


Who are the patients who deny suicidal intent? Exploring patients' characteristics associated with self-disclosure and denial of suicidal intent

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Abstract

Background: Patients' non-disclosure of suicidal ideation and intent concealment represent a major obstacle to the effective assessment of suicide risk and to the delivery of suicide prevention treatments. The present study aimed to investigate this phenomenon and to assess (1) if outpatient psychiatric patients are more or less likely to disclose intent to mental health clinicians in the context of psychiatric/psychological treatment than they are to in the context of research interviews with non-clinicians; and (2) if certain demographic, trait-like, and state-like characteristics may predict such disclosure differences.

Methods: A total of 780 psychiatric outpatient participants aged 18 to 84 and 193 clinician participants aged 25 to 54 were included in the study. The proportion of patients who disclosed to clinicians only, to research assistants (RAs) only, to both, and to none, was compared using a z-test. Univariate analyses were used to compare the participants' variables across disclosure groups, and significant individual predictors were included in multilevel regression analyses.

Results: Participants were more significantly more likely to disclose to RAs (10.4%) than to clinicians (5.6%), $p < 0.001$. Neuroticism and trait anxiety predicted disclosure to RAs vs no disclosure; low extraversion predicted disclosure to clinician versus no disclosure; and extraversion and trait anxiety predicted disclosure to RAs versus to clinicians.

Discussion: Patients' disclosure patterns, the personality variables predicting them, and their clinical implications were discussed in the context of the extant literature on patients' reasons for concealing suicidal ideation and intent.

KEYWORDS

concealment, nondisclosure, suicidal ideation, suicidal intent disclosure

Suicide is one of the 10 leading causes of death in the United States, claiming the lives of 123 people every day and accounting for 48,000 deaths per year.¹ Despite national efforts to improve suicide risk detection and

prevention,^{2–4} deaths by suicide increased by 35% from 1999 to 2018.^{5,6} An important obstacle to effective suicide prevention interventions is the difficulty to identify who is at high risk and when. A recent meta-analysis by Franklin

et al.⁷ indeed demonstrated that the predictive validity of predictors currently used to assess risk for suicide is just slightly better than chance. Clinicians' approach to assess short-term risk often involves reliance on the patients' self-reported ideation (SI), intent, planning, risk factors, and protective factors.^{8,9} Among these, a large weight is assigned to the patients' report of suicidal ideation or lack thereof.¹⁰ As a result, when suicidal thoughts and intent are denied, clinicians will typically judge patients to be at low risk for suicidal behaviors in the near future.¹¹

This practice was recently called into question,¹¹ as accumulating evidence suggests that adults and adolescents fail to report SI and intent prior to engaging in suicidal behavior. For example, a retrospective examination of suicide decedents' medical records indeed showed that two-thirds did not report SI at their last visit with their clinician, which took place up to 30 days before their death by suicide.^{12,13} If some of this phenomenon can be explained by the transient and fluctuating nature of SI and intent^{14,15} it remains that many patients make the conscious choice to conceal their ideation and intent.^{8,16} In a study examining 547 adult psychotherapy patients, Blanchard and Farber⁸ found that 31% of the respondents reported dishonesty on their thoughts of suicide and 10% on their attempts. Comparable or higher rates of SI concealment were found among students,¹⁷⁻¹⁹ adolescents,²⁰⁻²² geriatric patients,²³ patients in community mental health centers,^{24,25} and residents in correctional facilities.²⁶

Suicidal ideation concealment is a major obstacle to the effective delivery of suicide prevention treatments. In the absence of suicidal ideation disclosure, clinicians are likely to underestimate patients' risk for suicidal behaviors and thus to be oblivious to the patients' need for suicide prevention treatment.¹¹ As a result, 70% of those who conceal their ideation do not receive treatment.²⁷ Furthermore, engaging patients in treatment requires collaboration to define the goals and tasks of treatment,²⁸ and thus the patients' readiness to disclose their ideation. Last, individuals who experience suicidal ideation and conceal it were shown to experience higher psychological distress and lower well-being.^{29,30}

The phenomenon of ideation and intent concealment also raises concerns over the extensive use of self-report measure to assess suicidal ideation in research. Although this question was seldom investigated, burgeoning evidence suggests that members of the military are more likely to disclose suicidal ideation to researchers than clinicians.³¹⁻³³

