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How Common is Recent Denial of Suicidal Ideation among Ideators, Attempters, and Suicide Decedents? A Literature Review

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ABSTRACT

Objective: It is sometimes stated that most people who die by suicide deny suicidal thoughts before their deaths. This narrative review examines the empirical basis for this assertion.
Methods: Studies from 2000 to 2021 that examined the prevalence of the denial of suicidal thoughts among ideators in general, denial before suicide, and denial before and immediately after a suicide attempt were reviewed. Twenty-two papers met the inclusion criteria.
Results: About 50% of ideators denied suicidal ideation (SI) during interviews. In addition, about half of decedents denied SI in the previous week or month before suicide, whereas about 30% denied SI in the previous week or month before a suicide attempt.
Conclusions: The denial of SI among ideators, attempters, and suicide decedents is an alarmingly common occurrence. Findings support the clinical wisdom that denial of SI is, by itself, an inadequate indicator of suicide risk.

1. Introduction

As a self-reported symptom, thoughts of suicide pose a special challenge to clinicians. As with other thoughts, people can prevent their thoughts of suicide from being detected by concealing or misrepresenting them. However, unlike most thoughts, suicidal ideation (SI) marks a potentially lethal path. Once SI begins, about 60% of attempts will occur in the following 12 months [1]. Moreover, as the frequency and severity of SI increases, so, too, does the risk of suicide attempts and suicide [2]. In addition, numerous case reports highlight the denial of SI before suicide [3,4]. This combination of lethality and concealment has led suicidologists to routinely warn that the denial of SI does not indicate an absence of risk [5,6]. Some have also asserted that most people who die by suicide deny SI when asked [7].

The empirical literature on the denial of suicidal thoughts has not been previously reviewed. Knowing the prevalence of denial has clinical and empirical implications. If denial occurs frequently, then the assessment of suicidality, which relies heavily on the disclosure of SI to judge suicide risk, must be reexamined. Ways in which to decrease the prevalence of denial among ideators would need to become a focus of research. Accordingly, I review the literature on the denial of SI by people who harbor such thoughts. (By denial, I mean the intentional refusal to acknowledge existing SI upon direct inquiry as opposed to a "failure" to volunteer SI spontaneously.) I focus on four circumstances: the denial of SI by ideators in general (that is, not in the context of recent suicidal behavior), denial before suicide, denial before suicide attempts, and denial immediately after suicide attempts.

1.1. Indirect evidence that denial of SI is common

Several studies have found that ideators do not disclose SI, or they misreport their recent or past SI. For example, survey studies suggest that nearly 50% of ideators never disclose their SI to anyone (range: 23–72% [8–13]). Similarly, roughly 50% of adults reported withholding their SI or inaccurately reporting it to providers (range: 22–77% [10,14–18]). In the United States, national data show that about 75% of decedents do not disclose intent to die before suicide [19]. Although these studies did not directly examine denial of SI, denial presumably occurred regularly.

Authors have often cited different types of studies as evidence that denial is common before suicidal behavior: studies on suicidal communication, studies on the last contact before suicide, and, less

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commonly, studies on SI's accuracy in predicting suicidal behavior. However, all constitute indirect rather than direct evidence of denial. Studies on suicidal communication are retrospective and usually investigate whether people who died by suicide spontaneously conveyed their SI or suicidal intent to other people before their deaths. However, the absence of any recalled spontaneous disclosure of SI by clinicians, although suggestive, is not the same as SI that is directly assessed and denied. (For a review of the literature on suicidal communication, see Pompili et al. [20]).

Studies on the last contact with a provider before suicide also provide indirect evidence of the denial of SI. One systematic review found that during the month before death, nearly half of decedents met with health care providers, and about one in five patients saw a mental health provider before dying by suicide [21]. Still, it is unclear whether SI was denied during these last contacts. Similarly, many patients discharged from psychiatric units kill themselves within the first week or month [22]. A reasonable assumption is that inpatients were asked about SI before discharge and denied it [23], although studies have shown that clinicians sometimes neglect to inquire about SI [24,25].

More indirect evidence of denial comes from studies examining SI's sensitivity for identifying who will die by suicide. For example, in a meta-analysis by McHugh and colleagues [26], SI's sensitivity was 41%—a false negative rate of nearly 60%. This finding suggests that people deny SI so often that asking about SI is a poor test of who will die by suicide. The hitch, however, is the length of the average follow-up period in the study: 9.1 years. Many of the false negatives may well have been people who each accurately reported on their SI at the time of assessment but developed it at a later point.

