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Fellowship Capstone | Policy Brief

The Ontological Crisis in Suicide Prevention: Transcending Epistemological Silence through a Narrative Evidence Model

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I. Executive summary

The ongoing global health crisis of suicide continues to pose a significant challenge to medical systems worldwide. The behavioral health field frequently relies on reductionist, checklist-based assessments that fail to fully capture the complex lived realities of individuals in distress. The reliance on these evaluations can lead to a form of 'epistemological silence', in which profound suffering goes unspoken or unheard due to 'systemic epistemic injustice' in clinical encounters. This brief examines how patients experience credibility deficits and structural barriers that undermine the legitimacy of their testimony, and argues that these limitations can be addressed through a shift towards a narrative-evidence model. By focusing on collaborative assessment and valuing lived-experience expertise, this approach more effectively engages the social determinants and subjective 'crevices of despair' that drive suicidality.

II. Overview

Suicide remains a persistent global health crisis, yet current preventative paradigms often fail to address the nuanced, lived reality of those in crisis. Prevailing clinical models rely heavily on reductionist empirical checklists and diagnostic metrics to assess risk. While instruments such as the Beck Scale for Suicide Ideation (BSI) and the Columbia-Suicide Severity Rating Scale (C-SSRS) offer structural uniformity, they suffer from critical statistical limitations. These tools frequently fail to capture the nuanced, subjective 'crevices of despair' that precede a crisis, often resulting in 'epistemological silence', where the sufferer's pain goes unarticulated and unheard. Additionally, despite the widespread use of these standardized tools, mortality rates have remained stagnant, partly because of 'epistemic injustice', where their testimony is disregarded due to systemic biases. Patients can remain trapped in a cycle of 'epistemic contestation', where their own understanding of their crisis is undermined by clinical authority. Hence, this paper investigates the advantages of switching from a liability-focused observation model to a human-centered 'narrative evidence' model for suicide prevention strategies.

A. Relevance

The concept of 'epistemic injustice' was developed by Miranda Fricker to describe a harm done to a person in their capacity as a knower, specifically when a hearer deflates the credibility of a speaker due to prejudice. In the context of suicide prevention, this injustice manifests when clinicians prioritize tangible, objective evidence

over the patient's subjective report, often attributing credibility deficits to those with mental disorders. It implies a level of 'hermeneutical marginalization' where sufferers lack the conceptual resources to have their 'crevices of despair,' such as adverse social conditions that shape well-being beyond biology or behavior, understood within the dominant medical framework. Despite having acceptable global classification accuracy, meta-analyses of suicide prediction models reveal that their positive predictive value (PPV) for suicide mortality remains near zero (often ≤ 0.01%). This shows how the reliance on reductionist metrics may treat patients unfairly and inefficiently, failing to capture the idiosyncratic nature of the suicidal crisis.

III. History

A. Current Stances

The clinical management of suicide has historically been dominated by a biomedical structure that prioritizes objective observation over subjective experience. This paradigm has generally relegated the suicidal patient to the role of an unreliable narrator, viewing their distress through the 'medical gaze' which separates the disease from the person. Despite the proliferation of standardized risk assessment tools, suicide remains a leading cause of global mortality.

Individuals with lived experience of suicidality are fairly underrepresented in the co-creation of their own care plans, often facing a 'credibility deficit' within the psychiatric system. It is important to acknowledge that this exclusion manifests at the very beginning of the clinical encounter, from the initial risk assessment to the formulation of a diagnosis. Although checklists can be effective in standardizing care, it can lead to a phenomenon where individual's unique experiences of suffering are not acknowledged or addressed until they reach a compounding breaking point. Systemic epistemic injustice frequently marginalizes patients' voices as active contributors, limiting their ability to inform decisions about their own care, regardless of the severity of their suffering.

Diagnostic labels and perceived cognitive reliability can often be the turnover for a patient's ability to be heard. According to research on epistemic injustice, the testimony of a psychiatric patient is often given deflated credibility due to negative stereotypes regarding their emotional stability or cognitive capacity. It is a common bias across many clinical settings that those with mental health conditions are 'cognitively impaired' or 'unreliable,' and hence their narratives are dismissed as 'attention-seeking' or irrelevant. This dynamic constitutes 'testimonial injustice,' where the sufferer is stripped of their status as a 'knower'. Furthermore, patients often lack the conceptual resources to articulate drivers of distress related to the social determinants of health because medical frameworks prioritize biological symptoms, leaving the sufferer's pain structurally silenced.

IV. Policy Problem

A. Stakeholders

It is given that the primary stakeholders are individuals experiencing suicidal distress, particularly those whose lived reality is obscured by rigid clinical checklists.

Ideally, these patients should be 'co-authors' of their treatment plans, ensuring that the mechanisms used to assess them validate their status as 'knowers' of their own experience.

Clinicians and healthcare systems are also critical stakeholders, as they stand to benefit from a more effective, alliance-based therapeutic model. However, systemic pressures to prioritize objective evidence over patient narratives often cause 'moral injury' to providers, compelling them to work in defensive ways that contradict their compassionate instincts. Therefore, it is pivotal to sensitize healthcare organizations to the limitations of liability-focused models and the necessity of 'narrative evidence' to improve clinical outcomes and workforce sustainability.