Patients' reasons for concealing SI and intent with mental health-care providers were investigated in a few recent studies. Blanchard and Farber⁸ reported that patients conceal SI out of fear of being hospitalized (70% of respondents), to avoid emotional experiences like

Keypoints

- Patients were found to be more likely to disclose suicidal intents to research assistants, in the context of a research study, than to their clinicians in an outpatient clinic.
- Demographic variables and psychopathology did not predict which patients disclosed suicidal ideation and to whom.
- Patients who self-identified as being more extraverted and having more anxiety (trait) were more likely to disclose suicidal intent to research assistants than to clinicians.

shame and embarrassment, or just because they believe that they are at low risk for acting on their suicidal thoughts. Other studies suggested that fear of rejection and perceived isolation are also important motives for nondisclosure.^{24,34,35}

A handful of studies further explored patient characteristics associated with non-disclosure, yielding inconsistent findings. In a large sample of adult participants randomly selected from the general population in France, Husky et al.³⁶ found that being a male older than 70 years old increased one's chance of concealing SI, and that people tended to disclose to close ones rather than to mental health-care providers. The study also found that having a mental illness was associated with greater chances of disclosure, contrasting with prior findings in a psychological autopsy study of 200 suicide decedents in China.³⁷ A recent study on disclosure among inpatients found that patients with "emotionally unstable personality disorders," affective and cognitive dysregulation (as described in the proposed DSM "Suicide Crisis Syndrome"^{38,39}), and low satisfaction with treatment predicted lower SI disclosure at discharge.⁴⁰ Among adolescents, the current SI and recent suicidal behaviors, together with depression and anxiety severity were found to increase the likelihood of concealment among Israeli adolescents.²⁰ Psychological distress severity was also found to predict non-disclosure, together with age, poor health, frequent SI, and social isolation, in a Dutch sample,²⁹ and together with low well-being, low social support, and high perceptions of social stigma among Australian first responders.⁴¹

These studies examining the association between the patients' characteristics and disclosure primarily focused on specific populations (adolescents²⁰; inpatients⁴⁰; Chinese decedents³⁷; Dutch adults²⁹; Australian first responders⁴¹). Furthermore, most studies assessed the

presence or absence of disclosure through direct inquiry about the patients' past disclosure, such that the participants' self-views, values, and imprecise memories may have impacted their recall. More importantly, none of the studies conducted a comprehensive examination of the patients' demographic, trait-like, and state-like factors that may be associated with SI disclosure and concealment. Advancing the field's knowledge of such factors is important for several reasons. Firstly, it would help clinicians identify patients at high risk of concealing SI and intent. With such patients, clinicians could prioritize the development of a strong therapeutic alliance and address tensions with evidence-based strategies⁴² to foster a sense of mutual trust showed to contribute to the patients' readiness to disclose their SI.⁴³ Furthermore, clinicians could explore the patients' ambivalence about disclosure and demonstrate understanding of the patients' potential reasons for concealment, thus transforming their interaction with their patients into a meaningful therapeutic opportunity. From a more systemic standpoint, including the patients' demographic, trait, and state characteristics associated with concealment in suicide risk assessment algorithms may be instrumental in flagging patients who may be at risk for concealment, thereby augmenting clinicians' clinical decision making with regard to the patients' suicide risk. Last, with the exception of three studies,^{31–33} our field has not yet investigated whether patients are more or less likely to disclose SI to mental health clinicians in the context of psychiatric/psychological treatment than they are to in the context of research interviews with non-clinicians. If such differences exist, they would be worth exploring given that a large portion of the research on suicide risk assessments and prevention relies on data collected by research personnel outside of mental health treatment.

1 | THE PRESENT STUDY

The aim of this study was to advance the field's knowledge in regards to the patients' suicidal ideation and intent disclosure and concealment while addressing some of the limitations of the current literature on the topic. More specifically, our first research question explored the presence of disclosure patterns among patients interviewed about suicide intent by a mental health clinician and a research assistant (RA) within a short period. We were interested to know whether patients were more likely to disclose to mental health clinicians or RAs. In light of the extant literature,^{31–33} we predicted that patients would be more inclined to disclose intent to RAs, in the context of a research study, than to clinicians. Our second research question investigated the existence of patient characteristics associated with different

disclosure status. More specifically, we explored whether patients' demographic, trait-like (i.e. personality traits), and state-like characteristics (i.e., symptomatology type and intensity) differentiated (a) those who disclosed to clinicians versus those who did not disclose at all; (b) those who disclosed to an RA versus those who did not disclose at all; (c) those who disclose to an RA only versus to a clinician only. In light of the absence of literature in this domain, this second research question was exploratory and no hypotheses were formulated.

