HHS Public Access

Author manuscript

Arch Suicide Res. Author manuscript; available in PMC 2026 February 24.

Published in final edited form as:

Arch Suicide Res. ; : 1–17. doi:10.1080/13811118.2025.2611922.

Helping or Hurting? A Qualitative Exploration of Adolescents' Perceptions of Responses to their Suicide-Related Disclosure

Sarah R. Sullivan, MA[1,2], **Isabelle Meneses**[1], **Jhovelis Mañaná, MS**[1], **Jennifer S. Ford, PhD**[1,2], **Muhammad Waseem, MD**[3], **Regina Miranda, PhD**[1,2,*]

[1]Hunter College, City University of New York

[2]The Graduate Center, City University of New York

[3]NYC Health + Hospitals Lincoln

Abstract

Background: Suicide is a leading cause of death among adolescents in the United States. Timely suicide-related disclosure may be a gateway to life-saving interventions and support, yet little is known about *how* adolescents interpret the specific responses they receive after disclosing suicide ideation (SI) or suicide attempts (SAs). Existing research has relied heavily on self-report surveys and has not captured the concrete verbal, emotional, and behavioral reactions adolescents perceive as supportive or unsupportive. This study addresses this gap by qualitatively exploring adolescents' recalled experiences of disclosure responses from both informal and formal supports.

Methods: Semi-structured interviews were conducted with 82 adolescents (ages 12–19 years) who presented for clinical care related to SI or SA within the prior two weeks. Interviews drew from the Adolescent Suicide Ideation Interview and probed disclosure decisions and perceived reactions. Data were analyzed using thematic analysis to identify patterns in supportive and unsupportive responses.

Results: Analysis revealed a range of supportive (i.e., Providing Guidance and Supportive Action, Shared Emotional Experiences, Encouragement and Affirmation, Engagement and Communication, and Physical Presence and Comfort) and unsupportive (i.e., Forcible or Coercive Action, Minimizing or Dismissing Concerns, Blame and Guilt-Inducing Responses, and Anger and Hostile Reactions) disclosure responses.

[*]Correspondence to: Regina Miranda, Hunter College, CUNY, 695 Park Ave., Room 611HN, New York, NY 10065, regina.miranda@hunter.cuny.edu.

Contributorships

1. Sarah R. Sullivan - Conceptualization; Formal Analysis; Writing – Original Draft Preparation
2. Isabelle Meneses - Formal Analysis; Writing – Original Draft Preparation
3. Jhovelis Mañaná - Writing – Review & Editing
4. Jennifer S. Ford - Writing – Review & Editing
5. Muhammed Waseem - Writing – Review & Editing
6. Regina Miranda- Conceptualization; Investigation; Methodology; Supervision; Writing – Review & Editing

Declarations of interest: None

Conclusions: Supportive responses fostered safety and willingness to seek help, while unsupportive responses contributed to emotional distress and the desire to conceal in the future. Findings highlight the importance of caregiver and peer responses following suicide-related disclosure and suggest opportunities for interventions in crisis settings to enhance the disclosure experience.

Keywords

suicide; suicide-related disclosure; social reactions; adolescents; caregivers

Adolescent suicides have been rising in the United States (US) over the past two decades, in contrast to overall global trends in youth suicide (World Health Organization, 2025). Suicides increased by 57% among 15–19-year-olds between 2009 and 2017 in the US, and remained at this elevated level through 2021 (Curtin & Garnett, 2023). Adolescent suicide ideation (SI) and attempts (SA), which show worldwide prevalence rates of 14–23% and 5–16%, respectively, have also increased in the US. (Van Meter et al., 2023). In 2023, an estimated 20% of high school students reported SI, and about 10% of students reported making a SA (Verlenden et al., 2024). Many adolescents receive treatment for SI or SAs in the emergency department (ED) (Virk, Waine, & Berry, 2022), and there is a critical window of time after an adolescent discloses their SI or SA in which a caregiver's response may dissipate or exacerbate risk for further SI or SA after the adolescent is discharged from care. Supportive responses, including emotional validation, expressions of concern, and encouragement to seek professional help following suicide-related disclosure are associated with lower distress and increased treatment engagement (Eskin, 2003; Hasking et al., 2015; Klineberg et al., 2013; McClay, Brausch, & O'Connor, 2020). Unsupportive reactions, including dismissiveness, blame, or breaches of trust, can lead to further distress, social withdrawal, and heightened suicide-related risk (Frey, Hans & Cerel, 2016; Love & Morgan, 2021). Therefore, strengthening responses of individuals in adolescents' social networks after they disclose their SI or SAs is essential to reduce suicide-related risk.

Limitations of Current Approaches in Suicide-Related Disclosure Research

Studies on adolescent suicide-related disclosures have relied heavily on self-report measures via an online, asynchronous survey (Burke et al., 2021; Fox et al., 2022). Though valuable, such questionnaires often do not capture the complexity of adolescents' lived experiences. Existing research has largely focused on outcomes like depression or perceived burdensomeness (Brausch, Kalgren, & Howd, 2024; McClay et al., 2020). Fewer studies examine positive, actionable strategies within adolescents' networks that might reduce suicide-related risk. This gap is particularly concerning among ethnoracially minoritized populations, who may navigate unique cultural norms around family communication, suicide-related stigma, or prior experiences with systems of care that discourage them from disclosing their SI or SAs (Gulbas & Zayas, 2015; Shin et al., 2025).

Our prior research found that adolescents who perceived supportive (vs. unsupportive) responses to their SI or SA disclosure were significantly less likely to attempt suicide within the subsequent 12 months (Sullivan et al., 2025). However, the analyses did not examine the

specific nature of what adolescents considered to be supportive and unsupportive responses. Greater specificity is needed beyond broad statistical associations to guide interventions for caregivers or peers in response to adolescents' needs.

