina, suicide survivor

Introduction

Suicide is a pressing and perplexing public health problem: pressing because recent reports indicate increasing suicide rates (Curtin, Warner, and Hedegaard 2016), and perplexing because despite a large body of research dedicated to understanding why people die by suicide and identifying risk factors, suicidologists still struggle to understand why one person may turn to suicide whereas another does not (Joiner 2005). Since Jack Douglas' seminal work arguing for meaning-based suicide research (1967), scholars have argued that incorporating qualitative methodologies and the voices of those with lived experiences of suicidality may improve our ability to understand suicide (Hjelmeland 2010; Mueller and Abrutyn 2016), and therefore aid prevention and post-vention. For example, *The Way Forward*, published by the Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention (2014), called for more research that includes the voices of those who have lived through being suicidal, and several authors have identified the dearth of qualitative data that provides rich insight into the suicidal experience (Douglas 1967; Hjelmeland and Knizek 2010; Kral, Links, and Bergmans 2012).

Including data from individuals with lived experiences of suicidality can yield important insights into the culture of suicide that statistics alone cannot. Since Durkheim (1951), it has become clear that suicide is not simply a psychological phenomenon, but has social roots (Stack and Bowman 2011). As a social act (Kral 1994), suicide is laden with symbolic meanings learned from others.

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Where mental health issues play a role, social forces also matter. For example, the higher prevalence of suicidality among gay, lesbian, transgender, or bi-sexual youth is likely due, in part, to social rejection and stigmatizing cultural beliefs about same-sex attraction (Marshal et al. 2011; Mueller et al. 2015; Ryan et al. 2009). For others, how much support a person encounters could shape their experience of mental health problems, perhaps ameliorating their experience (Komiti, Judd, and Jackson 2006; Pescosolido 2013).

In this study, we draw on semi-structured, in-depth interviews with 20 individuals with a history of suicide ideation or suicide attempts in order to better understand the ways in which the perception of the need to manage stigma, seemingly for the sake of self and others, may hinder recovery from suicidality. Although prior work has acknowledged that suicide is highly stigmatized, our unique contribution is that we analyzed *survival narratives* to identify some of the common, everyday assumptions that accompany the lived experience of managing suicide stigma. Three dialectically interconnected themes emerged from the interview data: *stigma, silence*, and *misunderstanding*. Goffman's (1963) work on stigma frames the presentation of these data, yet it is arguable that our study participants were native sociologists in their own right who needed no help from Goffman in understanding and interpreting their situations. In what follows, we discuss a cultural approach to stigma and suicidality, our research methods, the dialectics of stigma, silence, and misunderstanding as interpreted from the narratives of our research participants, and accounting for suicidality and stigma. We conclude with some remarks about suicide stigma and mainstream culture.

Stigma: a cultural approach to suicide

The idea that suicide is a cultural phenomenon whose meaning, and therefore causal logic, varies across societies seems obvious to many (Barbagli 2015; Colucci and Lester 2013; Hecht 2013; Kral 1994), yet remains under-examined by suicidologists (Hjelmeland 2010; Mueller and Abrutyn 2016). Psychological research often emphasizes cognitive forces like depression, hopelessness, and psycheache as precursors to suicidality (Joiner 2005; Schneidman 1996), whereas sociologists overwhelmingly follow the Durkheimian tradition that resists cultural explanation in favor of structural explanations associated with integration (Maimon and Kuhl 2008; Pescosolido 1990; Wray, Colen, and Pescosolido 2011). Despite the relative neglect of culture, previous research underscores the reasons for exploring the symbolic-cultural facets of suicide. For instance, in what little cross-cultural research exists, primarily in anthropological suicidology, there is variation in meanings attributed to why people die by suicide, who typically dies, and how significant others tend to interpret suicidality (Chua 2012; Canetto 1997; Gulbas and Zayas 2015; Kitanaka 2008; Stevenson 2014).

