

**CONTENDING WITH COMPLEXITY: CRISIS WORKERS' PERSPECTIVES
ON SUICIDE, STIGMA, AND EXISTING MEASURES**

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ABSTRACT

Although there have been developments in the reduction of mental health stigma in recent decades, the stigma of suicide remains prevalent as suicide rates continue to climb (SAMSHA, 2024; Sudak et al., 2008). And while there are many existing measures of suicide stigma, none to date have been developed and evaluated in consultation with crisis workers who provide direct support and resources to individuals utilizing suicide prevention services. Our study aimed to explore ways in which existing psychometric tools do or do not align with contemporary experiences of suicide stigma, as observed by crisis counselors and specialists who have operated various crisis lines, including the 988 Suicide and Crisis Lifeline. During one-on-one interviews with 19 crisis workers, we asked participants about their conceptualizations of suicide stigma, their experiences as crisis workers, and perspectives on two measures of suicide stigma, the Suicide Opinion Questionnaire (Domino et al., 1982) and Scale of Suicide Stigma (Batterham et al., 2013).

Through these interviews we identified four primary themes: suicide stigma is complex, interpersonal, and preventable, suicide stigma measures miss the mark but not everyone agrees why, suicide stigma measures get it right at least some of the time, and how researchers could or should be measuring suicide stigma. For participants, their perspective was often not only professional but personal, with many participants having disclosed personal encounters with suicidality and suicide stigma. Participants were ultimately conflicted about their disapproval of specific measure items and were skeptical about the accuracy and effectiveness of the measures presented to them. Despite this, participants also identified accurate aspects of the measures, and most expressed preference for the Scale of Suicide Stigma (Batterham et al., 2013). Participants

also shared their recommendations for suicide stigma researchers. This included recommendations to factor in the role of identities and positionality of those being assessed for suicide stigma, consider impacts of social desirability on the effectiveness of suicide stigma measures, develop more implicit or nuanced measures targeted toward capturing the complexities of stigma, and to consult and collaborate directly with individuals who have experienced suicide ideation when developing or revising measures in the future.

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CHAPTER ONE

INTRODUCTION AND GENERAL INFORMATION

Introduction

Despite a decades-long understanding that suicide is preventable (Rutz, 2001), and a recent influx of federally supported suicide prevention initiatives (Canady, 2020), suicide and suicide ideation rates are higher than ever (SAMSHA, 2024). In the wake of the COVID-19 pandemic era mental health crisis, the 988 Suicide and Crisis Lifeline, originally known as the National Suicide Prevention Line, was approved by the Federal Communications Commission (FCC) and United States congress to switch from the former number (1-800-273-8255) to a designated three-digit dialing code (9-8-8) and for there to be significant expansion of call, text, and online chat service across all 50 states (Suran, 2023). This expansion included an increase in federal grants to facilitate the hiring of more crisis workers, including trained crisis counselors who answer calls/texts/chats, and certified crisis specialists who often provide additional quality oversight, supervision, and support. One of the hopes for bipartisan legislation authorizing the three-digit designation was that this would increase access to suicide prevention services and normalize the use of 988 as the mental health emergency equivalent to 911 (Suran, 2023). Still, according to the most recent National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration (SAMHSA), 49,449 Americans died by suicide in 2022, a record number of suicide deaths following a pattern of steadily increasing suicide rates since 2020 (SAMHSA, 2024). In addition, 1.5 million adults attempted suicide, and a staggering 12.8 million adults seriously considered killing themselves in 2023 (SAMSHA, 2024). The prevalence of serious suicide ideation was highest among young adults ages 18 to 25, with 4.2

million people—12.2%, of this population —reporting experiences of serious suicide ideation within the year 2023 (SAMSHA, 2024). Given that the SAMSHA survey focused on serious consideration of suicide, the 2023 base rates for individuals experiencing passive suicide ideation were likely even higher.

Despite the progress that has been made in the reduction of mental health stigma in recent decades, the prevalence of suicide stigma —the stigmatized attitudes against people who experience suicide ideation, engage in suicidal behaviors, and/or complete suicide —has remained stagnant (Sudak et al., 2008). For example, Batterham and colleagues (2013), documented significant discrepancies in the presence of stigmatized attitudes among those who do and do not experience suicide ideation. Specifically, they reported that those who do not experience suicide ideation hold significantly higher stigmatized attitudes toward those with ideation. This is especially worrisome given that fear of discrimination and stigma related to experiencing suicidality has been found to be related to suicide ideation (Oexle et al., 2018; Han et al., 2017). And, while suicide is a complex issue (Movahed et al., 2025), existing research literature supports the idea that the stigma of suicide is a relevant factor for not only better understanding the experiences of suicidal people, but for increasing access to suicide prevention services and care (Han et al., 2017; Wyllie et al., 2025).

Inspired by the possibility that reduction of suicide stigma may be an avenue to increase access to resources and decrease the number of preventable suicides, our research team set out to gain a better understanding of not only suicide stigma, but specifically how it is captured by researchers in existing psychometric tools. Upon learning of more than a dozen established suicide stigma measures (Ghasemi et al., 2015), including the most prominent of which that has been in use

since the 1980's (Domino et al., 1982), we also learned that no measure of suicide stigma has been developed and evaluated in consultation with crisis workers, such as crisis counselors and specialists, with expertise in suicide and suicide prevention. This led to concerns that, despite the psychometrically robust nature of some measures like that of Batterham and colleagues (2013), these measures may not accurately reflect lived experiences with suicide stigma, particularly in the post COVID-19 era.

In hopes to address this, we developed a qualitative research study in which we interviewed crisis counselors/specialists about their own conceptualizations of suicide stigma based on their interactions with individuals seeking help from suicide prevention services, including the 988 Suicide and Crisis Lifeline. As a part of the study, we also presented participants with two prominent measures of suicide stigma in order to gain a better understanding of their perspectives on these measures and identify ways in which existing measures of suicide stigma may or may not align with their observations and experiences.

CHAPTER TWO

LITERATURE REVIEW

Suicide Stigma

Widespread myths about suicide are thought to be an essential influence on the development of suicide stigma (Neuringer, 1988). Thomas Joiner, a leading suicide researcher, dedicated the entirety of *Myths About Suicide* (2010) to dispelling some of the most identifiable myths about suicide, including the myth that suicide is selfish. According to Witte and colleagues (2010), “the stigma surrounding suicide is complex, and partially stems from the way it has been regarded by religion and the law. For centuries, suicide was considered a mortal sin by the Catholic Church” (p. 1). Acting upon suicidal ideation or impulses was additionally considered a criminal offense until the late 20th century in many parts of the United States (Berman, 1990).

While seeking care, many individuals experiencing suicide ideation live in fear of stigmatization from medical professionals, including the fear of forced hospitalization (Richards et al., 2019). This dynamic of mistrust and diminished sense of autonomy can lead individuals to be reluctant to seek care at all (Pompili et al., 2007) or withhold information about their suicide ideation when assessed by medical professionals, even among those who later go on to attempt suicide (Richards et al., 2019). Historically, individuals with suicide ideation have also not been included in the creation of suicide prevention interventions (Eagles et al., 2003), despite ways in which consequences of suicide stigma have already expansively harmed and systematically disenfranchised suicidal individuals. Considering that suicide stigma often stems from broader systemic inaccessibility to resources and mental healthcare (Batterham et al., 2013), stigma serving as an additional obstacle in seeking care is especially disheartening. This also highlights

the importance of having an accurate understanding of suicide stigma in order to combat it and increase access to care (Wyllie et al., 2025).

Suicide stigma also does not occur within a vacuum or equally across all contexts and populations. In addition to systemic inaccessibility to resources, suicide stigma is entangled with other forms of systemic prejudice and injustices, and the origins of suicide stigma are also heavily rooted in social identities and culture (Abrutyn & Mueller, 2018). For example, Black identified individuals are thought to be more frequently impacted by suicide stigma due to the intersecting influences of racial identity, religious identity, gender identity, and cultural identity (Early & Akers, 1993; James et al., 2022). Whereas having religious beliefs and attending religious services influences one's likelihood of holding suicide stigma, with religious individuals broadly presenting with stronger stigmatized attitudes (Stack, 1998).

Measurement of Attitudes Toward Suicide

A multitude of measurement scales assessing a diversity of aspects related to attitudes toward suicide exist (e.g., Diekstra & Kerkhof, 1988; Domino et al., 1982; Ghasemi et al., 2015; Jenner & Niesing, 2000; Kodaka et al., 2011; Renberg & Jacobsson, 2003). One systematic review of available measurement tools identified 15 separate scales of attitudes toward suicide (Ghasemi et al., 2015). A similar systematic review identified 18 scales that assessed attitudes toward suicide, suicidal behavior, and mental health (Kodaka et al., 2011). These scales include the Semantic Differential Scale Attitudes Towards Suicidal Behavior (SEDAS; Jenner & Niesing, 2000), Suicide Attitude Questionnaire (SUIATT; Diekstra & Kerkhof, 1988), Attitudes Toward Suicide Scale (ATTS; Renberg & Jacobsson, 2003), and Suicide Opinion Questionnaire (SOQ; Domino et al., 1982). As asserted by Kodaka and colleagues (2011), the three measures frequently found

to be the most multidimensional and rigorously evaluated for validity (at the time) were the SOQ, SUIATT, and ATTS. Batterman and colleagues (2012) further reported that the SOQ was the by far most widely implemented among these surveys.

Suicide Opinion Questionnaire

The dominance of the Suicide Opinion Questionnaire (Domino et al., 1982) has endured from its development in the early 1980's to modern day, as items from the SOQ have been used to assess attitudes toward suicide as recently as 2022 (James et al., 2022). The SOQ in its various reiterations (e.g., Domino, 1980; Domino et al., 1982; Domino et al., 2000) has been used to assess attitudes toward suicide while factoring in a variety of global settings, languages, and cultural contexts. It has also been used to better understand correlations of attitudes with participant social identities such as gender, religious affiliation, and political ideology (Domino, 2005). In the original full version of the SOQ (Domino et al., 1982), respondents complete Likert scales to respond to 100 beliefs about suicide, and seven demographic questions (Kodaka et al., 2011). These beliefs range in topic from the morality of completing assisted suicide, whether certain individuals have a right to suicide, and assumptions about motivations for suicide. The Likert Scale responses options range from 1 (strongly disagree) to 5 (strongly agree). There have been multiple factor structure reiterations of this scale, including a two-factor structure, a five-factor structure, and an eight-factor structure, which were all derived from the original 15-factor structure (Anderson et al., 2008).

As an example, the 8-factor structure (Domino et al., 1989) featured eight separate “clinical” scales; Suicide Reflects Mental Illness, Cry for Help, Right to Die, Importance of Religion, Impulsivity, Suicide is Normal, Suicide Reflects Aggression/Anger, and Suicide is Morally Bad.

Examples of items from the full scale SOQ include, “John Doe, age 45, has just committed suicide. An investigation will probably reveal that he has considered suicide for quite a few years,” “The possibility of committing suicide is greater for older people (those 60 and over) than for younger people (20 to 30),” “The suicide rate is higher for minority groups such as Chicano, American Indians, and Puerto Ricans than for Whites,” “Suicide goes against the laws of God and/or of nature,” and “Some people are better off dead,” (Domino et al., 1980). See Appendix B for the full 100-item version of the SOQ (Domino et al., 1980).

However, despite the wide-spread use of the SOQ (Domino et al., 1982), there has been 40 years of persistent criticism of this scale by psychometricians and psychologists alike. Surface level critiques include its use of stigmatizing language, like the repeated use of the phrase “commits suicide.” Use of this phrase should be avoided because of negative religious and legal connotations and undertones (Sommer-Rotenberg, 1998). Additionally, as Kodaka et al. (2011) pointed out, the length of the SOQ can make it challenging to implement in clinical settings or survey research where time constraints may be an issue. Most notably, the SOQ has repeatedly been found to be both internally inconsistent and unreliable across different factor structures (Anderson et al., 2008; Rogers & DeShon, 1992). This is not entirely surprising given that the items originated from an extensive literature review and production of 3,000 index cards labeled with a swath of divergent concepts related to suicide (Domino et al., 1982). Despite gradual refinement of the index cards until 100 items were eventually reached, it has been identified that the construction of the items appears to lack theoretical background (Kodaka et al., 2011). As such, Anderson et al. (2008) highlighted the scale’s weak factor structure. They recommended that expansive use of the SOQ might be misguided and that it would serve suicide attitudes

research well to develop a more sound and contemporary scale. Rogers and DeShon (1992), similarly called for improved measures, though Domino (2005) later dismissed their claims and countered that assessment of internal consistency was not an appropriate method of evaluating validity.

While a consensus on these psychometric concerns has yet to be reached (Kodaka et al., 2011), and use of the SOQ has persevered (e.g., James et al., 2022), researchers were quick to develop novel iterations of attitudes toward suicide assessments, with many taking direct inspiration from the SOQ (Domino et al., 1982) format. Similar to the SOQ, most of these scales continued to utilize Likert scales as response mechanisms, in addition to demographics questions. And though many of these scales also explicitly declared intentions to improve upon the SOQ and utilized the identified shortcomings of the scale as starting points when developing their own measures, the scales do vary in terms of target audiences and contexts in which they are appropriate for use.

As an example, the SEDAS (Jenner & Niesing, 2000) is unique because it assesses attitudes toward suicide while accounting for the situational role of the individual being assessed. These context dependent roles, referred to as “actors/situations” included assessment of attitudes toward a hypothetical suicide of “...(a) my own suicide, (b) that of an adolescent (14 years), (c) that of an 81-year-old person, (d) that of a 34-year-old addict, (e) that of a person with an incurable tumour, (f) that of a suicide repeater, and (g) that of a person very dear to me,” (Jenner & Niesing, 2002, p. 140). The Suicide Attitude Questionnaire (SUIATT) sought to improve upon the original SOQ (Domino, 1980) by creating a more psychometrically sound 63-item scale that could be implemented across lay communities in the Netherlands for suicide prevention and psychoeducation purposes (Diekstra & Kerkhof, 1988). The Attitudes Toward Suicide Scale

(ATTS) similarly sought to make improvements in internal consistency and replicability, while also prioritizing applicability to rural communities in Sweden by involving both experienced clinicians and lay people in the development of their measurement items in the 1980's (Renberg & Jacobsson, 2003).

Despite these efforts, these attitude measurement tools have also faced psychometric scrutiny and criticism. One critique of SEDAS is the utilization of polarized adjectives as the anchors for the Likert scale. As an example, it has been thought that use of “depressed” on one end and “elated” on another might lead to confusion about the more ambiguous center of the Likert scale, leaving respondents wondering if a response of “3” means suicidal individuals are simultaneously depressed and elated (Batterham et al., 2012). Like the SOQ, both the SUIATT and ATTS have been criticized for the length of their items, time consuming administration, and lack of applicability in surveys or clinical settings (Kodaka et al., 2011). Batterham et al. (2012, p. 14) echoed previous scholars in criticizing the weak factor structures, moderate reliability, and moderate validity of the SUIATT, ATTS, and SEDAS (Anderson et al., 2008; Domino et al., 1982; Kodaka et al., 2011; Rogers & DeShon, 1992).

Scale of Suicide Stigma

In light of the psychometric inconsistencies and issues identified within existing measures assessing attitudes toward suicide, Australian researchers Batterham et al. (2012) also set out to develop a contemporary attitudes scale. The intention of this scale was not only to improve upon psychometric shortcomings of previous measures, but to focus explicitly on the stigma aspect of attitudes toward a person who might suicide, which is a novel distinction. The original Scale of

Suicide Stigma (SOSS), now considered to be the long form SOSS, is 58 items, also making it shorter than other scales (Batterham et al., 2012).

Like the SOQ (Domino, 1982) and a majority of other attitudes toward suicide measures, SOSS respondents are asked to complete Likert scales in response to a list of positive and negative descriptors of the average person who suicides. The Likert scale response selections range from 1 (strongly disagree) to 5 (strongly agree). The list of descriptors fall within 3 separate subscales; Stigma, Isolation/Depression, and Glorification/Normalization. As an example, the Stigma scale includes descriptors such as, “selfish,” “attention-seeking,” “cruel,” “shameful,” and “evil,” the Isolation/Depression scale contains descriptors such as, “sad,” “lost,” “broken,” “cutoff,” and “disturbed,” and the Glorification/Normalization scale includes descriptors such as, “understandable,” “motivated,” “fearless,” “strong,” and “noble,” (Batterham et al., 2012). See Appendix C for the full 58-item version of the SOSS.