2 | METHOD

2.1 | Participants and procedures

2.1.1 | Recruitment

The present study was conducted in the context of a trial that investigated the mental processes related to imminent suicide risk. Patient participants were recruited from psychiatric outpatient departments affiliated with Mount Sinai Hospital in New York City between October 2016 and December 2019 regardless of the severity of their self-reported suicidal ideation. Namely, inclusion criteria included: being a psychiatric outpatient between 18 and 65 years old and having the ability to comprehend the informed consent and the study measures. Patients who were not domiciled, did not speak English fluently, or were unable or declined to provide contact information to allow for payment and follow-up assessments were excluded from the study. Self-reported suicidal ideation was not an inclusion criteria, such that patients with very diverse levels of self-reported suicidal ideation participated in the study. Upon their first meeting with patients, treating and intake clinicians in these outpatient departments provided their patients with information about the study and invited those who were interested and met inclusion criteria to participate in the study.

Patients' eligibility was further assessed by a trained research assistant who invited eligible patients to participate in the study and described its procedures. Verbal and written consent to the study procedures was obtained from patients interested to participate in the study. The Icahn School of Medicine at Mount Sinai Institutional Review Board approved this study (IRB#139-08/223-14). For further details about the recruitment process, see Hawes et al.⁴⁴

2.1.2 | Patient participants

Patients included 780 psychiatric outpatients, of which 65% were women. Ages ranged from 18 to 84 ($M = 39.3$;

SD = 14.8). Thirty-seven % of the participants self-identified as White, 22.7% as Black, 6.8% as Asian, 0.8% as American Indian, and 32.7% as other/more than one race. The majority of participants was born in the United States (79%), never married (69.5%) and not employed in a full-time job (76.6%). The most common diagnoses in patients' charts were depressive disorders (50%), followed by bipolar disorders (14.5%). Years of education ranged from 3 to 30 years ($M = 14.3$, $SD = 2.95$).

2.1.3 | Clinician participants

A total of 193 clinicians were included in the study, of which 54.6% self-identified as women. Ages ranged from 24 to 54 ($M = 30.89$; $SD = 4.90$). Most of the clinicians were psychiatrists (85.5% including psychiatry attending and residents), 12.0% were psychologists (including licensed psychologists, psychology interns and psychology fellow), and 2.5% were licensed social workers.

2.1.4 | Assessments and compensation

Research assistants, typically Bachelor or Master students in psychology in their early twenties, met with patients to administer them a battery of self-reported measures up to 2 weeks following the patients' encounter with their intake/treating clinician. In parallel, clinicians were administered a self-report assessment immediately after their first meeting with their patient. Patients received a financial compensation (\$50) for their participation in the study assessment, and their treating clinicians were compensated with \$15 for each patient they referred to the study.

2.2 | Measures

2.2.1 | Suicidal intent

Clinicians assessed patients' suicide risk through a clinical interview based on the Columbia Suicide Severity Rating Scale (C-SSRS).⁴⁵ a structured interview about lifetime and past-month suicidal thoughts and behaviors. Patients' disclosure of suicidal intent to clinicians was then assessed using a single item of the clinician-report Short Clinical Assessment of Risk for Suicide (SCARS), a clinician-rated component of the Modular Assessment of Risk for Imminent Suicide (MARIS).⁴⁴ Namely, the SCARS 5th item asks clinicians to report whether patients disclosed suicidal intent or not (i.e., “[patient]

indicates intent to end own life at some point”), and was rated 1 when patients disclosed intent to the clinician and 0 when they did not.

In parallel, RAs assessed patients' suicidal risk using the C-SSRS. Patients' disclosure of suicidal intent to research assistants (RAs) was using the C-SSRS 5th item (i.e. “Have you had these thoughts and had some intentions of acting on them?”), which was rated 1 when patients disclosed intent to the RA and 0 when they did not.