Additionally, the literature on suicide contagion implicitly points to the effects prestigious role models, particularly entertainment celebrities, have on audiences exposed to their suicide (Stack 1987, 2005). Despite a lack of systematic evidence, several studies have found associations between the meanings media sources attribute to suicide (e.g., divorce, pill addiction, etc.) and the segment of the population most at risk of spikes in suicide rates (e.g., divorcees) (Pirkis and Warwick Blood 2001; Schmidtke and Hafner 1988; Stack 1992, 2009). Finally, an extensive body of scholarship has demonstrated a positive link between a personal role model's (e.g., a friend or family member) suicide and the probability of the exposed having suicidal thoughts and, in some cases, behaviors (Abrutyn and Mueller 2014; Bearman and Moody 2004; Mueller and Abrutyn 2015).

Goffman's concept of stigma (1963) is an excellent way to bring culture into suicide research. Most suicidologists understand that suicide is highly stigmatized (Mueller et al. 2015; Pescosolido 2013). Individuals with mental health problems are often shunned or made to feel as though they do not belong (Link et al. 2001). According to Goffman, stigma are relational status markers that signal to both the possessor and those deemed "normal" the former's negative esteem. Put differently, stigmatized attributes are "deeply discrediting" and reduce a stigma holder "from a whole and usual person to a tainted and discounted one" (Goffman 1963: 3). Ultimately, stigma are *cultural* in so far

as groups can develop stocks of knowledge and tacit assumptions about stigma, thus generating folk logics of stigma or "stigma-theories," i.e., sets of beliefs regarding the stigma. In turn, the beliefs behind the stigma can result in behavioral and attitudinal repertoires for interacting with a stigmatized individual, which take on an accomplished, given, quality. Because of the evaluative qualities of stigma, they take on a moral character (Yang et al. 2007). Stigma theories are often imposed with very real consequences for the negatively valued person whether he/she believes them or not (Thoits 2011). These beliefs often become self-fulfilling prophecies (Ridgeway 2006).

For Goffman (1963), there are two statuses regarding stigma: discredited and discreditable. A discredited stigma is publicly known; a discreditable stigma is not widely known publicly, but could be revealed. For instance, persons with mental illness frequently experience a discreditable status before disclosing their mental illness to others, but then can transition to a discredited status after disclosure (Corrigan and Penn 1999; Thoits 2011). Each status requires different impression management strategies. To manage a discredited stigma, individuals might deny their stigmatized status, pretend that the stigmatized status did not exist, or surround themselves with those who share the stigma. To manage a discreditable stigma, individuals might hide their identity, choose not to disclose their stigma by avoiding intimacy with others, or spend time with people who were ignorant of the stigma.

When a stigma results in the need to negotiate status during an interaction, the result could be problematic (Goffman 1963; Thoits 1985). Goffman emphasizes that the revealing of, or presence of, a stigmatized characteristic may disrupt social interaction by causing discomfort and awkwardness, particularly when others were ignorant about how to conduct themselves in response to the stigmatized attribute, or were unaware of their own status in relation to the stigma-holder (Goffman 1963; Grier, Rambo, and Taylor 2014; Lucas and Phelan 2012). In what he termed a "courtesy stigma," Goffman suggested that stigma not only affects the experiences of the stigma-holder, but also has social consequences for those with whom the stigma-holder most closely associates (Corrigan and Miller 2004; Goffman 1963). Many of these characteristics of stigma were described in the accounts of former suicide ideators and attempters.

The voices of suicide survivors: methods

Survival narratives were gathered from a convenience sample of 20. Semi-structured, in-depth interviews were conducted with adults who self-identified as being formerly suicidal, having either contemplated or attempted suicide in their past. The study participants were recruited through flyers and snowball sampling techniques over a six-month period in 2015. The interviews, which lasted between 60 and 90 minutes, were conducted in-person at a mutually agreed-upon location, or over the phone. Each interview was digitally recorded and transcribed. Interview topics included the life circumstances that led up to the participant's suicidal periods, the nature of the participant's relationship with family members before, during, and after being suicidal, the types of general reactions and support that the suicidal individual received from relatives, friends, colleagues, or mental health professionals, and how the participant's life perspective changed since being suicidal.