In 2013, Batterham and colleagues additionally produced a short form of the SOSS (SOSS-SF), which consists of 16 items within the same subscales. The authors have asserted that both the SOSS and SOSS-SF maintain sufficient internal, convergent, and construct validity (Batterham et al., 2013), which was reaffirmed by Williams and colleagues in 2018. Although one early self-identified limitation of the SOSS described by Batterham and colleagues was the need for, “further validation in a broader community-based sample” due to their participant pool consisting of university students and, “a number of non-academic” university staff (p.19), the SOSS has been successfully implemented and adapted across gender differences, cultural/linguistic contexts, and geographical locations with studies having been conducted in Australia, Germany, and the United States (Batterham et al., 2012, 2013; Ludwig et al., 2020; Williams et al., 2018).

But despite the psychometric strengths of the SOSS (Batterham et al., 2013), one limitation is that it does not appear to have been developed in consultation with crisis workers, nor does it appear to have been evaluated by crisis workers post measure development.

The Present Study

Though the lack of collaboration with crisis workers may arguably illuminate concerns about the accuracy of the SOSS (Batterham et al., 2013), the scale is not alone in this regard. While the inclusion of lay individuals in the item construction of the ATTS was one of the most distinguishing aspects of its development (Renberg & Jacobsson, 2003), they too do not appear to have collaborated or consulted with crisis workers. Domino and colleagues (1989) described themselves as having had “four clinical psychologists, two psychiatrists, and one social worker, all working full time in the suicide prevention field” (p. 353) re-sort the SOQ’s existing items into a new factor structure after the measure items had been developed, though they did not include crisis workers in the development of the actual items, nor revision of the item content. In fact, it does not presently appear that any of the studies concerning the item development for measures assessing attitudes toward suicide have sought collaboration or consultation with crisis workers, despite the probability that crisis workers have observed suicide stigma in their frequent interactions with individuals experiencing suicide ideation. Because of this, we argue that these measures may fall short of accurately depicting lived experiences with suicide stigma. There is the additional possibility that the existing measures of suicide stigma, having all been developed prior to 2020, may not be accurate to our current context in which suicide rates have continued to increase in a post-COVID-19 pandemic world (Movahed et al., 2025). This is especially given

the ways in which suicide stigma has been historically known to evolve across time and sociocultural and/or sociopolitical contexts (Berman, 1990; Witte et al., 2010).

Therefore, in the present study, we sought to learn how crisis specialists and crisis counselors with suicide prevention experience conceptualize suicide stigma, as well as how they interpret and perceive existing measures of stigma, by conducting one-on-one interviews with 19 self-identified crisis workers. We hope that increasing understanding of the contemporary perceptions of suicide stigma from specialists who most directly interact with the impacted population presents an opportunity for accountability among researchers in terms of potential disconnects between researchers and practicing professionals. This study received approval from the Institutional Review Board of The University of Tennessee, Knoxville.

Research Questions

Research Question 1: How do current crisis counselors and crisis specialists with suicide prevention experience define the stigma of suicide?

Research Question 2: How do current crisis counselors and crisis specialists with suicide prevention experience perceive existing measures of suicide stigma?

CHAPTER THREE

MATERIALS AND METHODS

Method

Participants

Participants were 19 self-identified crisis counselors or crisis specialists with experience in suicide prevention. Of these 19 participants, 12 identified as women, five as men, one as genderqueer, and one as non-binary. The mean age of the sample was 31.68 years ($SD = 13.25$). In terms of race, 16 participants identified as White, two as Hispanic, and one as Multiracial (African American, Filipino, and White). A number of participants mentioned having chronic medical conditions, two participants identified as currently having a disability, and 17 did not. Additional demographic information and self-selected pseudonyms for each participant can be found in **Table 1**.

While information about geographical location was not explicitly collected as a part of the interview protocol, participants self-identified as being located in both urban and rural settings, as well as geographical regions across the United States including the Pacific Northwest, the Rust Belt, and Appalachia. While almost all crisis workers reported at least some experience working with the 988 Suicide and Crisis Lifeline, they also described a range of other experiences working on different phone lines, online chats, text-based lines, and/or working at in-person crisis stabilization units. Some participants recalled working for the National Suicide Prevention Line prior to its transition to the three-digit 988 Suicide and Crisis Lifeline.

Participants also reported experiences working on different specialized support lines, including identity-based peer support lines for the LGBTQ+ community, basic needs lines that connect

callers with essential resources such as food and housing, lines in languages other than English including Spanish, support lines for people struggling with substance use, and support lines for victims of domestic violence. Participants, whose amount of experience ranged from one year to decades, disclosed holding a number of different levels of volunteer and/or paid positions within their organizations. Some of the differing levels and positions described included college students newly starting out as crisis counselors on the lines for university credit, paid crisis counselors or specialists with anywhere from one to five or more years of experience, crisis line administrative supervisors/shift leads, and even crisis line executive managers/directors.

Table 1. Demographic table of participants.

Pseudonym	Age	Gender Identity	Sex	Race	Ethnicity
Sunny	42	Non-binary	Female	White	Caucasian
Emily	21	Woman	Female	White	Not Hispanic or Latino
Jake	21	Man	Male	White	Not Hispanic or Latino
Mandy	23	Woman	Female	White	European Origin
S	42	Man	Male	White	Not Hispanic or Latino
Blue	34	Woman	Female	White	Not Hispanic or Latino
Bob	79	Man	Male	White	Italian
Cobalt	27	Genderqueer	Female	White	Not Hispanic or Latino
Counselor	31	Man	Male	White	Not Hispanic or Latino
Dee	21	Woman	Female	White	Irish
Diane	25	Woman	Female	White	Hispanic/Latino
DJ	28	Woman	Female	African American; Filipino; White	African American
J	30	Woman	Female	White	Irish and Sicilian

Table 1. Continued

Joey	26	Man	Male	Hispanic	Not Hispanic or Latino
Kara	22	Woman	Female	White	Not Hispanic or Latino
Lucy	34	Woman	Female	White	Jewish
Patricia	20	Woman	Female	Hispanic	Hispanic/Latino
Sam 1	34	Woman	Female	White	Not Hispanic or Latino
Sam 2	42	Woman	Female	White	Not Hispanic or Latino

Pseudonym	Sexual Orientation	Socio-Economic Class	Highest Education Level	Disability Status	Religion/Spirituality	Other*
Sunny	Straight	Lower Middle Class	High School Graduate	Yes	Spiritual; not religious	None
Emily	Straight	Upper Middle Class	Some college, no degree	None	Atheist	None
Jake	Gay	Middle Class	Bachelor's Degree	None	None	None
Mandy	Bisexual	Middle Class	Bachelor's Degree	None	Agnostic	None
S	Straight	Middle Class	Master's Degree	None	None	None
Blue	Gay	Lower Middle Class	High School Graduate	None	Christian	None
Bob	Straight	Middle Class	Bachelor's Degree	None	Catholic	None
Cobalt	Queer	Lower Middle Class	Master's Degree	Yes	Christian	None
Counselor	Straight	Lower Middle Class	High School Graduate	None	Christian	Certified Peer Recovery Support Specialist
Dee	Straight	Lower Class	Some College, no degree	None	None	None
Diane	Bisexual	Lower Middle Class	Master's in Progress	N/A	Catholic	None

Table 1. Continued

DJ	Bisexual	Middle Class	Some college, no degree	None	None	None
J	Lesbian	Lower Middle Class	Bachelor's Degree	None	None	Suicide survivor
Joey	Straight	Lower Middle Class	Associates Degree	None	Christian	Husband and father
Kara	Heterosexual	Middle Class	Some college, no degree	None	Jewish	None
Lucy	Heterosexual	Lower Middle Class	Bachelor's Degree	None	Atheist	Progressive, believes in Astrology, believes in gravity
Patricia	Bisexual	Middle Class	Some college, no degree	None	Catholic	None
Sam 1	Straight	Lower Middle Class	Some college, no degree	None	Christian	None
Sam 2	Human	Upper Middle Class	Bachelor's Degree	None	N/A	None

Note: *Participants were asked if there are any other identities they believed to be important to share with the researcher conducting the interview.

Measures

For the purpose of this study (i.e., understanding how crisis workers conceptualize suicide stigma and how it is assessed), participants were presented with the Suicide Opinion Questionnaire (SOQ, Domino et al., 1982) and the Scale of Suicide Stigma (SOSS, Batterham et al., 2012), but did not complete the measures, themselves. We chose these two scales because the SOQ is the most prolifically implemented and widely used measure, while the SOSS is a more contemporary measure of suicide stigma that explicitly aims to address critiques of previous measures, including the SOQ (Domino et al., 1982). When originally assessing the validity of the SOSS,

Batterham and colleagues (2012) also found the SOQ to be an appropriate comparative instrument, as did Williams and colleagues (2018). The full length 100-item SOQ was chosen to be presented to participants as opposed to the short form, given that Domino (2005) has asserted that the full form should be used in lieu of shorter reiterations whenever possible. As such, the long form 58-item version of the SOSS was also utilized.

Procedure

Given that individuals who experience suicide ideation are likely to encounter incidents of suicide stigma (Batterham et al., 2013), crisis workers who interact with suicidal people regularly would also be likely witnesses to suicide stigma. Following the recommendations outlined by Faugier and Sargeant (1997), we recruited participants through purposive snowball sampling, which is thought to be one of the more feasible methods available when studying stigmatized topics (p. 792). We initiated recruitment chains via emails sent by the first author to publicly listed email addresses of crisis workers on the websites of suicide prevention/crisis intervention agencies. We located these agency websites through the American Association of Suicidology's public online database of 114 accredited crisis agencies (American Association of Suicidology, 2025). The email requested that recipients who identify as an 18+ year old crisis specialist/crisis counselor with experience in suicide prevention see the attached recruitment flyer for an opportunity to participate in a study on the psychological measurement of suicide stigma. Those interested in participating were directed to a QR code on the flyer that directed them to a screener survey. The email also included a request to forward the email to others who identify as adult crisis specialists/crisis counselors with experience in suicide prevention.

Eligibility for participation, as defined by the inclusion criteria of being an 18+ years old crisis specialist/crisis counselor with suicide prevention experience, was confirmed prior to the scheduling of interviews by the first author through evaluation of responses to the screener survey. By having individuals involved in suicide prevention services forward the recruitment email and flyer, the choice to contact the researchers for more information or to participate remained with the potential participants. To protect participant privacy, no one, including other participants, was given notice or confirmation whether anyone had opted to participate in the study. Our reason for seeking participants over the age of 18 rather than a more specific age group is due to potential difficulties in obtaining adequate sample size. Crisis counselors and specialists were also not excluded on the basis of whether their suicide prevention experience is in a volunteer or paid capacity in order to capture the experiences of as many crisis workers as possible. We recruited participants and conducted interviews until data saturation (i.e., interviews were not eliciting any new information) was determined. While nine participants is typically the recommended minimum sample size to reach saturation for thematic analysis of lengthy interviews with a specific research purpose and primarily homogeneous sample (Morse, 2000), several additional interviews may be conducted to ensure data saturation. Our need to interview more than nine participants was in alignment with the diversity of experiences across our participant sample.

The procedure for this study was inspired by Galupo et al.'s (2014) study in which sexual minority community members were asked to assess the degree to which existing sexual orientation scales represent their personal experiences and conceptualizations of their sexuality. However, instead of conducting surveys, the first author conducted semi-structured interviews

remotely via a HIPPA compliant Zoom. The semi-structured interviews took place over the course of 60 minutes, following recommendations for cross sectional, semi-structured, in-depth interviews conducted one-on-one (Jamshed, 2014). In terms of choosing interviews over other data collection methods, according to Barriball and While (1994), semi-structured interviews are ideal for assessing conceptualizations and perceptions of emotionally sensitive or complicated topics. Similarly, semi-structured interviews can be advantageous when interviewing individuals about value or moral laden topics which they may not typically discuss with another person (Astedt-Kurki & Heikkinen, 1994). Interviews also allow the opportunity for participants to prioritize explaining aspects of the topic at hand that are important to them personally, allowing researchers to learn about their perceptions more expansively (Cridland et al. 2015). Individuals are also often known to experience a sense of empowerment and benefit from participating in qualitative research interviews (Hutchinson et al., 1994). By providing responses which would inform the need for modification of existing suicide stigma measures, participants had a stake in research that may directly impact their work in the long term, while additionally gaining an opportunity for short term cathartic relief (Hutchinson et al., 1994).

Following the framework for semi-structured interviews constructed by Kallio et al. and colleagues (2016), our interviews were guided by a semi-structured interview guide developed by the research team in advance. This guide was assessed for effectiveness by conducting pilot test interviews beforehand, which is thought to provide insight into what the experience will be like for the participant and bolster integrity of the qualitative interview process (Kallio et al., 2016). See **Appendix A** for the full interview guide. The informed consent, as well as verbal confirmation clearly warned participants about the potentially sensitive nature of the study,

indicated that participants may opt out of answering any study questions or leave the study any time, and contained disclosure of the plan for financial compensation which outlined the amount/type of compensation being provided, distribution details, and circumstances in which the participant will/will not receive compensation per university Interview Review Board guidelines. The first author prompted participants to ask questions or dictate any concerns before digitally signing the informed consent and provided participants with an additional copy of the informed consent to keep in case concerns arose after the interview, as well as the link to a list of self-care/support resources for crisis workers. These resources included information about contacting the 988 Suicide and Crisis Lifeline.

After informed consent was obtained by the first author, interviews began with an assessment of demographics based on the “Guidance for Researchers When Using Inclusive Demographic Questions for Surveys: Improved and Updated Questions” (Hughes et al., 2022). This was followed by open-ended questions asking about their experiences as a crisis worker, how they conceptualize suicide stigma, and their experiences, if any, seeing suicide stigma in their crisis work. Specifically, they were asked: “Please tell me a little bit about your experiences as a crisis counselor/specialist,” “How do you define the stigma of suicide,” and “Please describe your experiences with suicide stigma as a crisis counselor/specialist, if any.” The first author asked participants about their independent conceptualization and experiences first to avoid contamination by the presentation of the scales. Participants were asked follow-up questions as necessary and instructed to take all the time they needed on each question.

This set of questions was followed by the first author sharing a PDF copy of the Suicide Opinion Questionnaire (SOQ; Domino et al., 1982) and Scale of Suicide Stigma (SOSS; Batterham et al.,

2013), in that order. The scales were screenshared as individual PDF copies of the items, without labels. PDF copies of the scales were left on screen for the remainder of measure questions and participants were encouraged to take all the time they needed to read measure items. In alignment with questions asked by Galupo et al. (2014), when presented with each scale, participants were prompted to answer, "In what ways did this scale capture or fail to capture your understanding of a suicidal person's experience with suicide stigma" and "What is it like for you to imagine completing this measure about a suicidal person," in alignment with the instructions of these measures which ask participants to respond based on their beliefs about suicidal people or people who suicide. After both scales were presented, participants responded, and any clarifying questions had been asked, a quality check was conducted by asking participants to provide feedback about the interview session. Specifically, they were asked to, "Please indicate the ways in which today's experience did or did not allow you to accurately represent your perspective and experiences." Participants were asked if they had any further questions or concerns before the first author ended the Zoom interview and sent each participant a \$25 Amazon gift card to compensate them for their time.

Research Team

The research team consisted of a mixture of undergraduate students majoring in Psychology, Counseling Psychology PhD students, and one PhD level faculty advisor at a large public university in the Southeastern United States. The team had three coders, one auditor, and one research assistant who aided with cleaning of transcriptions and organization of participant demographics information. Of the coding team members, Sarah, the first author, is a Counseling Psychology PhD student. She is a White, cisgender woman, who identifies as questioning

heterosexual, holds agnostic religious/spiritual affiliation, has invisible disabilities, and was 27 at the time of data collection. Eric, who also served as a coder, is an undergraduate student majoring in Psychology and Sociology. He is Hispanic, identifies as a bisexual cisgender man, and was 22 at the time of data collection. Hannah, the third member of the coding team, is a Counseling Psychology doctoral student. She is a White, cisgender woman, who identifies as bisexual, and was 27 at the time of data collection. Joe, the research study's primary faculty advisor, served as the coding team's auditor and is a tenured professor of psychology. He is a White, cisgender man, who identifies as gay, and was 46 at the time of data collection.