2.2.2 | Assessment of the participants' demographic characteristics

Participants' demographic characteristics were collected using a demographic questionnaire. In this study, we used only the four most basic demographic characteristics: participants' gender, age, the participants' ethnicity (Hispanic vs. non-Hispanic), and the participants' race (multiple choice question which included six options: American Indian, Asian, Native Hawaiian, Black, Other, and White).

2.2.3 | Assessment of trait variables

Big Five Inventory (BFI). The BFI⁴⁶ is a self-report inventory constructed to measure the Big Five personality dimensions, which includes 44 items ranked on a 5-point scale ranging from 1 (*Disagree strongly*) to 5 (*Agree strongly*), and subdivided in five subscales: Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness. The BFI demonstrated good psychometric properties.^{46,47} In our sample, the subscales achieved good internal consistency (Extraversion: $\alpha = 0.80$, Agreeableness: $\alpha = 0.75$, Conscientiousness: $\alpha = 0.80$, Neuroticism: $\alpha = 0.78$, and Openness: $\alpha = 0.78$). In this study, the participants' average score on each subscale was computed.

Childhood Trauma Questionnaire-Short Form (CTQ-SF). The CTQ-SF⁴⁸ is a 25-item self-report measure assessing five types of childhood maltreatment (physical abuse, physical neglect, emotional abuse, emotional neglect, and sexual abuse). Items were ranked on a 5-point scale, ranging from 1 (*Never true*) to 5 (*Very true*). The CTQ-SF demonstrated good psychometric properties (Bernstein et al., 2003). In our sample, the subscales achieved good internal consistency (physical abuse: $\alpha = 0.88$, physical neglect: $\alpha = 0.72$, emotional abuse: $\alpha = 0.88$, emotional neglect: $\alpha = 0.89$, and sexual abuse: $\alpha = 0.89$). In this study, the participants' average score on each subscale was computed.

The Relationship Scales Questionnaire (RSQ). The RSQ⁴⁹ is a 30-item self-report questionnaire regarding

close relationships. The scale contains four subscales, labeled Secure, Fearful, Preoccupied, and Dismissing ranked on a 5-point Likert scale ranging from 1 (*not at all like me*) to 5 (*very much like me*). The RSQ demonstrated good psychometric properties.^{49,50} The subscales internal reliability as reported in the literature⁵¹ and in our sample was as follows: Secure: $\alpha = 0.50$ (in our sample: $\alpha = 0.32$); Fearful: 0.79 (in our sample: $\alpha = 0.76$); Preoccupied: $\alpha = 0.46$ (in our sample: $\alpha = 0.44$); Dismissing: $\alpha = 0.64$ (in our sample: $\alpha = 0.58$). In this study, participants' average score on each subscale was computed.

The Trait Anxiety subscale of the State-Trait Anxiety Inventory (STAI). The STAI⁵¹ is a widely used measure of state and trait anxiety, which consists of two subscales assessing Trait and State Anxiety, which both demonstrated good psychometric properties.^{52–55} The trait anxiety subscale consists of 20 items ranked on a 4-point Likert scale ranging from 1 (Almost never) to 4 (Almost always), and it demonstrated excellent internal consistency in our sample ($\alpha = 0.92$). In this study we used the participants' average score on the subscale.

2.2.4 | Assessment of state variables

The Beck Depression Inventory (BDI). The BDI⁵⁶ is a self-report measure widely assessing the intensity of depression in psychiatrically diagnosed patients. It contains 21 groups of statements in which patients can choose one or more statements, scored as the highest number they chose (ranging from 0 to 3). The BDI has demonstrated excellent psychometric properties.⁵⁶ In our sample, the BDI demonstrated excellent internal reliability ($\alpha = 0.91$). In this study, the participants' average score on the BDI was used after excluding the 9th group of statements which assess the patients' suicidal ideation and intent.

The Brief Symptom Inventory (BSI). The BSI⁵⁷ is a 53-item self-report measure of psychiatric symptomatology with nine broad psychopathology subscales (somatization, obsessive compulsive, interpersonal problems, depression, anxiety, hostility, phobic anxiety, paranoia, and psychoticism). The BSI demonstrated excellent psychometric properties.⁵⁷ In our sample, the BSI demonstrated excellent internal consistency ($\alpha = 0.97$). In this study, we used the Global Symptom Index (GSI) as a composite measure of current distress after excluding the BSI items reflecting depression symptoms and suicidal ideation.