Taken together, the aforementioned investigations only suggest that SI is underreported; they do not shed light on how often ideators deny SI when asked. For the purpose of better estimating the prevalence of denial of SI, this review focuses on studies that directly measured the denial of SI.

2. Method

I searched PubMed and PsycInfo for quantitative, peer-reviewed studies published in English from January 1, 2000, to April 24, 2021. To qualify, studies must have reported the prevalence of either ideators who denied SI or people who denied SI upon direct inquiry and shortly thereafter died by suicide or made suicide attempts. Studies on denial after a suicide attempt were also included. Because the denial of SI has been labeled in different ways, I included several search terms. Each query used variations of "suicide" plus variations of one of the following: denial, disclose, conceal, hide, and nondisclosure. Queries yielded 1368 unduplicated studies. I screened out irrelevant papers in several phases. First, I reviewed titles, then abstracts, and finally, I read the articles. I supplemented the electronic searches with hand searches of relevant papers. I also added papers that I knew to be relevant but did not appear in either the electronic or hand searches. I excluded studies on suicidal communication as well as studies that examined the traits of concealment or nondisclosure rather than the actual denial of SI. Finally, I excluded studies on denial before suicidal behavior if the denial occurred more than one month before the behavior; this was done on the basis that older denials were more likely to reflect accurate reporting.

3. Findings

Twenty-two papers met inclusion criteria: 13 were relevant to denial of SI generally, seven to denial before suicide, two to denial before a suicide attempt, and one to denial following a suicide attempt. One study was relevant to the denial of SI before suicide and before a suicide attempt. (See Supplementary Table 1 for a list of all included studies.)

3.1. How common is the denial of SI generally?

Investigators who examined methods of assessing SI have found that ideators often deny SI. For example, researchers studying the role of anonymity in the disclosure of SI found evidence of denial. In a large sample of Army soldiers (N = 1712), Warner et al. [27] found that respondents to an anonymous survey disclosed four times as much SI as they did on a non-anonymous survey (1.2% vs. 4.7%). A similar pattern was observed in another study of Army soldiers [28], as well as in samples of National Guard soldiers [29], veterans, and community adults [30].

Researchers have also consistently found that ideators commonly endorse SI on self-report measures but deny it during subsequent interviews (Table 1). For example, Gratch et al. [31] asked depressed adults to report the presence of SI on a smartphone app during a one-week monitoring period. Nearly 60% of those reporting SI on the app denied the experience during a telephone interview held within 24 h of the study's completion. Using different methods, other investigators have produced similar findings using outpatients [32], inpatients [33,34], primary care patients [35], and cancer patients [36]. Across studies, the average rate of denial was 57% (range = 18–94%). These data are consistent with older findings [37] and with a well-known phenomenon: People are more likely to report sensitive information on questionnaires than they are to reveal it during interviews [38].

Finally, Millner, Lee, and Nock [39] found that people who deny a gate question about SI subsequently endorse other forms of SI. Specifically, participants completing an online survey were asked the following gate question: "Have you ever seriously thought about killing yourself?" Regardless of their answers, they were asked whether they experienced various forms of SI. Remarkably, of the participants who replied "no" to the gate question, 31% endorsed as their most severe thoughts one of the following: "I should kill myself," "Maybe I should kill myself," and "I wish I was dead." Deming et al. [30] found similar results using an anonymous exit survey.

3.2. How common is the denial of SI before suicide?

Seven studies examined the denial of SI in the week or month before suicide (Table 2). Most relied on chart reviews for evidence that a patient was asked about but denied SI. Three used item 9 of the Patent Health Questionnaire (PHQ-9 [40]) as the indicator of denial (a "not at all" response to "Thoughts that you would be better off dead, or of hurting yourself in some way" during the past two weeks). Although some variability existed, on average, about half of the decedents denied SI within the week or month before suicide.

Several noteworthy patterns also exist. Patients' denial of SI to

Table 1
Studies in which SI was self-reported but denied during a subsequent interview.