The first author, Sarah, had previously accumulated over 1,200 hours of direct talk time across more than four years of experience on the 988 Suicide and Crisis Lifeline as a certified crisis counselor/specialist and administrative supervisor. Another member of the coding team, Eric, has had similar certification and 2+ years of experience in both volunteering and working as a paid crisis counselor for the 988 Suicide and Crisis Lifeline. While Joe, the auditor, and Hannah, another member of the coding team, have had clinical practicum experience and knowledge of suicide assessment, they have not had experience directly serving as crisis counselors/specialists.

Data Analysis

The research team conducted reflexive thematic analysis as outlined by Braun and Clarke (2006). Given the lack of existing studies addressing our specific research questions, and our consideration for the ways in which our current sociopolitical and sociocultural contexts may inform the results, we determined that inductive open coding grounded in the interview data collected be the most effective way to derive key themes presented by participants. While we believe each coding team member's varied familiarity with crisis intervention/suicide prevention

work provided additional depth and perspective to the coding process, we also recognized that these individual differences emphasized the need to actively engage in continued discussion of positionality and a need to reach consensus about decisions made. All three members of the coding team were trained by the research lab's primary faculty advisor in open inductive coding and in the process of developing coding memos that address one's positionality when identifying codes and themes. All members of the research team were also encouraged to follow recommended guidelines for "vulnerable listening" that were created for qualitative researchers conducting interviews on particularly emotional, sensitive, or difficult topics (McClelland, 2017). Vulnerable Listening, as defined by McClelland and colleagues, (2017), is a method of consuming qualitative data (e.g., listening to interview recordings, reading interview transcripts) while consciously acknowledging and attending to one's own mental, emotional, and physical reactions to listening. Though only the first author of the research team directly conducted interviews, engaging with transcripts of detailed experiences with suicide and stigma still had the potential to be emotionally challenging for the research team to engage with.

Audio recordings and transcripts automatically generated by Zoom were uploaded to and stored on a secure digital drive. All audio recordings were listened to multiple times as the transcripts were cleaned of any potentially identifying information and edited for accuracy. Developing themes were regularly assessed and documented in memos after transcription of interviews, with particular attention to whether saturation as defined by Braun and Clarke (2021) had been achieved. After transcriptions were cleaned, each coding team member coded the first interview and met with the auditor for a calibration meeting. Once all coders and the auditor were in agreement, coders began to independently code interviews, generate coding memos, and develop

individual codebooks. Members of the coding team met to consolidate their individual codebooks into a unified code book and discuss coding memos. The research team regularly consulted with the auditor to discuss the unified codebook, and the emerging themes identified in coding memos. The auditor continued to provide feedback throughout the data analysis process.

CHAPTER FOUR

RESULTS

From the interviews, the research team identified four primary themes and a number of subthemes. Primary themes include: Theme One: Suicide stigma is complex, interpersonal, and preventable; Theme Two: Suicide Stigma measures miss the mark but not everyone agrees why; Theme Three: Suicide stigma measures get it right at least some of the time; and Theme Four: How researchers could or should be measuring suicide stigma. These themes were derived while holding in mind the dynamic relationship between participants' responses, their unique positionality, and the unique positionality of the research team. While crisis workers use several different terms to refer to the people seeking support on various platforms (e.g., callers, chatters, help seekers, visitors, clients) for the purposes of clarity we will primarily be using the term "visitors," to encapsulate all the above.

Theme One: Suicide Stigma is complex, interpersonal, and preventable

The first primary theme we identified in the data reflected the ways participants conceptualize suicide and suicide stigma. Based on participant reports, participants' crisis intervention and suicide prevention work experience, as well as their own personal experiences with suicidality and stigma, serve as the foundation for how they have come to understand suicide and the stigma attached to it. Subthemes explored the following concepts: suicide is complicated, suicide stigma is as complex as the act it is associated with, internalized suicide stigma, suicide stigma is not static or universal, no one is immune to suicidality or its stigma, and perpetuation vs. prevention.

Suicide is complicated

When describing their understanding of suicidality, participants explained it often involves an overwhelming emotional experience and a desire to escape pain. They described suicide ideation as sometimes being the only way for people who are miserable and suffering to “take control.” They further explained that, at its core, is a sense of feeling alone. And, while they acknowledged that sometimes suicide ideation gives people a sense of relief, completion of suicide requires a conscious, voluntary effort. Participants emphasized that most people who have thoughts of suicide do not have the intent for suicide and will not complete suicide. They also pointed out that suicidal people typically think of all potential solutions before considering suicide and much of the time it is thoughts about how suicide will impact others that prevents intent or completion. They additionally identified that recovery from suicidality is not linear-- sometimes suicidal people have “good days,” just as they have bad days. They pointed out that suicide ideation is also sometimes accompanied by homicidal ideation, which participants described as some of the most difficult interactions to navigate, especially because they rarely know what the results of the situation are after their interactions. Some participants also described what suicide is not. For example, some participants reported a belief that medically assisted death is distinct from suicide, while others identified it as an atypical form of suicide, but still suicide, nonetheless. Many participants also emphasized that suicide is not attention seeking. They noted that even though a need to receive attention is sometimes part of suicide ideation, this is never the root cause of suicidality.

As for who is impacted by suicidality, participants described the 988 Suicide and Crisis line receiving visitors with a wide range of different socioeconomic statuses, gender identities, racial

identities, ages, and education backgrounds. One participant recalled experiences interacting with children as young as 7 or 8 years old that contacted the Lifeline for support, and some participants reported that adolescents appear to be the age group who contact the lines most frequently. Multiple participants reported a belief that everyone experiences a suicidal thought at least once in their life, but that suicidality impacts people differently depending on their identities and backgrounds and even the language they speak. As an example, Diane, a crisis counselor with four years of experience answering both English and Spanish speaking crisis lines, reported that suicidality on the Spanish line is accentuated by hopelessness and the lack of resources related to the chronic stigma they face. She said, “It’s like a lifelong thing. It’s usually not something that just comes out of the blue and so they call because they wanna (sic) talk to somebody and then by the end of the call they’re... They get agitated because they see no solution because they’ve gone to these mental health facilities. They’ve gone to the ER. They’ve tried these medications, and they’ve been treated badly by medical staff or by their psychiatrist or you know... And it’s just... Everything’s so local to them and they can’t escape it. I’ve noticed a lot of that when it comes to how stigma impacts our care for them because after a while people just kind of give up.”

Suicide stigma is as complex as the act it is associated with

Participants collectively described suicide stigma as consisting of prejudice, misunderstandings, taboos, negative connotations, and the belief that one should not have suicidal thoughts.

According to Lucy, a crisis counselor who has been working 30 hours per week on a crisis and suicide lifeline since 2021, suicide stigma is the social pressure to deny the question of existence, even though questioning whether we should be here is human. Lucy continued, “...stigma, is

pretty much [a] result of comparing yourself to whatever social norm that exists. And I guess, you know, the social norm is to want to live.”

Participants also identified ways in which suicide stigma can be found within how people talk about suicide, including stigmatization of the word “suicide” and a view that discussion of suicide is “very depressing.” While multiple participants noted that “commit” suicide language is stigmatizing, in part due to having a connotation of an “act of violence,” participants also shared a belief that recent social media self-censorship (e.g., digital creators abstaining from explicit use of the word “suicide” in social media posts about suicide) has led to suicide language being “less intense.” Participants described this self-censorship as an obstacle to conversations about suicide and many gave examples of preferred language about suicide, including the use of suicide as a verb (e.g., “suicided”) or the phrase “died by suicide.”

Participants described suicide stigma as emerging from ignorance, lack of education, and lack of understanding of suicide, specifically. They also described suicide stigma as emerging from fear, rather than hate, despite ways in which stigma can provoke feelings of anger. Participants explained that emotional reactions to suicidality and the ambiguity of whether a suicidal person may live or die by suicide can sometimes lead others to treat suicidal people like dangerous animals and attempt to hospitalize them. Participants elaborated that it can also lead people to judge, generalize, and make assumptions about suicidal people instead of engaging in subjective perspective taking. Some of the assumptions participants described are an overestimation of the resources available to suicidal people in a crisis, and that suicide ideation will dissipate quickly, despite some people being chronically, rather than acutely, suicidal. According to participants, suicide stigma can be also comorbid with other forms of stigma, including mental health stigma,

broadly, and stigma against people who use substances. Participants noted an example of this in their observations that seeking mental health care appears to remain stigmatized, while seeking physical health care is not.

Participants described suicide stigma as meaning that suicidal people are seen as “weak,” “cowards,” “flawed,” “lack[ing] self-control,” “weird,” “seeking attention,” “selfish,” “broken,” “the problem,” and having “a moral failure.” Participants also noted that suicide stigma also means that non-suicidal self-injury or self-harm may also be seen as attention seeking.

Participants explored ways in which there is both internalized and externalized suicide stigma but noted that suicide stigma typically starts as externalized stigma before being internalized.

Almost all participants detailed the role of interpersonal relationships with family members, friends, or loved ones in exposure to external suicide stigma. Participants reported that this can often be observed in third-party helpline visitors who are seeking help on behalf of someone else because they do not know how to support their loved one or how to engage in conversations about suicide. They also reported that sometimes third-party visitors are afraid of the risks that discussion of suicide could enable due to the myth that asking about suicide will cause someone to become suicidal. Participants explained that from their perspective, third-party visitors often do not want to be responsible if someone is suicidal, and sometimes they want to “fix” their suicidal loved one, “make them normal,” or “force” them to get help. Colbalt, a crisis specialist currently working at an adult crisis stabilization unit, explained, “Sometimes, when we get people that like voluntarily walk-in, they have, like, family or friends that came with them. Um, and sometimes it's the family or friend that brought them, and we have to obviously make sure that they're consenting because we're like, ‘this is voluntary. We can't force you to do it.’ And

how it's very interesting when sometimes the person consents. But you can tell they still don't want to be there. And the person they're with is like, 'well, they said all this,' 'they're doing this.' 'I want them to get help,' and the person's just like 'no,' and you can tell, like the stigma they hold within themselves, which is interesting. And then other times, if you talk with somebody and you're like, 'can I call this person and ask some questions when you call them?' They're like, 'Oh, my gosh, they do this all the time.' So it's just... It's very interesting that it can be the person that you're talking to, or it can be like their support system.” This urge to focus on solutions was described by participants as being related to the urgency to save someone’s life, despite this not being helpful because there may not be solutions available.

Many participants disclosed observing or personally experiencing instances in which family members who hold suicide stigma are embarrassed or ashamed of their suicidal family member. Some participants reported a belief that these feelings can be especially common in parents of young suicidal people. Most participants shared a similar belief that people are especially impacted by suicide stigma within their interpersonal relationships because it leads them to be uncomfortable to disclose the struggles they are navigating. Participants further explained that loved ones can also convey messages about suicide being a sin and send family members away because they are having thoughts of suicide, which they believed to be a part of suicide stigma. Participants noted that sometimes the development of empathy for a suicidal person, unfortunately, only happens after the person has died by suicide. Conversely, participants noted that a lack of suicide stigma within familial relationships and having an existing support system increases willingness to seek needed mental health support. J, a suicide survivor who was inspired to dedicate the past five years working as a crisis counselor and supervisor after

recovering from her own suicide attempt, described her personal experiences, "...I come from a family who has dealt with mental illness extensively. And so, therefore there's not really been that stigma kind of over over weighing any of us...Or weighing over any of us. We've always been very open about our struggles and kind of reaching out and getting help that's needed." J further explained that while she has observed many examples of Lifeline visitors and other crisis workers "struggling" to receive needed support because of the "barrier" of familial suicide stigma, this thankfully was not the case for her. J credited having a family support system that normalized help seeking as a lifesaving factor in the aftermath of her attempt and described herself as, "very lucky for that."

Internalized suicide stigma

Participants frequently described a process by which internalization of stigma emerges when suicidal people hear external messages from those around them and broader society. They explained that from their perspective, internalized stigma consists of "shame," "self-hatred," "weakness," and a belief that they need a particular diagnosis or severity of risk level to earn or deserve support. Participants emphasized that silence about the issue of suicide leads people to internalize stigma by feeling like a burden for talking about suicide with others, that they have done something wrong by bringing it up, or that they are selfish for seeking support from others. Participants further explained that suicidal people begin to wonder if, "there's something wrong with them," or that they are "crazy" for having thoughts of suicide. According to participants, this creates a desire to keep conversations "lighthearted and fun" to avoid "intense" conversations. Participants also explained that holding stigma to begin with also makes acknowledging one's one suicide ideation more difficult. Participants described ways in which

suicidal people live in fear of disclosing their thoughts for fear of provoking anger, fear of being sent away, fear of being called attention seeking, and fear of being made fun of. Almost all participants described this as a barrier to seeking support, accessing care, and connecting to suicide prevention resources, including crisis lines.

Participants explained that sometimes before a conversation even starts on a crisis line, some visitors will say they are not suicidal even if they disclose later in the conversation that they are.

Participants described experiences in which some visitors will become offended, and conversations become tense, when crisis workers assess for suicidal thoughts and suicide risk.

Participants explained that, from their perspective, it is scary for people contacting the suicide hotline to say “yes” they are suicidal because of suicide stigma. One crisis counselor thought this may be, in part, due to a realization that admission of these thoughts or struggles with self-harm may mean acknowledging it is really happening, in addition to fear of hospitalization.

Participants noted that there is also the fear of being judged. Participants explained that suicide stigma makes people feel “bad” for seeking support even if they need it. According to participants, visitors seem to perceive themselves to be burdens that need to carry their struggles alone. Many crisis workers also recalled interactions in which visitors reported fears that they are wasting a crisis worker’s time or violating a time constraint by talking for a longer time or that they are bothersome reaching out.

Suicide Stigma is not static or universal

There were 44 mentions by participants about how suicide stigma is not static and is impacted by context. Aspects of important context described by participants include temporal, physical (e.g., geographical, regional), and sociopolitical contexts. Participants also described ways in which

suicide stigma is intertwined with the intersecting identities one holds, which changes what the stigma consists of and how/who it impacts. While suicide stigma is personal, participants noted that it is different across communities and is connected to cultural norms, including norms around communication of emotions. As for national differences and differences based on global location, participants described culture in the United States as contributing to suicide stigma through the myth of meritocracy and attributing unfortunate circumstances to individual failing. Regionally within the United States, participants from Appalachia described the region as lacking access to education and information on suicide that has led to increased prevalence of suicide stigma in these states. Blue, a current shift supervisor with five years of experience as a crisis specialist on numerous crisis, substance use, and basic needs lines in Appalachia explained their perspective, “It probably depends on where you are in the world, I guess somewhere like [Appalachian state]... There's not a lot of education or information about suicide, I don't think. And so, you've got people who are like very old school from... From an older generation who don't believe in mental health, and that's what they believe they just think that you can't deal with. You know, whatever life throws at you. And and you're a coward, or whatever. But that generation is dying out. So, it's changing. I think it's probably constantly changing, would probably be my answer, and that it depends on where you are.”

According to Bob, a crisis worker with decades of experience providing crisis services to various populations including veterans, first responders, and students, there are occupational differences in suicide stigma. Bob explained that this is related to perceptions about which jobs are naturally challenging and involve a certain amount of suffering, leading people in these occupations to be less likely to seek support, “...one of the hardest things is when you separate people into groups

like law enforcement, first responders, or mental health people like technicians or psychologists and psychiatrists, or whatever. Each one of them have their own little niche, you know. And the hard thing is when I talk to officers, police officers, not only, you know, in my department, but other departments... They always come across as being the problem solvers, you know. They're called to a scene to solve a problem. And so, they're always looked up to as having a higher standard of ability to deal with these crisis situations. But when you really talk to them alone privately, it's really difficult for them. But they're not going to admit that. They're not going to show it. Because they look at as a sign of weakness, and so they don't want to establish that.”