The median age of the participants was 35.5 years (range = 22–65 years). The sample included three male participants (15%), 16 female participants (80%), and one participant who identified as gender-fluid (5%). Eighteen participants identified as white (90%), one identified as biracial (5%), and one identified as Asian (5%). Seven of the participants (35%) identified as former suicide ideators and 13 (65%) identified as suicide attempters. Three of the participants (15%) identified as mental health professionals.

The interviews were coded using QSR Nvivo 10 software. The participants' privacy and anonymity were protected by assigning pseudonyms and changing or redacting identifying details, including the names of specific people and places. All the transcripts were first coded using a grounded open-coding process that was issue-focused, concentrating on notable, recurring themes (Weiss 1995). They were further coded to narrow the focus of the analysis, integrating similar

excerpts from participant cases to draw attention to the themes most relevant for this study (Weiss 1995). In the following section, we analyze the participants' descriptions of the stigma process while enacting a suicidal identity.

Dialectics of stigma, silence, and misunderstanding

Three dialectically interconnected themes were identified by study participants: *stigma, silence*, and *misunderstanding*. Everyone in the study associated *stigma* with their own suicidal ideations or attempts. A spoiled identity was described as something to be managed and negotiated with oneself and others (Goffman 1963). *Silence* was specified by most as a strategy engaged in by self and others to negotiate interacting around suicide stigma. All the participants reported *misunderstandings* around the meaning of suicide, particularly among significant others who were described as relying on inaccurate information or no information at all, regarding why people sometimes feel suicidal. We also note how silence and misunderstandings are described as perpetuating suicide stigma for self and others. In the discussion that follows, each of the themes identified in the dialectic—stigma, silence, and misunderstanding—are foregrounded in their own sections. The themes are not mutually exclusive; rather, they are described as moments in an emergent, ongoing, dialectical process, which may serve to silence those who have lived through suicidal periods and/or isolate them from gaining access to resources and thus heightening the intensity of the suicidal experience.

Stigma around suicidality

All 20 participants reported stigma around suicidality at least two or more times during their interviews. Fourteen participants (70%) noted situations where they felt stigmatized 10 or more times during the 60–90-minute interviews. Participants expressed feeling discriminated against, judged, excluded, or devalued by family members, rental/leasing agents, hospital staff, and university personnel—feelings that have been reported in past studies of those who attempt suicide (Wiklander, Samuelsson, and Asberg 2003). Perhaps more surprisingly, respondents felt stigmatized from co-workers who specialized in mental health, which has also been found in previous research (Wolk-Wasserman 1985).

In terms of family, Danielle noted, "It was sort of like I brought shame upon my family and stuff like that." Elise stated, regarding her family, "[If they] find out about a suicide attempt… they will judge you for that, because it's, you know… a loss of control, something scary, something fearful, to discriminate against."

Elise related a specific instance of discrimination when she tried to rent a room:

> One time, I was looking for a room to rent in a house, and this older lady had a spare room … While she was interviewing me, I said I had a disability pension [for mental illness]. And she said, "Oh, no, I can't. There used to be a girl here who had depression and she made a suicide attempt and there was too much drama with the ambulance here," and she was so upset, and she said she didn't want that kind of goings on in her home, so, she refused to rent to me.

Morgan chronicled returning to her university following a hospital stay after she threatened to jump off a building, but did not make an attempt:

> The school had told my roommates what happened, and, I don't know. It was really weird because the school was even like wanting to kick me out of the dorms. And the whole experience was weird, it was like me trying to reassure everyone else that it was okay, instead of the other way around. It was me having to explain to everybody, like, "Oh, its fine. Everything's fine." …I felt like they were afraid of me a little bit, like everyone felt like they had to walk on eggshells.

Andrew also described being rejected by a school after disclosing his history attempting suicide:

> I asked them why I didn't get in, and their response essentially was that they didn't know how stable I could possibly be with my mental health and they didn't want to take a gamble with the students that were on that campus.

A few participants claimed that medical staff stigmatized suicidality. Nathan reported:

> You know, quite often, the first responders, or the people in the emergency rooms, actually do more damage by their actions. They're not treating people with respect, and they're showing their own prejudice and discrimination. I've always steered clear of emergency rooms, but there are a lot of people who I have met that had the experience of the emergency room, being chained or handcuffed, having their feet handcuffed to a gurney, or whatever. It's really quite dehumanizing.

