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"I still think there's like a huge stigma": Understanding suicide-related stigma among those with lived experiences

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ABSTRACT

The present study aimed to understand the experiences of those with a history of suicidal thoughts versus suicide attempts with regards to suicide-related stigma and whether there were differences between these groups. Thirty participants aged 18 to 71 years (70% female) took part in one-to-one interviews about their experiences of suicide-related stigma, 50% had a history of suicidal thoughts, and 50% had a history of suicide attempts. Five main themes were identified: 1) *"suicide is stigmatised;"* 2) *"it's like the elephant in the room, nobody wants to talk about it;"* 3) *"I was so ashamed;"* 4) *"I think generally people think suicide is selfish, cowardly, inexplicable, mad;"* and 5) *"So I guess it's about being taken seriously and being believed almost."* Both groups (suicidal thoughts group and suicide attempts group) described similar experiences of suicide-related stigma. Suicide-related stigma often made them feel more suicidal, unsupported, and hesitant to seek help.

Suicide is a global health concern, with around 727,000 people dying by suicide each year across the world (WHO, 2024). Moreover, research findings show that one suicide can affect up to 135 individuals (Cerel et al., 2019). It is estimated that over the course of a lifespan 1 in 5 people experience suicidal thoughts and 1 in 15 people attempt suicide (MIND., 2020). The number of people affected by suicide either through their own suicidal thoughts or behaviors or by the death of a loved one to suicide emphasizes the need for research in this area. However, as highlighted in a recent *Lancet Commission* (Thornicroft et al., 2022, p. 1438) for many people mental health stigma is "worse than the condition itself". The combination of the high levels of suicide globally and the double jeopardy of being suicidal and the associated stigma emphasizes the importance of research in this area. Link and Phelan (2001) define stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination. In addition, suicide-related stigma can take the form of self-stigma (internalized stigma people hold about themselves; Busby Grant et al., 2016; Hanschmidt et al., 2016; Sheehan et al., 2017), public stigma (stigma held by members of society about suicide; Busby Grant et al., 2016), anticipated/perceived stigma (the fear of being discriminated against due to stigma; Busby Grant et al., 2016) or structural stigma (societal-level conditions, norms and policies that constrain the stigmatized; Hatzenbuehler & Link, 2014; Hatzenbuehler, 2018).

The *Lancet Commission* also discusses the different consequences of stigma such as social exclusion related to education, the workplace and the community. Suicide-related stigma has been associated with suicide attempt survivors feeling isolated, unsupported, and ashamed of their suicide attempt as a result of the negative labels attached to suicide and their internalization of these (Oexle et al., 2019; Rimkeviciene et al., 2015). Research has found that suicide-related stigma is linked to decreased help-seeking, complicated grief, increased mental health concerns and an increase in suicide risk (Carpiniello & Pinna, 2017; Feigelman et al., 2023; Fong & Yip, 2023; Maclean et al., 2023; Oexle et al., 2020; Ruzhenkov et al., 2015; Sheehan et al., 2020; Wyllie et al., 2025). Interestingly, the Carpiniello and Pinna (2017) study describes how increased levels of suicidality may also cause higher levels of suicide-related stigma, suggesting a reciprocal relationship between stigma and suicide. However, there are a few papers which highlight the protective

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nature of suicide-related stigma (Oexle et al., 2022; Prawira & Sukmaningrum, 2020).

Relevant to the current study, however, is the idea that individuals attach undesirable or negative labels to a group of individuals in order to create an "us" vs "them" dynamic which separates individuals into groups and ultimately leads to the discrimination of individuals who are negatively labeled and fall into the "them" category (Andersen et al., 2022; Link & Phelan, 2001). Previously published literature highlights that stigmatizing attitudes and negative labels attached to those who attempt suicide or die by suicide include: "attention-seeking", "stupid", "selfish", "crazy", "weak", and "immoral" (Rimkeviciene et al., 2015; Sheehan et al., 2017). Individuals often report experiencing these stigmatizing attitudes from friends and family (Binnix et al., 2018; Fulginiti & Frey, 2018), and more worryingly from health-care professionals (Freeman et al., 2022; Gaffney & Bergmans, 2022). Several studies have highlighted that stigma was experienced at the point of help when individuals have felt that they were not taken seriously or were simply told they did not deserve help and treatment following an attempt (Freeman et al., 2022; Gaffney & Bergmans, 2022; Ruzhenkov et al., 2015). However, the findings have been mixed. For example, Maple et al. (2020) found that a doctor had defended a suicide attempt survivor, after she experienced stigma from her family after an attempt. Stigmatizing attitudes are experienced by individuals, however they can also be perceived or internalized by those with experiences of suicidal thoughts and/or behaviors (Heard et al., 2022; Oexle et al., 2019; Rimkeviciene et al., 2015). Among those bereaved by suicide, the silence around suicide within communities as a result of stigma may have a negative effect on their capacity to be open about their loss, causing unnecessary pain among these individuals (Carlon et al., 2025).