Participants noted that there are also legal and legislative influences on suicide stigma. Some participants reported a belief that suicide stigma fluctuates depending on the current administration in White House, especially surrounding funding access for crisis services. Dee, an undergraduate psychology student with two years of experience volunteering as a crisis counselor for crisis and basic needs hotlines, recalled the fear of losing lifeline funding that she and her colleagues experienced the day after the 2024 election. She elaborated, “...And everyone else surrounding me, including myself, like we were upset, that the fact that that's also an idea that they're gonna like, take away the hotlines. And how are people supposed to basically live if they've only relied on the hotline? Or if they never even introduced to that line? It's obviously really scary to like, just like, not have a hotline. And like... Let people be upset and like not have affordable like therapy? Because therapy could be expensive, and healthcare is expensive. So, it's just a whole... thing.” Diane emphasized that there is also less support for suicidal people who do not have citizenship status, with immigration status being an additional barrier to support. She also explained that, based on her experiences, suicide stigma changes depending on ethnicity,

people are treated worse when seeking help as someone with marginalized ethnic identity. Diane noted that language is also a factor; there are fewer resources for non-English speakers and especially Spanish speakers.

In terms of contextual impacts identified by participants, there were by far the most mentions about religious influences on suicide stigma. Participants described religious suicide stigma as the fear of being religiously shamed, disowned, and buried improperly. Participants also reported that they have heard stigmatized message sin which suicidal people are described as selfish, going to “hell,” and not only that suicide is a “sin,” but that it is the worst sin one can engage in. Participants added that suicidal people also receive messages that religion can “cure” or “fix” suicidality. Participants explained that religious suicide stigma can be more personal and complex than other forms of suicide stigma and leads religious individuals to look down on suicidal people. They also noted a belief that internalized religious suicide stigma and belief in damnation can lead to feelings of seeing suicide as a deserved punishment.

Another aspect of identity with influences on suicide stigma identified by participants was gender. Participants described ways in which male identified individuals have a considerable number of challenges seeking mental health support and face the most suicide stigma of any gender. Participants explained that part of gendered stigma are messages that describe help seeking as incongruent with masculinity. Participants identified one implication of these messages is that female identified individuals are more able to engage in conversations about emotions. Participants also explained that are many stereotypical descriptions of young women being the main demographic of suicidal people, even if this is inaccurate. Sam 1, a counseling master’s student who decided to work as a crisis counselor after contacting a crisis line herself

years prior, recalled that the controversial book and Netflix series, 13 Reasons Why, as an example of this, “I guess, in our popular culture, like 13 Reasons Why, like, that's the average you know, victim... And like, just based off of TV shows that we watch, you know, because I used to love to watch like Lifetime. And that was like a big thing. And there's this picture that your average, you know... The average person who contemplates suicide is this young teenage girl who, you know, may have everything going for her, but she's just not happy.” Sam 1 expressed that this has continued to be the common depiction of suicide in the media as she has continued to observe these gendered stereotypes in television shows that her own teenage children watch.

As for age, participants reported that they have observed suicide stigma to be more prevalent among older generations and described suicide stigma as a barrier to older individuals seeking help. On the contrary, one participant noted concerns for impacts of suicide stigma on younger individuals because it can be dangerous for children to lack space to discuss thoughts of suicide and other “big feelings.” Participants explained that age is also a factor in how someone might respond to the idea of a person’s right to die. Specifically, they highlighted a belief that the younger someone is, the more hesitant they are to endorse that person’s right to die. This appears to align with the ideas shared by participants about manifestations and impacts of suicide stigma being dependent on historical and temporal context. Participants noted that suicide has had different implications at different points in history and described the belief that suicidal people are weak or flawed as an example of an outdated form of suicide stigma that was once common in the 1950’s and 1960’s. Several participants reported a belief that suicide stigma is no longer held by people for as long throughout their lives as it used to be, and that suicide stigma is not as

widespread as the world continues to change. Participants explained that, in their experience, there has also been a notable shift in the past five years toward more open discussion about mental health, especially within their personal support circles and on social media.

No one is immune to suicidality or its stigma

Participants described suicide stigma as showing up and impacting suicidal people in many contexts. Several participants reported that suicide stigma is especially present when contacting emergency dispatch for crisis line visitors that are actively attempting suicide or are in imminent danger of a lethal suicide attempt. Participants explained that, in their experience, dispatchers, police, and emergency medical technicians often do not understand crisis workers and are resistant to providing suicidal people with emergency intervention. Participants explained that this is especially the case for chronically suicidal visitors. Participants described witnessing a “lack of empathy” among medical professionals toward suicidal people, broadly, though they felt that mental health care professionals who have not worked in suicide prevention also do not appear as accustomed to or comfortable with these discussions. Participants reported a belief that there are not enough resources and support for suicidal people in general, and that sometimes non-suicide support lines over-rely on the 988 Crisis and Suicide Lifeline because other lines sometimes will not take calls from people who are suicidal.

Participants emphasized that no one is immune to mental health struggles and suicidality, including crisis workers. 12 participants shared that they are in their role as a crisis worker because they have personally experienced mental health struggles, been suicidal, reached out to the 988 Suicide and Crisis Lifeline for support, have had close losses of others by suicide deaths, and/or attempted suicide themselves. Participants did not describe this as a negative aspect of

their work, however. Many participants, including Sunny, described their experiences as empowering and advantageous to supporting others, “All my life, I’ve you know, just always been a safe person for people to just tell me. Like, really what they’re feeling. No judgments, not trying to fix it. Just kind of sitting with people in the darkness. I struggled, myself, with self-harm and suicidal ideation when I was a teenager.” Sunny explained that losing her husband to suicide preceded her decision to work as a crisis counselor and supervisor across multiple crisis line services, including an LGBTQ+ lifeline. She continued, “I find that because life hasn’t handed me a good deck to play with, you know... That has really been an advantage in this line of work because the people reaching out. I’ve been there. I- I know exactly what they’re going through. So, it helps me to really give them the kind of support that they’re needing.”

Participants noted, however, that having personal experiences with crisis requires crisis workers to be aware of their triggers and may require additional support when engaging in crisis work.

Participants also explained that no one is immune to holding suicide stigma, including crisis workers. Participants explained that this includes being susceptible to pressures that suicide stigma creates surrounding the dichotomy of strength vs. weakness, and a belief that crisis workers should be able to handle their suicidal thoughts or mental health struggles because of their profession. Some participants shared that they held their own suicide stigma prior to training and described continuing to acknowledge and address the potential their own biases on an ongoing basis. Participants explained that they have witnessed stigmatized assumptions made by crisis workers about who is or who is not suicidal, especially frequent visitors who contact a crisis line multiple times a day. Several participants explored how suicide stigma can also show up in the inconsistency found in least invasive intervention protocols in which crisis workers are

ideally meant to avoid calling for involuntary rescue unless it is necessary to save someone's life. They explained that this is partly given that active rescues can result in involuntary hospitalization for crisis line visitors. More than half of participants reported a belief that being a crisis worker who resists suicide stigma means resisting the urge to "take that option of suicide away" and respecting the decision about suicide that visitors ultimately make. Participants explained that this means facilitating acceptance and validation regardless of their decision. Outside of crisis work, one crisis counselor, Mandy, recalled witnessing suicide stigma on her university's campus in the aftermath of a student suicide, "In general, we had a student die from suicide last semester. Jumping off one of the parking garages that... it's really close to, like, our classroom. So, it's not even just visitors. It's like there's people very close to us that have faced those thoughts. And until a teacher, like, let us talk about it, we were kind of silent about it. And the University has also been silent about it, which was, which is upsetting. No, I know there's probably legal things going on with that, and like with the family, too. But it's definitely, like, frustrating, because, you know, that's like a whole student that lost their lives because they were suffering so much. And the university didn't really like outwardly acknowledge it, or try to do anything differently." Mandy became tearful while explaining that, to her, the silence conveyed the message that universities only see students who die by suicide as another person who can be replaced or that students who die by suicide are simply "lost tuition dollars."

Perpetuation vs. prevention

Participants explained that suicide stigma can be perpetuated or prevented based on actions taken. Some participants shared a belief that there is a need to continually assess and reflect one's own stigma and engage with continued education. Participants also emphasized that crisis

workers should also remember that “difficult” visitors are not difficult people but are going through difficult circumstances. Many crisis workers noted they did not receive any training or education on suicide prevention until they entered the suicide prevention field. One participant, S., was already established as a master’s level therapist when he became drawn to crisis work. He explained this was because he had not learned a lot about suicide in his training and wanted to learn more. As a current graduate student, Mandy noted the striking difference between the “silence” and discomfort displayed within her graduate cohort surrounding conversations about suicide and the comfort and frequency of these discussions she witnesses as a crisis counselor. She described this as reinforcing stigma.

Several participants reported that working as a crisis worker and being exposed to suicidal people has broadened their perspectives on other people’s lifestyles and what difficulties others may have to navigate. They explained that the more you talk about suicide, the more you can regulate your emotions during conversations about suicide and feel comfortable discussing it. Participants also explained that, in their experience, regularly assessing suicide risk and actively engaging in discussion of suicide combats stigma because it combats uncertainty and empowers suicidal people. Many noted the importance of ASIST (Applied Suicide Intervention Skills Training) often required by the 988 Suicide and Crisis Lifeline, and how it specifically addresses stigma at the beginning of the program. Blue recalled her experience with ASIST, “... first time I filled it out I just realized that I had a lot to learn that I didn't know a whole lot, and my beliefs were kind of backwards, I guess you could say.” She continued, “Well, everybody starts somewhere, I guess. I don't know (laughs)... I have learned a lot, and I continue to learn more.” Participants reported a belief that education should not be reserved for those who work in the

mental health field, however. They also described a belief that education should begin early in school-based interventions to combat stigmatized beliefs about suicide that children inherit from their parents. According to participants, early intervention would also increase access to important resources. Because of her experiences with a campus suicide loss, Mandy reflected on what a more effective and less stigmatizing approach to student suicides on campus would be, “If the university were to be open about it, I think conversation would be started, and I think that's when people would feel more comfortable. Maybe sharing resources. It's not necessarily all about just like telling your friends what you're feeling, but just like knowing who to reach out to when if you have those thoughts. So, I think that would target the stigma of a taboo subject... also, just like if the university were more open about it... Maybe students would feel like, you know, if I'm having these thoughts like I am cared for like I am a part of a community that wants me to thrive, and it doesn't really like... Instead of a community that doesn't really care or is more individualistic. Like, I think if the university showed more of an openness to it, and it, instead of just posting random pictures and parking garages of ‘call this hotline,’ or whatever like, you know, if we're actually actively getting emails or people are talking about it, people in higher positions are talking about it... Then that is what will bring the community together and give us a more collectivist perspective on just like us as students rather than us, being just everyone for themselves...”

Six participants remarked on the importance of authenticity in crisis work and how this is required to be effective in navigating stigma and supporting someone in crisis. DJ, a full-time crisis counselor who has been involved with crisis work since 2022, described authenticity and being a “witness” for visitors as essential to her approach, “I think when people hear a crisis

counselor they think of, you know, kind of someone on par with like an EMT, someone who's like literally pulling someone out of like their mental fire that is... their emotions and pain. And although those moments definitely do exist, and some of the work does include that, the biggest thing I've kind of realized just in, like, my own personal life philosophy is that I want to be a witness, and I want to be witnessed by other people and for people. And sometimes, a lot of the time, we think when we're trained to be a crisis counselor, or when we think of what help looks like for another person, it's to 'show up in this way where I can like do something for you.' And so like, sit here in your pain. Like, you know, helping could be sitting in that uncomfortability with them, validating that experience. Helping could be providing practical resources. And the hardest thing for me is like helping can also be just kind of like accepting and witnessing that if someone ultimately does want to choose suicide. Like, it's not your decision to change their mind or tell them that it's wrong. And if that's truly the way that they want to go, I think, in a weird way, it is helping by just acknowledging that and witnessing them.”

Participants also explained that it often takes time to break through suicide stigma with visitors. Some participants described a method in which they begin a call by letting someone know it is “okay” to talk about suicide first. They also described the importance of teaching third-party visitors, who contact crisis lines to seek support on behalf of someone else, how to talk to others about suicide with others. Participants shared that unconditional positive regard, even toward perpetrators of assault or those who are contemplating homicide, is one way that crisis workers can combat stigma. They also explained that there is importance in a crisis worker’s willingness to provide individualized support, sit in the darkness and discomfort of suicidality, and give validation to visitors instead of pity. Participants shared a belief that reducing suicide stigma and

increasing discussion of suicide would mean less feelings of isolation and loneliness during times of struggle. They explained that, from their perspective, visitors who reach out for support are brave, and talking about suicide also inspires others to share about their struggles.

Participants also emphasized the belief that the development of the 988 Suicide and Crisis Lifeline and its initiatives play a role in the increase of education about suicide and in reducing suicide stigma.

Theme Two: Suicide stigma measures miss the mark but not everyone agrees why

Another theme identified by researchers elaborates on the ways in which participants expressed conflicting critiques and concerns across both measures without unilateral agreement on which aspects of the measures they held concerns for and why. This is despite participants expressing a preference for the SOSS (Batterham et al., 2013) overall. Participants also explored ways in which their emotional reactions to the measures, as well as their individual identities and experiences, are connected to their critical perceptions of the measures.

What is inaccurate about the SOQ

Participants described experiencing strong emotional reactions to the SOQ (Domino et al., 1980) items. Specifically, they reported that the measure elicited feelings of anger, aggravation, and frustration, which they further described as making it difficult to imagine completing this measure. Participants explained that, from their perspective, the measure lacks the nuance necessary to assess suicide stigma and asserts generalizations about suicide that would make the measure difficult to complete. Participants emphasized this was the case for items which used the word “most” while only being partly accurate. According to participants, these “absolutes” made them perceive the SOQ as “less” of a comprehensive scale of suicide stigma than the SOSS

(Batterham et al., 2013). Several participants described concerns that this would lead people who are less informed to ascribe unfounded accuracy to the items and retain the false information presented in the measure after completion.

Participants reported that while the measure has the potential to be effective, they believe it contains many misconceptions and assumptions which may make it less effective for certain populations. In particular, they described the measure as not being universal, and many reported a belief that effectiveness would depend on demographics including education level and background. Some thought that the SOQ appears to be geared toward the general population but would be complex for someone who does not have crisis experience to complete. Participants also reported thinking that the measure would also be accurate for those who have been suicidal, but not for those who have not. They further noted that the measure may not account for people who are suicidal due to lack of basic needs, may not be accurate for people with minoritized identities, and may not be accurate for religious individuals because it is too religiously connotated. Many participants concluded the measure would not be an accurate measure for assessing suicide stigma in crisis workers. One participant, Diane, expressed concerns that some items, when stated in Spanish, have different meanings and thus may only measure suicide stigma accurately for English speaking participants. She also explained that measure seems to be created through a “Western lens,” “A lot of these statements are kind of written in the lens that only Americans or Westerners would interpret. Like it was made with that mindset. Which is you know just it just, that’s usually how it is, but I do notice that like a lot of the statements would be interpreted differently. Like even some of these, if you say them in Spanish they mean something different, so that’s just one thing that comes to mind, obviously because it's written in English.”

Diane also shared concerns that the items about the military would only be accurate in the United States given the American historical context provided in these items.

Participants believed that responses to the measure would be “all over the place.” They also reported a belief that the general public and crisis counselors/specialists alike may give responses that skew more negatively. One participant expressed concerns that the measure makes assumptions that suicide is good or bad and seems to have a specific agenda, possibly a religious one. Participants emphasized a perception that some items are “pretty intense,” but constructs are “all over the place.” Furthermore, participants reported that some items do not relate to one another, are contradictory, and/or do not make sense. As an example, participants noted that the items surrounding the concept of dignified death or “assisted suicide” is not accurately part of suicide/suicide stigma. Similarly, participants mentioned that items about “heroic suicide,” in which military members allow themselves to be killed in combat to save others or complete their mission, are also not relevant to suicide stigma because this is not a form of suicide from their perspective. Participants also reported that items sympathetic to suicidal people would not accurately measure stigma from their perspective. They shared concerns about the validity of the measure and began to ask questions on how items were created. Participants expressed the belief that while some items are known examples of suicide stigma, there are many “hot-takes” in the items that are uncommon, unpopular, or unheard of. As an example, one participant identified an item about completing suicide “to get even” as something they have never observed in their experiences.

Almost all participants expressed hesitance surrounding the measure’s proposition of “facts” and claims about suicide, which they perceived not be authentic or accurate. Participants explained

that this is because some items appeared to be a mix of opinion and fact, which they believed would not be helpful in measuring suicide stigma. Participants especially emphasized that the statistical claims were confusing and appeared to be statistical falsehoods. Cobalt described a desire to “Google” items afterward because of the hesitance and uncertainty created by them. Participants further elaborated on concerns that whether these items are factual or not would change how someone is answering. They described this as misleading and reported concerns that this would further create a discrepancy in accuracy for crisis workers and people who do not have experience with suicide.