*The State Anxiety subscale of the State-Trait Anxiety Inventory (STAI).*⁵¹ The state anxiety subscale consists of 20 items ranked on a 4-point Likert scale ranging from 1

(Not at all) to 4 (Very much so), and it demonstrated excellent internal consistency in our sample ($\alpha = 0.93$). In this study we used the participants' average score on the subscale.

2.3 | Statistical analysis

Out of 780 patients who were included in the study, data completeness ranged from 96% to 99%, depending on the scale. With a small percentage of data points missing in a random pattern from a large data set, missing data are not a major concern,⁵⁸ and missing data were thus handled with listwise deletions in all analyses.

A z-test was employed to compare the proportion of patients in the four disclosure groups (i.e., “disclosure to RA”, “disclosure to clinician”, “disclosure to both”, and “disclosure to none”). Univariate analyses were used to determine the relationships between each explanatory variable (demographic, trait-like characteristics, and state-like characteristics) and the dependent variable (disclosure group membership). Namely, one-way ANOVAs were used to compare the participants' scores on continuous variables across the disclosure groups, and chi-square tests were used for categorical variables. Post-hoc pairwise comparisons were conducted among the disclosure groups using Tukey adjustment method for multiple testing for the continuous variables and Benjamini and Hochberg method for the categorical variables.⁵⁹

The small group of 16 patients who disclosed to the RA and the clinician (“disclosure to both”) was included in the univariate analysis, for descriptive purposes, but was excluded from the multivariate analyses because it was too small to allow any group comparisons. Thus, multivariate analyses focused on the three other disclosure groups only (“disclosure to RA”, “disclosure to clinician,” and “disclosure to none”).

Two multivariate prediction models were run: The first one is a multinomial logistic regression that was applied to the data to build a prediction model for disclosure group membership. The second model is a logistic regression that was applied only to participants who disclosed suicidal intent ($N = 125$) to characterize the participants who chose to disclose intent to RA versus to Clinician. All the models were built using stepwise regression with a 5% significance level of the score chi-square for entering an effect into the model, and the 5% significance level of the Wald chi-square for an effect to remain in the model. All explanatory variables were candidate predictors in each one of the models. Only significant individual predictors were included in the multivariate analyses. Statistical analyses were performed using the SAS for Windows version 9.4.

TABLE 1 Patients' sociodemographic, trait, state, and disclosure characteristics

Variable	<i>n</i> (%) or mean [SD], as appropriate
Sociodemographic variables	
Age	39.3 [14.8]
Gender (Female)	486 (65)
Ethnicity (Hispanic or Latino)	281 (37)
Race	
American Indian	6 (0.8)
Asian	53 (6.8)
Black	177 (22.7)
White	289 (37)
Other	234 (32.7)
Years of education	14.3 [2.95]
Substance abuse	269 (34.5)
Domiciled	456 (97.1)
Full-time employment	175 (22.4)
Diagnosis	
Depressive disorder	390 (50.0)
Anxiety disorders	69 (8.8)
Bipolar disorder	113 (14.5)
Psychosis/schizophrenia spectrum disorder	57 (7.3)
Trauma and stress-related disorders	102 (13.1)
Other	49 (6.1)
Trait variables	
Childhood trauma	2.2 (0.9)
Secure attachment	2.8 (0.7)
Fearful attachment	3.3 (1.0)
Preoccupied attachment	3.0 (0.8)
Dismissive attachment	3.4 (0.8)
Extraversion	3.0 (0.8)
Agreeableness	3.7 (0.7)
Conscientiousness	3.3 (0.8)
Openness	3.7 (0.7)
Trait anxiety	2.7 (0.6)
State variables	
Depression	1.0 (0.6)
Anxiety	2.3 (0.6)
Psychological distress	2.4 (0.9)
Disclosure status	
Disclosure to none	639 (81.9%)
Disclosure to RA only	81 (10.4%)

TABLE 1 (Continued)

Variable	<i>n</i> (%) or mean [SD], as appropriate
Disclosure to clinician only	44 (5.6%)
Disclosure to both	16 (2.1%)

3 | RESULTS

3.1 | Disclosure status

Table 1 presents the number and proportion of participants who reported intent to clinician, the RA, both, or neither. Overall, 81.9% of the participants denied intent to their clinician and RA, 10.4% reported intent to the RA only, and 5.6% reported intent to the clinician only, 2.1% reported intent to both.