All three respondents who worked in the mental health field supported this perception and claimed that suicide stigma was prevalent among professionals who work with suicidal people. Heather stated:

> Even though I was working in the mental health field at that time, I had mental health professionals working all around me, in their cubicles, and talking on the phone, and doing brief strategic counseling for people, and of course handling the occasional suicidal call. And well, I mean, I knew that if I went to someone in my field and said, "I'm suicidal," they're going to pick up the phone and call, and I was going to be committed.

Nancy, who claims her experience with attempting suicide inspired her work in the mental health field, likewise described concern about being stigmatized at her workplace:

> And if you're an employee there, clearly you don't say that [you are suicidal], because if you do, you're going to get fired, or something like that. I feel like it's still challenging to be able to talk about. I feel like professionals are not well-prepared, and I feel like they don't know how to respond properly.

Research participants reported stigma was spoiling their identity with loved ones and impacting their access to resources such as housing, employment, education, and, as we will see, even mental healthcare for suicidality. Nancy's claim "clearly you don't say that" in her workplace foreshadows the next "moment" in understanding the dialectics of suicidality and stigma—silence.

Silence around suicidality

Thirteen of the participants claimed that the stigma around suicidality, at times, created a dynamic that rendered them silent or silenced about their suicidal experiences. They claimed to discuss their suicidality with loved ones less or not at all, because they feared the responses of others. Likewise, their loved ones, at times, were described as silent, cutting off, minimizing, or redirecting discussion about suicidal experiences. Participants claimed that sometimes loved ones told no one else about the participant's suicidality. These silences were characterized as reinforcing suicidal feelings. Thoits (2011) similarly found that respondents who struggled with mental health stigma were reluctant to share with others or seek help because they feared shaming from others, especially those outside their intimate circle.

Tessa's response reflects this logic:

> Well, people who are contemplating or going through suicide, they don't wear their emotions on their faces. They're very scared. They're very, well, they make themselves isolated for a reason, to make sure no one knows about why they're doing this. Because they will be judged. They will be critiqued.

Veronica described remaining silent about her suicidality:

> I think that has to be one of the major features of people who attempt suicide, or think about suicide, or become suicidal, is it is essentially a lonely business…. If you're serious about it, and it does scare you, then you don't go tell people about it. And then, that isolates you further. And that contributes to the fear, and you wanting to isolate yourself. You don't want other people to feel the fear, so you kind of just take it on yourself, and you're like, "well, I don't want to freak everybody else out, because I'm freaked out."

All three of the mental healthcare workers in this study described workplace silences regarding their suicidal past, or even chose not to seek help, because of the stigma associated with it. Heather stated, "I hid it very well. There is no one who knew I was even depressed. I am not exaggerating; no one knew… So, I never went to see a mental health professional." Stacie expressed similar sentiments:

> I mean, I feel like since there is still such a stigma attached, that nobody that I work with [in the mental health field] knows that I've attempted suicide, or the depth of my depression. It's quite a shame really, but it's really also very fascinating. I think there are still a lot of people that don't get it.

When Paige threatened suicide as a teenager, she felt that her father minimized, or even dismissed, her suicidality. She claimed she was sent to her room, silenced for being "too dramatic:"

> When I grabbed the knife, I realized: oh my God, this is final, and this will probably hurt, and what happens if it doesn't work out? When I noticed my father there, it was really dramatic. I was like, "Ugh, I can't do it!" And he was like, "You're so dramatic! Go to your room!" And so I went back and laid down and fell asleep on the floor… I think he had so much to deal with, so much pressure, he just couldn't take it.

Regarding her family's coping following her suicidality, Danielle characterized them as "forgetting:"

> But, you know, we never sat down and talked about it. And they never went to counseling. And maybe my parents talked about it, I don't know. There were a few relatives that knew, but pretty much it was just like forgetting that it happened I guess.

When describing her parents' attempt to redirect conversation away from her suicidality to their own feelings, Hillary characterized her parents as unsupportive:

> I wanted to die! I wanted to end my existence! I wanted to be no more! It was like, "Do you not understand what I'm saying?" And I think, with my parents mainly, that was the biggest thing: they looked at it like, "But what did I do? We've done this, and we've done that…"

"I think there are a lot of people that still don't get it," and "Do you not understand what I am saying?" foreshadow the last moment to be described in this dialectic—misunderstanding.