Participants described potential use of this measure as concerning due what they perceived to be flaws and specific items that would not measure stigma accurately or would otherwise be potentially harmful. As for specific items that participants identified concern for, item two (“Almost everyone has at one time or another thought about suicide”) was described as “too human” and thus would not measure stigma accurately.

Items 11 (“Many suicides are the result of the desire of the victim to “get even” with someone”) and 67 (“Sometimes suicide is the only escape from life’s problems”) were identified as broadly inaccurate. According to J, who has experience employed in a prison setting, item 54 (“Prisoners in jail who attempt suicide are simply trying to get better living conditions”) is inaccurate as well. Item 62 (“From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated”) prompted an upset emotional reaction from multiple participants and was described as appearing to be rooted in eugenics. Item 15 (“Suicide is more prevalent among the very rich and the very poor”) was described as framing the prevalence of suicide unfairly to economic extremes. According to participants, items four (“The actual suicide rate in

the U.S. is much greater than reflected by official statistics”), 22 (“Suicide rates vary greatly from country to country”), and 24 (“John Doe, age 45, has just committed suicide. An investigation will probably reveal that he has considered suicide for quite a few years”) appear to be accurate facts that would not measure stigma accurately. Item five (“Suicide prevention centers actually infringe on a person’s right to take his/her life”) was identified by participants as inaccurate and concerning for its potential to discourage people from seeking support from suicide prevention services. According to participants, item 38 (“People who commit suicide must have a weak personality structure”) is offensive and does not reflect capacity for exhaustion from stress. Item 73 (“Heroic suicides [e.g., the soldier in war throwing himself/herself on a live grenade] should be viewed differently from other suicides [e.g., jumping off a bridge] was described as framing some suicides as “more suitable” or “more valid,” which participants reported is inaccurate. Some also identified item 18 (“Suicide is an acceptable means to end an incurable illness”) and item 46 (“In times of war, for a captured soldier to commit suicide is an act of heroism”) as irrelevant to suicide stigma. Items 45 (“Most people who commit suicide do not believe in an afterlife”) and 81 (“People who commit suicide lack solid religious convictions”) were described as depicting relationships between suicide and religion which cannot be substantiated. Participants identified item 85 (“Potentially, every one of us can be a suicide victim”) as too sympathetic to measure suicide stigma. Item 37’s (“It’s rare for someone who is thinking about suicide to be dissuaded by a ‘friendly ear’”) mention of rarity was described as inaccurate. Item 27 (“The Japanese KamiKaze pilots who destroyed themselves by flying their airplanes into a ship should not be considered as suicide victims”) was described as being dependent on minority group differences. Item 9 (“I would feel ashamed if a member of

my family committed suicide”) was identified as emotionally difficult to read. Items on the prevalence of suicidality for elderly people were also described as generally inaccurate. Participants expressed concern for pressures of social desirability on answers if they were to complete measure for both crisis workers and suicidal people. There were also concerns that this measure is not accurate to suicidal people's experiences. Half of participants expressed concerns about the measure itself being stigmatizing and reported a belief that it reinforces stigma. The measure's language was described by participants as stigmatizing and irresponsible through uses of the phrase “commits suicide.” The measure was further described by participants as “untrue,” “offensive,” “cold,” “brutal,” “unempathetic,” and “harmful” to suicidal people. Participants expressed concerns that the measure villainizes individuals who die by suicide and lacks humanizing context. The measure was also described as void of empathy for suicidal people and may discourage suicidal people from reaching out for support. Patricia, a university student who has served as a crisis counselor for one year, expressed the belief that this measure should not be used professionally. She connected this to concerns that if suicidal people were to complete this measure, it could, “push them toward wanting to commit suicide a little bit more” and described use of the measure as “scary.” Several participants experienced the measure's 100 item length as too long. The items were also described as repetitive and overwhelming, leading to concerns that participants may agree with items to “rush through” the measure without focusing on what items they are responding to. Sunny felt that participants may decide to end their time completing the measure early due to its length, “If I was a person taking that, like I said, I probably would be like ‘Nope. I'm not doing this anymore.’”

What is inaccurate about the SOSS

Most participants commented on the negativity of the SOSS (Batterham et al., 2013) item content. Participants described a belief that this would create a skew in responses because there are too many negative items with very few positive. Participants reported that this makes the measure appear leading, negatively biased, and seem to be “aggressively” pushing a narrative. Participants expressed concern that this would incline some measure respondents to strongly disagree on all items, while others might answer down the middle. Additionally, participants expressed concerns that respondents may make even more negative assumptions about suicidal people because of the items, which would “automatically” increase the level of stigma found in the results. While many participants commented on enjoying the one-word items, Mandy reported these short items would make it difficult for her to reflect on the degree to which she agrees or disagrees with different items. Participants also emphasized a belief that respondents also would not answer accurately or “truthfully” if they knew what the measure was measuring. Almost all participants mentioned that knowing stigma was being measured would alter their responses. Several participants expressed a belief that respondents would thus be likely to strongly disagree, disagree, or answer too neutrally, especially if they are crisis workers. Participants reported a belief that this measure would not be accurate for crisis workers, suicide survivors, or suicide loss survivors. They further expressed a belief that crisis workers would not want to complete the measure. For example, DJ disclosed that she would, “hate it so much.” Participants also further described concerns that respondents might give polarized responses, and it may not be realistic for respondents to complete in the moment due to being more reflective in nature. Participants also described scenarios in which respondents might neither agree nor

disagree because they would not want to generalize the experiences of suicidal people like the measure asks one to. Participants reported that some of the items reinforce stigma, are “offensive,” “judgmental,” and would be upsetting to a suicidal person because of its harshness. Participants expressed concern that this would make suicidal people responding to the measure feel misunderstood and could reinforce their internalized stigma, especially given a reported belief that the measure appears to be made to measure suicide stigma in people who have not been suicidal before. Many participants noted the extremity of the “evil” and “barbaric” items, which J even described as “crazy.” Some participants mentioned never hearing these descriptors about suicide prior to seeing this measure, and Colbalt reported a belief that these items may be more closely related to religious perceptions of suicidality as “demonic presence.”

Participants noted that from their perspectives, the isolation/depression scale fits more accurately to conceptualizing suicide itself and does not align with measuring stigma, though one participant felt that this item made the inaccurate assumption that all suicidal people are depressed or isolated. Another thought there should be more items in this scale and would want to add more mental health related items that identify risk factors which predispose people to lower threshold for crisis and stress levels. Concerns were expressed surrounding ways in which this measure potentially depicts the responsibility of being suicidal solely on suicidal person, as well as concerns that the stigma section would be more accurate, less leading, and less biased if it was switched to first person tense. Participants expressed a preference for SOSS overall, but many still described the measure as not being completely accurate. Participants expressed uncertainty about glorification/normalization section, with several reporting a belief that it should not be included in a suicide stigma measure. Some participants stated that this section was

the measure's only flaw or inaccuracy, with some elaborating on concerns that this section may normalize suicide and reinforce it or encourage it. According to participants, a crisis worker would struggle to respond to these items. Mandy, in particular, described a belief that these items may not be distinguishable from characteristics that people may hold unrelated to their suicidality.

Participants described uncertainty as to whether this measure would generalize to other countries and suicide stigma norms. While some noted there is a broad range of items, they also noted that some are rare and not frequently seen as a part of suicide stigma. Additionally, there were participant concerns that the measure essentializes suicidality into accusations (e.g., “punishing others,” “being selfish”) and lacks nuance and may cause people to select responses that are not wholly accurate. According to participants, the “embarrassment” item does not seem accurate to suicide stigma, nor do the “ignorance” item, or the “unfair” items. One approach described as potentially more helpful is if the measure had items representing a full range of emotions opposed to only sadness, isolation, and anger. Participants noted that the individual subjectivity in interpretation of adjectives included in the item (e.g., selfishness, weakness, ignorance) may be too variable to be accurate. Relatedly, some expressed concerns that the measure may not be consistent across different populations because of the adjectives and differences across generations, religious identities, geographical regions (e.g., north vs. South) and nation of origin. Participants emphasized that navigating the emotional responses to the measure would also impact responses. Participants identified experiencing a number of emotional responses to the measure, including feeling angry, “very sad,” disheartened, and disappointed.

Theme Three: Suicide stigma measures get it right at least some of the time

Theme three captures how participants expressed conflicting beliefs about the accuracies of the measures, despite a reported preference overall for the SOSS. Participants appeared to express less than half as many sentiments about the accuracies of the measures compared to the number of concerns for inaccuracy expressed during interviews.

What is accurate about the SOQ

While only one participant reported a belief that SOQ (Domino et al., 1980) is more accurate at measuring stigma than the SOSS (Batterham et al., 2013), others described it as an accurate measure, overall, or at least partly accurate based on their own observations of suicide stigma. This included accuracy of what lifeline visitors report, especially third-party visitors seeking support on behalf of someone else. One participant, S., described the measure as thorough and reported that it has, “good points in terms of stigma.” S. further elaborated his belief that the measure features a broad range of suicide stigma across cultures and demographics, and reported that it covers, “just about every incident of suicide you could think of.”

Participants reported a belief that some items would be especially accurate in measuring religious suicide stigma. Accurate examples of suicide stigma identified by participants include those which say suicide is “stupid,” “a sin,” and “wrong.” Other items participants identified as accurate to suicide stigma are those that say suicidal people are “weak,” “mentally ill,” “doing it for attention,” and “impulsive.” Items three, “(The suicide rate is higher for Blacks than Whites”), 31 (“Most people who try to kill themselves don’t really want to die”), 59 (“Suicide is not normal behavior”), 92 (“Some people are better off dead”), 95 (“People do not have the right to take their own lives”) were described as participants as commonly shared sentiments of

suicide stigma. Participants reported that the measure accurately measures internalized suicide stigma overall, including item 67 (“Sometimes suicide is the only escape from life’s problems”), while item 62 (“From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated”) accurately measures external suicide stigma. Item 32 (“Suicide can happen without warning”) was described as a “straightforward statement” that reflects truth though suicide can happen “with and without warning.”

Some of what was identified as inaccurate in this measure by crisis workers was identified as accurate by others. Some saw the statistics and facts as a valued and positive aspect of the measure. In particular, S. perceived the statistics in the SOQ (Domino et al., 1982) as authentic hoped there could be more statistics added for a more accurate measure of suicide stigma. Others believed one’s status as a crisis worker would not impact accuracy of measure, with one participant reporting a belief that if a crisis worker could not identify the measure as misleading, it would mean they may not be prepared for the job. Contrary to what some participants thought, others believed dignified death for incurable diseases is accurate to include when measuring suicide stigma. And though the measure is negative, some participants reported that this is accurate to stigma. While most participants agreed that the measure is stigmatizing itself (e.g., use of “commits suicide”), some thought this is accurate if one is attempting to measure suicide stigma. According to Jake, an undergraduate student serving as a crisis counselor in hopes of becoming a forensic psychologist in the future, the use of stigmatizing language may be more in alignment with language used by the average person despite crisis counselor’s dislike of this phrase. Jake further noted that even if “suiciding” as a verb is more appropriate, the average person may not know what this means if it were to be incorporated into the measure. Mandy

alone reported a dislike of the one worded SOSS (Batterham et al., 2013) items and preferred the detailed nature of the SOQ (Domino et al., 1982) items, which she believed to be worded well. Lastly, one participant expressed a desire not to change items included in the measure and described their trust that researchers have included items for a reason and there may be unseen purposes behind the items that they see as inaccurate.

What is accurate about the SOSS

As with the other measure, some of what was identified as inaccurate about the SOSS (Batterham et al., 2013) by some crisis workers was seen as accurate by others. While many described the level of negativity of measure items as inaccurate, others felt this negativity was accurate to suicide stigma. Participants described the deeming nature of some items as a clear indicator of stigma, especially if one answered that they strongly agree. Some participants reported that the negativity could also mean respondents would be less likely to answer down the middle and may answer more accurately. Others felt there was an accurate balance of negative, positive, and neutral items in the measure. While some expressed concern the isolation/depression scale would not be accurate to include because it is more objective about suicide, others said this was accurate and should be included.

While one participant found the reflective and seemingly feelings-oriented nature of the SOSS would make it more difficult to respond to in the moment, most who commented on the reflective nature of the measure described this as positive aspect of the measure. One-word items were described as conveying the emotions associated with suicide stigma which they felt would make the measure more accurate. One participant elaborated that this aspect makes it appear the measure was created thoughtfully. Six participants described the conciseness of the one-word

items of the measure as easier to understand, less overwhelming, and more straightforward. Lucy described the measure as, “short and sweet.”

Participants indicated preference for SOSS (Batterham et al., 2013), overall, with some directly identifying what they perceived as improvements from the SOQ (Domino et al., 1980). This measure was described as more empathetic and humbler in language and categorization.

Participants reported a belief that there is also more “leeway” and less absolutes than the SOQ (Domino et al., 1980). Many participants concluded the SOSS (Batterham et al., 2013) is accurate, overall, particularly related to what suicidal people experience and how they are viewed. Other descriptions of the measure were that it is thorough and valid. Some expressed a belief that the measure could be applied to a diverse range of ways that suicide stigma presents and that the measure is accurate across cultures and religion. The measure was described by S. as a measure one could “learn a lot” from. Though some of the items, such as “evil” and “barbaric” were described as less common or even unseen, one participant reported a belief that the items should remain included because they could understand how some people might hold these beliefs.

Items that were described by participants as especially accurate were the first-person items, which aligned with what lifeline visitors report experiencing. Weakness and selfishness items were identified by participants as especially prevalent to internalized stigma. The “evil” item was identified as especially accurate for religious suicide stigma, and the “seeking attention” item was identified as especially accurate to suicide stigma experienced by children. “Punishing others,” “selfish,” “weak,” and “wanting attention” items were described by many participants as consistent with what they have observed on the lines. Several participants felt this measure

would be more accurate for certain populations than others. According to participants, populations this measure would be especially accurate for include crisis workers who need to assess their own suicide stigma, suicidal people with internalized stigma, people without experiences in crisis work, and populations living in the United States.

Theme Four: How researchers could or should be measuring suicide stigma

Some participants argued that no number of measure items would fully capture the complexities of suicide and suicide stigma. And despite their differences, all participants described ways in which both measures have flaws. Some participants felt both measures would be inappropriate to give to a suicidal person, significantly limiting the population that they believed the SOQ (Domino et al., 1980) or SOSS (Batterham et al., 2013) should be administered to. While participants were not directly solicited for broad measure recommendations, many participants provided feedback about how researchers could or should approach creating a suicide stigma measure from their perspectives as crisis workers.

According to participants, one consideration for constructing a measure of suicide stigma is that the average person would approach measures differently after witnessing or experiencing suicidality. Participants connected this recommendation to their belief that the “average person” may be prone to agreeing with items whereas trained professionals may be cautious due to their education, empathy, and understanding for suicidal people. Participants expressed a belief that researchers must consider how identities and positionality would factor into how a measure should be constructed and who it is effective for. Participants also emphasized that measures of suicide stigma should attempt to measure whether relationships with suicidal people affects

stigma, and account for the ways in which existing measures would not be as effective in measuring suicide stigma in crisis counselors or specialists.

Another key consideration described by participants is accounting for the impacts of social desirability bias on how respondents respond to measures of suicide stigma. Participants emphasized concerns that social desirability would dictate how individuals answer and should also be accounted for. According to participants, if respondents were aware suicide stigma was being assessed, this would skew answers due to a desire not to be seen as holding stigma against suicidal people. Several participants noted a belief that measures would be more effective if people did not know what is being assessed and acknowledged that they would especially not want to be perceived as holding stigma because of their role as crisis workers. Explicit stigma was described as being mitigated for most crisis workers through training and experience, but participants felt there should be consideration for measuring suicide stigma at the implicit level. Two participants reported a belief that stigma in crisis workers would be most accurately measured at implicit level, which they believed would also mitigate the lack of nuance in the SOQ measure (Domino et al., 1980).

Participants emphasized that suicide cannot be boiled down into neat categories and that measures of suicide stigma should aim to assess more nuanced feelings. One solution suggested was to ask respondents to identify their own adjectives about suicidal people rather than presenting them with a predetermined set. According to Jake, it would also be helpful to add a “don’t know” option to any Likert Scale to prevent respondents from inaccurately selecting a response despite being uncertain of their answer. Participants identified ways in which demographic questions and the background of respondents should be factored into responses for

more accurate results, though it was also acknowledged that this could be an arduous task for researchers. The relationship between suicide stigma and identities like ethnicity, religion and class was emphasized by participants as a crucial factor to consider in measure development due to a belief that the nature of suicide stigma is personal. Diane expressed concerns that a Spanish-speaking line userbase was not represented in either of the measures presented but should be.

