Suicidal Ideation and Testimonial Injustice

Lucienne Spencer & Matthew Broome

Introduction

According to the Office for National Statistics, 5,275 suicides were registered in England and Wales in 2022.[1] In the provisional Quarter 4 2022 data (October to December 2022), there were 16.8 suicide deaths per 100,000 males (1,036 deaths registered) and 5.3 suicide deaths per 100,000 females (340 deaths registered). Psychiatric illness constitutes the most common cause of suicide worldwide.[2] The most common psychiatric illnesses attributed to suicide are depression, substance use disorder and psychosis; however, people diagnosed with anxiety, personality disorders, eating disorders and PTSD are also at high risk.[3]

Preventative strategies are being developed to curtail these high rates of suicide, including new methods of identifying people who are of high risk, crisis management, more effective follow-up care and caution around reporting suicide in the media.[4] Despite increasing concern for ever-high suicide rates, reports of the intent to kill oneself are frequently met with incredulity, with potentially fatal results. In this paper, we identify an overlooked means of tackling high rates of suicide by addressing how claims of suicidal ideation are received. High-risk individuals with suicidal ideation are too often overlooked by the healthcare system because their suicide claims are dismissed as deceitful. By addressing the testimonial injustice met by people with suicidal ideation and rethinking how we receive claims of suicide, we can build more effective suicidal prevention strategies.

---

1 Office for National Statistics (ONS), released 5 April 2023, ONS website, statistical bulletin, Quarterly suicide death registrations in England: 2001 to 2021 registrations and Quarter 1 (Jan to Mar) to Quarter 4 (Oct to Dec) 2022 provisional data.

2 Brådvik, Louise: Suicide Risk and Mental Disorders, in: International journal of environmental research and public health 15 (2018) 9.

3 Ibid.

4 Garrat, Katherine et al., Suicide Prevention: Policy and Strategy, in: House of Common Libraries, Number CBP-8221, 2023.

Epistemic Injustice in the Philosophy of Psychiatry

In her opening to 'Evolving Concepts of Epistemic Injustice', Fricker asks: "What does the concept of epistemic injustice do for us? What should we want it to do?"[5] While some would have us believe that we live in an era where dissonant voices are louder than ever, in reality, most are still straining to be heard. To amplify these voices, it is vital to understand the mechanisms that silenced them in the first place. The concept of epistemic injustice offers a distinct way to expose previously obscured complex epistemic inequalities that silence some of the most marginalised in our society.

Why apply the concept of epistemic injustice to the philosophy of psychiatry? Psychiatric healthcare has distinct social power structures that can be found in no other institution. Fricker defines "social power" as "a practically socially situated capacity to control others."[6] In the case of psychiatry, this social power, bestowed upon the clinician by their training and clinical expertise, takes on a unique form.[7] The clinician possesses the power to legally detain a person under the Mental Health Act; to define the state of mind of their patient and to position them in a conclusive diagnostic category; to prescribe treatment to their patient, sometimes in the form of medication that may transform their mental state significantly.

This social power is primarily used to positively impact the lives of people with psychiatric illness by alleviating unwanted symptoms and providing tools for recovery. Nevertheless, research has shown that epistemic asymmetries in the healthcare system may sometimes fuel testimonial injustice, whereby the testimony of a patient is given an undue credibility deficit.[8] In this paper, we use the concept of testimonial injustice to highlight the silencing of those with suicidal ideation.

Stigma and Suicide

According to Fricker, seeking knowledge from our environment is an essential aspect of human nature.[9] A key part of gaining knowledge is through the testimony of other people. To seek out reliable testimony, we possess a faculty of "testimonial

5 Fricker, Miranda: Evolving Concepts of Epistemic Injustice, in: Kidd, Ian James/Medina, José Pohlhaus, Jr., Gaile (eds.): The Routledge Handbook of Epistemic Injustice, London 2019, 53–60, 53.

6 Fricker, Miranda: Epistemic Injustice. Power and the Ethics of Knowing. Oxford 2007, 13.

7 Carel, Havi/Kidd, Ian James: Epistemic injustice in healthcare. A philosophical analysis, in: Medicine, Health Care and Philosophy, 17 (2014) 4, 529–540, 530.

8 Kidd, Ian James/Spencer, Lucienne J/Carel, Havi: Epistemic Injustice in Psychiatric Research and Practice, in: Philosophical Psychology, 2022.