3.2 | Univariate analyses

The proportion of patients in the “disclosure to RA” group (10.4%) was significantly larger than that in the “disclosure to clinician” group (5.6%), $p < 0.001$. Table 2 presents a comparison of the participants' sociodemographic, trait, and state variables across the four disclosure groups. Among the sociodemographic variables compared, age was the only one that significantly differed across groups, such that patients who disclosed intent to RAs only were younger than those who did not disclose at all ($M = 35.6$ vs. $M = 40$, $p = 0.008$).

Among the attachment styles compared, significant differences in patients' secure, fearful, and preoccupied attachment styles were found between the disclosure groups, such that patients in the “Disclosure to none” group had higher scores on the secure attachment scale compared to patients in the other three disclosure groups ($M(\text{ra} + \text{clinician}) = 2.60$, $M(\text{both}) = 2.24$ vs. $M(\text{none}) = 2.89$, $p < 0.001$); patients in the “Disclosure to RA” had higher scores on the preoccupied attachment scale compared to those in the “Disclosure to none” group ($M(\text{ra}) = 3.29$ vs. $M(\text{none}) = 3.01$, $p = 0.012$); and patients in the “Disclosure to RA” group had higher scores on the fearful attachment scale compared to those in the “Disclosure to none” group ($M(\text{ra}) = 3.83$ vs. $M(\text{none}) = 3.23$, $p < 0.001$).

With regard to the BFI dimensions, the groups differed in the patients' extraversion, conscientiousness and neuroticism, such that patients in the “disclosure to clinician” and “disclosure to both” groups had lower extraversion scores than those in the “disclosure to none” group ($M(\text{clinician}) = 2.51$, $M(\text{both}) = 2.45$ vs. $M(\text{none}) = 3.04$, $p < 0.001$);

TABLE 2 Univariate comparison of the patients' characteristics across the three groups of disclosure

Variables	Group a: Disclosure to clinician only, N = 44	Group b: Disclosure to RA only, N = 81	Group c: Disclosure to none, N = 639	Group d: Disclosure to both N = 16	Overall significance	Significant pairwise comparisons
<i>Sociodemographic variables</i>						
Age	36.1 (15.3)	35.3 (12.4)	40.0 (15.0)	32.4 (14.0)	0.005	c > b
<i>Gender</i>					0.92	
Male	17 (39.5%)	27 (35.1%)	219 (34.8%)	5 (31.2%)		
Female	26 (60.5%)	50 (64.9%)	410 (65.2%)	11 (68.8%)		
<i>Ethnicity</i>					0.876	
Hispanic	18 (41.9%)	30 (37.0%)	233 (36.7%)	5 (31.2%)		
<i>Race</i>						
American Indian, Asian, & Native Hawaiian	4 (9.09%)	1 (1.28%)	57 (9.03%)	3 (18.8%)		
Black	10 (22.7%)	20 (25.6%)	147 (23.3%)	4 (25.0%)		
White	15 (34.1%)	37 (47.4%)	237 (37.6%)	6 (37.5%)		
Other	15 (34.1%)	20 (25.6%)	190 (30.1%)	3 (18.8%)		
<i>Trait variables</i>						
Child trauma	2.26 (0.90)	2.40 (0.81)	2.18 (0.85)	2.05 (0.63)	0.134	
Secure attachment	2.60 (0.68)	2.60 (0.57)	2.89 (0.70)	2.24 (0.79)	<0.001	c > a,b,d
Fearful attachment	3.52 (0.96)	3.83 (0.86)	3.23 (1.04)	3.48 (0.99)	<0.001	b > c
Preoccupied attachment	2.95 (0.81)	3.29 (0.88)	3.01 (0.81)	3.20 (0.92)	0.025	b > c
Dismissive attachment	3.57 (0.87)	3.57 (0.73)	3.37 (0.78)	3.63 (0.46)	0.042	
Extraversion	2.51 (0.87)	2.89 (0.83)	3.04 (0.83)	2.45 (0.83)	<0.001	c > a,d
Agreeableness	3.70 (0.73)	3.58 (0.76)	3.68 (0.69)	3.36 (0.84)	0.215	
Conscientiousness	3.29 (0.86)	3.14 (0.68)	3.36 (0.77)	2.84 (0.76)	0.007	c > d
Neuroticism	3.63 (0.72)	4.17 (0.93)	3.53 (0.86)	4.04 (0.59)	<0.001	b > a,c
Openness	3.50 (0.57)	3.77 (0.80)	3.76 (0.68)	3.45 (1.06)	0.039	
Trait anxiety	2.72 (0.69)	3.13 (0.44)	2.65 (0.60)	2.89 (0.42)	<0.001	b > a,c
<i>State variables</i>						
Depression	1.01 (0.63)	1.37 (0.54)	0.96 (0.58)	1.35 (0.54)	<0.001	b > a,c; d > c
Psychological distress	2.60 (1.01)	2.89 (0.82)	2.35 (0.84)	2.85 (0.76)	<0.001	b > c
Anxiety	2.27 (0.65)	2.59 (0.62)	2.24 (0.64)	2.43 (0.60)	<0.001	b > a,c