Many participants expressed a belief that measures of suicide stigma should not utilize statistics because there may only be some truth to them, they can convey absolutes, and lead to measure respondents believing that items are factual. Participants also described a belief that measures of suicide stigma should also not use “commit suicide” language. This was described as partly because measures of suicide stigma should not appear to condemn suicide as an action. One participant, Colbalt, expressed concern that an aspect not captured by existing measures, though should be, is the positive emotions (e.g., peace, happy, energetic) that some people feel about their decision to suicide. Colbalt elaborated that some witnessing these positive emotions in suicidal people can lead people to assume someone is “better,” when they are actually “ready” to die. A final recommendation expressed by participants was a belief that if measures of suicide stigma aim to be accurate, they should initially construct their items based on the lived experiences of stigma suicidal people report and then broaden them, as necessary. According to Sunny, if researchers have not consulted with suicidal people during measure development, this would convey to her that researchers are fearful and uncomfortable to reach out and learn more, which she believed to a reinforcement of suicide stigma in itself.

CHAPTER FIVE

DISCUSSION, IMPLICATIONS, AND CONCLUSION

Discussion

While we were surprised by the degree to which participant perceptions of the two measures were polarized and conflicting, many of these criticisms were consistent with past critiques of existing suicide stigma measures. As an example, the Scale of Suicide Stigma (Domino et al., 1980) has previously received criticism for its length and potential issues the number of items may cause in administering the measure (Kodaka et al., 2011). Participant reports that the measure appeared “all over the place” and questions about how the measure was constructed is also consistent with existing criticisms about the measure appearing to lack theoretical background (Kodaka et al., 2011). As for the Scale of Suicide Stigma (Batterham et al., 2013), some of the critiques participants provided about the polarized adjectives and a concern for respondents to answer neutrally were consistent with critiques of the Semantic Differential Scale Attitudes Towards Suicidal Behavior (SEDAS; Jenner & Niesing, 2000) identified by Batterham and colleagues in 2012. Interestingly, participant recommendations about measures of suicide stigma needing to account for positionality of respondents was an aim of the SEDAS (Jenner & Niesing, 2000), which was unique because it accounted for the situational role of the individual being assessed.

In terms of conceptualizations of suicide and suicide stigma, there were many significant overlaps between existing theories of suicide and suicide stigma and participant responses. As an example, participants frequently discussed the role of interpersonal relationships as a mediator for both suicide as an act and the stigma associated with it. This is consistent with arguably one

of the most known theories of suicide, The Interpersonal Theory of Suicide (Van Orden et al., 2011), which posits the idea that risk for suicide completion is driven by thwarted belongingness, perceived burdensomeness, and hopelessness within interpersonal relationships. Participant descriptions of third-party interactions as more urgently seeking intervention were also consistent with findings from an evaluation of 988 Suicide and Crisis Lifeline data, which revealed that third-party interactions were in part characterized by a higher than usual rate of emergency interventions (Gould et al., 2021). Furthermore, a literature review published by Casant and colleagues in 2022 supports the possibility of global urban-rural disparities in suicide prevalence, particularly amongst men, and highlighted higher rates of stigmatization amongst rural populations as a potential factor in these disparities.

There is also consistency between participant conceptualizations of suicide stigma and research that has been published since our study began. Among a number of recent studies on the role of family members and support networks in help seeking behaviors, one study found negative impacts of parental suicide stigma on help seeking for suicidal children (Hoffman et al., 2024; Burke et al., 2023). This is in alignment with reports by participants that external suicide stigma within a family unit is a frequent resource of suicide stigma and a barrier to accessing care. It has also been found that identifying as female and living in an urban location was associated with increased help seeking behaviors (Burke et al., 2023), which is consistent with participant conceptualizations of increased suicide stigma amongst those who identify as male, and those who live in rural geographical regions. Additionally, recent research reaffirming suicide stigma as a barrier to support access (Batterham et al., 2022) is also in alignment with participant reports that comfortability with disclosing suicidality to family and friends would increase one's

willingness to seek support. This study also affirmed that individuals are more likely to seek support if they have a mental health condition, and that the need for intervention services, such as suicide and crisis lifelines, to offer individualized care and support (Batterham et al., 2022). Suicide stigma is a complex construct to measure and generalizability, as with many measures, seems to be a relevant challenge. Based on our findings, the impact of cultural and historical context on suicide stigma is one factor worth attending to. We believe this presents an argument for either a more timeless and universal measure to be developed, or at least a suicide stigma measure developed post-2020. This is due to our unique sociopolitical and sociocultural context after the COVID-19 pandemic and the development of the 988 Suicide and Crisis Lifeline, as well as the many other historical shifts in suicide stigma identified by participants. There are also clear concerns from participants about unintended consequences of these existing measures of suicide stigma on suicidal individuals who may be given these measures, as well as lay people who may perceive items on these measures to be an accurate source of information about suicidal people. While no measure is expected to be void of flaws, we also believe that these concerns should not be ignored and should be considered in future research involving measures of suicide stigma, especially the Suicide Opinion Questionnaire (Domino et al., 1980). We also believe participants provided valuable recommendations for researchers developing suicide stigma measures and hope these may be applied in the future.

Implications

All the contributions of crisis counselors and specialists highlighted in this study speak to the importance of initiatives like the 988 Suicide and Crisis Lifeline in not only preventing suicide, but in combating suicide stigma by providing support and training. This also unfortunately

speaks to the dangers of the recent efforts to federally defund 988's LGBTQ+ Lifeline, a line which some of our participants had identified operating, by the current presidential administration (Chatterjee, 2025). These decisions are directly counter to the bipartisan legislation that designated the 988 Suicide and Crisis Lifeline to have a three-digit number, given that this legislation also called for expansion of services to populations most vulnerable to suicide, including the LGBTQ+ community (Suran, 2023).

Another contemporary implication related to suicide stigma is the "TikTokification" of suicide language, in which individuals, especially young people, are self-censoring the word "suicide" on social media to avoid suppression of their content by social media algorithms (Andrew, 2024). This phenomenon transcended social media recently during a controversy in which the Museum of Pop Culture in Seattle changed a memorial plaque dedicated to Kurt Cobain to refer to his cause of death as "un-aliving" himself (Andrew, 2024). While the museum reported that this change was out of respect for those who struggle with their mental health (Ander, 2024), the results of our study suggest that the avoidance of the word suicide only reinforces stigma, rather than combatting it.

Crisis workers participating in our study also offered recommendations about what is helpful in crisis work and what they value. As an example, more than a quarter of participants endorsed the importance of coworker support, mentorship, self-care, and resources for crisis workers. While this was not a focus of the current study, researchers could consider future studies directly soliciting this feedback to improve crisis work for both the workers and the populations they serve.

We believe that feedback on existing measures of suicide stigma we collected from participants implies the potential for development of an implicit or unconscious measure of suicide attitudes in the future. This is in part due to the frequent concerns participants expressed about the impacts of social desirability if respondents were to be aware that suicide stigma is being measured. Existing implicit attitudes measures have been found to be valid and accurate ways to implicitly measure stigmatized attitudes, including racism (Cunningham et al., 2001). There are also implications for the development of an existential theory of suicide stigma grounded in Terror Management Theory (Soloman et al., 1998) due to participant conceptualizations of suicide stigma being a reaction to a suicidal person's violation of the social norm of wanting to be live. We also believe Intergroup Contact Theory (Allport, 1954) could be aligned to reports from participants about the reduction of suicide stigma through contact with suicidal people. The above and our results also vouch for the importance of a multi-disciplinary approach to studying suicide and its stigma involving collaborators in social work, social psychology, clinical/counseling psychology, and psychiatry. The feat of developing an accurate measure of suicide stigma has been a challenge for decades, and a multidisciplinary approach with the involvement of lay people may be a meaningful path forward. Researchers should consider prioritizing involvement of non-academic specialists and lay people, especially those within communities (e.g., rural communities) that are not only thought to be impacted the most by suicide stigma but often have the most barriers to involvement in research. For many of the participants, this was their first time interacting with a researcher or taking part in a study – as researchers we should aim to change this.

Limitations and Strengths

The arguably foremost limitation of our study is that we did not explicitly aim to interview individuals with a lifetime experience of suicide ideation, even if we were inadvertently able to interview crisis workers who have experienced suicidality. While the research team had begun a similar study interviewing a population of individuals with lifetime suicide ideation, several obstacles surrounding research involving suicidal individuals led to data collection delays. An additional limitation is that an even broader participant sample may have been helpful, especially given that we only interviewed participants based in the United States. It is likely that other countries operate crisis lines differently or have different cultural norms around suicide, though other countries may also not be as directly affected by the current sociopolitical situation in the United States. It would have been helpful to specifically ask participants about their geographical region within the United States and about their veteran status, even if many disclosed this information without prompting.

A unique strength of our study was our research team's mixed levels of experience in suicide prevention and crisis intervention. These differences in positionality allowed us to explore meaningful questions about the influences of our own experiences on our perception of participant responses. As one example, two members of the coding team, Sarah and Eric, are both from Appalachia and have crisis line experiences in that region. Whereas Hannah and Joe, another member of the coding team and the auditor, originate from the Midwest and do not have any crisis line experience. This led to a meaningful discussion of how Sarah and Eric's perception of crisis work could be prone to regional bias and how crisis line experience in Appalachia may be experientially unique from crisis work in other regions. Additionally, one

participant, Jake, remarked that it was helpful to have someone who has also been a crisis worker facilitate the interviews. He explained that, because of this, he felt more comfortable knowing that the interviewer understood the “ins and outs” of his role. When asked about the degree to which she was able to represent her perspectives during the interview, Diane expressed her feelings about the study also allowing her to advocate for better representation of the Spanish speaking community she serves, “If anything, I think it's really good. I think it's really nice. Because I feel like a lot of people wouldn't like who aren't from other ethnicities might have not caught like, for example, like the wording for other like some sayings do not apply. They don't make sense... Yeah, I just like... The fact that I was able to apply the community that I specifically worked for because I, I know a lot of them wouldn't ever be given the chance to discuss it this way.” We believe these examples serve as additional reasons for researchers to involve crisis counselors and specialists in suicide and suicide stigma research in the future.

Conclusion

Suicide and its associated stigma are complex, complicated, and deeply nuanced phenomena that are undoubtedly challenging to accurately define and assess in a single measure. And while it is an arduous task to attempt to psychometrically capture the complexities of suicide stigma, suicide rates are higher than ever (SAMSHA, 2024), and the urgency to accurately assess suicide stigma and develop interventions to combat it could be critical in the efforts to reduce the number of preventable suicides (Wyllie et al., 2025). And though it is unreasonable to expect a single measure to perfectly capture every aspect of a phenomenon and be appropriate for use with every population, we believe an implicit or unconscious measure of suicide stigma may bring us closer to a more comprehensive and universal measure. We also believe in the

importance of including crisis workers and those who have experienced suicide ideation in these research endeavors in the future. While this study serves as a novel source of data to better understand the how practicing professionals conceptualize suicide stigma and perceive existing measures, our findings merely scratch the surface of the many perspectives yet to be heard and measures to be developed. We are grateful to those who have begun this work, but we also believe that it must continue.

REFERENCES

- Abrutyn, S., & Mueller, A. S. (2018). Toward a cultural-structural theory of suicide: Examining excessive regulation and its discontents. *Sociological Theory*, 36(1), 48–66.
<https://doi.org/10.1177/0735275118759150>
- Allport, G. W. (Gordon W. (1954). *The nature of prejudice*. Addison-Wesley Pub. Co.
- Anderson, A. L., Lester, D., & Rogers, J. R. (2008). A psychometric investigation of the Suicide Opinion Questionnaire. *Death Studies*, 32(10), 924–936.
<https://doi.org/10.1080/07481180802440258>
- Andrew, S. (2024, August 17). *The death of Nirvana's frontman is raw for many. A photo showing the word 'unalived' stirred fresh emotion*. CNN.
<https://edition.cnn.com/2024/08/17/entertainment/unalive-meaning-kurt-cobain-seattle-museum-cec/index.html>
- Åstedt-Kurki, P., & Heikkinen, R.-L. (1994). Two approaches to the study of experiences of health and old age: the thematic interview and the narrative method. *Journal of Advanced Nursing*, 20(3), 418–421. <https://doi.org/10.1111/j.1365-2648.1994.tb02375.x>
- Barriball, K. L. & While, A. (1994). Collecting data using a semi-structured interview: a discussion paper. *Journal of Advanced Nursing*, 19(2), 328–335. <https://doi.org/10.1111/j.1365-2648.1994.tb01088.x>
- Berman, A. L. (Ed.). (1990). *Suicide prevention: Case consultations*. 162.
<https://psycnet.apa.org/fulltext/1990-98362-000.pdf>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>

- Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13(2), 201–216.
<https://doi.org/10.1080/2159676X.2019.1704846>
- Batterham, P. J., & Christensen, H. (2012). Longitudinal risk profiling for suicidal thoughts and behaviours in a community cohort using decision trees. *Journal of Affective Disorders*, 142(1), 306–314. <https://doi.org/10.1016/j.jad.2012.05.021>
- Batterham, P. J., Caelear, A. L., & Christensen, H. (2013). Correlates of suicide stigma and suicide literacy in the community. *Suicide & Life-Threatening Behavior*, 43(4), 406–417.
<https://doi.org/10.1111/sltb.12026>
- Batterham, P. J., Caelear, A. L., & Christensen, H. (2013). The Stigma of Suicide Scale: Psychometric properties and correlates of the stigma of suicide. *Crisis: the Journal of Crisis Intervention and Suicide Prevention*, 34(1), 13–21. <https://doi.org/10.1027/0227-5910/a000156>
- Batterham, P. J., Caelear, A. L., Reily, N., Tang, S., Han, J., & Christensen, H. (2022). Factors associated with professional mental health service use among adults with suicidal ideation. *Journal of Affective Disorders*, 307, 278–285.
<https://doi.org/10.1016/j.jad.2022.04.013>
- Berman, B. L., & Peck, M. L. (1990). Case consultation: suicide postvention. *Suicide & Life-Threatening Behavior*, 20(2), 187–192.
- Burke, C. T., Caelear, A. L., Cruwys, T., & Batterham, P. J. (2023). Are Parents the Key? How parental suicide stigma and suicide literacy affect help-seeking attitudes and intentions

- for their child. *Journal of Youth and Adolescence*, 52(11), 2417–2429.
<https://doi.org/10.1007/s10964-023-01841-3>
- Canady, V. A., (2020). Field lauds congressional support of 988 suicide prevention, MH crisis line. *Wiley Periodicals, Inc.* 30(37), 1–3. <https://doi.org/10.1002/mhw.32517>
- Casant, J., & Helbich, M. (2022). Inequalities of suicide mortality across urban and rural areas: A literature review. *International Journal of Environmental Research and Public Health*, 19(5), 2669. <https://doi.org/10.3390/ijerph19052669>
- Chatterjee, R. (2025, April 28). *The government suggests defunding the 988 suicide hotline for LGBTQ+ youth*. NPR. <https://www.npr.org/sections/shots-health-news/2025/04/28/nx-s1-5375847/federal-government-may-cut-988-suicide-hotline-for-lgbtq-youth>
- Cridland, E. K., Jones, S. C., Caputi, P., & Magee, C. A. (2015). Qualitative research with families living with autism spectrum disorder: Recommendations for conducting semistructured interviews. *Journal of Intellectual & Developmental Disability*, 40(1), 78–91. <https://doi.org/10.3109/13668250.2014.964191>
- Cruikshanks, D. R., & Slavich, S. P. (1994). Further investigation of popular misconceptions about suicide. *Omega: Journal of Death and Dying*, 28(3), 219–228.
<https://doi.org/10.2190/DTW7-DPDB-JGUQ-FWW1>
- Cunningham, W. A., Preacher, K. J., & Banaji, M. R. (2001). Implicit attitude measures: Consistency, stability, and convergent validity. *Psychological Science*, 12(2), 163–170.
<https://doi.org/10.1111/1467-9280.00328>
- DeShong, H., Tucker, R. P., O’Keefe, V. M., Mullins-Sweatt, S. N., & Wingate, L. R. (2015). Five factor model traits as a predictor of suicide ideation and interpersonal suicide risk in