9 Fricker: Epistemic Injustice, 86.

sensibility": a "perceptual faculty" that allows the hearer to view a speaker in an "epistemically loaded" way. Through this perceptual faculty, certain people appear epistemically reliable.[10] The upshot is that persuasive prejudicial attitudes cause certain groups to register as epistemically unreliable through our testimonial sensibility. In this instance, the marginalised speaker is vulnerable to testimonial injustice.

What are the identity prejudices that may influence the way we receive testimony from people with suicidal ideation? Although the person in question is likely to have intersecting identities that further undermine their credibility (regarding their race, gender, sexuality etc.), people with suicidal ideation are likely to encounter at least a double identity prejudice as someone who is 1) perceived to be mentally ill and 2) as a person with suicidal ideation or with a history of suicide attempts.[11] Concerning the first identity prejudice, there is much research on the entrenched, multidimensional prejudicial attitudes towards people with mental health problems, according to which such people are perceived to be crazy, dangerous, socially awkward, unpredictable, or even less than human.[12]

While the stigma attached to suicidality and mental ill health overlap, suicidality is more likely to be perceived as selfish, incompetent, emotionally weak, and immoral.[13] Although suicide has largely been decriminalised[14], the perception that suicide is morally wrong persists. People who have attempted suicide frequently report their actions being perceived as emotionally abusive: "The immediate reaction is, 'How dare you do something to me when we are trying so hard to help you?'"[15] Rimkeviciene *et al.* include an example of one person whose partner was able to obtain a domestic violence order against her following a suicide attempt: "In court the patient received the following explanation: 'cutting myself in self-harm was an act of violence that I've created against him'."[16]

There are two key categories in the literature on epistemic injustice in psychiatric illness thus far. The first are people perceived to be too irrational or "crazy" for their

---

10 Ibid., 70.

11 It is worth noting that the stigma attached to mental illness in turn contributes toward suicidality (Rüsch, Zlati et al.: Does the stigma of mental illness contribute to suicidality?, in: Br J Psychiatry 205 (2014) 4.

12 Boysen, Guy. A./Chicosky, Rebecca. L./Delmore, Erin E.: Dehumanization of mental illness and the stereotype content model, in: Stigma and Health, 8 (2023) 2, 150–158.

13 Sheehan, Lindsay L et al.: Stakeholder Perspectives on the Stigma of Suicide Attempt Survivors, in: Crisis 38 (2017) 2, 73–81, 3.

14 However suicide is still illegal in several countries; see (Mishara, Brian L./Weisstub, David N.: The legal status of suicide: A global review, in: International Journal of Law and Psychiatry, 2016, 54–74).

15 Rimkeviciene, Jurgita et al.: Personal Stigma in Suicide Attempters, in: Death Studies, 39 (2015) 10, 592–599, 595.

16 Ibid.

testimony to be reliable. In this category, we would place people who have unusual experiences, delusions or have been diagnosed with psychosis. The second category includes people whose psychiatric illnesses are not taken seriously, so their testimony is dismissed as exaggerated or attention-seeking. This category would include people with Borderline Personality Disorder, Depression and OCD. In some cases, people with psychiatric illnesses find themselves in a double-bind, suffering from the stigma of both categories: they are perceived to be simultaneously "crazy" and yet "attention-seeking." This is known as a "wrongful depathologisation," whereby the experiences of the marginalised person are concurrently stigmatised and trivialised.[17]

The immorality attached to suicidal ideation gives the stigma they experience an additional quality to other forms of pathophobia.[18] A person with suicidal ideation may happen to do immoral things; we hold the view that people with mental illness may have moral responsibility for their actions.[19] However, the stigma we refer to considers the suicidal ideation itself to be immoral. This immorality can be perceived in two ways. Firstly, suicidal ideation is deemed genuine and immoral due to the harm caused to friends and relations if the person were to end their life. Secondly, the suicide claim is considered disingenuous and merely a ploy to attain some further goal. This second understanding of the immorality attached to suicidal ideation is of concern here, as it is the form of stigma that most commonly tracks people with suicidal ideation into the healthcare system. In what follows, we will demonstrate that the unique stigma attached to people with suicidal ideation leaves them vulnerable to testimonial injustice whereby the speaker's testimony is downgraded or dismissed altogether due to implicit identity prejudices. Unlike most forms of testimonial injustice identified in the epistemic injustice literature, whereby testimony is dismissed as fallible or exaggerated, suicide claims may be considered deceitful.

---

17 Spencer, Lucienne/Carel, Havi: "Isn't everyone a little OCD?": the epistemic harm of wrongful depathologisation, in: Philosophy of Medicine, 2 (2021) 1.