Misunderstanding around suicidality

All 20 participants reported misunderstanding around suicidal experiences. Misunderstanding will be used here as an umbrella term to cover an array of failures to relay information about suicidality. Participants frequently reported feeling that significant others would not acknowledge or comprehend the depth of their suicidal feelings. Participants described feeling personally misunderstood during their suicidal period(s) or that significant others lacked knowledge regarding suicide. Tessa characterized misunderstanding as oversimplification:

> People don't want to think that hard. People don't want to see the real truth, I guess. Or they just don't think it's a very important factor that leads up to suicide or attempted suicide. They're just like "Okay, well, she might be unstable." Or, you know, something very simple. They try and simplify suicide. That's it. That's their whole kind of thing. That's why people don't talk about it, just because it's a very unknown kind of subject.

When there is no script around the topic of suicide, or the script is perceived to have been written incorrectly, social interactions are described as problematic.

Prior research has found that people viewed suicide as a *selfish* act (Batterham, Calear, and Christensen 2013), as *attention seeking* (Sudak, Maxim, and Carpenter 2008), or as *weak* (Batterham, Calear, and Christensen 2013). Our study participants appealed to these categories as exemplars for being misunderstood. Tim described suicide as something he attempted out of desperation, not because he was being selfish:

> You know, through my attempts, I kept thinking, "I love my family, and I hate the fact that I have to do this to my family. But, it's something I need to do." It was something I needed to do. I felt like I needed to do it. You know, what if people say, "Yea, well, you needed to do it to your family, so it was a selfish move." And I'm like, "No, it was a very difficult move!" I mean part of it is [that they're] trying to help me, but that's the least of my concerns in that moment.

Danielle also characterized selfish as an inaccurate representation of suicidality:

> Having gone through that, I now do not work with the idea that suicide is a selfish task. I mean, I can now view it as being an immense pain, you know? A type of pain that won't go away. A type of anguish. And I can identify with people who feel that way because I know what they're going through. And I know that it's hard. They don't want to feel like that. They don't want to have those feelings. But a lot of times it's the brain make-up, or situations that they're in, I can sympathize with those people.

In both situations, defining their choices as selfish was characterized as dismissing and/or displacing other interpretive possibilities for their suicidal experiences.

In terms of being perceived as attention seeking, Nathan discussed the difference between suicidal ideation and an attempt as follows:

> But, that's a perception, from what I've observed… because when you attempt, quite often, you'll have that comment, "Oh, you're only seeking attention," or whatever. And my argument to that is, "So? So what?! You know? The person is crying out for help! So why should attention-seeking be something to be devalued?"

Danielle described going back to work after an absence, where she identified a particular brand of attention seeking, the "cry for help:"

> I sort of lied to my bosses because I didn't want them to know exactly what was going on… I don't think they really knew how to handle it. And, for my family and everything, we didn't talk about it again. I just kind of swept it under the rug. They chalked it up to a cry for help.

In both cases, the misunderstanding was described as silencing further conversation about suicidality.

Veronica claimed that disclosing her suicidality would make her appear vulnerable or weak. She stated, "And so, I keep it in. And, I don't know, I think also there's something about it that might make me feel like it's expressing a vulnerability and a weakness. I don't usually show that in my outward personality." Paige's version of weak cruelly covered multiple dimensions of attempting suicide:

> Some people see it as, "Oh, well, you're weak," you know? "You failed." Or, "You're weak, not only for believing that you should commit suicide, but you're weak for trying to commit suicide, and you failed at it, so you can't even kill yourself."

Each exemplar of misunderstanding served as stigmatizing definitions of self, which were described as shutting down further communication regarding suicidal experience.

The majority of participants characterized family members or loved ones as lacking knowledge about where to turn to seek help for their suicidal loved one, or not knowing what to do, how to act, or what to say, during or after a suicidal crisis. Participants often stated that their family members should have sought help for themselves during the participants' suicidal period(s). Participants felt that this might have helped alleviate the ignorance or shame that family members were faced with upon learning of a loved one's suicidal crisis.