The existence of suicide-related stigma can likely be explained by the historical criminalization of suicide (e.g., suicide was only legalized in the UK in 1961) and the associated potentially stigmatizing language often used to describe the actions of those who have died by suicide, for example, use of the term 'committed suicide'. Moreover, suicide is still illegal in at least 23 countries around the world (IASP, 2025). Many efforts have been made to tackle suicide-related stigma, for example through peer-to-peer school-based suicide prevention training (Wright-Berryman et al., 2022), mass media efforts (Niederkrotenthaler et al., 2014), and suicide prevention strategies which specifically address stigma (Scottish Government, 2025). Though it is clear from recent research that more work is necessary to tackle the negative effects of such stigma globally (WHO, 2024).

Overall, it is clear that the stigmatization of suicide is damaging to those with a history of suicidal thoughts and/or behaviors. However, despite the importance of understanding suicide-related stigma, to the best of our knowledge no published research has investigated whether such experiences differ between those with a history of suicidal thoughts versus those who have attempted suicide. It is interesting to consider whether differences exist regarding suicide-related stigma in the context of the IMV model given that it argues that people who think about suicide differ from those who attempt suicide (O'Connor, 2011; O'Connor & Kirtley, 2018), with existing research highlighting the importance of volitional factors (e.g., Wetherall et al., 2018). Therefore, our research will investigate whether themes are similar or different across the two groups i.e., this study aims to explore the experiences of suicide-related stigma among those who have a history of suicidal thoughts and behaviors. This study also extends the existing research to those who experience suicidal ideation, as previous studies have tended to focus on those bereaved by suicide or those who have attempted suicide.

The proposed research, therefore, aims to address two research questions. Firstly, what is the experience of suicide-related stigma among people with a history of suicidal ideation or suicide attempt(s)? The second aim is to understand whether the experiences of suicide-related stigma thematically differ between those with a history of suicidal ideation and those with a history of suicide attempt(s)?

Methods

Participants and recruitment

In total, 30 participants took part in this study (15 with a history of suicidal ideation and 15 with a suicide attempt history) and were recruited between November 2023 and February 2024 via adverts posted on social media channels X and Instagram and using adverts posted by the Scottish Action for Mental Health charity. All participants were resident in Scotland at the time of the interview and had experienced either suicidal ideation or suicide attempt(s) within the last five years. Participants ranged in age from 18 to 71 years old ($M = 28.7$ years old), 70% were female and 86.7% were white (Table 1). Before recruitment began ethical approval was granted by the College of Medical, Veterinary and Life Sciences ethics committee at the University of Glasgow (200230021).

Table 1. Participant characteristics.

Participant	Age	Gender	Ethnicity	Sexual Orientation	Ideation or Attempt History
1	27	Female	White	Queer	Attempt
2	34	Male	White	Heterosexual	Ideation
3	27	Female	White	Heterosexual	Attempt
4	20	Female	Indian	Heterosexual	Attempt
5	21	Female	White	Queer	Ideation
6	20	Male	White	Heterosexual	Ideation
7	25	Female	Indian	Heterosexual	Ideation
8	18	Female	White	Bisexual	Ideation
9	21	Female	White	Bisexual	Ideation
10	24	Female	White	Gay	Attempt
11	21	Female	White	Bisexual	Ideation
12	20	Trans Male	White	Bisexual/Pansexual	Attempt
13	25	Trans Male	White	Bisexual	Attempt
14	23	Female	White	Bisexual	Ideation
15	24	Male	Bangladeshi	Bisexual	Attempt
16	30	Female	White	Bisexual	Ideation
17	19	Female	White	Bisexual	Ideation
18	19	Female	White	Bisexual	Attempt
19	49	Female	White	Heterosexual	Attempt
20	48	Female	White	Heterosexual	Attempt
21	26	Female	White	Bisexual	Attempt
22	25	Male	White	Heterosexual	Attempt
23	23	Male	White	Questioning	Attempt
24	34	Female	White	Lesbian	Ideation
25	39	Male	White-Latino	Gay	Attempt
26	71	Female	White	Heterosexual	Ideation
27	39	Female	White	Heterosexual	Ideation
28	20	Gender Fluid	White	Bisexual	Attempt
29	28	Female	White	Heterosexual	Ideation
30	41	Female	White	Heterosexual	Ideation

Design

Semi-structured interviews using open-ended questions were conducted either in person, online via Zoom, or over the telephone depending upon the participants' preference. The use of semi-structured interviews to explore similarities and differences between the two suicidal history groups was possible because we asked the same core interview questions to all participants. The semi-structured method also allowed for flexibility to follow up on unique points for each individual participant.

Procedure

Interested participants were invited to complete an online screening questionnaire to determine whether they were eligible to take part in the research. The screening questionnaire began with the participant information sheet followed by questions related to their eligibility for the study. Participants were eligible to take part if they had experienced suicidal thoughts or behaviors in the last five years, lived in Scotland and were aged 16 or over. Those who were not eligible to take part were emailed a support sheet including several relevant support organizations such as the Samaritans, Breathing Space and Papyrus. Participants who were eligible to take part were contacted and the participant information sheet, privacy notice, and consent form were emailed to them. These documents were read, signed, and returned before the beginning of the scheduled interview. Participants were not eligible if they were at imminent risk of suicide, were actively psychotic or if they had a cognitive disability.