18 People with suicidal ideation are not the only people with psychiatric illness who are perceived to be immoral. This too could be said of people with addictions and of people with eating disorders. Future research should explore the impact of these 'immorality' prejudices in cases of epistemic injustice.

19 In line with Broome, Matthew/Bortolotti, Lisa/Mameli, Matteo: Moral Responsibility And Mental Illness: A Case Study, in: Cambridge Quarterly Of Healthcare Ethics, 19 (2010) 2, 179–187.

Testimonial Injustice

A recent study by Bergen et al examined cases in which patients seeking emergency care for self-harm and suicidality.[20] Using conversation analysis, Bergen *et al.* found cases of testimonial injustice in the emergency department as claims of suicidal ideation had been undermined, questioned and recharacterized by healthcare practitioners.[21] Through several different communication practices (such as speaking over the patient, challenging the authenticity of the patient's suicidal ideation and attempting to confront the patient with inconsistencies in their account), some clinicians demonstrated that they were not sufficiently receptive to their patient's testimony.

Such testimonial injustice can be found in narratives of suicidal ideation in the literature. Consider the following example:

> Tom is 22 and has made a couple of serious attempts on his life following prolonged periods of depression. "When I regained consciousness after the last attempt", he said, "I was told 'If you really want to kill yourself, you would have done it'." Tom, like many other people, feels like when he now contacts the crisis team, they treat him brusquely. "It is like they will only take me seriously if I actually die.[22]

Petrea Taylor (2020) (2022) has developed studies showing that suicide claims from women are particularly likely to be dismissed as attention-seeking and manipulative, as they encounter additional misogynistic identity prejudices. Below are some of the reports collated by Taylor:

> Even if you tell [clinicians] you were suicidal, it is not taken seriously. They almost refuse to treat you. They refuse to talk to you. You are just worthless... You can come out of [the hospital] feeling three times worse than when you go in with a crisis... because [the clinicians] are too judgmental.[23]
> "I just said to [psychiatrist], "You aren't listening to me!" [Psychiatrist responded],

---

20 Bergen, Clara et al.: Implying Implausibility and Undermining versus Accepting Peoples' Experiences of Suicidal Ideation and Self-Harm in Emergency Department Psychosocial Assessments, in: Frontiers in Psychiatry 14 (2023).

21 Ibid.

22 Watts, Jay: Some Mental Health Services Are Telling Patients: 'If You Really Wanted to Kill Yourself, You Would Have Done It.', in: The Independent , (14/12/2017), www.independent.co.uk/voices/mental-health-nhs-suicide-crisis-untrained-staff-high-risk-underfunding-a8110186.html (12/04/2024).

23 Taylor, Petrea: System Entrapment: Dehumanization While Help-Seeking for Suicidality in Women Who Have Experienced Intimate Partner Violence, in: Qualitative Health Research 30 (2019) 4, 530–546.

> "Well nothing is wrong with you."[24]
> "[the new psychiatrist] came in and said, "You are manipulating the system…"[25]

Beyond self-reports, institutionalised testimonial injustice is reflected in the language surrounding suicidal ideation.[26] The very language implemented in the context of suicidal patients betrays inherent sigma, as such patients are not referred to as 'communicating' or even "confessing" suicidal urges but of "threatening suicide."[27] This terminology suggests that the patient is blackmailing the clinician, using the 'threat' of suicide as part of an ultimatum to force them to give in to the patient's demands. This language is particularly prevalent in psychiatric concepts such as "contingency based suicide" and "malingering." We shall proceed to address each in turn.

"Contingency-based suicide" is a term coined by Lambert & Bonner (Lambert & Bonner, 1996)[28] and can be defined as follows:

> These patients may communicate their suicidality as conditional, aimed at satisfying unmet needs; secondary gain; dependency needs; or remaining in the sick role. Faced with impending discharge, such a patient might increase the intensity of his suicidal statements or engage in behaviors that subvert discharge. Some go as far as to engage in behaviors with apparent suicidal intent soon after discharge.[29]

The authors add that such patients may have "mood disorders, personality pathology, substance use disorder, or a history of serious suicide attempt."[30] In their guide on discharging patients who "threaten" "contingency-based suicide," Bundy *et al.* provide the case study of Mr K, who is described as "male sex, white race, low-social support, mood disorder, substance use disorder (SUD), and chronic pain."[31] Bundy *et al.* recommend not taking Mr K's threat of suicide seriously as "his statement that

---

24 Taylor, Petrea: Challenging the Myth of "Attention Seeking" Women with Suicidality. A Grounded Theory Study about Applying Counter-Pressure to Manage System Entrapment, in: Issues in Mental Health Nursing 43 (2022) 7, 613–624, 616 f.