Study	Time between self-report and interview	Sample of ideators	Percentage denying
Glassmire et al. (2016)	unclear (over several testing sessions)	forensic inpatients (N = 229)	81%
Gratch et al. (2020)	no more than 7 days	community adults (N = 50)	58%
Uebelacker et al. (2011)	mean of 9 days	primary care patients (N = 166)	66%
Terril et al. (2021)	same day	outpatients (N = 485)	73%
Viguera et al. (2015)	same day	outpatients (N = 343)	94%
Walker et al. (2011)	mean of 10 days	cancer patients (N = 330)	25%
Yigletu et al. (2004)	24 h	inpatients (N = 50)	18%
Average			59%

Note: Samples are of ideators without known recent suicidal behavior.

Table 2
Studies examining denial of SI in the week and month before suicide.

Study	Measure	Sample	Percentage denying
Berman (2018)	chart review	mixed	67% (final month, N = 132)
Busch et al. (2003)	chart review	inpatients	78% (final week, N = 76)
Denneson et al. (2010)[a]	chart review	mixed	67% (final month, N = 61)
Smith et al. (2013)[a]	chart review	mixed	73% (final week, N = 43) 73% (final month, N = 111)
Louzon et al. (2016)[a]	PHQ	mixed	50% (final week, N = 6) 61% (final month, N = 31)
Simon et al. (2013)	PHQ	outpatients	0% (final week, N = 3) 17% (final month, N = 12)
Simon et al. (2016)	PHQ	mixed	47% (final week, N = 17) 36% (final month, N = 78)
Average			52% (overall) 50% (final week) 54% (final month)

[a] Denotes studies on veterans. PHQ, Patient Health Questionnaire. "Mixed" means the sample included inpatients and outpatients.

providers is considerably more common in studies using chart reviews than in studies using item 9 of the PHQ as the indicator of denial (70% vs. 41%). This is consistent with the finding discussed earlier: The denial of SI is more likely in interviews. In addition, the denial of SI appears to be more common among veterans, regardless of the method used to assess SI. Finally, although some studies included post-discharge suicides, only Berman [25] reported these data separately. In that sample, discharged patients were more likely to have denied SI than patients still in treatment at the time of death were (87% vs. 38%).

3.3. How common is the denial of SI before suicide attempts?

Denial before attempts has been less frequently studied, but findings indicate that denial is somewhat less common before attempts than before suicides. In two retrospective studies of outpatients, Simon and colleagues [2,41] found that 25–36% of attempters denied SI on item 9 of the PHQ the week before a suicide attempt, and the figure was 27–39% in the month before a suicide attempt. In the 2013 study, they also found that 31% (N = 13) of those denying SI each made a suicide attempt within one day of completing the PHQ.

3.4. How common is denial following a suicide attempt?

Although several examined studies were not about the denial of SI per se, the investigators explored whether people who had engaged in apparent suicide attempts acknowledged them as such. McClay and colleagues [42] reviewed the medical records of the survivors of self-inflicted gunshot wounds. Twenty-nine percent of patients who were admitted to emergency rooms for self-inflicted gunshot wounds to their heads, chests, or abdomens denied to the consulting psychiatrist that they had intended to die. Of these, in more than a third (43%), evidence was found that the gunshot wounds occurred under suspicious circumstances (e.g., collaterals reported seeing the person place the gun in his or her mouth). Older studies using a similar method arrived at comparable findings [43].

4. Discussion

As part of a systematic inquiry, asking people about suicidal thoughts is a common-sense way of assessing suicidal thinking. Although experts have warned that decedents usually deny SI before suicide, the current review shows that the denial of SI is more widespread and common than previously acknowledged. Regardless of context—be it outside of suicidal behavior, before suicide, or before or after a suicide attempt—ideators deny SI roughly one-third to one-half of the time. This is an alarming finding. Without reliable information about SI, providers will make less accurate risk assessments, and treatment opportunities will be lost [44]. Morbidity and mortality are obvious consequences.

This review's findings indicate that a considerable gap exists between what patients are thinking and how providers currently solicit disclosure. Technical factors, such as phrasing and assessment competence, and relational factors, such as warmth and trust, are clearly in play and need further study. Additionally, the mental health field may need to do more to earn the trust of those living with suicidal thoughts. This could include adopting a view of suicidal ideation as a signal of unbearable pain rather than only as a risk to be managed [45], embracing a stepped care model of responding to suicidality [46], and incorporating the recommendations of suicide attempt survivors for improving treatment [47]. Hospitalization, although commonly relied upon for acutely suicidal individuals, is not a risk-free treatment choice [48,49].