Overall, 13 interviews were conducted via Zoom, seven over the telephone and 10 face-to-face. On average interviews lasted 40 minutes and 19 seconds, with two outliers (one interview which was unusually short, at 9 minutes, and one which was much longer, at 97 minutes). At the beginning of the interview participants were asked whether they were happy for the interview to be audio-recorded and then they were asked to provide demographic information (age, gender, ethnicity, sexual orientation, experience of suicide) as well as their current level of suicidal ideation. All participants at this stage stated that they were not currently experiencing suicidal thoughts. The interviews explored participants' experiences of suicide and their attitudes toward suicide as well as the attitudes of others. Participants were reminded that they were only to share what felt comfortable for them, that they could take a break or stop the interview at any time, and that they did not have to answer all of the questions. Consistent with the approach of Dinos et al. (2004) and Rimkeviciene et al. (2015), stigma was not mentioned (until the final question) to avoid leading the participant. Instead, we asked about their

attitudes toward suicide in order to tap into their stigmatizing views and the views of others (see supplementary material 1 for the topic guide). It is also worth noting here that members of a lived experience panel at SAMH provided feedback on the topic guide in order to ensure that the questions we asked were sensitive and relevant to the topic.

After the interview was complete, participants were thanked for their participation and asked to rate their current level of suicidal ideation on a scale from 0 to 10. Participants were also invited to complete a safety plan (four participants chose to do so) and they were given the opportunity to ask any questions or raise any concerns they may have. After the interviews, participants were emailed a support sheet with details of relevant support organizations and a £25 high street shopping voucher to thank them for their time. The interviews were audio-recorded on a Dictaphone, and transcribed verbatim.

Ethical considerations

Given the sensitive topic of this research, we followed a rigorous safety protocol. First, we screened participants in advance and ensured that none of the participants were currently experiencing suicidal ideation before we conducted the interview. We also explained to participants at the beginning and throughout the interview that they did not have to take part, that they could take a break or stop the interview at any time, and that they did not have to answer any of the questions they did not want to (without having to provide any justification). Participants were also reminded to only share information that they felt comfortable sharing and we offered support information to all participants as well as to individuals who did not meet our eligibility criteria. All participants were offered the option of completing a safety plan with JW and a risk assessment was undertaken with each participant before the interview was terminated. Participants were also provided with the interviewer's email address to contact if they had any questions or if they wished to withdraw their data at a later date.

Data analysis

Our sample size was based on the principles of achieving data saturation outlined by Francis et al. (2010) and what is pragmatic, yet informative, within these populations. Although the notion of sample size and data saturation within qualitative research remains much debated (Braun & Clarke, 2019) we aimed to and achieved sufficient data to provide a rich understanding. We believe that we reached data saturation as there was no new information coming out of the final interviews. All 30 interviews were analyzed using the five-step Framework Method (Gale et al., 2013; Goldsmith, 2021). This type of analysis allows for clear comparisons to be drawn between groups which facilitated our analysis comparing the experiences of those with a history of suicidal ideation to those with a history of suicide attempt(s), hence our decision to use this qualitative analysis method. The Framework Method has five distinct steps and the following paragraph explores the actions we took at each step.

The Framework Method requires a spreadsheet matrix to be created to compare findings across groups (i.e., suicidal ideation vs suicide attempt groups). Within the current study each group had a separate matrix, rows contained individual participants, and the codes and eventual themes and sub-themes were displayed in the columns. At stage 1 of the analysis, the interviews were listened to, and transcripts were read and re-read for familiarization. In listening to and reading the interview data, JW began to develop the framework for each suicidal history group whereby codes were developed for different aspects of the participants' experiences (stage 2). Stages 3 and 4 were conducted together with all transcripts revisited to investigate whether the codes were recognizable within the transcripts. We also selected the quotations which best represented these codes to aid auditability; these were added to the matrices. Quotes for each of the participants were taken from the transcripts to illustrate these codes where applicable. Once steps 1–4 had been completed KR and NB reviewed the coding of the matrices to ensure there was accuracy and consistency in the coding. The matrices, codes, and quotes were discussed among the research team and refinements were made at several stages to ensure that the data were accurately represented within this study. Finally, at stage five (mapping and interpretation) we identified patterns in the data and created a narrative summary through our five main themes (and sub-themes). During this stage the two separate matrices were compared to explore the similarities and differences between the groups.

Results

When exploring the experiences of suicide-related stigma among those with a history of suicidal ideation and those with a history of suicide attempts, there were no differences in these experiences or themes

(Aim 2). The only difference within the transcripts was that those with a history of suicide attempt(s) reported that they experienced suicide-related stigma within a hospital setting, whereas those with a history of suicidal ideation did not report this as they were not hospitalized. As a result, the findings are synthesized and presented together as a single sample.

