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Tackling stigma in self-harm and suicide in the young

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Four in five suicides in young people (younger than 30 years) globally occur in low-income and middle-income countries (LMICs), and self-harm has been identified as an antecedent in many of these deaths.[1,2] Young people who self-harm could benefit from targeted suicide prevention programmes that are found in high-income countries (HICs), but these are conspicuously absent in most LMICs.[2,3] One reason for the absence of such programmes in many countries lies in the widespread unfavorable attitudes towards self-harm and suicide.[1] Attempting suicide is a punishable offence in more than 40 countries across sub-Saharan Africa, the Middle East, and southeast Asia, and contributes to substantial under-reporting due to the associated legal ramifications.[4] Arising from negative attitudes deeply embedded in religion, health systems, and social policy, stigma is a major barrier to overcoming youth suicide and self-harm.[5]

Stigma refers to the restricted knowledge and prejudiced attitudes leading to discriminatory behaviour towards a group of people.[6] With regard to self-harm, public stigma (prejudice in the general population towards people who self-harm) can be distinguished from self-stigma (the negative attitudes that those who self-harm hold against themselves).[6] Public stigma typically arises when the belief that an individual is responsible for causing their condition is widespread.[6] Such attributions are too common, with those who self-harm also often endorsing these negative stereotypes themselves.[6] In this context, a better understanding of the drivers of self-harm becomes central in promoting engagement with health systems and mitigating the effects of discrimination. Overcoming the stigma around self-harm and

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suicide in young people, in LMICs in particular, will not be straightforward. Stigma reduction strategies from HICs are not easily transferrable to LMICs. One example is the National Alliance on Mental Illness' campaign to end discrimination that was launched in the USA, which aimed to educate the public, facilitate treatment-seeking, and reduce stigma by promoting neurobiological bases of mental illnesses, such as alcohol dependence, schizophrenia, and depression. The campaign had little effect on social tolerance towards those with mental illness, but it increased the likelihood of support for treatment from people around those facing mental health issues.[7] However, such campaigns might not be suitable for many LMICs with different levels of health literacy in particular.[7] A better understanding of the factors associated with self-harm and suicide in LMICs, particularly in young people, will be important in designing stigma reduction initiatives. Psychological autopsy studies in HICs have shown that psychiatric disorders are present in many individuals who die by suicide, but this proportion is considerably lower in LMICs, where suicide has been more often associated with an acute emotional reaction to a stressful event in the context of a range of socioeconomic stressors.[3]

Any contact with a mental health service after self-harm provides an opportunity to target self-stigma, which has a central role in clinical engagement and future help-seeking. Self-stigmatisation influences all interactions with caregivers and family members, as well as peers, health workers, and the health service system beyond. Self-stigma can be explored through an assessment of beliefs about self-harm, the affective responses it elicits (eg, anger or shame), and a young person's capacity to discuss these. A similar strategy can be adopted with caregivers and family members, after obtaining consent from the mental health service user. Incorporating peer support workers (ie, people with a lived experience of self-harm) in mental health services can prove useful in LMICs, in particular, where resources are sparse but social networks are strong.[8] Peer support workers can be integrated into mental health service teams, co-designing service delivery models and sharing their own experiences to facilitate the provision of non-judgmental and non-discriminatory services.

Beyond stigma in clinical settings, targeting public stigma more broadly will be crucial in LMICs. Co-designing stigma reduction programmes with users of mental health services will be important. A better understanding of the explanatory models of young people who self-harm and their caregivers is not only useful in guiding a clinical response but it is also important to identify social and cultural prejudices.[9] Addressing stigma within the health system and in professional groups would be a useful starting point. Promoting staff awareness and knowledge about self-harm, especially as an antecedent of suicide, can lead to a better understanding of the effects of prejudiced beliefs on mental health service users and their potential role in propagating stigma towards those who self-harm.

There are good reasons for hope. Social media offers a new way to reach young people, and has the potential to increase uptake and acceptability of clinical programmes.[10] Ultimately, stigma reduction strategies must extend to the communities in which young people are living, their leaders, and the repressive laws that will continue to foment prejudice.

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