Why do ideators deny SI but engage in suicidal behavior within days or weeks? Although some authors have speculated that ideators are attempting to avoid discovery [50], the reasons may be more complex. Some may truly have no SI at the time of assessment but later experience a sudden onset. Indeed, studies using ecological momentary assessments of SI have demonstrated gross fluctuations in frequency can occur over short periods [51]. Studies on reasons why people withhold SI suggest that fear may lead to denial. For example, patients report fears of hospitalization, overreaction, shame, and stigma [14,52,53]. In addition, some may believe that their symptoms are not serious, that disclosure is pointless, or that trusted confidants are not available [52].

This review's findings should be understood in light of several limitations. First, although I attempted to methodically cull relevant studies, the review was not a systematic one. As such, bias is possible, and there were no checks on the quality of included studies. Second, the assessment of SI was not uniform in the reviewed studies. Regarding questionnaires, many studies relied on item 9 of the PHQ, the phrasing of which covers thoughts of death as well as thoughts of self-injury with unspecified intent. Other studies coded SI as present if either active or passive thoughts of SI were endorsed. Still others relied on questions with different frequencies of SI (e.g., from an unspecified frequency to "I have thought a lot"). In studies that compared questionnaires with structured interviews, the timeframe for SI (e.g., the past week) was not always the same, and the two methods often used different questions to ask about SI. In addition, the time between the administration of the questionnaire and the interview varied from 24 h to three weeks. Many studies relied on medical records to determine whether SI had been denied. As a result, we cannot know how providers asked about SI.

In summary, the denial of SI appears to be more common than previously appreciated. The rates of denial found in this review signal an urgent need to investigate why ideators deny SI as well as to improve how clinicians assess SI in the consulting room. In the meantime, clinicians would be well served by following the longstanding clinical wisdom that denial of SI is, by itself, an inadequate indicator of suicide risk.

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Appendix A. Supplementary table

A supplementary table for this article can be found online at https://doi.org/10.1016/j.genhosppsych.2021.07.009.