The experiences of suicide-related stigma among those with a history of suicidal ideation/attempt(s) can be summarized into five main themes, and seven sub-themes (Table 2). The main themes were labeled according to participant quotes: 1) *"suicide is stigmatised;" 2) "it's like the elephant in the room, nobody wants to discuss it;" 3) "I was so ashamed;" 4) "I think generally people think suicide is selfish, cowardly, inexplicable, mad;"* and 5) *"So I guess it's about being taken seriously and being believed almost."*

Theme 1: "suicide is stigmatised"

Across all 30 interviews participants spoke about how suicide-related stigma existed for them to some degree either through awareness of the stigma, direct experience of being stigmatized, or self-stigmatization. All but one of the participants explicitly stated that they believed there was stigma attached to suicide: *"I think that there's still like huge stigma" (6, ideation)*, a similar quote from an individual who had attempted suicide also fits here: *"suicide tends to be quite…I guess it was like, more stigmatised. There was…it came along with quite a lot of preconceptions" (13, attempt).* Worryingly, suicide-related stigma was also commonly experienced in health-care settings: *"so that was when I sort of was aware that even in a helping profession there's a, there's still a stigma" (24, ideation).* Only two participants stated that they had not experienced suicide-related stigma. One of these participants expressed their awareness of suicide-related stigma despite not experiencing it, however the other participant said: *"personally I don't think that there is a stigma." (22, ideation).* The reason for this is unclear, but he was from a rural part of Scotland with a very supportive network of people around him.

One participant expressed a belief that suicide should be stigmatized: *"in some ways I suppose I think it should be taboo" (11, ideation).* Participants in both groups, expressed their belief that suicide-related stigma had decreased over time: *"it's not as a taboo subject, as it was, but it's still got a long way to go" (30, ideation).* Furthermore, participants shared their awareness that the topic of suicide is becoming more prevalent in the media: *"it's being spoken about more in media, social media, TV and radio, so it's improving but there's still a way to go" (1, attempt).* Similarly, a small number of participants discussed feeling like the view of suicide as *"weak"* and *"selfish"* was shifting: *"as much as I hate social media, it has done quite a good job at like, making people realise that mental health is not like a moral failing" (18, attempt).* Across most of the interviews the awareness of suicide-related stigma was a common theme.

Table 2. Overarching themes and corresponding sub-themes.

Overarching Theme	Sub-theme 1	Sub-theme 2
(1) "suicide is stigmatised"	Lack of understanding	Hostile reactions
(2) "it's like the elephant in the room, nobody wants to discuss it."		
(3) "I was so ashamed"	Blame	Guilt
(4) "I think generally people think suicide is selfish, cowardly, inexplicable, mad"	Self-stigma	
(5) "So I guess it's about being taken seriously and being believed almost"	Over-protection/ Over-reaction from others	Validity of reasons for suicidal thoughts and/or behaviors

Sub-theme: Lack of understanding

Participants discussed several different ways in which suicide is misunderstood, for example participants explored the stereotypes associated with those who have experienced suicidal thoughts and attempts. Participants discussed the view that suicide only happened to certain types of people: *"there's this idea that it's a poor person problem. And that everyone would hate to be associated with that." (5, ideation)* or that only *"heroin addicts"* die by suicide (*19, attempt*). Participants also expressed the shock from family and friends because they did not fit into the stereotype of someone who dies by suicide. Several participants stated the need to acknowledge that suicide can happen to anyone: *"this can happen in any direction. It does not need to happen to people below you" (25, attempt).* On the contrary, a few participants highlighted *"most people nowadays get it" (11, ideation)* and an understanding from friends and family that suicide "*can affect anyone*" *(15, attempt).* Thus, highlighting that knowledge and understanding of suicide differed among participants and their families across both groups.

Sub-theme: Hostile reactions

Most participants highlighted the *"very volatile and very openly aggressive" (24, ideation)* reactions they received from friends, family, and healthcare professionals when they spoke about their suicidal thoughts and behaviors. Participants spoke of the negative

emotions their family and friends held about their suicidality: *"I mean overwhelmingly for my family, I just, I feel this like, air of like, anger, disappointment, sadness…a big amount of frustration as well" (20, attempt)* and how *"they'd sometimes get quite angry"* (9, ideation). Related to this, participants recalled being shouted at by friends and family when they found out about their suicidal thoughts and behaviors. One participant was shouted at by a police officer who took them home after a suicide attempt (*28, attempt)*. Participants also expressed how their suicide attempts were used to *"manipulate" (13, attempt)* them and were often used against them: *"if somebody wanted to have a grievance with you in some way that could be used against you… 'You're the girl that tried to commit suicide'" (20, attempt)*. Several participants also expressed feeling like an "*inconvenience" (13, attempt)* to hospital staff and as though they were abusing the time and resources of the hospital and taking it from others who were more deserving: *"this didn't really need to happen. Now there's one less bed in toxicology…a person who needs this for a reason that they couldn't control, could've used it better"* (*13, attempt*). This sub-theme clearly highlights how these stigmatizing reactions may affect the way in which some individuals are treated within hospital settings but also by those close to them.

Theme 2: "it's like the elephant in the room, nobody wants to discuss it."

Most of the participants discussed the ways in which suicide-related stigma led to silence and secrecy among their inner circle as well as how it prevented them from talking about their experiences of suicide. There was an awareness among the participants of the fact that suicide is *"just not something that's spoke about at all" (3, attempt)*. Participants discussed how suicide-related stigma directly impacted upon their openness about their experiences of suicide: "*it definitely made me feel like I couldn't tell people" (12, attempt)* and *"I didn't even want to say the word" (16, ideation)*. One participant disclosed that the interview was the first time he had openly talked about his suicidal thoughts. These quotes all highlight that participants across both groups believed that suicide was best kept a secret as it was not spoken about and was meant to be kept *"hush, hush" (14, ideation)*.