Informal Supports in Suicide-Related Disclosure

Recent studies indicate variation in suicide-related disclosure rates among youth with prior SI or SAs who have access to social contacts or a history of mental health treatment. Disclosure rates have ranged from 72% in an online sample of 154 U.S. adolescents recruited via Instagram (Spears, Shin, & Cha, 2025) to 82% in a community-based sample of 513 Australian youth with a history of SI who had engaged with mental health services (McGillivray et al., 2022). Similarly, rates between 73% and 80% have been reported among 1,495 adolescents with self-injurious thoughts and behaviors and prior mental health treatment experience (Fox et al., 2022). When deciding whether to disclose, individuals consider factors like timing, context, recipient characteristics, perceived necessity, and anticipated responses – particularly others' potential reactions (Chaudoir & Fisher, 2010). Parents, siblings, and peers – referred to as informal supports – are often better positioned to spontaneously receive unprompted suicide-related disclosures. Research on non-suicidal self-injury similarly indicates that adolescents typically choose informal rather than formal sources when they disclose (Simone & Hamza, 2020). A study of unhoused emerging adults found that unmet mental health needs were associated with nearly nine times greater odds of disclosing suicide-related thoughts to a friend (Fulginiti et al., 2020). Together, these findings suggest that adolescents frequently rely on informal supports when in distress; however, these supports may be ill-equipped to respond effectively, underscoring the importance of strengthening their ability to provide help.

Reactions to Suicide-Related Disclosure

Qualitative research with adults described supportive reactions to suicide-related disclosure as including validation, emotional availability, and thoughtful engagement (Frey, Hans & Cerel 2017). Feeling unburdened – rather than a burden – was central to perceiving the interaction as positive. Researchers have identified nonjudgmental listening, calm concern, and a strong therapeutic alliance as features of supportive disclosure experiences among adults (Love & Morgan, 2021; Richards, Whiteside et al., 2019; Richards, Hohl et al., 2019). It remains unclear whether these features are interpreted as supportive by adolescents.

Reponses to adolescents' suicide-related disclosures may impact their immediate mental health outcomes and future willingness to seek help. In a cross-cultural and quantitative study, adolescents who shared SI generally described positive responses from others, such as feeling understood and accepted (Eskin, 2003). Other quantitative and qualitative studies found that adolescents who had stopped self-harming often reflected positively on disclosure experiences, citing improved emotional understanding and overall well-being (Hasking et al., 2015; Klineberg et al., 2013). These findings suggest the potential for supportive responses to mitigate SI by promoting trust, emotional safety, and open communication about mental health.

Quantitative research echoes qualitative findings. Adolescents who disclosed SI were previously found to report lower current SI (Eskin, 2003), and disclosure was associated with increased family and peer support, which in turn reduced feelings of burdensomeness and isolation (Frey & Fulginiti, 2017). Family support also mediated the relationship between SA disclosure and depressive symptom severity (McClay et al., 2020), while positive disclosure experiences were linked to posttraumatic growth (Frey et al., 2019). Thus, fostering supportive disclosure environments may reduce immediate suicide-related risk and encourage ongoing openness, as well as better long-term mental health outcomes.

In contrast, negative responses, such as judgment or threats of hospitalization, can undermine trust and discourage future disclosures. Adolescents in a diversely representative city-based sample described negative initial reactions when self-harm was discovered, which led to concealment of future SI (Klineberg et al., 2013). A qualitative study of adults found that fear of hospitalization and loss of autonomy led patients to not report their SI to providers (Richards, Whiteside, et al., 2019). More broadly, hostile reactions to other concealable identities have been associated with poorer health outcomes (Camacho, Reinka, & Quinn, 2020). Adolescents who perceived insufficient concern from providers also reported reduced future willingness to disclose (Love & Morgan, 2021). Adverse reactions can – advertently or inadvertently – perpetuate a cycle of concealment and hinder suicide prevention efforts.

Both the act of disclosing and its elicited reactions are influential in shaping suicide-related outcomes. Supportive reactions are consistently associated with better mental health, increased connectedness, and greater likelihood of future disclosure. Aversive responses can deepen distress, reinforce stigma, and delay help-seeking. Despite these insights, existing work has primarily examined adults' disclosure experiences or has focused on broad correlates such as perceived support. Very little is known about the specific verbal, emotional, and behavioral reactions that adolescents themselves interpret as supportive or unsupportive. Furthermore, prior research leaves unclear whether features identified as supportive among adults, such as validation, calm concern, or thoughtful engagement, carry the same meaning for adolescents.

To address these gaps, a qualitative approach is needed to capture adolescents' lived experiences and the nuanced ways they interpret others' responses following suicide-related disclosures. This would provide the necessary foundation for developing interventions that strengthen supportive communication within adolescents' networks.

The Present Study

The present study sought to fill this gap by qualitatively examining how adolescents perceived the responses given by others after they disclosed their SI or SAs before receiving clinical care. Specifically, we aimed to identify the types of verbal, emotional, and behavioral responses that adolescents recalled receiving from informal and formal sources, like peers, family members, and providers, and to explore how these responses influenced their emotional state, sense of connection, and willingness to seek help. We sought to

inform the development of interventions that promote supportive communication and reduce potentially harmful reactions following adolescent suicide-related disclosures.

Methods

This study involved secondary analysis of existing data. Between January 2018 and September 2022, 82 adolescents aged 12–19 years (M = 15.23, SD = 1.95) were recruited as part of a larger study on adolescent SI (see Miranda et al., 2025 and Sullivan et al., 2025, for details). Eligibility required presentation for clinical care related to SI (n = 63) or SA (n = 19) within the two weeks preceding the research interview. Most participants (n = 70; 85%) were recruited from a pediatric ED in a large New York City hospital. See Table 1 for sample characteristics.

Adolescents aged 18–19 provided written informed consent before participating, while participants under age 18 provided written assent after one of their caregivers provided permission for participation. Procedures received Institutional Review Board approval.