Nancy claimed she wished that her parents had asked her more probing questions during her suicidal period, but that they were not willing to do so:

> I wish my parents would have pressed further. Because they spent a lot of time talking about us, all of us children, you know, with all of our different stumbles and stuff. And they could see that there, I mean, they are both well educated, they could see that there was something going on. But they didn't know how to handle it, and they didn't know what to do about it… but they were content, if I just verbally said I was fine, then they were content with that.

Similarly, Elise stated:

> Often they would be alarmed, but not really know what to do, or not have the skills to help me. They, at best, would tell me to get help, or go to the hospital or something. But nobody actually, like, drove me to the hospital, or intervened in any way other than talk to me on the phone.

Sometimes loved ones were described as avoiding the participant as a result of not knowing what to do. In this regard, Stacie commented:

> I didn't see any of my friends after that. They just didn't know how to handle it. I mean, who knows how to handle somebody who tries to commit suicide? At one point, they did come back. They called me, and they wanted me to go out with them. And I lived probably about an hour from the college. And they came down, but then they never came back anymore.

When family members and loved ones are construed as having no formulas for interacting, they are framed as constructing meanings based on misunderstandings, bad information, or no information at all. These, in turn, are described as dialectically perpetuating stigma, and reinforcing silences.

Accounting for suicide and stigma

In this research, we have identified three dialectically interrelated themes that our study participants appeal to in their survival narratives: stigma, silence, and misunderstandings. All of the participants described experiences with stigma in the aftermath of suicidality, all of them described experiences with misunderstanding, and most of them described experiences with various forms of silences. Each of these themes individually reflected aspects of our participants' collective cultural understandings, or stocks of knowledge, about suicide. Taken together, they comprised a complex system of beliefs, which served them in accounting for their experiences with suicidality and its aftermath. We conclude that our study participants are, in fact, very well-informed theorists of stigma, possibly to their detriment.

At the outset of this study, we attempted to identify clear, mutually exclusive categories regarding stigma and suicide to present to readers. It was impossible. Often we identified excerpts from the transcripts to illustrate a theme, only to be confronted with the presence of the other two themes. Once we became sensitized to the idea of a dialectical relationship between the three themes, our troubles understanding what our participants were trying to express to us and how to present it dissolved. In their survival narratives, our study participants employed all three themes to narrate a nuanced, native theory of suicide stigma, and to frame their experiences. Although the evidence is compelling that this is likely the truth of their experience, that these things really did happen to them, that their interpretations of events are likely correct, the so-called truth is irrelevant for understanding the point that we would like readers to take away from this study.

Danielle may not have brought shame to her family; perhaps she only thought she did. Elise may not have been discriminated against while renting a room; she may have been the one misunderstanding. Nathan did not report being stigmatized by medical staff regarding his suicidality; he only heard about it from others. If we had the ability to observe suicide survivors in their everyday lives, 24 hours a day, seven days a week, we may or may not observe them acting like those with mental illness (Lucas and Phelan 2012; Major and O'Brien 2005), who also reported interpersonal difficulties such as relationship disruptions, and acquiring employment, housing, mental healthcare, and education. If we watch closely, they may or may not be observed discussing their suicidality with loved ones less or not at all, because they feared their responses. Significant others may or may not silence them, cut them off, minimize their feelings, or redirect discussion about suicidal experiences as a coping mechanism. Loved ones may or may not choose to tell others about the participant's suicidality in order to avoid the courtesy stigma associated with their actual identity (Corrigan and Miller 2004; Goffman 1963) such as "bringing shame to the family." Significant others may or may not lack knowledge regarding suicide. We cannot know these things from these interviews.