When discussing their experiences of telling friends and family, many participants across the suicidal ideation and the suicidal attempt(s) groups felt that their loved ones wanted to keep it a secret: *"It felt like this is the thing we need to keep the lid on and hopefully it doesn't get out" (18, attempt)*. Several participants knew that suicide and being open about suicide made people in their lives uncomfortable: *"well I think when you do talk about it, people look at you like you've said a swear word at the table, like, and it can be quite uncomfortable" (21, attempt)*. When discussing their history with suicidal thoughts and attempts, participants emphasized that friends and family chose to *"ignore it" (26, ideation)* or the conversation was shut down: *"I know for a fact when I've spoken to my parents about it, oh God, you know, the subjects changed pretty quickly" (30, ideation)*. Participants expressed similar experiences when it came to healthcare professionals after being hospitalized for a suicide attempt: *"I felt like this, like, pariah in the corner in the ward. Nobody speak to that girl because she's the one that attempted suicide…she's just taking up a bed" (20, attempt)*. These quotes highlight the isolating experiences of discussing suicidal thoughts and attempts as participants reported being ignored or dismissed by those around them and worryingly by healthcare professionals too. These isolating experiences and the expressed views that suicide is *"taboo" (21, attempt)* clearly limited the participants willingness to be open and the help and care they received when they were open about their suicidal experiences.

A few of the participants, despite their awareness of suicide-related stigma, chose to be open about their suicide attempt(s) in the hope it would be helpful: *"I decided to be open about it because I thought it would help me take control of it and stop the kind of gossip that happens around it" (20, attempt)*.

Theme 3: "I was so ashamed"

Most of the participants attached a lot of shame and embarrassment to their suicidal history: *"it almost feels embarrassing to say out loud" (11, ideation)*. Participants in both groups disclosed that there was shame attached to their suicidal thoughts and attempt(s): *"the shame of like admitting like, okay, well I'm taking this route out" (16, ideation)*. A small number of participants (n = 3) expressed that they were not ashamed or embarrassed about their suicidal history: *"I'm still not embarrassed about it, about being open about it" (20, attempt)*. Interestingly, participant 24 expressed: *"I still carry a little bit of shame"* despite not believing her suicidal thoughts were "*anything to feel shame about"* but rather *"external society views"*.

Participants also explored the shame associated with suicide that was expressed by those around them and how this impacted upon their relationships for example, participants discussed how some people were

"ashamed of being friends" (5, ideation) with them after discovering they were experiencing suicidal thoughts and/or behaviors. Participants reported losing friends because of the embarrassment these friends attached to associating with someone who was suicidal.

Sub-theme: Blame

Participants discussed their experiences of being blamed for their suicidal thoughts and/or attempts: *"there was a lot of blame on me" (10, attempt)* and how this made them feel and respond to their own suicidal thoughts and behaviors: *"I would say I am at fault because I feel I made the decision – I chose this way" (4, attempt)*. Participants also highlighted that family members wanted to blame someone: *"well, somebody must be to blame" (10, attempt)*. Participant 13 did not only report being blamed for his suicidal thoughts and attempt(s), but he also reported being told *"you are the reason this family is in shambles"* and that his suicide attempt was the reason for that.

Sub-theme: Guilt

Several participants described how others made them feel guilty for their suicidal thoughts and/or behaviors as one participant describes experiences with his mother: she *"basically used it, like, to make me feel guilty because of how it affected her. Even though I'm pretty sure the most effect it had on her is that she probably felt embarrassed that it happened" (13, attempt)*.

Participants also reported personally experiencing feelings of guilt attached to their suicidal thoughts and attempt(s): *"I definitely felt guilty…" (17, ideation)*. Specific to the suicide attempt group were feelings of guilt surrounding their attempt: *"I know especially when you have had an attempt in the past, there was feelings of guilt and shame or failure because you haven't been able to complete it" (3, attempt)*. Some participants reported having to forgive themselves for their suicide attempt(s), reportedly spending a lot of time afterwards thinking *"how could you?" (19, attempt)*. Feelings of guilt were also expressed with regards to being hospitalized for their suicide attempts: *"I did feel really guilty about taking up the bed in the hospital…but I also felt bad in a general sense from the fact of 'how could I possibly think about going and leaving my children without their mum?'" (20, attempt)*. This guilt was worsened by their experiences within the hospital ward, when healthcare professionals ignored them and made them feel they should not be there: *"I think that their silence with me probably added to that feeling" (20, attempt)*. On the contrary, one participant stated that he did not feel guilty about attempting suicide *(25, attempt)*.