B. Risks of Indifference

The risk of indifference to the ontological crisis in suicide prevention lies in the stagnation of mortality rates and the perpetuation of epistemic violence against vulnerable populations. If stakeholders continue to rely on reductionist empirical checklists, it is a given that the cycle of 'epistemic contestation' will continue unhindered. As a result, resources are misallocated, and the underlying factors driving the crisis remain obscured. This is not to mention that inaction discourages future help-seeking, where patients whose testimony is dismissed are significantly less likely to engage with services during future crises. Apart from such clinical failures, indifference also neglects the broader social determinants of suicide, leaving the structural roots of the crisis unaddressed. Therefore, it only makes sense for there to be a shift toward human-centered models rather than maintaining the status quo.

C. Nonpartisan Reasoning

Because suicide is a multifaceted public health crisis that affects the social and economic fabric of communities, it is imperative that nonpartisan intervention takes place to shift the paradigm of care. The benefits of such intervention include but are not limited to the following:

1) Clinical Efficacy and Resource Efficiency: Shifting from low-utility prediction models to narrative assessments benefits the entire healthcare system. Current reliance on checklists generates a high volume of false positives, wasting resources on ineffective interventions while missing the nuanced reality of those at actual risk. By adopting a 'narrative evidence' model that identifies specific drivers of distress, systems can target interventions more precisely. This improves the therapeutic alliance and clinical outcomes, transforming a defensive, liability-based expenditure into a strategic investment in recovery.

2) Restoration of Agency and Human Rights: A human-centered workforce improves patient engagement by bringing the 'lived experience' perspective to the table. Addressing 'epistemic injustice' aligns with fundamental human rights principles by restoring the patient's status as a credible source of knowledge. When patients are empowered to articulate their own needs without fear of dismissal, the healthcare system becomes more just and responsive.

Therefore, removing the barriers of 'hermeneutical injustice' paves the way for a more ethical care environment that benefits all relevant stakeholders.

3) Community Resilience and Social Stability: As is now made explicit through the 'crevices of despair' framework, suicide is often a response to structural factors. A narrative model effectively captures these upstream social determinants, allowing for interventions that address the root causes of distress rather than just the symptoms. When prevention strategies integrate these broader social factors, they contribute to overall community well-being and stability, ensuring that vulnerable populations are supported before a crisis becomes fatal.

V. Tried Policy

To begin with, a significant policy implemented in the United States aimed at standardizing suicide prevention that has struggled to meet its goals is the Universal Suicide Risk Screening mandate, specifically the adoption of the Columbia-Suicide Severity Rating Scale (C-SSRS). Recommended by The Joint Commission in 2019, this policy requires healthcare providers to screen every patient entering an emergency department for suicide risk, regardless of their medical reason for visiting.

However, the policy has received its fair share of clinical and ethical backlash. For starters, the mandate has faced criticism for its statistical inefficiency, as the C-SSRS often produces a high volume of false positives, leading to the unnecessary over-medicalization and 'boarding' of patients in psychiatric wards.

In action to this, many clinicians argue that the tool's near-zero positive predictive value fails to accurately identify those in imminent danger, potentially wasting life-saving resources. Additionally, rather than fostering a genuine therapeutic alliance, this policy is more procedural in nature and prioritizes institutional liability over the patient's subjective narrative. As a result, the 'epistemological silence' continues to exist, masked by a bureaucratic checklist that fulfills legal requirements without addressing the root causes of a patient's despair.

VI. Policy Options

Transition to Narrative-Based Assessment Protocols

Clinical assessments are often tainted by 'the medical gaze,' where negative stereotypes regarding a patient's emotional stability lead to a credibility deficit. A standardized narrative-evidence framework ensures that clinicians are required to document the patient's subjective life context rather than just ticking risk boxes.

To overcome this, I recommend adopting a collaborative assessment model, such as the Collaborative Assessment and Management of Suicidality (CAMS). This shifts the clinician's role from a 'judge of risk' to a 'co-author of safety,' ensuring the patient's status as a 'knower' is structurally protected.

Integration of Lived-Experience Peer Support

Integrating Certified Peer Support Specialists (individuals with lived experience of suicidality) into clinical teams redistributes the 'epistemic power.'

By incorporating the presence of peer specialists in crisis interventions, healthcare systems can bridge the gap between biological symptoms and lived reality. This mitigates the 'hermeneutical marginalization' patients feel, as they are met by someone who possesses the conceptual resources to understand their 'crevices of despair.'

Epistemic Transparency and Open Notes Mandate

Epistemic Transparency requires that patients have full, real-time access to their psychiatric records and the 'risk formulations' written about them.

Strengthening 'Open Notes' policies in behavioral health ensures that patients can see how their testimony is being translated into clinical data. This allows patients to challenge 'testimonial injustice' directly, ensuring that the drivers of their distress are not structurally silenced or misinterpreted by clinical authority.

VII. Conclusions

In this paper, I have explored the ontological crisis within current suicide prevention paradigms and the systemic barriers faced by those in distress, going into an in-depth analysis of how reductionist empirical checklists generate 'epistemological silence'. However, out of the potential path corrections, the option that is the most clinically efficacious and ethically urgent is the shift to a 'narrative evidence' model, operationalized through collaborative frameworks like the Collaborative Assessment and Management of Suicidality (CAMS).

With that said, the subjective experience of suicidality is a complex phenomenon, and in order to address it, validating the patient as a credible 'knower' of their own pain is essential to gaining an adequate understanding of the 'crevices of despair' driving their crisis. Though we have a long way to go in achieving a healthcare culture that fully honors 'testimonial justice' and overcoming the structural inertia of liability-focused observation, it can be achieved by focusing on policy structures that integrate lived experience expertise, limiting the adverse impact of social determinants, and prioritizing the therapeutic alliance. I believe these barriers can be overcome if we envisage prevention in a pragmatic manner that restores patient agency and follow through the solutions systematically.

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