- a college sample. *Psychiatry Research*, 226(1), 217–223.
<https://doi.org/10.1016/j.psychres.2015.01.002>
- Diekstra, R. F. W., & Kerkhof, A. J. F. M. (n.d.). Attitudes toward suicide: Development of a Suicide Attitude Questionnaire (SUIATT). *Current Issues of Suicidology* (pp. 462–476). Springer Berlin Heidelberg. https://doi.org/10.1007/978-3-642-73358-1_63
- Domino, G., Gibson, L., Poling, S. & Westlake, L. (n.d.). Suicide Opinion Questionnaire. *Journal of Clinical Psychology*. <https://doi.org/10.1037/t15314-000>
- Domino, G., Moore, D., Westlake, L., & Gibson, L. (1982). Attitudes toward suicide: A factor analytic approach. *Journal of Clinical Psychology*, 38(2), 257–262.
[https://doi.org/10.1002/1097-4679\(198204\)38:2<257::AID-JCLP2270380205>3.0.CO;2-I](https://doi.org/10.1002/1097-4679(198204)38:2<257::AID-JCLP2270380205>3.0.CO;2-I)
- Domino, G., Macgregor, J. C., & Hannah, M. T. (1989). Collegiate Attitudes toward Suicide: New Zealand and United States. *Omega: Journal of Death and Dying*, 19(4), 351–364.
<https://doi.org/10.2190/1WU3-V74Y-5VFM-6TC4>
- Domino, G. (2005). Cross-cultural attitudes towards suicide: The SOQ and a personal odyssey. *Archives of Suicide Research*, 9(2), 107–122.
<https://doi.org/10.1080/13811110590903963>
- Eagles, J. M., Carson, D. P., Begg, A., & Naji, S. A. (2003). Suicide prevention: A study of patients' views. *British Journal of Psychiatry*, 182(3), 261–265.
<https://doi.org/10.1192/bjp.182.3.261>

- Early, K. E., & Akers, R. L. (1993). “It’s a white thing”: An exploration of beliefs about suicide in the African-American community. *Deviant Behavior*, 14(4), 277–296.
<https://doi.org/10.1080/01639625.1993.9967947>
- Faugier, J., & Sargeant, M. (1997). Sampling hard to reach populations. *Journal of Advanced Nursing*, 26(4), 790–797. <https://doi.org/10.1046/j.1365-2648.1997.00371.x>
- Galupo, P. M., Mitchell, R. C., Gryniewicz, A. L., & Davis, K. S. (2014). Sexual minority reflections on the Kinsey Scale and the Klein Sexual Orientation Grid: Conceptualization and measurement. *Journal of Bisexuality*, 14(3-4), 404–432.
<https://doi.org/10.1080/15299716.2014.929553>
- Garakani, A., Buono, F. D., Larkin, K., Polonsky, M., & Goldberg, J. F. (2022). Development and validation of a new scale to measure chronic suicidal ideation: The Chronic Suicidal Ideation Inventory-5 (CSI-5). *Journal of Psychiatric Research*, 150, 160–164.
<https://doi.org/10.1016/j.jpsychires.2022.03.021>
- Ghasemi, P., Shaghghi, A., & Allahverdipour, H. (2015). Measurement scales of suicidal ideation and attitudes: A systematic review article. *Health Promotion Perspectives*, 5(3), 156–168. <https://doi.org/10.15171/hpp.2015.019>
- Gould, M. S., Lake, A. M., Kleinman, M., Galfalvy, H., & McKeon, R. (2022). Third-party callers to the national suicide prevention lifeline: Seeking assistance on behalf of people at imminent risk of suicide. *Suicide & Life-Threatening Behavior*, 52(1), 37–48.
<https://doi.org/10.1111/sltb.12769>

- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, 18(1), 59–82.
<https://doi.org/10.1177/1525822X05279903>
- Han, J., Batterham, P. J., Callear, A. L., & Randall, R. (2018). Factors influencing professional help-seeking for suicidality: A systematic review. *Crisis : The Journal of Crisis Intervention and Suicide Prevention*, 39(3), 175–196. <https://doi.org/10.1027/0227-5910/a000485>
- Hughes, J. L., Camden, A. A., Yangchen, T., Smith, G. P. A., Domenech Rodríguez, M. M., Rouse, S. V., McDonald, C. P., & Lopez, S. (2022). Invited editorial: Guidance for researchers when using inclusive demographic questions for surveys: Improved and updated questions. *Psi Chi Journal of Psychological Research*, 27(4), 232–255.
<https://doi.org/10.24839/2325-7342.JN27.4.232>
- Hoffman, S., Croft, J., Wood, D. S., & Marsiglia, F. F. (2025). The impact of parental suicide stigma on youth suicide stigma in Mexico. *Journal of Interpersonal Violence*, 40(9–10), 2055–2070. <https://doi.org/10.1177/08862605241270008>
- Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of Participating in Research Interviews. *Image: The Journal of Nursing Scholarship*, 26(2), 161–166.
<https://doi.org/10.1111/j.1547-5069.1994.tb00937.x>
- James, T., Spates, K., Cureton, J. L., Patel, S., Llyod, C., & Daniel, D. (2022). “Is this really our problem?”: A qualitative exploration of Black Americans’ Misconceptions about Suicide. *Deviant Behavior*, 44(2), 204–221. <https://doi.org/10.1080/01639625.2022.2026746>

- Jamshed, S. S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy*, 5(4), 87–88. <https://doi.org/10.4103/0976-0105.141942>
- Jenner, J. A., & Niesing, J. (2000). The construction of the SEDAS: a new suicide-attitude questionnaire. *Acta Psychiatrica Scandinavica*, 102(2), 139–146. <https://doi.org/10.1034/j.1600-0447.2000.102002139.x>
- Joiner, T. (2010). *Myths about suicide*. Harvard University Press.
- Kallio, H., Pietilä, A.-M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, 72(12), 2954–2965. <https://doi.org/10.1111/jan.13031>
- Kendall, L., Coiro, J., Knobel, M., Lankshear, C., & Leu, D. J. (2008). The Conduct of Qualitative Interviews: Research Questions, Methodological Issues, and Researching Online. In *Handbook of Research on New Literacies* (1st ed., pp. 133–150). Routledge. <https://doi.org/10.4324/9781410618894-7>
- Kodaka, M., Poštuvan, V., Inagaki, M., & Yamada, M. (2011). A systematic review of scales that measure attitudes toward suicide. *International Journal of Social Psychiatry*, 57(4), 338–361. <https://doi.org/10.1177/0020764009357399>
- Lee, H., & An, S. (2016). Social stigma toward suicide: Effects of group categorization and attributions in Korean health news. *Health Communication*, 31(4), 468–477. <https://doi.org/10.1080/10410236.2014.966894>
- Ludwig, J., Liebherz, S., Dreier, M., Härter, M., & von dem Knesebeck, O. (2020). The Stigma of Suicide Scale: Psychometric validation of the German Short Version (SOSS-SF-D). *Psychiatrische Praxis*, 47(8), 433–439. <https://doi.org/10.1055/a-1145-3992>

- McClelland, S. I. (2017). Vulnerable Listening: Possibilities and Challenges of Doing Qualitative Research. *Qualitative Psychology*, 4(3), 338–352.
<https://doi.org/10.1037/qup0000068>
- McIntosh, J. L., Hubbard, R. W., & Santos, J. F. (1985). Suicide facts and myths: A study of prevalence. *Death Studies*, 9(3-4), 267–281.
<https://doi.org/10.1080/07481188508252523>
- Morse, J. M. (2015). Analytic strategies and sample size. *Qualitative Health Research*, 25(10), 1317–1318. <https://doi.org/10.1177/1049732315602867>
- Moskos, M. A., Achilles, J., & Gray, D. (2004). Adolescent suicide myths in the United States. *Crisis: the Journal of Crisis Intervention and Suicide Prevention*, 25(4), 176–182.
<https://doi.org/10.1027/0227-5910.25.4.176>
- Neuringer, C. (1988). The meaning behind popular myths about suicide. *Omega: Journal of Death and Dying*, 18(2), 155–162. <https://doi.org/10.2190/RGHW-W8JT-8J6V-LQAJ>
- Oexle, N., Waldmann, T., Staiger, T., Xu, Z., & Rüsch, N. (2018). Mental illness stigma and suicidality: the role of public and individual stigma. *Epidemiology and Psychiatric Sciences*, 27(2), 169–175. <https://doi.org/10.1017/S2045796016000949>
- Pompili, M., Amador, X. F., Girardi, P., Harkavy-Friedman, J., Harrow, M., Kaplan, K., Krausz, M., Lester, D., Meltzer, H. Y., Modestin, J., Montross, L. P., Bo Mortensen, P., Munk-Jørgensen, P., Nielsen, J., Nordentoft, M., Saarinen, P. I., Zisook, S., Wilson, S. T., & Tatarelli, R. (2007). Suicide risk in schizophrenia: Learning from the past to change the future. *Annals of General Psychiatry*, 6(1), 10–10. <https://doi.org/10.1186/1744-859X-6-10>

- Renberg, E. S., & Jacobsson, L. (2003). Development of a Questionnaire on Attitudes Towards Suicide (ATTS) and its application in a Swedish population. *Suicide & Life-Threatening Behavior*, 33(1), 52–64. <https://doi.org/10.1521/suli.33.1.52.22784>
- Rogers, J., & DeShon, R. P. (1992). A reliability investigation of the eight clinical scales of the suicide opinion questionnaire. *Suicide & Life-Threatening Behavior*, 22(4), 428–441. <https://doi.org/10.1111/j.1943-278X.1992.tb01037.x>
- Richards, J. E., Whiteside, U., Ludman, E. J., Pabiniak, C., Kirlin, B., Hidalgo, R., & Simon, G. (2019). Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: A qualitative study. *Psychiatric Services (Washington, D.C.)*, 70(1), 40–45. <https://doi.org/10.1176/appi.ps.201800342>
- Rutz, W. (2001). Preventing suicide and premature death by education and treatment. *Journal of Affective Disorders*, 62(1), 123–129. [https://doi.org/10.1016/S0165-0327\(00\)00356-6](https://doi.org/10.1016/S0165-0327(00)00356-6)
- Solomon, S., Greenberg, J., & Pyszczynski, T. (1998). Tales from the crypt: On the Role of death in life. *Zygon*, 33(1), 9–43. <https://doi.org/10.1111/0591-2385.1241998124>
- Sommer-Rotenberg, D. (1998). Suicide and language. *Canadian Medical Association Journal (CMAJ)*, 159(3), 239–240.
- Stack, S. (1998). Heavy metal, religiosity, and suicide acceptability. *Suicide & Life-Threatening Behavior*, 28(4), 388–394. <https://doi.org/10.1111/j.1943-278X.1998.tb00974.x>
- Substance Abuse and Mental Health Services Administration. (2021, October). Key substance use and mental health indicators in the United States: *Results from the 2020 National Survey on Drug Use and Health*.

<https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>

Substance Abuse and Mental Health Services Administration. (2024, July). Key substance use and mental health indicators in the United States: *Results from the 2023 National Survey on Drug Use and Health*. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>

Sudak, H., Maxim, K., & Carpenter, M. (2008). Suicide and stigma: A review of the literature and personal reflections. *Academic Psychiatry*, 32(2), 136–142.
<https://doi.org/10.1176/appi.ap.32.2.136>

Suran, M. (2023). How the new 988 Lifeline is helping millions in mental health crisis. *The Journal of the American Medical Association*, 330(11), 1025–1028.
<https://doi.org/10.1001/jama.2023.14440>

Tatarelli, R., Pompili, M. & Girardi, P. (2007). *Suicide in psychiatric disorders*. Nova Science Publishers.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, 117(2), 575–600.
<https://doi.org/10.1037/a0018697>

Williams, C. L., Cero, I., Gauthier, J. M., & K. Witte, T. (2018). Examination of the latent factor structure and construct validity of the stigma of suicide scale-short form. *Death Studies*, 42(10), 616–626. <https://doi.org/10.1080/07481187.2017.1416431>

- Witte, T. K., Smith, A. R., & Joiner Jr, T. E. (2010). Reason for cautious optimism? Two studies suggesting reduced stigma against suicide. *Journal of Clinical Psychology*, 66(6), 611–626. <https://doi.org/10.1002/jclp.20691>
- Wyllie, J. M., Robb, K. A., Sandford, D., Etherson, M. E., Belkadi, N., & O'Connor, R. C. (2025). [Rev. of Suicide-related stigma and its relationship with help-seeking, mental health, suicidality, and grief: scoping review]. *BJPsych Open*, 11(2), e60-. <https://doi.org/10.1192/bjo.2024.857>

APPENDIX

Appendix A: Interview Protocol

1. CO-PI (Sarah Stambaugh) will start the Zoom meeting and admit the participant to the Zoom room.
2. Once in the Zoom meeting, CO-PI will ask participant to confirm their identity.
 - a. “Could you tell me your first and last name please?”
3. Once identity has been confirmed, CO-PI will introduce herself and participants will be given a sent a PDF copy of the informed consent via the chat feature and additionally presented with information about the study verbally.
 - a. “Thank you for confirming your name. My name is Sarah Stambaugh and I am a student researcher at the University of Tennessee, Knoxville on the Suicide Stigma Study research team. I am going to provide you with information about this study and provide you with this consent form that I will ask you to read and indicate any questions you may have before digitally signing. Do you understand?”
 - b. If participant indicates they do not understand, CO-PI will ask follow up questions as necessary and/or stop the study if necessary. If the participant indicates that they understand, the CO-PI will continue.
 - c. “Today you are here because you indicated interest in participating in the Suicide Stigma Study. We are asking you to be in this research study because you are 18 years or older and currently a crisis specialist/crisis counselor with suicide prevention experience. Is this correct?”

- d. If participant indicates this is not correct, CO-PI will ask follow up questions as necessary and/or stop the study if necessary. If the participant indicates that this is correct, the CO-PI will continue.
- e. “The purpose of the research study is to learn what crisis specialists/crisis counselors think about the way researchers measure the stigma of suicide. If you agree to be in this study, we will ask you to participate in a one-hour in person interview that I will record using the Zoom recording feature. During the interview we will ask you to:
 - 1) Answer questions about your demographics like gender, race, and age. 2) Tell us about your experiences as a crisis specialist/crisis counselor. 3) Look at psychology measures of suicide stigma and answer questions about them. 4) Give us feedback about how you felt about the study.

Being in this study is up to you. You can say no now or leave the study later. Even if you decide to be in the study now, you can change your mind and stop at any time. You can also skip any questions you do not want to answer. If you decide to stop before the study is completed, we ask that you tell me. If you change your mind after the study is completed, please contact me or Dr. Joe Miles, using the contact information at the bottom of the consent form as soon as possible.

It is possible that someone could find out you were in this study or see your study information, but we believe this risk is small because of the procedures we use to

protect your information. Another possible risk includes temporary discomfort or emotional distress because of the topic of the questions. We do not expect you to benefit from being in this study. Your participation may help us to learn more about suicide stigma. We hope the knowledge gained from this study will benefit others in the future.

We will protect the confidentiality of your information by storing this form in a secure One Drive only accessed by the research team. If you choose to participate in the study, we will not tell anyone whether you participated or any information about your participation. The audio recording of this interview will be stored in a secure One Drive only accessed by the research team and deleted once we have transcribed the interview. We will delete any personal information about you from the transcript of the interview. We will ask you to tell us if you have a preferred code name or pseudonym to use during this study that would conceal your identity. We will provide you with a code name or pseudonym if you do not have a preference.

If information from this study is published or presented at scientific meetings, your name and other personal information will not be used. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what information came from you. Although it is unlikely, there are times when others may need to see the information we collect about you. These include: People at the University of Tennessee, Knoxville who oversee

research to make sure it is conducted properly, government agencies (such as the Office for Human Research Protections in the U.S. Department of Health and Human Services), and others responsible for watching over the safety, effectiveness, and conduct of the research. If a law or court requires us to share the information, we would have to follow that law or final court ruling. We will not keep your information to use for future research or other purposes. Your name and other information that can directly identify you will be deleted from your research data collected as part of the study. We will not share your research data with other researchers or anyone else.

Do you have any questions or concerns so far?”