Theme 4: "I think generally people think suicide is selfish, cowardly, inexplicable, mad"

All of the participants expressed experiencing suicide-related stigma in the form of negative labeling, they explained how they often felt they were viewed differently as a result of their suicidal history: "*nobody just looks at you as, like an actual person…they can only see you for like your traumas and your experiences" (28, attempt)*. In this study, participants described several undesirable labels that were attached to them as a result of their suicidal experiences, for example participants across both suicidal history groups reported being regarded as attention-seeking: *"I think a lot of people see them as attention seeking" (17, ideation)*. Participants also expressed being labeled as selfish by those around them, including healthcare professionals: *"it's that kind of perception that its selfish. You shouldn't even have those kind of thoughts. Even from professionals" (3, attempt)*. Participants also expressed an awareness of the fact that those who are suicidal can be viewed as crazy - *"a raving loony", (19, attempt) or "a psychopath" (8, ideation)*.

Participants described how suicide was labeled as a *"mental or emotional weakness" (7, ideation)* by those around them as well as in the media and in things like video games where it is often described as the *"cowards' way out" (21, attempt)*. Other commonly reported labels of suicide were that it is *"silly" (14, ideation), "stupid" (23, attempt) or "overdramatic" (20, attempt)*. Participants also reported being told they were suicidal because it was *"trendy" (11, ideation)* and they had seen it online. Among the religious participants in this study, suicide was described as sinful: *"at least in the way I was always taught about it, suicide is seen as a sin*" (12, attempt). These participants reported that suicidal ideation/attempt(s) were believed to be *"the influence of Satan" (9, ideation)* and *"against the bible" (5, ideation)*. A similar stigma was expressed by those who were not religious in that they were aware of suicide being viewed as *"morally wrong" (14, ideation)* or a *"moral failing" (18, attempt)* or *"bad" (6, ideation)*.

The way individuals were treated as a result of their suicidal history was also stigmatizing: *"I guess people were sort of treated like freaks" (13, attempt)*. Several participants reported being bullied as a result of their suicide attempt(s) and the undesirable labels

attached to suicide being used to do so. It was also clear that the support a person received was dependent upon whether their suicidal experiences were stigmatized or not as was highlighted by participant 19 who disclosed that her husband said: *"I'm surprised I came to this hospital with you…you selfish cow" (19, attempt).* Participants in both groups discussed their experiences of being discriminated against at work due to the stigma related to suicide. Participants disclosed that they did not talk about their suicidal thoughts and/or behaviors at work because *"if I talk about it, it might work against my promotion at work" (25, attempt).* Participants reported that they were viewed as less *"capable"* or trustworthy at work and how this led to them feeling they had to *"overcompensate" (25, attempt)* to ensure they were not defined by their suicidal history: *"if you're not capable of keeping yourself like on the planet, 'how could you be capable of like anything else?'" (28, attempt).*

Participant 22 was the only participant who did not believe that there was a stigma attached to suicide, and this may arguably be due to the fact that he did not have any stigmatizing experiences: *"I've not had any experience of people being critical towards it or 'man up'" (22, attempt).* Furthermore, a small number of participants expressed that their close circle did not attach negative labels to those that are suicidal: *"everyone in my friend group is very conscious that it's not something that people do for attention"* (13, attempt).

Sub-theme: Self-stigma

Participants also had internal stigma related to their suicidal history which resulted in them attaching undesirable labels to themselves. These participants stated that they would not view others who were suicidal as selfish or weak, but they do feel that way about themselves: *"I do think the idea that it's, like, a weak thing, or it's something that's shameful, is just something that I apply to myself and not, not to other people" (10, attempt).* When talking about their suicidal history, participants in both groups explicitly attached negative labels to their suicidal thoughts and/or behaviors: *"it's the most selfish thing I think I've ever done in my entire life" (19, attempt).* Participants in the suicidal ideation group reported feeling "*stupid*" and *"cowardice" (11, ideation)* for having suicidal thoughts. Moreover, one participant stated the abnormality he felt about his suicidal experiences: *"it's not biologically correct to feel that way, as animals, we're hardwired to reproduce and to survive…so in my head, it's like this is against the natural order of things, so clearly, it's wrong" (15, attempt).* Similar to this was the idea that suicide is irrational: *"I don't think suicide is a very rational thing to begin with" (18, attempt).* These participants expressed their views that having suicidal thoughts makes them abnormal or irrational, as well as how this may contribute to worries about being viewed as *"the damaged one" (8, ideation).*

Interestingly, despite not believing there was a stigma attached to suicide, participant 22 did stigmatize his own suicide attempt(s), participant 22 expressed self-stigma in the form of feeling like a *"fraud"* since he had attempted suicide multiple times. He stated that he felt *"if you really were suicidal, then you'd be dead…are you just seeking attention from people?"*. Furthermore, those with a history of suicide attempt(s) also reported feeling like a failure: *"I'd failed at ending the suffering I was in" (13, attempt).* The feeling of failing was also expressed among the ideation group: *"I feel a failure because I don't cope" (26, ideation).*

Theme 5: "so I guess it's about being taken seriously and being believed almost"

Most participants reported that they were not believed or taken seriously when expressing their suicidal thoughts and/or attempt(s): *"I feel like it's not taken seriously" (14, ideation).* Several participants reported not being believed or their families being in denial: *"my father elected not to believe us…if you asked him today…he would say that me or my sister were never suicidal" (5, ideation).* Moreover, participants reported that when they reached out for help from both family and friends as well as healthcare professionals some were told: *"you don't feel like that" (9, ideation).* It was common within the sample for participants who had attempted suicide or expressed suicidal ideation during their teenage years to report being told by family and friends as well as healthcare professionals that it was *"just hormones" (28, attempt)* causing them to feel belittled and not listened to. Participants also reported having to *"prove"* that they were suicidal in order for professionals to "*believe that it's a real suicide attempt" (23, attempt).* A small portion of the sample more positively reported that they were taken seriously by different healthcare professionals: *"everyone that I've met in the health profession takes it seriously" (5, ideation).*

