A pandemic of Body, Mind, and Spirit: The Burden of “Social Distancing” in Rural Communities During an Era of Heightened Suicide Risk

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Death by suicide is a serious problem in the United States and rural communities are disproportionately affected by these tragedies.1 According to the National Vital Statistics System (NVSS), suicide rates in rural communities have risen significantly over the past few decades.1 The gap between the suicide rates in rural and urban communities is broadening and suicide rates are increasing at a faster rate in rural communities than they are in urban communities.1 For example, between 2010 and 2015, the suicide rates per 100,000 population in non-metropolitan/rural counties increased by 7.1% compared to 1.6% in urban counties.1 These findings may be explained by factors such as decreased access to mental health resources, stigma, and economic stressors.2 Importantly, social isolation is an ongoing concern in rural areas, worsens mental health, and is a factor in suicide risk.2 Accordingly, there is an increased emphasis on the need to build social supports or connectedness among communities as a strategy to combat suicide.2

Social connection has been described as “the variety of ways we can connect to others socially – through physical, behavioral, social-cognitive, and emotional channels.”3 The term social connection is frequently used to describe the social integration that may decrease the risk of suicide.4 Of course, the term social connection has taken on new relevance and meaning in rural America in the wake of the recent COVID-19 pandemic. What was until recently seen as a critical positive characteristic is suddenly described as a situation and a condition to avoid. Landmark work conducted by Durkheim
demonstrates that social connectedness is a vital factor in emotional well-being and societal stability. This may be especially true in the face of a public health crisis where individuals encounter enormous psychological stress whether due to physical illness, trauma, or economic instability. While these stressors are, of course, jarring for any population, these events may only exacerbate what rural populations have been increasingly facing for many years: namely, barriers to health care, inconveniences in the marketplace, and economic hardships. Lack of access to mental health care may be compounded in rural settings in the face of pandemics, which necessitate the re-allocation of resources not only to more populated areas, but also to the treatment of the medically ill. Rural areas experience structural limitations such as poor Internet, which may limit access to 21st century resources including telemental health, working from home, and video conferencing with friends and family that are widely available to urban dwellers. Existing difficulties in accessing public transportation and the Internet may be compounded by the current COVID-19 pandemic, causing great challenges to addressing health care needs and obtaining basic necessities. Finally, people living in rural communities may be at greater risk for suicide during economic crises.

These findings argue that our attention to suicide risk in rural populations should be further heightened (rather than diminished) in the context of the COVID-19 pandemic. The pandemic has the potential to create additional obstacles to care, further erode mental health, and intensify suicide risk. Yet, one of the most paradoxical issues created by this pandemic is the tension between society’s call for “social distancing” and the critical need for rural populations to take active steps to strengthen and enhance their sense of social integration and social connectedness. In fact, groups with greater social integration may fair better during times of crisis, including pandemics. These observations raise 2 important questions. First, is there a need to reframe public health messaging to ensure that there is adequate attention to the physical and mental well-being of rural populations? Second, what (if any) interventions have shown promise in promoting social connectedness in rural populations during a crisis where people need to physically separate to prevent the spread of an infectious disease?

**Does Public Health Messaging Matter When It Comes to Suicide Prevention in Rural Communities?**

Over the past few months, public health officials, lawmakers, and the media have rapidly adopted the terms “social distancing,” “self-quarantine,” and “isolation” in order to combat the spread of COVID-19. Naturally, some physical separation of people is required to protect the common good, and yet “social connection” is essential to promote health and in particular, prevent suicide. How do we reconcile these 2 equally crucial behaviors without comprising the efficacy of either in rural populations? More importantly, is our use of specific terms protecting the physical and mental health of rural America? While the term “social distancing” is intended to ensure that members of society avoid close physical contact with others, the term can induce a strong sense of social disconnection at all costs. This is reiterated by related behavioral measures (e.g., legal fines, possible social ostracization) that are now tied to this term in order to ensure the health of the public. Notably, “social distancing” is a term that historically has been closely tied to mental health stigma and prejudice. In addition, greater “social distancing” has been associated with less empathy. These factors, in turn, are important contributors to an individual’s risk for death by suicide.

Of course, an argument can be made that society at large is really interested in ensuring that individuals maintain physical or bodily separation from others in order to mitigate the risk for the spread of illness. Perhaps, public health messaging should speak more directly to rural communities about the key need for physical separation or bodily boundaries during this time of crisis, while at the same time heavily emphasizing the key need to pursue emotional and social connections with others in order to preserve their mental well-being. In fact, while rural communities may be learning about how viruses spread and their associated harms through the media and government sources, these communities are receiving comparably far less education around the importance of taking steps to mitigate the serious psychological consequences that can follow in the wake of a pandemic. Indeed, the term “social distancing” may highlight the peer as the source of the threat, when the real threat is the virus. We propose the term “physical separation, while maintaining social connection.”

**What Can Be Done to Bolster Connectedness and Prevent Suicide in Rural Communities During a Pandemic?**

Despite the potential for their vulnerabilities to be exacerbated by the COVID-19 pandemic, rural communities have considerable resilience in times of stress and adversity. In relation to suicide risk, the tendency for rural communities to have strong loyalty to family
and a sense of solidarity with their community may be protective. It has long been understood that successful interventions to help communities recover from disasters rely on recognizing and building upon the resiliency inherent in communities. Similarly, rural communities may benefit from suicide prevention strategies that promote connectedness. Therefore, it is possible that focusing on the unique features of rural populations that confer resilience could help in designing interventions to mitigate suicide risk in the context of the COVID-19 pandemic.

In the case of pandemics in particular, aspects of rural communities that put them at risk could also be tapped into for developing resilience during a pandemic and quarantine. Studies of past pandemics have highlighted both the potential for resiliency and pathological responses. For instance, a study conducted during the Severe Acute Respiratory Syndrome (SARS) pandemic in Hong Kong found that many surveyed individuals reported greater social support, a better lifestyle, and more mental health awareness during versus before the pandemic. Several factors were thought to contribute, including having more time and the ability to reassess priorities. Psychological resilience and community-connectedness may also be protective during a disaster or public health crisis. Chan and associates also tested a strength-focused intervention during the SARS pandemic, “The Strength-Focused and Meaning-Oriented Approach to Resilience and Transformation (SMART),” with a group of adolescents and people with chronic disease. The intervention emphasized resilience and transformation in the aftermath of panic and quarantine. The intervention targeted awareness, strength, and meaning-making in the mind, body, and spirit. Among adolescents exposed to the SMART intervention, there was a significant decrease in perceived social disintegration and a significant gain in self-mastery and social responsibility or engagement.

In addition to focusing on resilience and promoting participatory research to discover the needs of rural communities, it may be vital to create interventions that are more collective in nature, rather than focused on the individual. This might be especially important given that rural communities may struggle more with stigma and be less likely to seek treatment. A focus on community strength rather than individual problems may be more palatable and ameliorative for people in rural communities.

The COVID-19 pandemic has highlighted the tension between the need for physical distancing and the necessity for social connection. Being embedded in social relationships is particularly pressing for rural populations with their higher risk for suicide, and in the midst of this pandemic. The coalescence of risk and protective factors inherent in the rural community make a good case for turning more pointedly toward interventions that promote social connection. This directly addresses the call to make social connection a more prominent concern for health policy.

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