25 Ibid., 617.

26 Frey, Laura M et al.: What's in a word? Clarifying terminology on suicide-related communication, in: Death Studies 44 (2022) 12, 808–818.

27 Ibid.

28 Lambert, Michael. T./Bonner, Johnnie: Characteristics and six-month outcome of patients who use suicide threats to seek hospital admission. Psychiatric Services, 47(1996) 8, 871–873.

29 Bundy, Christopher/Schreiber, Matthew/Pascualy, Marcella: Discharging Your Patients Who Display Contingency-Based Suicidality. Six Steps, in: Current Psychiatry 13(2014) 1, e1-e3, 1, https://www.mdedge.com/psychiatry/article/79222/depression/discharging-your-patients-who-display-contingency-based (12/04/2024), 1.

30 Ibid.

31 Ibid, 2.

he will kill himself if discharged appears to be an expression of unmet needs (housing, pain management) that is representative of his limited and often-maladaptive coping and skills, rather than an indicator of imminent risk of death."[32] Bundy *et al.* suggest that Mr K's case can be distinguished from an authentically suicidal patient purely from Mr K's use of an ultimatum in his testimony to clinicians. Note that, in the case study of Mr K, the so-called "ultimatum" is as follows: "if I am discharged then I will kill myself." Bundy *et al.*'s account fails to draw a clear distinction between a case that could be fatal and one that could be a manipulative ploy. This inability to distinguish between the two is because both cases look outwardly the same, as we cannot fully determine the patient's intentions.

People with mental health problems are often some of the most marginalised in our society. From these outskirts, they are less likely to enter higher education or find employment and have an increased risk of crime victimisation, poverty, and homelessness.[33] Therefore, relief from a poor socioeconomic position would be advantageous to the patient with suicidal ideation; such external benefits should not be cause for downgrading their testimony. Moreover, those in a poor socioeconomic position are naturally a high-risk group for suicide.[34] It is important not to let a patient's socioeconomic status impact the credibility of their suicidal ideation.

The literature on contingency-based suicide uses language that reflects a battle between the "demanding" and "unyielding" patient and the "caring" yet "fearful" clinician who must not "give in" to the patient's "manipulative" behaviour; discussions mainly surround the doctor's fear of liability versus the scarcity of resources, particularly hospital beds.[35] The literature on contingency-based suicide exposes an inherent identity prejudice against psychiatric patients that portrays them as controlling and deceitful. These identity prejudices may lead clinicians to downgrade the credibility of suicidal claims.

---

32 Ibid.

33 Mental Health Taskforce. The Five Year Forward View For Mental Health. England.nhs.uk 2016, https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (12/04/2024).

34 Stack, Steven: Contributing factors to suicide: Political, social, cultural and economic, in: Preventive Medicine, 152 (2021).

35 Wilson, Jo. E. et al.: Identifying and addressing the hidden reasons why patients refuse discharge from the hospital, in: Psychosomatics 57(2016) 1, 18–24; Wedig Michelle. M. et al.: Predictors of Suicide Threats in Patients with Borderline Personality Disorder Over 16 Years of Prospective Follow-Up, in: Psychiatry research, 208 (2013) 3, 252–6; Berlin, Jon. S.: The Joker and the Thief. Persistent Malingering as a Therapeutic Impasse, in: Psychiatric Times. Psychiatric Issues in Emergency Care Settings 2 (2007) 5; Lambert, Michael. T.: Suicide Risk Assessment and Management. Focus on Personality Disorders, in: Current Opinion in Psychiatry, 16 (2003) 1, 71–76.

A similar narrative can be found in the literature on malingering. The DSM-5 defines malingering as "the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives."[36] The DSM-5 claims that malingering is not in itself a psychiatric illness. What differentiates malingering from psychiatric disorders whereby the patient feigns, exaggerates or creates illness (e.g. Munchhausen's Syndrome), is the pursuit of external benefits. This may include drugs, evading criminal prosecution, avoiding work or school, paid leave from employment, or shelter. According to the DSM-5, malingering "should be strongly suspected" in the following situations:

a) A medicolegal context e.g. a patient presents with an illness while facing trial.
b) Marked discrepancy between the individual's "claimed stress or disability" and "objective finding and observation".
c) Lack of compliance with diagnostic evaluation, treatment regimen and follow up care.
d) Presence of anti-social personality disorder.