References

[1] Nock MK, Borges G, Bromet EJ, Alonso J, Angermeyer M, Beautrais A, et al. Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. Brit J Psychiatry 2008;192:98–105.
[2] Simon GE, Coleman KJ, Rossom RC, Beck A, Oliver M, Johnson E, et al. Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice. J Clin Psychiatry 2016;77:221–7.
[3] Simon RI, Gutheil TG. A recurrent pattern of suicide risk factors observed in litigated cases: lessons in risk management. Psychiatr Ann 2002;32:384–90.
[4] Fawcett J, Rosenblate R. Suicide within 24 hours after assessment in the emergency department: look for and manage anxiety. Psychiatr Ann 2000;30:228–31.
[5] Simon RI. Behavioral risk assessment of the guarded suicidal patient. Suicide Life Threat Behav 2008;38:517–22.
[6] Silverman MM, Berman AL. Suicide risk assessment and risk formulation part I: a focus on suicide ideation in assessing suicide risk. Suicide Life Threat Behav 2014;44:420–31.
[7] Nestadt PS, Triplett P, Mojtabai R, Berman AL. Universal screening may not prevent suicide. Gen Hosp Psychiatry 2020;63:14–5.
[8] Encrenaz G, Kovess-Masféty V, Gilbert F, Galéra C, Lagarde E, Mishara B, et al. Lifetime risk of suicidal behaviors and communication to a health professional about suicidal ideation: results from a large survey of the French adult population. Crisis 2012;33:127–36.
[9] Eskin M. A cross-cultural investigation of the communication of suicidal intent in Swedish and Turkish adolescents. Scand J Psychol 2003;44:1–6.
[10] Calear AL, Batterham PJ. Suicidal ideation disclosure: patterns, correlates and outcome. Psychiatry Res 2019;278:1–6.
[11] Drum DJ, Brownson C, Burton Denmark A, Smith SE. New data on the nature of suicidal crises in college students: shifting the paradigm. Prof Psychol 2009;40:213–22.
[12] Mérelle S, Foppen E, Gilissen R, Mokkenstorm J, Cluitmans R, Van Ballegooijen W. Characteristics associated with non-disclosure of suicidal ideation in adults. Int J Res Publ Health 2018;15:1–14.
[13] Chu J, Lin M, Akutsu PD, Joshi SV, Yang LH. Hidden suicidal ideation or intent among Asian American Pacific Islanders: a cultural phenomenon associated with greater suicide severity. Asian Am J Psychol 2018;9:262–9.
[14] Blanchard M, Farber BA. "It is never okay to talk about suicide": patients' reasons for concealing suicidal ideation in psychotherapy. Psychother Res 2020;30:124–36.
[15] Love M, Farber BA. Honesty in psychotherapy: results of an online survey comparing high vs. low self-concealers. Psychother Res 2019;29:607–20.
[16] Levy AG, Scherer AM, Zikmund-Fisher BJ, Larkin K, Barnes GD, Fagerlin A. Assessment of patient nondisclosures to clinicians of experiencing imminent threats. JAMA Netw Open 2019;2:e199277.
[17] Love HA, Morgan PC. You can tell me anything: disclosure of suicidal thoughts and behaviors in psychotherapy. Psychotherapy 2021. 10.1037%2Fpst0000335.
[18] Høyen KS, Solem S, Cohen LJ, Prestmo A, Hjemdal O, Vaaler AE, et al. Non-disclosure of suicidal ideation in psychiatric inpatients: rates and correlates. Death Stud 2021:1–9.
[19] Petrosky E, Ertl A, Sheats KJ, Wilson R, Carter CJ, Blair JM. Surveillance for violent deaths — National Violent Death Reporting System, 34 states, four California Counties, the District of Columbia, and Puerto Rico, 2017. MMWR Surveill Summ 2020;69:1–38.
[20] Pompili M, Belvederi Murri M, Patti S, Innamorati M, Lester D, Girardi P, et al. The communication of suicidal intentions: a meta-analysis. Psychol Med 2016;46:2239–53.
[21] Stene-Larsen K, Reneflot A. Contact with primary and mental health care prior to suicide: a systematic review of the literature from 2000 to 2017. Scand J Public Health 2019;47:9–17.
[22] Appleby L, Shaw J, Amos T, McDonnell R, Harris C, McCann K, et al. Suicide within 12 months of contact with mental health services: national clinical survey. BMJ-Brit Med J 1999;318:1235–9.
[23] Nock MK, Park JM, Finn CT, Deliberto TL, Dour HJ, Banaji MR. Measuring the suicidal mind: implicit cognition predicts suicidal behavior. Psychol Sci 2010;21:511–7.
[24] Hom MA, Stanley IH, Podlogar MC, Joiner TE. "Are you having thoughts of suicide?" Examining experiences with disclosing and denying suicidal ideation. J Clin Psychol 2017;73:1382–92.
[25] Berman AL. Risk factors proximate to suicide and suicide risk assessment in the context of denied suicide ideation. Suicide Life Threat Behav 2018;48:340–52.
[26] McHugh CM, Corderoy A, Ryan CJ, Hickie IB, Large MM. Association between suicidal ideation and suicide: meta-analyses of odds ratios, sensitivity, specificity and positive predictive value. BJPsych Open 2019;5:e18.