Within the ideation group, participants stated that because they had not attempted suicide, they felt they were not taken as seriously as someone who had: *"I find people almost don't take you seriously if you say, 'Oh, I'm suicidal', and they're, like, 'Have you tried to*

kill yourself?'" (17, ideation). Arguably, those with a history of suicidal ideation not being taken seriously could be related to the negative label of suicidal behavior being *"attention-seeking" (7, ideation)* as participants stated that if they had not attempted suicide they were viewed as *"faking it" (26, ideation).* Participants across both groups also described *"jokes constantly" (16, ideation)* being made about suicide, for example participants disclosed that after telling people about their suicidal thoughts, those around them said: *"just go and do it, if you really meant it you'd be dead by now" (27, ideation).* Similar experiences were reported among those who had attempted suicide, as participants recalled sarcastic remarks being made about them *"not even being able to kill myself properly" (28, attempt)*, highlighting that these individuals are often not taken seriously when expressing their desire to die by suicide.

Sub-theme: over-protection/over-reaction

Participants described feeling like people became *"hyperaware of everything" (5, ideation)* and *"overprotective" (5, ideation)* upon learning about their suicidal thoughts and/or behaviors. Participants described feeling as though people in their lives were overly cautious around them: *"don't touch this person, don't kind of go near this person, because, because of what they're going through" (29, ideation).* Participants expressed how this over-protection became suffocating and how it was unhelpful: *"it's like padded cells or it's like, yeah, it's safe but I don't feel good" (18, attempt).* Participants also reported a fear of hospitalization, which they felt would be an overreaction to their suicidal thoughts and/or behaviors: *"I'd heard stories about people like being rushed to hospital and I was like 'Fuck, I don't want that'" (18, attempt).* Participant 16 explained: *"I would say it really helped that they [healthcare professionals] didn't, like, overreact or underreact at all… they didn't shut me down or say, like, you know, you're just feeling down or something like that. And I found that really, really helpful because I could keep going in the conversation without them trying to, like, put a plaster on my head or something like that." (16, ideation).* Again, suggesting that over-reacting or not believing someone who is suicidal can be very damaging as this participant highlights how helpful it was to have a positive experience when seeking help.

Sub-theme: Validity of reasons

Participants explained that many people question an individual's reasons for suicide, suggesting that people view some reasons for feeling suicidal as more valid or reasonable than others: *"…they will judge why you are, like, as if there's, like, a validity of how much you go through can be classed as suicidal'" (8, ideation).* The idea that there was a scale of validity with regards to suicidal thoughts and/or behaviors was also described within the healthcare profession as staff would question *"are you suicidal enough? Are you self-harming in the right way? Or what's deemed to be the right way" (24, ideation),* again highlighting that there is a scale for how serious a person's suicidal thoughts and/or behaviors are even among helping professions. Participants across both groups also explored how people around them believed they should not be feeling suicidal because "*nothing bad happened for you to feel that way" (3, attempt).*

Discussion

The interviews have deepened our understanding of the experiences of suicide-related stigma among those with a history of suicidal ideation/attempt(s). This research also explored whether there were differences in experiences of suicide-related stigma between the two groups. Interestingly, there were no clear differences in those with a history of suicidal ideation vs those with a history of suicide attempt(s) regarding their experiences of suicide-related stigma. This research is the first to make this comparison and the results highlight the shared experiences of these groups and the importance of tackling the roots of suicide-related stigma in order to protect these groups from such stigma. When considering the IMV model (O'Connor, 2011; O'Connor & Kirtley, 2018) and the differentiation it makes between those who attempt suicide and those who think about suicide, our results suggest that suicide-related stigma may have a more pervasive effect, acting as a pre-motivational phase factor which affects people with different suicidal histories similarly. However, more research is needed to fully understand the extent to which these experiences are more universal given our sample was predominantly white and female.

Addressing the first research question, experiences of the stigma associated with suicide appear to have predominantly negative consequences. Participants reported feeling ashamed, guilty, and embarrassed which could arguably be as a result of the negative stereotypes/labels that were attached to them. Existing research has found similar findings, highlighting that being labeled negatively as a result of suicidality is common across samples and countries (Carpiniello & Pinna 2017; Lee & An, 2024; Wyllie et al., 2025). Furthermore, this shame and embarrassment could

be linked to silence and secrecy among those experiencing suicidal thoughts and attempt(s) as their shame could prevent them from opening up. It was also highlighted within the transcripts that friends and family did not want to talk about or share the participants' suicidality with others, again due, in part, to feelings of shame. Previous research has also highlighted the silence and secrecy that is attached to suicide as a result of stigma therefore strengthening our findings (Mayer et al., 2020; Wyllie et al., 2025). The differences between participants' beliefs about others who are suicidal versus their own suicidality are worth noting. Several participants in both groups expressed that they do not believe others who are suicidal are "attention-seeking" or that they should not feel ashamed of their suicidality, but they attached these labels and this shame to their own suicidal thoughts and attempt(s). Moreover, the only participant who expressed he did not believe there was a stigma attached to suicide later went on to explain how he stigmatized his own suicide attempt(s), again highlighting that self-stigma plays a large role in the way individuals view their own suicidality.