Interviews were primarily conducted in ED examination rooms, or in a private room within the hospital or research facilities. There were a few exceptions in which participants were interviewed remotely via Zoom (e.g., for interviews conducted soon after the COVID-19 pandemic). All adolescents completed the Adolescent Suicide Ideation Interview (ASII; Miranda et al., 2021), a semi-structured, audio-recorded interview assessing details surrounding their most recent SI and/or SA. The suicide-related disclosure section specifically asked whether participants told anyone about their SI or intent (e.g., “Did you tell anybody that you were having those thoughts?”), follow-up prompts to elicit detail (“Whom did you tell?”), timing of disclosure (“When did you tell him/her/them?”), and perceptions of the recipient’s reaction (“What did that person do after you told him/her/them?”). In addition, disclosure-related content that emerged in other sections of the interview (e.g., description of the day) was also included, although the majority of disclosure data were obtained through the disclosure-specific questions. Interviews were typically 45–90 minutes long. The disclosure-related section was not specifically timed; however, we estimate that it took about 8–10 minutes.

When adolescents were interviewed after discharge from the ED, a structured risk-assessment protocol was administered at the session to determine whether disclosure to caregivers or clinicians was warranted or whether additional clinical referral was needed (Miranda et al., 2022). Interviewers were supervised by a licensed clinical psychologist (last author), in collaboration with a postdoctoral research associate, and immediate consultation was available for any safety concerns.

Interviewers and Training.

Interviews were conducted by research assistants with at least a bachelor’s degree in psychology or a related discipline. Interviewers were trained by the last author (a licensed clinical psychologists) or by another Ph.D.-level psychologist with extensive experience in administering the Adolescent Suicide Ideation Interview, and they participated in

regular supervision meetings. Interviews were audio-recorded, transcribed, and reviewed by supervisors (see Miranda et al., 2025 for further details).

Data Analysis

Quantitative. Descriptive frequencies were calculated to characterize SI disclosure patterns, including the initiation of the disclosure experience, the recipients and methods of disclosure, and the specific timing and latency of the disclosure events.

Qualitative. Research assistants transcribed interviews, and transcripts were then analyzed by three independent coders (including SS and IM), who received an orientation to thematic analysis from JF, an expert in qualitative methods. One of these coders was also an interviewer on the study. Training of coders was overseen by SS, who had prior instruction in qualitative methods through graduate-level coursework and individualized training by a qualitative methods expert. Coder training included didactic instruction based on Braun and Clarke (2006), review of example studies, coding of pilot transcripts with group discussion, and iterative codebook development. Each coder independently read and highlighted key excerpts on perceived reactions to suicide-related disclosure in all transcripts, and also reviewed the entire interview to ensure that no relevant contextual information was missed. Coders wrote detailed notes, re-read excerpts, and then collaboratively refined an Excel-based codebook through consensus meetings. The team developed an operational definition for each generated code, using participant language and contextual cues to guide the differentiation and inclusion of codes. RM provided additional guidance and oversight during team meetings.

The distinction between supportive and unsupportive responses was not imposed *a priori* but emerged organically during the coding process. Although the team did not initially structure the analysis around these categories, participant narratives consistently clustered into patterns that reflected supportive or unsupportive responses. This thematic organization was further informed by participants' responses to structured interview items. For example, adolescents were asked directly, "What did that person do after you told them?" and interviewers were then asked to select from predefined response options, such as "provided a sympathetic response," "displayed anger or a derogatory response," or "ignored warning." These structured responses, in combination with adolescents' qualitative descriptions, helped ground the distinction in participants' lived experiences and perceptions rather than in assumptions or preexisting frameworks.

Accordingly, the analytic process reflected a combination of inductive and deductive approaches: inductive, in that themes were derived from adolescents' accounts of their experiences following disclosure; and deductive, in that semi-structured interview items guided coding. This approach enhanced rigor by ensuring that thematic distinctions were grounded in participants' data while also being informed by relevant theoretical frameworks.

In some cases, participants recounted differing experiences across time points or with different members of their support network (e.g., one caregiver responding supportively, another dismissively). To capture this nuance, segments of text could be assigned multiple codes, when appropriate. Co-coding was permitted to ensure that distinct thematic elements

within a single participant's narrative – particularly when they reflected varied responses or relationships – were fully represented. Based on this approach, 63% of participants described predominantly supportive responses, 30% described predominantly unsupportive responses, and 6% reflected mixed experiences involving both supportive and unsupportive elements.

The researchers followed clearly defined analytic procedures, including transcription, data summarization, codebook development, and matrix charting (Creswell & Creswell, 2017). Regular consensus meetings were held to resolve disagreements and refine definitions iteratively. Qualitative consensus meetings included all three coders to promote equitable participation and guard against dominance by any single individual. The codebook and thematic matrix underwent several rounds of revision. Codebook creation continued until thematic saturation was achieved.

Results

Characteristics of Disclosure

The vast majority of participants reported telling someone about their SI or SA (89%), rather than being asked by others. Youth most frequently disclosed to peers (37%), followed by parents (30%) and mental health professionals (28%), with over half of the sample (56%) choosing to tell only one person. While in-person communication remained the primary method of disclosure (68%), digital communication via text or email was also used by nearly a quarter of participants (24%). Disclosures were most frequent during the afternoon (29%). The majority of youth (37%) disclosed within 30 minutes of experiencing SI, and nearly a quarter of participants (24%) waited more than two hours to speak with someone. See Table 2 for details.

Qualitative Exploration of Perceptions of Disclosure Experience

The qualitative findings were organized into major themes reflecting distinct forms of communication and behavior. Supportive responses included 1) Providing Guidance and Supportive Action, 2) Shared Emotional Experiences, 3) Encouragement and Affirmation, 4) Engagement and Communication, and 5) Physical Presence and Comfort. Harmful responses were captured through themes of 1) Forcible or Coercive Action, 2) Minimizing or Dismissing Concerns, 3) Blame and Guilt-Inducing Responses, and 4) Anger and Hostile Reactions.