According to a study conducted by Rumschick and Appel[37], in one month psychiatrists suspected one-third of patients of malingering, and 20% were strongly or definitely suspected of malingering. Of those strongly or definitely suspected of malingering, patients with suicidal ideation comprised the majority (58%).[38] Of the patients who claimed suicidal ideation and were suspected of malingering, 18% were admitted, 32% were held, and 50% were discharged.[39]

Regarding people with suicidal ideation, the second of the malingering criteria appears to be particularly problematic. It does not seem possible for the clinician to identify a discrepancy between the individual's claim of suicidal ideation and 'objective finding and observation'. As in contingency-based suicide, there is no measure to verify the suicide claims objectively. In addition, a lack of compliance with diagnostic evaluation, treatment regimen and follow-up care is not at odds with genuine suicidal ideation. Moreover, to dismiss a claim of suicidal ideation on the grounds of an anti-social personality disorder appears to be epistemically unjust; although a person with a personality disorder may sometimes be dishonest, this is not a good reason to apply a confirmation bias and discredit their claims as malingering, especially when the results could be potentially fatal.

---

36 American Psychiatric Association. Diagnostic and statistical manual of mental disorders: dsm-5. 5th edn. Arlington, VA: American Psychiatric Association. 2013, 726.

37 Rumschik, Sean. M./Appel, Jacob. M.: Malingering in the psychiatric emergency department: Prevalence, predictors, and outcomes, in: Psychiatric Services, 70 (2019) 2, 115–122.

38 Ibid., 118.

39 Ibid., 119.

To be clear, we recognise that some people who make suicide claims may lie to gain some external benefit. Indeed, one study reported that 12% of hospitalized patients they interviewed who had reported suicidal ideation admitted in anonymous surveys that they had lied or exaggerated the suicidal ideation to gain admission.[40] However, we do argue that in attempting to distinguish those with genuine suicidal ideation from malingerers, the decision made by the clinician risks being unintentionally influenced by identity prejudice. In these instances, people with suicidal ideation may be met with testimonial injustice.

We do not suggest that all, or even many, clinicians are insensitive to those with suicidal ideation. They are often very sympathetic and successfully prevent suicide in their patients. Moreover, clinicians are restricted by pressures on time and resources, impacting the quality of care delivered to people with suicidal ideation. Nevertheless, testimonial injustice does sometimes occur. When it does, it is through implicit biases despite the clinician's best intentions. Indeed, the clinician may have morally good motives for de-prioritising a patient they perceive as being deceitful to dedicate time and resources to those who need it. Moreover, in some cases, the healthcare system itself, as opposed to individual clinicians, maintains an environment of testimonial injustice.

Testimonial Smothering

Kristie Dotson adds to the literature the concept of epistemic "violence" as an essential way of understanding some of the extreme forms of silencing that emerge from unequal epistemic climates.[41] A sub-section of epistemic violence includes what Dotson terms "testimonial smothering."[42] Testimonial smothering occurs when "the speaker perceives one's immediate audience as unwilling or unable to gain the appropriate uptake of proffered testimony."[43] Drawing on Hornsby and Langton's speech-act account of silencing, Dotson attributes testimonial smothering to a failure to take up the speaker's speech-act. After a prolonged experience of "pernicious ignorance," the subject is coerced into "self-silencing."[44]

In discussing suicidal ideation with friends and family members, people are often met with evasiveness: "If we don't talk about it, well, it's not an issue. If we talk

40 Rissmiller, David A. et al.: Prevalence of Malingering in Suicidal Psychiatric Inpatients: A Replication, in: Psychological Reports 84 (1999) 3, 726–730.

41 Dotson, Kristie: Tracking Epistemic Violence, Tracking Practices of Silencing, in: Hypatia, 26 (2011) 2, 236–25.

42 Ibid., 244.

43 Ibid.

44 Ibid.

about it, well, then it is an issue and we'll have to deal with it."[45] Kidd identifies this as 'aversive pathophobia', a vice commonly displayed in individuals around ill people:

> Aversiveness might include flat refusals or expressions of reluctance to interact with them, or, when that cannot be avoided, adoption of behavioural styles that tend to diminish the quality and frequency of those interactions – staring and glaring at the visible signs of illness, for instance, or peremptory tones of voice, or monosyllabic answers to questions.[46]

In the discussion of suicidal ideation, aversive behaviour may be motivated by the high stakes of the conversation and the vulnerability of the person in question. There may be a fear that the person with suicidal ideation is so fragile that one may say the wrong thing and push them over the edge. The context of such a conversation is charged with intensity, heightened emotions and a feeling of exposure. And yet, whatever the motivation behind aversive behaviour, it is likely to create an environment that silences those with suicidal ideation. People are likely to truncate their testimony regarding suicidal ideation because their audience is perceived to be ill-disposed to receive it.