- f. If participant indicates they do not understand or have questions/concerns, CO-PI will ask follow up questions as necessary and/or stop the study if necessary. If the participant indicates that they understand, the CO-PI will continue.
- g. “We will email you a \$25 Amazon gift card at the end of the study. If you decide to leave the study early, or do not answer any of the questions, you will still receive the \$25 Amazon gift card. In the event that we stop the study due to you not being eligible, you will still receive full compensation. If you decide to leave the study early or we have to stop the study, we will plan to keep any responses collected before stopping the study unless you ask us not to. We use procedures to lower the possibility of experiencing brief discomfort or emotional distress while participating in this study. This includes allowing you to skip any questions you

do not want to answer and providing you with a list of resources. Even so, you may still experience discomfort or emotional distress, even when we are careful to avoid this. Please tell me at any time if no longer want to continue the study. You can leave the study at any time. If you have questions or concerns about this study, or have experienced a research related problem or injury, contact me, Sarah Stambaugh, or Dr. Joe Miles. Before reviewing and digitally signing this form, do you understand what I have explained?”

- h. If no, ask necessary follow up questions. If yes, ask “Do you have any questions or concerns?”
- i. If participant has questions or concerns before digitally signing, questions and concerns will be answered/addresses as necessary.
- j. If the participant indicates that they understand and have no questions or concerns before signing, they will be provided with a PDF copy of the informed consent via chat and asked “please review and digitally sign this informed consent. I will also provide you with an additional blank PDF copy to keep.”
- k. After participant digitally signs the informed consent and sends it in the chat, researcher will check the form to confirm that the participant has digitally filled out and signed the form. The CO-PI will ask a final time if the participant has any questions and will be sent with an additional blank PDF of the informed consent to keep via the Zoom chat. “Here is a copy of the consent form for you to keep our contact information.”

- l. CO-PI will provide participant with a link to a list of resources and encourage participant to visit link if any emotional distress or concerns that arise as a result of the interview.
 - m. “Here is a link with a list of resources for you to keep. I encourage you to use them if you need to.”
 - n. CO-PI will digitally sign the researcher portion of the informed consent form.
4. “Before we get started, do you have a preferred code name or pseudonym that I can refer to you as for this study? If so, what is it? Take all of the time you need before answering.”
 - a. CO-PI will allow participant to identify a code name or pseudonym. If participant indicates that they have no preference, CO-PI will provide them with one, “for today’s study I am going to refer to you as the code name ____.”
5. CO- PI will turn on Zoom recording.
 - a. “Okay [insert code name or pseudonym here], we will now begin. I am first going to ask you a series of questions about your identities and demographics information, followed by more sensitive questions. Please take all of the time you need before answering any of the questions. If you prefer not to answer any of these questions or are uncomfortable, please tell me, and we will skip to the next question. If you are unsure what I am asking, please tell me and I can clarify and/or provide examples. Do you understand?”
 - i. CO-PI will answer any follow up questions and provide examples as necessary. CO-PI will also ask follow-up questions as necessary.

- b. “What age are you currently?”
 - c. “What is your gender identity?”
 - d. “What was the sex assigned to you at birth?”
 - e. “What race or races do you identify as?”
 - f. “What ethnicity or ethnicities do you identify as?”
 - g. “What is your sexual orientation?”
 - h. “What is your current socioeconomic class?”
 - i. “What is your current highest education level?”
 - j. “Do you currently identify as having any disabilities?”
 - k. “What is your current spiritual and/or religious identity?”
 - l. “Are there any other identities you hold that you believe are important to share with me?”
6. This will be followed by open-ended questions assessing how they independently conceptualize suicide stigma. Participants will be asked follow up questions as necessary.
- a. “I am now going to ask a couple of open-ended questions that also may be more sensitive in nature. Please take all of the time you need before answering any of the questions.”
 - b. “Please tell me a little bit about your experiences as a crisis counselor/specialist.”
 - c. “How do you define the stigma of suicide?”
 - d. “Please describe your experiences with suicide stigma as a crisis counselor/specialist, if any.”

7. This will be followed by the presentation of the Suicide Opinion Questionnaire (SOQ; Domino et al., 1982) and Scale of Suicide Stigma (SOS; Batterham et al., 2014), in that order. The scales will be screenshared as individual PDF copies of the items, without labels.
 - a. “I am now going to show you some of the ways that psychologists measure suicide stigma. I will show you one measure at a time and ask you to answer a question about the measure after you have looked over it.”
 - b. CO-PI will share screen of a PDF copy of the Suicide Opinion Questionnaire (SOQ; Domino et al., 1982) and say, “look over this measure and read each of the items. Take all of the time you need. Once you are done looking over it, please tell me.”
 - c. Once participant indicates that they are done reviewing the measure, CO-PI will ask, “in what ways did this scale capture or fail to capture your understanding of a suicidal person’s experience with suicide stigma?” and “what is it like for you to imagine completing this measure about a suicidal person?”
 - d. CO-PI will ask any follow up questions as necessary.
 - e. CO-PI will remove the first measure and present a physical copy of the Scale of Suicide Stigma (SOS; Batterham et al., 2014) and say, “Look over this measure and read each of the items. Take all of the time you need. Once you are done looking over it, please tell me.”
 - f. Once participant indicates that they are done reviewing the measure, CO-PI will ask “in what ways did this scale capture or fail to capture your understanding of a

suicidal person's experience with suicide stigma?" and "what is it like for you to imagine completing this measure about a suicidal person?"

- g. CO-PI will ask any follow up questions as necessary.
8. After both of the scales have been presented, participant has responded, and any clarifying questions have been asked, a quality check will be conducted by asking participant to provide feedback about the interview session.
 - a. "Please indicate the ways in which today's experience did or did not allow you to accurately represent your perspective and experiences."
 - b. Co-PI will ask any follow up questions as necessary.
 9. Once participant has answered, CO-PI will state "We are now at the end of the study. Do you have any final questions or comments before we conclude?"
 10. If participant indicates that they have no further questions, CO-PI will remind the participant about the researcher contact information, "please remember that if you need to contact us for any reason, you can locate our contact information at the bottom of your consent form."
 11. CO-PI will email the participant the code for a \$25 Amazon gift card.
 12. CO-PI will turn off Zoom recording.
 13. CO-PI will promptly upload the informed consent and Zoom recording to the university sponsored One Drive only accessible by the research team.

Appendix B: Suicide Opinion Questionnaire (Domino et al., 1982)

1. Most persons who attempt suicide are lonely and depressed.
2. Almost everyone has at one time or another thought about suicide.
3. The suicide rate is higher for Blacks than for Whites.
4. The actual suicide rate in the U.S. is much greater than reflected by official statistics
5. Suicide prevention centers actually infringe on a person's right to take his/her life
6. Most suicides are triggered by arguments with a spouse or partner
7. The higher incidence of suicide is due to the lesser influence of religion
8. Many suicide notes reveal substantial anger towards the world.
9. I would feel ashamed if a member of my family committed suicide.
10. Most suicide attempts are impulsive in nature.
11. Many suicides are the result of the desire of the victim to "get even" with someone
12. In the U.S. suicide by shooting oneself is the most common method.
13. People with incurable diseases should be allowed to commit suicide in a dignified manner.
14. Those who threaten to commit suicide rarely do
15. Suicide is more prevalent among the very rich and the very poor
16. Individuals who kill themselves out of patriotism do so, not because they are courageous, but because they enjoy taking major risks
17. Suicide is a leading cause of death in the U.S.
18. Suicide is an acceptable means to end an incurable illness
19. People who commit suicide are usually mentally ill
20. Some people commit suicide as an act of self-punishment.

21. The feeling of despair reflected in the act of suicide is contrary to the teachings of most major religions
22. Suicide rates vary greatly from country to country
23. I feel sorry for people who commit suicide
24. John Doe, age 45, has just committed suicide. An investigation will probably reveal that he has considered suicide for quite a few years.
25. Suicide is acceptable for aged and infirm persons.
26. The suicide rate among physicians is substantially greater than for other occupational groups
27. The Japanese KamiKaze pilots who destroyed themselves by flying their airplanes into a ship should not be considered as suicide victims.
28. Different cultural child rearing practices are probably unrelated to suicide rates.
29. Suicide is clear evidence that man/woman has a basically aggressive and destructive nature
30. Over the past ten years the suicide rate in this country has increased greatly.
31. Most people who try to kill themselves don't really want to die.
32. Suicide happens without warning.
33. A business executive arrested for fraud or other illegal practices should face punishment rather than seek suicide as an escape.
34. Most suicide victims are older persons with little to live for.
35. A person who tried to commit suicide is not really responsible for those actions.
36. About 75% of those who successfully commit suicide have attempted suicide at least once before.
37. It's rare for someone who is thinking about suicide to be dissuaded by a "friendly ear."

38. People who commit suicide must have a weak personality structure.
39. The method used in a given suicide probably reflects whether the action was impulsive or carefully and rationally planned
40. Social variables such as overcrowding and increased noise can lead a person to be more suicide-prone.
41. A large percentage of suicide victims come from broken homes.
42. A rather frequent message in suicide notes is one of unreturned love.
43. People who set themselves on fire to call attention to some political or religious issue are mentally unbalanced
44. The possibility of committing suicide is greater for older people (those 60 and over) than for younger people (20 to 30).
45. Most people who commit suicide do not believe in an afterlife.
46. In times of war, for a captured soldier to commit suicide is an act of heroism.
47. Suicide attempters are typically trying to get even with someone.
48. Once a person is suicidal, he/she is suicidal forever
49. There may be situations where the only reasonable resolution is suicide.
50. People should be prevented from committing suicide since most are not acting rationally at the time.
51. The suicide rate is higher for minority groups such as Chicano, American Indians, and Puerto Ricans than for Whites.
52. Improvement following a suicidal crisis indicates that the risk is over.

53. People who engage in dangerous sports like automobile racing probably have an unconscious wish to die.
54. Prisoners in jail who attempt suicide are simply trying to get better living conditions.
55. Suicide among young people (e.g., college students) are particularly puzzling since they have everything to live for
56. Once a person survives a suicide attempt, the probability of his/her trying again is minimal
57. In general, suicide is an evil act not to be condones
58. People who attempt suicide and live should be required to undertake therapy to understand their inner motivation
59. Suicide is normal behavior
60. Many victims of fatal automobile accidents are actually unconsciously motivated to commit suicide.
61. If a culture were to allow the open expression of feelings like anger and shame, the suicide rate would decrease substantially
62. From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated.
63. Suicide attempters who use public places (such as a bridge or tall building) are more interested in getting attention.
64. A person whose parent has committed suicide is a greater risk for suicide.
65. External factors, like lack of money, are a major reason for suicide.
66. Suicide rates are a good indicator of the stability of a nation that is, the more suicides the more problems a nation is facing.

67. Sometimes suicide is the only escape from life's problems.
68. Suicide is a very serious moral transgression.
69. Some individuals have committed suicide to preserve their honor; these were victims of cultural values rather than disturbed personal attributes.
70. If someone wants to commit suicide, it is their business and we should not interfere.
71. A suicide attempt is essentially a "cry for help."
72. Obese individuals are more likely to commit suicide than persons of normal weight
73. Heroic suicides (e.g., the soldier in war throwing himself/herself on a live grenade) should be viewed differently from other suicides (e.g., jumping off a bridge)
74. The most frequent message in suicide notes is of loneliness.
75. Usually, relatives of a suicide victim had no idea of what was about to happen.
76. Long term self-destructive behaviors, such as alcoholism, may represent unconscious suicide attempts.
77. Suicide attempts are typically preceded by feelings that life is no longer worth living.
78. Suicide goes against the laws of God and/or of nature.
79. We should have "suicide clinics" where people who want to die could do so in a painless and private manner.
80. Those people who attempt suicide are usually trying to get sympathy from others.
81. People who commit suicide lack solid religious convictions
82. People with no roots or family ties are more likely to attempt suicide.
83. People who bungle suicide attempts really did not intend to die in the first place.

84. Passive suicide, such as an overdose of sleeping pills, is more acceptable than violent suicide such as by gunshot.
85. Potentially, every one of us can be a suicide victim.
86. Suicide occurs only in civilized societies.
87. People who die by suicide should not be buried in the same cemetery as those who die naturally.
88. Most people who commit suicide do not believe in God
89. Children from larger families (i.e., three or more children) are less likely to commit suicide as adults than single or only children.
90. Suicide attempters are, as individuals, more rigid and less flexible than non-attempters.
91. The large majority of suicide attempts result in death.
92. Some people are better off dead.
93. People who attempt suicide are, as a group, less religious
94. As a group, people who commit suicide experienced disturbed family relationships when they were young.
95. People do not have the right to take their own lives.
96. Most people who attempt suicide fail in their attempts.
97. Those who commit suicide are cowards who cannot face life's challenges.
98. Individuals who are depressed are more likely to commit suicide.
99. Suicide is much more frequent in our world today than it was in early cultures such as Egypt, Greece, and the Roman Empire.
100. People who are high suicide risks can be easily identified

Appendix C: Scale of Suicide Stigma (Batterham et al., 2013)

Using the scale below, please rate how much you agree with the descriptions of people who take their own lives (suicide). In general, people who suicide are . . .

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Stigma					
Punishing others	☐	☐	☐	☐	☐
Selfish	☐	☐	☐	☐	☐
Hurtful	☐	☐	☐	☐	☐
Reckless	☐	☐	☐	☐	☐
Weak	☐	☐	☐	☐	☐
Irresponsible	☐	☐	☐	☐	☐
Attention-seeking	☐	☐	☐	☐	☐
Cowardly	☐	☐	☐	☐	☐
Senseless	☐	☐	☐	☐	☐
Ignorant	☐	☐	☐	☐	☐
Unfair	☐	☐	☐	☐	☐
Unjustifiable	☐	☐	☐	☐	☐
Stupid	☐	☐	☐	☐	☐
Cruel	☐	☐	☐	☐	☐
A burden	☐	☐	☐	☐	☐
Strange	☐	☐	☐	☐	☐
Unnatural	☐	☐	☐	☐	☐
Failures	☐	☐	☐	☐	☐
Shallow	☐	☐	☐	☐	☐
Shameful	☐	☐	☐	☐	☐
Pathetic	☐	☐	☐	☐	☐
Vengeful	☐	☐	☐	☐	☐
Violent	☐	☐	☐	☐	☐
Unforgiveable	☐	☐	☐	☐	☐
An embarrassment	☐	☐	☐	☐	☐
Arrogant	☐	☐	☐	☐	☐
Immoral	☐	☐	☐	☐	☐
Useless	☐	☐	☐	☐	☐
Lazy	☐	☐	☐	☐	☐
Barbaric	☐	☐	☐	☐	☐
Evil	☐	☐	☐	☐	☐
Isolation/ Depression					
Unhappy	☐	☐	☐	☐	☐
Depressed	☐	☐	☐	☐	☐

In pain	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐
Hurt	☐	☐	☐	☐	☐
Disconnected	☐	☐	☐	☐	☐
Lost	☐	☐	☐	☐	☐
Isolated	☐	☐	☐	☐	☐
Lonely	☐	☐	☐	☐	☐
Miserable	☐	☐	☐	☐	☐
Trapped	☐	☐	☐	☐	☐
Alienated	☐	☐	☐	☐	☐
Broken	☐	☐	☐	☐	☐
Cutoff	☐	☐	☐	☐	☐
Withdrawn	☐	☐	☐	☐	☐
Disturbed	☐	☐	☐	☐	☐
Glorification/ Normalization					
Understandable	☐	☐	☐	☐	☐
Committed	☐	☐	☐	☐	☐
Brave	☐	☐	☐	☐	☐
Motivated	☐	☐	☐	☐	☐
Rational	☐	☐	☐	☐	☐
Realistic	☐	☐	☐	☐	☐
Strong	☐	☐	☐	☐	☐
Dedicated	☐	☐	☐	☐	☐
Powerful	☐	☐	☐	☐	☐
Fearless	☐	☐	☐	☐	☐
Noble	☐	☐	☐	☐	☐

VITA

Sarah Anne Stambaugh, originally from Chattanooga, Tennessee, is a lifelong resident of the state of Tennessee. She was a first-generation undergraduate student at the University of Tennessee, Knoxville and is now pursuing a Doctor of Philosophy in Counseling Psychology. She is interested in the study of suicide and stigma with the hopes that this research may improve the lives of people who experience suicidality. She is immensely grateful for all of the support she has received from her advisor, research team, and loved ones.