Helpful Responses

The sub-theme, *Providing Guidance and Supportive Action* ($n = 23$; 28%), included responses that were action-oriented, involving advice, problem-solving, or directing the adolescent to resources. They reflected a desire to help in tangible ways. One participant remembered: "And she was like, 'you shouldn't do it, I know I could help you, relax, just stay calm, behave, and do not touch anything, do not hurt yourself…'" (Y75: 12-year-old cisgender female with SA). Adolescents commonly described others actively helping them access care, involving family members or professionals to ensure safety. These moments often signaled a turning point toward receiving formal support. As one participant explained:

> "She suggested to bring my aunt in and we talk about it and then she called my parent and we all talked about it. And that's when she started talking about [Hospital] and that's when I was like, 'I don't care about wherever I go…I just want it. I need the help.'" (Y66: 17-year-old cisgender female with SI).

Adolescents also described *Shared Emotional Experiences* (*n* = 20; 24%), in which they received empathetic reactions during or following disclosure and support was conveyed through shared emotional experiences, which made them feel understood. One participant recounted: "He kinda been through the same thing and he tell me like 'I had seen the knife in my kitchen so many times, and I just think about stabbing myself and I haven't done it. So, if I'm still here, then your bitch ass do need to be here … stay here, stay with me'" (Y49: 14-year-old cisgender female with SI). Adolescents described responses conveying care through solidarity, helping some youth feel connected.

Responses involving *Engagement and Communication* (*n* = 17; 21%) were ones in which individuals attempted to engage adolescents in dialogue, distract them, or communicate clear messages against self-harm, which helped de-escalate the situation for some youth. One participant reflected on a peer's approach to shifting focus: "She was able to like distract me from thinking so much of it. She like brought up different topics" (Y161: 18-year-old transgender male with SI). Another participant shared how a direct instruction had a lasting effect: "They told me not to do it. And I said okay, I won't… I put it on my forearm, then after they told me not to, I put it back into the kitchen drawer" (Y106: 17-year-old cisgender male with SI). The distraction noted in these qualitative responses often interrupted harmful behavior.

Responses of *Encouragement and Affirmation* (*n* = 16; 20%) involved affirming and supportive verbal responses, often characterized by reassurance and recognition of the adolescent's worth. One participant shared: "…I was feeling really disappointed in myself and … I didn't think I would deserve to live, and then she told me… 'Don't say that, honey, because, … you deserve to live and everything's gonna be okay. It was just a moment where you felt that, like it's okay." (Y73: 14-year-old cisgender female with SI).

Adolescents also reported receiving *Physical Presence and Comfort* (*n* = 5; 6%) in the form of nonverbal gestures. Adolescents described moments where being held had a profound emotional effect, such as: "She just stood there and hugged me a long time" (Y50: 16-year-old cisgender female with SI). Another added: "I remember she hugged me and she said it's gonna be okay" (Y80: 13-year-old cisgender female with SA).

Harmful Responses

Some youth described *Forcible or Coercive Action* (*n* = 14; 17%), taken without consent, often involving law enforcement or psychiatric holds. These encounters, while perhaps intended to ensure safety, were experienced as traumatic and stripping away of autonomy. One youth noted: "I decided I won't go down without a fight. And that ended up with me getting tazed and in handcuffs" (Y108: 12-year-old transgender male with SI). Another shared: "…I didn't want her to call anybody. And then, she … went and got her phone, and

she called the ambulance… And they brought me here…I was kinda sad because it … didn't go the way I planned." (Y124: 18-year-old cisgender female with SA).

Several participants described responses that involved *Minimizing or Dismissing Concerns* (*n* = 10; 12%), ranging from passive indifference to active dismissal. One youth recalled: "He just continued watching TV" (Y88: 15-year-old cisgender female with SI), while another noted: "...he said something like 'get over it' and 'tell someone'..." (Y139: 14-year-old genderqueer-identifying adolescent with SI). Such reactions were described as alienating.

Some adolescents described *Blame and Guilt-Inducing Responses* (*n* = 7; 9%), which intensified their emotional burden and led to feelings of shame. One participant explained: "And then that's when she started telling me 'you're being selfish'...I actually went, I went to the bridge, I was by the edge and everything, but then I was just like nah, I kept crying and crying. Her mom talked to me and she was like 'you're being selfish right now,'..." (Y35: 17-year-old cisgender male with SI). Others were scolded or interrogated in ways that framed their behavior as intentional wrongdoing: "They were like, 'why would you do that, you know, we never taught you this, where did you get this from, who showed you how to do this' and they were like, 'you know how this affects you and like your future'" (Y133: 15-year-old cisgender female with SI). One adolescent noted, of her mother's response: "She said …, 'Oh you wanna like mess up your brothers' lives, and stuff.' They don't really care; they'll get over it, you know?" (Y138: 15-year-old cisgender female with SA).

Finally, responses of *Anger and Hostile Reactions* (*n* = 7; 9%) emerged in several narratives, sometimes escalating the adolescent's distress. In some cases, disclosure recipients projected their own emotional struggles or responded with aggression. One adolescent described the emotional fallout of a parent's intense reaction:

> "My mom … was really upset. She [said], 'oh, if you want to kill yourself, … then you should just go do it ...' So that made me upset. And she like told me to get out of my room. So I got up from my room, and I … almost started to have a panic attack... My breathing just got really like, uneven, and I wasn't breathing really correctly. And I had a breakdown…" (Y121: 15-year-old cisgender female with SA).

In other instances, youth felt betrayed when confidentiality was broken or when trust was violated: "I just felt annoyed, kind of betrayed, like I thought this would be confidential and I told you that I wouldn't act on it anyway" (Y111: 13-year-old cisgender female with SI).

While many adolescents recalled moments of compassion and connection that facilitated safety and emotional support, others described interactions that heightened distress, compromised trust, or contributed to further isolation.

Discussion

How adolescents perceived others' reactions to their suicide-related disclosure ranged from highly supportive to harmful. Supportive reactions – including encouragement, affirmation, emotional connection, and supportive actions – were often remembered as emotionally

impactful and validating. Unsupportive or harmful responses, such as minimization, blame, coercion, or anger, were experienced as invalidating, frightening, and potentially worsening adolescents' distress or isolation. These findings provide insight into the relational context of adolescent SI and SAs.