A small, but noteworthy number of participants said that suicide-related stigma was a protective factor for them as it prevented them from attempting suicide and in some cases it encouraged them to seek help. This was often due to the fear of sinning and going to hell if they were to attempt or die by suicide. This is consistent with previous research which has shown that suicide-related stigma can possibly be a protective factor associated with decreased current suicidality (Oexle et al., 2022). Research has also uncovered that suicide-related stigma resulting from religious beliefs (e.g., unnatural/sinful) can increase help-seeking intentions (Prawira & Sukmaningrum, 2020). However, most of the participants expressed that suicide-related stigma led to negative help-seeking experiences or a desire to keep their suicidal experiences a secret and not seek help in order to avoid stigmatizing experiences. In some cases, it was difficult to establish whether participants were discussing the stigma related to suicide or whether the stigma was related to mental health and self-harm, given that these tend to be interlinked. However, it is clear from previous reviews that stigma toward both mental health and suicide discourages help-seeking intentions and behaviors (Clement et al., 2015; Morena et al., 2025; Omandi, 2024; Rowe et al., 2014; Schnyder et al., 2017).

As stated earlier, most of the existing qualitative research in this area focuses on those bereaved by suicide, with fewer papers on those with a history of suicide attempt(s) and none (to our knowledge) on those with a history of suicidal thoughts. The findings of this qualitative study complement existing research which reported that those who have attempted suicide are viewed as "attention-seeking", "selfish", "crazy" and "weak" (Sheehan at el., 2017; Oexle et al., 2019). Existing studies have also highlighted the idea that suicide should be kept "hush, hush", with the result that people can be isolated and shunned as a result of their experiences of suicide (Ohayi, 2019; Sheehan et al., 2018).

Strengths and limitations

The current research has several strengths worth highlighting, for instance the sample (n = 30) allowed for a wide range of experiences to be captured. Furthermore, semi-structured interviews allowed for flexibility as well as consistency across interviews and the Framework Method is a well-established and rigorous method for conducting comparisons. Moreover, several members of the research team were involved in the coding and the creation of themes which helped to minimize any potential bias. The findings of this study extend previous research by addressing a key gap within the research literature, namely by comparing those with a history of suicidal ideation to those with a history of suicide attempt(s).

Despite several strengths, a number of limitations are worth noting. First, as we excluded those who were imminently suicidal, our findings may not be generalizable to individuals currently in crisis. In addition, our sample was self-selecting. Given the nature of stigma, those who have had especially stigmatizing experiences may have avoided taking part in our research. Furthermore, as we recruited individuals who had suicidal thoughts and attempt(s) in the last 5 years, the findings may have been affected by recall bias. Only JW conducted the interviews and although this is a strength in terms of consistency of approach, JW brought her own biases, consciously or unconsciously, to the interviews. These biases could include interpretative biases as a result of working within the suicide prevention field and being knowledgeable about the suicide-related stigma literature. However, to minimize such biases, both KR and NB cross-checked themes and sub-themes across transcripts.

Implications

This research is the first to compare the experiences of those with suicidal thoughts to those who have attempted suicide, allowing for a deeper understanding of the shared experiences of suicide-related stigma

between these groups. This study identified similarities between individuals with a history of suicidal thoughts and/or attempts and as shown in previous research, those bereaved by suicide (Evans & Abrahamson, 2020; Hanschmidt et al., 2016; Pitman et al., 2016). Therefore, indicating that stigma-related interventions and prevention efforts could be similar for both groups. Importantly, these insights can inform clinical practice, public health strategies and policy making decisions targeting suicide-related stigma. Specifically, these findings highlight the need to recognize and challenge stigmatizing attitudes toward suicide as part of health professionals' training as such attitudes can affect help-seeking. Such training should also focus on the development of compassionate, non-judgemental communication and support techniques. Moreover, it would be beneficial for policymakers to develop education and training programmes around suicide prevention within workplaces given that most people who die by suicide are in employment (Hallett et al., 2024). To this end, education around suicide, open conversations and the language used when talking about suicide have been identified as effective ways to reduce the stigma related to suicide (Carlon et al., 2025; Marek & Oexle, 2024). Furthermore, this research gives a voice to those with suicidal thoughts who are an under-represented group within this area.

Conclusion

This research is a valuable addition to the evidence base on suicide-related stigma, it highlights that experiences are similar regardless of whether an individual has experienced suicidal thoughts and/or suicide attempt(s). The research also uncovered the negative implications of suicide-related stigma among those with lived experience, as it often causes them to feel unsupported, isolated, ashamed, selfish, and weak. The findings of this research should be considered when developing intervention and prevention strategies as they clarify that experiences across groups affected by suicide are not dissimilar and therefore these individuals could be supported by similar interventions/prevention strategies related to suicide-related stigma.

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