What we can observe are the claims they make with an interviewer regarding their experiences with suicidality. Herbert Blumer, one of Goffman's professors, stated "…people act toward things on the basis of the meaning that these things have for them, not on the basis of the meaning that these things have for the outside scholar" (1969:51). Along a similar vein, Thomas and Thomas wrote, "if men define situations as real, they are real in their consequences" (1928:572, as cited in Merton 1995). All of our study participants claimed to deal with, or be concerned about, negative social labels that change their social identities and self-concepts. They also, like good stigma theorists, claimed to manage their identities with strategies such as lying about their status, not wearing their

emotions on their face, or otherwise hiding the identity (passing). They reported not talking, "sweeping it under the rug," and avoiding intimacy with others. They also described not wanting to disrupt social interaction by causing discomfort and awkwardness (they are symbolic interactionists and ethnomethodologists, as well). If those who have suicidal ideation or a suicide attempt in their history view themselves as heavily stigmatized, unable to secure resources, and toxic enough to stigmatize their loved ones, they are going to act on those beliefs, which, in turn, will bring about real-world consequences and create a self-fulfilling prophecy for them. This suggests repercussions beyond individual identity and social interactions.

The dialectics of suicide and stigma: The big picture

Surviving suicidal ideation or a suicide attempt, as portrayed by our study participants, is quite the challenge. Stigma has an accomplished, taken-for-granted, character for those who assign it and those who experience it. As stated earlier, stigma theories are often imposed from without with very real consequences for the negatively valued person whether one believes them or not (Thoits 2011). These beliefs, in turn, often become self-fulfilling prophecies (Ridgeway 2006). It is our contention, based on these data, that stigma can be imposed from within, whether one believes it or not. And this, in turn, also creates self-fulfilling prophecies.

Stigma can be thought of as a regulatory sanction, which blocks an individual's access to connection and thus integration with the group, or as Neil Peart of the 1980's pop rock band, Rush, informs us in his song entitled Subdivisions, "conform or be cast out." The deeply discrediting nature of suicide stigma is assumed by all of the study participants. In order to recover, individuals must address the issues that made suicide an option for them. In addition, if survivors of suicidality act as if their assumptions about stigma are true, they will avoid having interactions with others around their status with suicide (indeed, they may avoid most or all social interaction, period). Said differently, they will "cast themselves out" before others can do it to them. The perceived need to do impression management serves to "dis"-integrate the individual from the group. By being silent, avoidant, or otherwise shutting down communication when they sense others are discomforted by the topic of suicide, they isolate themselves.

For Blumer, "…meanings are handled in, *and modified through* [emphasis ours], an interpretative process used by the person in dealing with the things he/she encounters" (1969: 63). Because of stigma, the dialogue between those with suicidality and mainstream society is stagnant. Other interpretive possibilities for suicidal experiences can be dismissed, displaced, or outright silenced. At the macro-level, avoiding stigma through silence would perpetuate potential misunderstandings, or create an outright knowledge vacuum as described by some of our participants. Logic dictates that silence will ensure the existence of a closed, negative, non-correcting, feedback loop, which can serve to isolate suicide ideators and attempters from influencing the mainstream discourses regarding them, or constructing and modifying alternative definitions of their situations. Likewise, isolation prevents suicide ideators and attempters from internalizing more positive definitions of their situations from others. Without dialogue, social change is slow and suicidal ideation and attempts will continue to be stigmatized, silenced, and misunderstood.

Although most suicidologists understand that suicide is highly stigmatized, the meanings assigned to the stigma can be elucidated only by those who are subject to it. Psychological research emphasizes the cognitive forces involved in suicide. Typical sociological research on suicide is quantitative in nature and explores the structural explanations of suicide. Although such methods are important and useful, exclusive adherence to these perspectives neglects the role of culture in possible explanations regarding vulnerability to suicide. Additionally, they tell us little about the "on the ground," lived experiences of suicidality. By answering the call to take a qualitative approach to research on suicide, it is our hope to begin to disrupt the stagnant discourses and silences around suicidality. By listening to former suicide ideators and attempters, we were made privy to a very complex set of beliefs about stigma that served not only as a

potential barrier to seeking help (Batterham, Calear, and Christensen 2013; Canetto and Sakinofsky 1998; Rusch et al. 2014; Simon and Nath 2004), but also as a potential barrier preventing them from reintegrating back into society. Integration, like dialogue, is a two-way street. Stigma and marginalization interrupt the processes whereby the meanings around suicide are handled and modified in an interactive manner.

Declaration of interest

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