Supportive responses were associated with comfort, emotional regulation, and in some cases, initiation of formal help-seeking. Words of reassurance and reminders of adolescents' value helped buffer against hopelessness. Participants highlighted the affective quality of these interactions (e.g., tone, presence, and shared vulnerability) as key to their helpfulness. These relational aspects appeared to foster a sense of being heard and valued and also reinforced the adolescent's agency and self-worth during periods of emotional dysregulation. Such findings align with prior research emphasizing the protective function of perceived social support in mitigating suicide-related risk (Czyz et al., 2013).

Conversely, a substantial proportion of participants described invalidating or distress-inducing experiences. These reactions heightened feelings of isolation, shame, and distress. For some adolescents, responses that they perceived as punitive or coercive (e.g., forced hospitalization, parental anger) appeared to erode their trust. Blame and guilt-inducing responses intensified emotional burden, and angry and hostile reactions escalated adolescents' distress. These findings are consistent with research on the negative consequences of stigma and unsupportive responses following mental health disclosures (Ganzini et al., 2013; Klineberg et al., 2013).

Young people's fear of how others may respond to their self-harm disclosures has been found to be a barrier to help-seeking (Cox et al., 2024), underscoring the need to differentiate which reactions are perceived as unsupportive. One example is the experience of being stigmatized. A study of adults recruited from a national suicide organization's listserv suggested that individuals first disclose SI to someone in their social network or to a non-mental health professional, often resulting in a delay before they receive mental health or medical care (Frey et al., 2016). The gap between these two points of contact is a barrier that impacts willingness to disclose, which may be similar among adolescents. This barrier may especially hinder help-seeking, based on whether the first point of contact with a non-mental health professional results in stigmatizing reactions.

Narratives involving parental invalidation or emotional dysregulation, such as anger, blame, or threats, were particularly concerning. These responses demonstrated that the disclosure recipient not only failed to address the distress but, in some cases, exacerbated SI. These dynamics raise considerations about how caregiver stress, intergenerational trauma, and cultural beliefs about mental health may shape reactions to SI and/or SA. These findings highlight the need for family interventions and psychoeducation that acknowledge caregiver burden while centering youth safety.

Implications for Practice

The most common theme was *Providing Guidance and Supportive Action*, suggesting that support, particularly when paired with emotional sensitivity, may be particularly significant. Adolescents' descriptions of being linked to mental health resources or encouraged to

disclose to and engage family marked a turning point toward formal care. This highlights the potential value of equipping peers, caregivers, and school personnel with concrete and compassionate strategies to respond constructively to SI and/or SA disclosures.

These findings have several clinical implications. First, they support the development of brief interventions that inform caregivers, educators, and providers on how to respond to adolescents' suicide-related disclosures. Second, interventions should be attuned not only to enhancing support but also to mitigating harm. Providing education about the emotional and behavioral consequences of invalidating responses may reduce unintentional re-traumatization. Furthermore, family-based crisis interventions in the ED are shown to decrease the likelihood of inpatient admission (Wharff, Ginnis, & Ross, 2012), making this a critical window for caregiver psychoeducation. Given the role and time educators have with adolescents, school staff may benefit from additional training in responding to suicide-related disclosures with compassion, calmness, and non-judgmental support (Crowe et al., 2020). Suicide intervention skills among community and healthcare providers are shown to vary based on levels of experience (Scheerder et al., 2010), suggesting the need for further development of suicide intervention training for providers.

Integrating social support education into brief suicide prevention interventions for adolescents may enhance their effectiveness. Social support training and education for adolescents' social networks could be integrated into brief interventions for increased accessibility and scalability, such as through use of videos or digital minicourses (see Dobias et al., 2021). Additionally, family-based crisis interventions have been shown to increase caregiver understanding of treatment and treatment engagement (Wharff et al., 2012). Intervention strategies can focus on relationship building in which the listener allows space for narratives to be disclosed, provides appropriate responses, and helps the adolescent build autonomy in seeking help from providers. These are promising pathways for embedding supportive social network training within feasible and acceptable interventions to address adolescent suicide risk.

Coercive or punitive responses may lead to loss of trust. This is especially detrimental in crisis settings, where adolescents may develop structural mistrust if they have experienced structural trauma, such as with the police or forced hospitalizations (Packard et al., 2025). Barriers to ED treatment exist and are exacerbated for youth of color (Nash et al., 2021; Samra et al., 2019). When combined with the effects of unsupportive responses like forcible and coercive action, adolescents' willingness to disclose and overall help-seeking is likely hindered.

Incorporating youth perspectives on what they perceive as supportive and unsupportive into provider training might help improve responses to suicide-related disclosures. Additionally, culturally responsive or community-informed adaptations of interventions may also benefit from understanding these perspectives. In this way, community-based and culturally tailored supports may lessen stigmatization and structural mistrust.

Strengths, Limitations, and Future Directions

A strength of this study includes its assessment of adolescents shortly after SI and/or SA, enhancing the clinical relevance of the data. The sample also reflected diversity across identities, including racial, ethnic, sexual and gender, and socioeconomic backgrounds, allowing exploration of experiences across varied backgrounds.

Despite these strengths, there are several limitations. First, reliance on adolescents' retrospective accounts introduces the possibility of recall bias or social desirability effects. Second, as this was a secondary analysis of interviews originally designed for broader research purposes, the responses to questions about suicide-related disclosure were straightforward and not deeply probed, limiting the richness of some sub-theme descriptions. Third, while the sample consisted mostly of youth of color, our data did not allow for detailed exploration of how race, ethnicity, or cultural factors shaped disclosure experiences or responses, highlighting an important area for future study. Fourth, participants were recruited primarily from acute, crisis-focused settings, and their experiences may differ from adolescents in other care settings or those with less severe presentations. Adolescents who seek treatment and agree to participate in research interviews may differ meaningfully from those who decline, particularly concerning their comfort with disclosure. Finally, this study included only adolescent perspectives and not those of caregivers or other informants, preventing exploration of potentially divergent views on these interpersonal interactions.