Note: N = 780. Continuous variables are reported with mean and standard deviation, categorical variables are reported with frequency and percent.

patients in the “disclosure to both” group had lower extraversion scores than those in the “disclosure to none” group (M(both) = 2.84 vs. M(none) = 3.36, $p < 0.001$); and patients in the “disclosure to RA” group had higher neuroticism scores than those in the “disclosure to clinician” group (M(ra) = 4.17 vs. M(clinician) = 3.63, $p < 0.00$). With regard to trait anxiety, patients in the “disclosure to RA” had higher trait anxiety scores than those in the “disclosure to clinicians” group (M(ra) = 3.13 vs. M(clinician) = 2.72, $p < 0.001$).

Among the state variables compared, significant differences in depression, state anxiety and psychological

distress levels were found across groups. Specifically, patients in the “disclosure to RA” group had higher levels of depression (M(ra) = 1.37 vs. M(clinician) = 1.01 and M(none) = 0.96, $p < 0.001$) and state anxiety (M = 2.59 (ra) vs. M(clinician) = 2.27 and M(none) = 2.24, $p < 0.001$) than those in the “disclosure to clinician” and “disclosure to none groups”; patients in the disclosure to both” group also had higher depression levels than those in the “disclosure to none” group (M(both) = 1.35 vs. M(none) = 0.96, $p < 0.001$); last, patients in the “disclosure to RA” group had higher levels of psychological distress than those in

TABLE 3 Multinomial regression results of stepwise selection method: Prediction of group membership

Variable (disclosure to none as a reference)	Odds ratio	95% confidence interval		P value
<i>Disclosure to clinician</i>				
Extraversion	0.43	0.27	0.67	<0.001
Neuroticism	0.98	0.56	1.73	0.947
Trait anxiety	0.78	0.34	1.75	0.541
<i>Disclosure to RA</i>				
Extraversion	1.12	0.83	1.51	0.475
Neuroticism	1.67	1.13	2.47	0.010
Trait anxiety	3.32	1.78	6.19	<0.001

Note: $N = 764$.

Variable	Odds ratio	95% confidence interval		p-value
Extraversion	2.04	1.17	3.53	0.011
Trait anxiety	5.00	2.12	11.77	<0.001

Note: $N = 125$.

TABLE 4 Logistic regression results of stepwise selection method: prediction of disclosure to RA versus to Clinician

the “disclosure to none” group ($M(\text{ra}) = 2.89$ vs. $M(\text{none}) = 2.35$, $p < 0.001$).

3.3 | Multivariate analysis

3.3.1 | Results of Model 1

Predictors of group membership as a result of the stepwise multinomial regression are presented in Table 3. The multinomial regression model was statistically significant, ($\chi^2[8] = 70.05$, $p < 0.001$). The model explained 15.0% (Nagelkerke R^2) of the variance. Participants with higher neuroticism and trait anxiety scores were more likely to disclose to RAs than to not disclose at all [Mean neuroticism: OR = 1.67, 95% CI (1.13, 2.47), and $p = 0.010$, Mean trait anxiety: OR = 3.32, 95% CI (1.78, 6.19), and $p < 0.001$]. Participants with lower extraversion scores values were more likely to disclose to clinicians than not to disclose at all [OR = 0.43, 95% CI (0.27, 0.65), and $p < 0.001$].