This testimonial smothering may be more commonly performed by males, who are more likely to avoid discussing suicidal ideation outright than females. A study conducted by Balt et al found that boys "rarely included straightforward disclosure of suicidal thoughts or clearly recognizable suicidal behaviour."[47] Boys would be more likely to make ambiguous hints or jokes, if suicidal ideation were to be mentioned at all.

In the context of the healthcare encounter, there is evidence that patients intentionally omit, or even deny, their experiences of suicidal ideation to the clinician. A study by Blanchard and Farber showed that, in a sample of 547 people, 31% claimed to have denied to their therapist the suicidal ideation they had been experiencing.[48] A leading cause of being deceitful about suicidal ideation can be attributed to the aforementioned stigma attached to suicide: "It's really embarrassing,

---

45 Rimkeviciene, Jurgita et at.: Personal Stigma in Suicide Attempters, in: Death Studies 39 (2015) 10, 592–599, 595.

46 Kidd, Ian J: Pathophobia, Vices, and Illness, in: International Journal of Philosophical Studies, 27 (2019) 2, 286–306, 292.

47 Balt, Elias et al.: Gender differences in suicide-related communication of young suicide victims, in: PloS one vol. 16,5 e0252028. 21 May. 2021, 6.

48 Blanchard, Matt/Farber, Barry A.: Lying in psychotherapy. Why and what clients don't tell their therapist about therapyand their relationship, in: Counselling Psychology Quarterly 29 (2016), 90–112.

you know what I mean? Especially in my world, where no one would expect me to do that. I just was so embarrassed."[49]

A further reason for denying suicidal ideation is due to a belief that their testimony will not be taken seriously:

> I don't feel they would have done anything. [...] I just feel like they would just be going, 'Well, you're an alcoholic and these feelings are normal and so on and so forth. There's nothing we can do for you. You just have to get through it.'[50]

In a further study conducted by Blanchard and Farber, results showed that 17% of people with suicidal ideation often blamed therapists for "discouraging disclosure": "either because they failed to ask, did not seem to care enough, or seemed unsympathetic. Those noting this motive implied that they would have disclosed their suicidal ideation had it not been for something about their therapist."[51]

Although Dotson argues that in a case of testimonial smothering the marginalised individual silences their own testimony, she clarifies that the responsibility lies with those who create an environment where such self-silencing is enabled.[52] In the words of Joseph H. Obegi: "If people are saying on paper that they have thoughts of suicide and then deny it when we talk to them, the problem is us... There is something going on in the interaction and how we are asking that is discouraging disclosure."[53]

Conclusion

In January 2018, the UK government announced a "zero suicide ambition" for mental health patients treated in hospitals. While we believe significant strides have been made towards "zero suicide," we propose that an environment of well-attuned testimonial sensibility is essential to achieving this goal. As there is no accurate way of distinguishing between genuine and disingenuous suicide claims, we must take each one seriously. We also argue that it is essential that we attune our testimonial sensibility so that our judgements are not skewed by intersecting identity prejudices, such as socioeconomic positions. While the individual may be able to at-

---

49 Richards, Julie E. et al.: Understanding Why Patients May Not Report Suicidal Ideation at a Health Care Visit Prior to a Suicide Attempt: A Qualitative Study, in: Psychiatric Services 70 (2019) 1, 40–45.

50 Ibid., 42.

51 Blanchard/Farber: Lying in psychotherapy, 130–131.

52 Dotson: Tracking Epistemic Violence, 244.

53 D'Arrigo, Terri: Half of patients with Suicidal thoughts deny it, in: Psychiatric News 2021, https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2021.10.9 (23/08/2023).

tain external benefits through their suicide claim, we should not assume that this is the overriding reason for the claim or that the claim is deceitful. In demonstrating well-attuned testimonial sensibility to suicide claims, we can create an environment whereby individuals with suicidal ideation are less likely to participate in self-silencing. We hope to have shown that philosophical approaches, such as epistemic injustice, may open up new ways of thinking about suicide prevention strategies.