Future research directions might include longitudinal designs to examine how perceived caregiver support evolves and relates to changes in SI and/or SA. Expanding to dyadic or multi-informant approaches, such as interviewing both adolescents and caregivers, could provide a more nuanced understanding of the interpersonal dynamics that impact disclosure. Additionally, future studies should include more in-depth, targeted probing of disclosure experiences, with attention to contextual factors such as race, ethnicity, and socioeconomic status, to capture the full complexity of supportive and unsupportive responses.

Conclusion

An adolescent's SI or SA disclosure can be a crucial intersection in their journey toward recovery. Social support may be a modifiable factor that influences adolescents' willingness to seek help and engage in care. To respond effectively, members of the social network may benefit from accessible resources that promote supportive reactions. By decreasing unsupportive responses and fostering security, clinicians, educators, and policymakers can help reduce barriers to disclosure and improve outcomes for youth who consider or attempt suicide.

Ethics Statement

Adolescents aged 18–19 provided written informed consent before participating; participants under age 18 provided written assent after one of their caregivers provided permission for participation. The Institutional Review Boards of the City University of New York (#2016–1491; March 23, 2017), New York City Health + Hospitals/Lincoln (#17–023; December 13,

2017), and the Visiting Nurse Service of New York (#E18–003; August 7, 2018) approved study procedures.

Data Availability

Data are available upon reasonable request to the corresponding author and with a data use agreement, when relevant.

Acknowledgments

Thanks to Emelyn Auad, Ari Bengiyat, Nathalie Berrios, Gerson Borrero, Kara Buda, Amy Castillo, Lia Davis, Trey Dellucci, Daniela Diaz Rincon, Hannah Ellerbeck, Sebastian Escobar, Jannatun Ferdowsi, Abigail Findley, Evan Gilmer, Judelysse Gomez, Kimberley Gonzalez-Quiles, Maiya Hotchkiss, Zara Khan, Flynn Kelly, Emily Kline, Jose Menjivar, Tenasia Moore, Ana Ortin-Peralta, Erica Rodriguez, Alejandra Roma, Christina Rombola, Beverlin Rosario-Williams, Sashana Rowe-Harriott, Lisbeth Rubi, Allan Shikh, Anna Simonyan, Ashley Vargas, and Mariah Xu for their assistance with data collection and/or coding. Thanks also to Jackaira Espinal, Alice Greenfield, and Sandra Runes for assistance with participant recruitment.

Study Funding

Funded, in part, by NIH Grants MH091873 and GM149429, and the Kaiser Permanente Center for Gun Violence Research and Education.

References

Braun V, & Clarke V (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77–101. 10.1191/1478088706qp063oa

Brausch AM, Kalgren T, & Howd C (2025). Characteristics of disclosure of suicidal and nonsuicidal behaviors in a clinical sample of adolescents. Research on Child and Adolescent Psychopathology, 53, 305–315. 10.1007/s10802-024-01269-8 [PubMed: 39589652]

Burke TA, Bettis AH, Barnicle SC, Wang SB, & Fox KR (2021). Disclosure of self-injurious thoughts and behaviors across sexual and gender identities. Pediatrics, 148, e2021050255. 10.1542/peds.2021-050255 [PubMed: 34521728]

Camacho G, Reinka MA, & Quinn DM (2020). Disclosure and concealment of stigmatized identities. Current Opinion in Psychology, 31, 28–32. 10.1016/j.copsyc.2019.07.031 [PubMed: 31430614]

Chaudoir SR, & Fisher JD (2010). The disclosure processes model: understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. Psychological Bulletin, 136, 236–256. 10.1037/a0018193 [PubMed: 20192562]

Cox JA, Mills L, Hermens DF, Read GJM, & Salmon PM (2024). A systematic review of the facilitators and barriers to help-seeking for self-harm in young people: A systems thinking perspective. Adolescent Research Review, 9, 411–434. 10.1007/s40894-024-00241-3

Creswell JW, & Creswell JD (2017). Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications.

Crowe R, Townsend ML, Miller CE, & Grenyer BFS (2020). Incidence, severity and responses to reportable student self-harm and suicidal behaviours in schools: A one-year population-based study. School Mental Health: A Multidisciplinary Research and Practice Journal, 12, 841–851. 10.1007/s12310-020-09390-x

Curtin SC, & Garnett MF (2023). Suicide and homicide death rates among youth and young adults aged 10–24: United States, 2001–2021. https://www.cdc.gov/nchs/data/databriefs/db471.pdf

Czyz EK, Horwitz AG, Eisenberg D, Kramer A, & King CA (2013). Self-reported barriers to professional help seeking among college students at elevated risk for suicide. Journal of American College Health, 61, 398–406. 10.1080/07448481.2013.820731 [PubMed: 24010494]

Dobias ML, Schleider JL, Jans L, & Fox KR (2021). An online, single-session intervention for adolescent self-injurious thoughts and behaviors: Results from a randomized trial. Behaviour Research and Therapy, 147, 103983. 10.1016/j.brat.2021.103983 [PubMed: 34688102]

Eskin M (2003). A cross-cultural investigation of the communication of suicidal intent in Swedish and Turkish adolescents. Scandinavian Journal of Psychology, 44, 1–6. 10.1111/1467-9450.t01-1-00314 [PubMed: 12602997]

Fox KR, Bettis AH, Burke TA, Hart EA, & Wang SB (2022). Exploring adolescent experiences with disclosing self-injurious thoughts and behaviors across settings. Research on Child and Adolescent Psychopathology, 50, 669–681. 10.1007/s10802-021-00878-x [PubMed: 34705197]

Frey LM, & Fulginiti A (2017). Talking about suicide may not be enough: family reaction as a mediator between disclosure and interpersonal needs. Journal of Mental Health, 26, 366–372. 10.1080/09638237.2017.1340592 [PubMed: 28675074]