[27] Warner CH, Appenzeller GN, Grieger T, Belenkiy S, Breitbach J, Parker J, et al. Importance of anonymity to encourage honest reporting in mental health screening after combat deployment. Arch Gen Psychiatry 2011;68:1065–71.
[28] Vannoy SD, Andrews BK, Atkins DC, Dondanville KA, Young-McCaughan S, Peterson AL. Under reporting of suicide ideation in US Army population screening: an ongoing challenge. Suicide Life Threat Behav 2017;47:723–8.
[29] Anestis MD, Green BA. The impact of varying levels of confidentiality on disclosure of suicidal thoughts in a sample of United States National Guard personnel. J Clin Psychol 2015;71:1023–30.
[30] Deming CA, Harris JA, Castro-Ramirez F, Glenn JJ, Cha CB, Millner AJ, et al. Inconsistencies in self-reports of suicidal ideation and attempts across assessment methods. Psychol Assess 2021;33:218–29.
[31] Gratch I, Choo TH, Galfalvy H, Keilp JG, Itzhaky L, Mann JJ, et al. Detecting suicidal thoughts: the power of ecological momentary assessment. Depress Anxiety 2021;38:8–16.
[32] Glassmire DM, Stolberg RA, Greene RL, Bongar B. The utility of MMPI-2 suicide items for assessing suicidal potential: development of a Suicidal Potential Scale. Assessment 2001;8:281–90.
[33] Yigletu H, Tucker S, Harris M, Hatlevig J. Assessing suicide ideation: comparing self-report versus clinician report. J Am Psychiatr Nurses Assoc 2004;10:9–15.
[34] Glassmire DM, Tarescavage AM, Burchett D, Martinez J, Gomez A. Clinical utility of the MMPI-2-RF SUI items and scale in a forensic inpatient setting: association with interview self-report and future suicidal behaviors. Psychol Assess 2016;28:1502–9.
[35] Uebelacker LA, German NM, Gaudiano BA, Miller IW. Patient health questionnaire depression scale as a suicide screening instrument in depressed primary care patients: a cross-sectional study. In: The Primary Care Companion for CNS Disorders. 13; 2011. e1–6.
[36] Walker J, Hansen CH, Butcher I, Sharma N, Wall L, Murray G, et al. Thoughts of death and suicide reported by cancer patients who endorsed the "suicidal thoughts" item of the PHQ-9 during routine screening for depression. Psychosomatics 2011;52:424–7.
[37] Kaplan ML, Asnis GM, Sanderson WC, Keswani L, de Lecuona JM, Joseph S. Suicide assessment: clinical interview vs. self-report. J Clin Psychol 1994;50:294–8.
[38] Tourangeau R, Yan T. Sensitive questions in surveys. Psychol Bull 2007;133:859–83.
[39] Millner AJ, Lee MD, Nock MK. Single-item measurement of suicidal behaviors: validity and consequences of misclassification. PLoS One 2015;10:e0141606.
[40] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med 2001;16:606–13.
[41] Simon GE, Rutter CM, Peterson D, Oliver M, Whiteside U, Operskalski B, et al. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv 2013;64:1195–202.
[42] McClay MM, O'Connor SS, Groh BN, Baudino M, Venanzi L, Shields A, et al. Denial of suicide attempt among hospitalized survivors of a self-inflicted gunshot wound. Psychiatr Serv 2018;69:657–63.
[43] de Moore GM, Plew JD, Bray KM, Snars JN. Survivors of self-inflicted firearm injury: a liaison psychiatry perspective. Med J Aust 1994;160:421–5.
[44] Cukrowicz KC, Duberstein PR, Vannoy SD, Lin EH, Unützer J. What factors determine disclosure of suicide ideation in adults 60 and older to a treatment provider. Suicide Life Threat Behav 2014;44:331–7.
[45] Stallman HM, Ohan JL. The alignment of law, practice and need in suicide prevention. BJPsych Bull 2018;42:51–3.
[46] Jobes DA. Managing suicidal risk: A collaborative approach. 2nd ed. New York: Guilford; 2016.
[47] Hom MA, Bauer BW, Stanley IH, Boffa JW, Stage DL, Capron DW, et al. Suicide attempt survivors' recommendations for improving mental health treatment for attempt survivors. Psychol Serv 2020. 10.1037%2Fser0000415.
[48] Borecky A, Thomsen C, Dubov A. Reweighing the ethical tradeoffs in the involuntary hospitalization of suicidal patients. Am J Bioeth 2019;19:71–83.
[49] Ward-Ciesielski EF, Rizvi SL. The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: a critical review and recommendations for research. Clin Psychol-Sci Pr 2021;28:60–71.
[50] Resnick PJ. Recognizing that the suicidal patient views you as an adversary. Curr Psychiat 2002;1:8.
[51] Kleiman EM, Turner BJ, Fedor S, Beale EE, Huffman JC, Nock MK. Examination of real-time fluctuations in suicidal ideation and its risk factors: results from two ecological momentary assessment studies. J Abnorm Psychol 2017;126:726–38.
[52] Burton Denmark A, Hess E, Becker MS. College students' reasons for concealing suicidal ideation. J Coll Stud Psychother 2012;26:83–98.
[53] Richards JE, Whiteside U, Ludman EJ, Pabiniak C, Kirlin B, Hidalgo R, et al. Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: a qualitative study. Psychiatr Serv 2018:1–6.