Frey LM, Drapeau CW, Fulginiti A, Oexle N, Stage DL, Sheehan L, Cerel J, & Moore M (2019). Recipients of suicide-related disclosure: The link between disclosure and posttraumatic growth for suicide attempt survivors. International Journal of Environmental Research and Public Health, 16, 3815. 10.3390/ijerph16203815 [PubMed: 31658681]

Frey LM, Hans JD, & Cerel J (2016). Perceptions of suicide stigma: How do social networks and treatment providers compare? Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37, 95–103. 10.1027/0227-5910/a000358

Frey LM, Hans JD, & Cerel J (2017). An interpretive phenomenological inquiry of family and friend reactions to suicide disclosure. Journal of Marital and Family Therapy, 43, 159–172. 10.1111/jmft.12180 [PubMed: 27371940]

Fulginiti A, Hsu H-T, Barman-Adhikari A, Shelton J, Petering R, Santa Maria D, Narendorf SC, Ferguson KM, & Bender K (2020). Few do and to few: Disclosure of suicidal thoughts in friendship networks of young adults experiencing homelessness. Archives of Suicide Research, 26, 500–519. 10.1080/13811118.2020.1795018 [PubMed: 32698698]

Ganzini L, Denneson LM, Press N, Bair MJ, Helmer DA, Poat J, & Dobscha SK (2013). Trust is the basis for effective suicide risk screening and assessment in veterans. Journal of General Internal Medicine, 28, 1215–1221. 10.1007/s11606-013-2412-6 [PubMed: 23580131]

Gulbas LE, & Zayas LH (2015). Examining the interplay among family, culture, and Latina teen suicidal behavior. Qualitative Health Research, 25, 689–699. 10.1177/1049732314553598 [PubMed: 25288407]

Hasking P, Rees CS, Martin G, & Quigley J (2015). What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. BMC Public Health, 15, 1039. 10.1186/s12889-015-2383-0 [PubMed: 26453187]

Klineberg E, Kelly MJ, Stansfeld SA, & Bhui KS (2013). How do adolescents talk about self-harm: A qualitative study of disclosure in an ethnically diverse urban population in England. BMC Public Health, 13, 572. 10.1186/1471-2458-13-572 [PubMed: 23758739]

Love HA, & Morgan PC (2021). You can tell me anything: Disclosure of suicidal thoughts and behaviors in psychotherapy. Psychotherapy, 58, 533–543. https://doi-org.proxy.wexler.hunter.cuny.edu/10.1037/pst0000335 [PubMed: 33734741]

McClay MM, Brausch AM, & O'Connor SS (2020). Social support mediates the association between disclosure of suicide attempt and depression, perceived burdensomeness, and thwarted belongingness. Suicide and Life-Threatening Behavior, 50, 884–898. 10.1111/sltb.12622 [PubMed: 32053246]

McGillivray L, Rheinberger D, Wang J, Burnett A, & Torok M (2022). Non-disclosing youth: a cross sectional study to understand why young people do not disclose suicidal thoughts to their mental health professional. BMC Psychiatry, 22, 3. 10.1186/s12888-021-03636-x [PubMed: 34983460]

Miranda R, Ortin-Peralta A, Rombola C, Mañaná J, Espinal J, & Waseem M (2025). Suicide ideation subtypes that predict a future and earlier suicide attempt among adolescents. Journal of Clinical Child and Adolescent Psychology. 10.1080/15374416.2025.2585444

Miranda R, Ortin-Peralta A, & Mañaná J (2022). High-Risk Questionnaire for Adolescent Suicide Ideation Study. 10.17605/OSF.IO/QEA98

Miranda R, Shaffer D, Ortin-Peralta A, De Jaegere E, Gallagher M, & Polanco-Roman L (2021). Adolescent Suicide Ideation Interview, version A. Available at https://osf.io/8j7b5

Nash KA, Zima BT, Rothenberg C, Hoffmann J, Moreno C, Rosenthal MS, & Venkatesh A (2021). Prolonged emergency department length of stay for US pediatric mental health visits (2005–2015). Pediatrics, 147, e2020030692. 10.1542/peds.2020-030692 [PubMed: 33820850]

Packard SE, Verzani Z, Finsaas MC, Levy NS, Shefner R, Planey AM, Boehme AK, & Prins SJ (2025). Maintaining disorder: Estimating the association between policing and psychiatric hospitalization among youth in New York City by neighborhood racial composition, 2006–2014. Social Psychiatry and Psychiatric Epidemiology, 60, 125–137. 10.1007/s00127-024-02738-7 [PubMed: 39088094]

Richards JE, Hohl SD, Whiteside U, Ludman EJ, Grossman DC, Simon GE, Shortreed SM, Lee AK, Parrish R, Shea M, Caldeiro RM, Penfold RB, & Williams EC (2019). If you listen, I will talk: The experience of being asked about suicidality during routine primary care. Journal of General Internal Medicine, 34, 2075–2082. 10.1007/s11606-019-05136-x [PubMed: 31346911]

Richards JE, Whiteside U, Ludman EJ, Pabiniak C, Kirlin B, Hidalgo R, & Simon G (2019). Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: A qualitative study. Psychiatric Services, 70, 40–45. 10.1176/appi.ps.201800342 [PubMed: 30453860]

Samra S, Taira BR, Pinheiro E, Trotzky-Sirr R, & Schneberk T (2019). Undocumented patients in the emergency department: challenges and opportunities. Western Journal of Emergency Medicine, 20, 791–798. 10.5811/westjem.2019.7.41489 [PubMed: 31539336]

Scheerder G, Reynders A, Andriessen K, & Van Audenhove C (2010). Suicide intervention skills and related factors in community and health professionals. Suicide and Life-Threatening Behavior, 40, 115–124. 10.1521/suli.2010.40.2.115 [PubMed: 20465346]

Shin KE, Spears AP, Zhang R, & Cha CB (2025). Suicide-related disclosure patterns among culturally minoritized youth: Examining differences across race, ethnicity, gender identity, and sexual orientation. Suicide and Life-Threatening Behavior, 55, e13026. 10.1111/sltb.13026 [PubMed: 38032047]

Simone AC, & Hamza CA (2020). Examining the disclosure of nonsuicidal self-injury to informal and formal sources: A review of the literature. Clinical Psychology Review, 82, 101907. 10.1016/j.cpr.2020.101907 [PubMed: 32891855]

Spears AP, Shin KE, & Cha CB (2025). Characterizing silence: Adolescents' nondisclosure of their suicidal thoughts and behaviors to their family and peers. JAACAP Open, 3, 496–505. 10.1016/j.jaacop.2024.12.005 [PubMed: 40922770]

Sullivan SR, Rombola C, Ortin-Peralta A, Carmichael CL, Ford JS, Waseem M, & Miranda R (2025). Impact of perceived responses to suicide-related disclosure on future suicide ideation and attempts among adolescents. Research on Child and Adolescent Psychopathology. 10.1007/s10802-025-01389-9

Verlenden JV, Fodeman A, Wilkins N, Jones SE, Moore S, Cornett K, Sims V, Saelee R, & Brener ND (2024). Mental health and suicide risk among high school students and protective factors—Youth Risk Behavior Survey, United States, 2023. MMWR Supplements, 73. 10.15585/mmwr.su7304a9

Van Meter AR, Knowles EA, & Mintz EH (2023). Systematic review and meta-analysis: International prevalence of suicidal ideation and attempt in youth. Journal of the American Academy of Child and Adolescent Psychiatry, 62, 973–986. 10.1016/j.jaac.2022.07.867 [PubMed: 36563876]

Virk F, Waine J, & Berry C (2022). A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. BJPsych Open, 8, e56. 10.1192/bjo.2022.21 [PubMed: 35241211]

Wharff EA, Ginnis KM, & Ross AM (2012). Family-based crisis intervention with suicidal adolescents in the emergency room: A pilot study. Social Work, 57, 133–143. 10.1093/sw/sws017 [PubMed: 23038875]

World Health Organization (2025). Suicide worldwide in 2021: Global health estimates. Geneva: World Health Organization.

Highlights

- Analyzed how adolescents perceived others responded to suicide-related disclosures.
- Supportive responses provided guidance, shared emotion, affirmation, and presence.
- Unsupportive responses were coercive, dismissive, blaming, and angry.
- Suggest psychoeducation for parents, peers, and educators on supportive vs. harmful response to suicidal adolescents.

Table 1:

Participant Characteristics ($N = 82$)

	n	%	*M*	*SD*
Age (years)			15.23	1.95
Clinical Presentation				
Suicide ideation	63	77		
Suicide attempt	19	23		
Previous suicide attempt	46	56		
Clinical Setting at Recruitment				
Pediatric emergency department	70	85		
Outpatient clinic	10	12		
Adult emergency department or inpatient unit	2	2		
Birth Sex				
Female	66	80		
Male	16	20		
Gender				
Cisgender female	54	66		
Cisgender male	14	17		
Transgender male	5	6		
Gender nonconforming/Genderqueer	4	5		
Missing	5	6		
Ethnoracial Group				
Hispanic, Multiracial	52	63		
Hispanic, Black	17	21		
Black, non-Hispanic	11	13		
Multiracial, non-Hispanic	2	2		
Place of Birth				
Mainland US-Born	76	93		
Born outside of mainland US [+]	6	7		
Sexual Orientation				
Heterosexual	33	40		
Bisexual	20	24		
Pansexual	10	12		
Lesbian/Gay	5	6		
Asexual/No sexuality	3	4		
Other/Not sure	6	7		
Missing	5	6		
Annual Household Income				
$0–25,000	32	39		
$25,001–40,000	14	17		
$40,001–70,000	8	10		
$70,001–100,000	7	9		

	n	%	*M*	*SD*
> $100,000	3	4		
Missing	18	22		
Received government assistance				
Yes	55	67		
No	16	20		
Not Reported	11	13		

Note. Percentages are based on *N* = 82 and rounded to one decimal place.

+Includes one adolescent born in Puerto Rico and the 5 adolescents born outside of the US.

Table 2:

Characteristics of SI Disclosure ($N = 82$)

Category	Variable	*n*	%
How disclosed			
	Told someone	73	89
	Youth was asked	9	11
To Whom Disclosed [+]			
	Sibling/friend	30	37
	Parent [++]	25	30
	Therapist, psychologist, etc.	23	28
	Teacher/school counselor	15	18
	Other recipient [++]	12	15
	Romantic Partner	7	9
	Other adult family member	2	2
	No person specified	2	2
To How Many Disclosed			
	1 person	46	56
	2 people	20	24
	3 or more people	11	13
	Missing	5	6
How Disclosed [+]			
	In person	56	68
	Text message or email	20	24
	Phone call/Voicemail	12	15
	Written/Typed note	3	4
	Social Media/Instant Message/Online Chat	3	4
	Not specified/other	2	2
When Disclosed			
	Early morning (woke up-9AM/before school)	10	12
	Mid-morning (9AM/after school started-noon)	18	22
	Afternoon (noon-5PM)	24	29
	Evening (5–8PM)	8	10
	Night (8PM-midnight)	9	11
	Middle of the Night (after midnight)	3	4
	Following Day	2	2
	Missing/Unable to Recall/Not specified	8	10
How Soon Disclosed	Time Between SI and Disclosure		
	Immediate (< 5 minutes)	11	13
	5–30 minutes	20	24
	30–60 minutes	8	10

Category	Variable	*n*	%
	1–2 hours	9	11
	More than 2 hours	20	24
	Missing/Unable to recall	14	17

[+] Participants could select multiple responses; percentages may exceed 100%.

[++] For parent, 20 were mothers and 5 were fathers. The “other” recipients of disclosure included medical doctors, police, and suicide hotlines. Age ranges were only collected for those considered a peer. For sibling/friend, the ages ranged from 9–23 years and for romantic partners the ages ranged from 15–22 years.