3.3.2 | Results of Model 2

Presented in Table 4, the logistic regression model was statistically significant, $\chi^2(2) = 20.55$, $p < 0.001$. The model explained 23.9% (Nagelkerke R^2) of the variance. Participants with higher extraversion and trait anxiety were more likely to disclose to RAs than to clinicians [Mean extraversion: OR = 2.04, 95% CI (1.17, 3.53), and $p = 0.011$; Mean trait anxiety: OR = 5.00, 95% CI (2.12, 11.77), and $p < 0.001$].

4 | DISCUSSION

The purpose of the present study was to advance the field's knowledge about suicidal intent disclosure by (1) examining disclosure patterns among patients who were separately interviewed by clinicians and RAs; and (2) investigating patient characteristics that may be predictive of differential disclosure to clinicians versus RAs. First, results indicated that a significantly larger proportion of patients disclosed suicidal intent to RAs (10.4%) than to clinicians (5.6%). This finding is consistent with three studies examining disclosure of suicidal ideation in the military,^{31–33} which found that service members were more likely to report current suicidal thoughts on a confidential (i.e., for research purposes only) suicidal ideation measure than on a suicidal ideation measure explicitly integrated into the study's risk protocol (i.e., it had the potential to trigger a referral to onsite military mental health personnel). This finding also aligns with the literature on nondisclosure that suggests that patients may choose not to disclose suicidal ideation to clinicians due to fears of loss of autonomy/involuntary hospitalization⁸ and/or feelings of shame, embarrassment, and fear of judgment.^{16,60} While RAs informed patients, at the beginning of the assessment, that they would inform clinicians if patients were found to be at high risk for imminent suicidal behavior, it is plausible that patients experienced RAs as far removed from the treatment team, and thus felt less threatened to disclose intent to them. Lastly, it is important to note that RAs and clinicians may have developed very different relationships with the patients. RAs were typically younger than clinicians, they cherished the opportunity that the study provided to interact with patients, and did not experience any time pressure, nor the responsibility for the patients' lives and outcomes. As a

result, it is very possible that RAs displayed more empathy than clinicians, and that patients felt more comfortable disclosing intent to them as a result. Future studies will need to further investigate the type of relationship RAs and clinicians develop with patients, and the impact of such differences on the patients' trust and disclosure. Of note, it is not possible to rule out that the differential disclosure rates may also have been impacted by the chronology of the assessments: patients met with RAs up to 2 weeks after meeting with clinicians, and may thus have felt more comfortable sharing suicidal intent during their second encounter than during their first.

Second, none of the state variables assessed differentiated between patients in the different disclosure groups. This finding may suggest that patients' decision to disclose intent did not stem from their actual experienced distress and suicidal intent, and rather from their decision to disclose or conceal intent. However, results indicated that several patient characteristics—especially personality traits—predicted their patterns of suicidal intent disclosure.

In Model 1, patients who disclosed suicidal intent to RAs reported higher levels of neuroticism and trait anxiety than those who did not disclose suicidal intent at all. One possibility is that individuals with higher levels of neuroticism and trait anxiety may have been experiencing more suicidal ideation and intent, and thus, disclosed it to RAs at greater rates. Interestingly, neuroticism and trait anxiety did not differentiate patients who disclosed to clinicians from those who did not disclose suicidal intent at all, suggesting that disclosure patterns did not necessarily stem only from actual levels of suicidal intent. If such had been the case, trait anxiety and neuroticism would also have differentiated patients who disclosed to clinicians from those who did not disclose at all. Alternatively, it is possible that the detail-oriented nature of the RA interview, which used a multitude of empirically-validated self-report measures and structured interviews, pulled for more disclosure among patients with higher levels of neuroticism and trait anxiety.

Interestingly, extraversion was the only trait that differentiated patients who disclosed to clinicians from those who did not disclose suicidal intent at all; specifically, patients who disclosed suicidal intent to clinicians were less extraverted than those who did not disclose suicidal intent at all. Although counterintuitive, this finding may need to be interpreted in relation to the interpersonal dynamics that develop between patients and clinicians. Namely, when clinicians meet with introverted and thus more guarded patients, they may put forth greater effort to help patients develop a sense of safety and to address the patients' ambivalence about disclosure, resulting in more readiness to disclose. RAs may not have had such training in clinical and interpersonal intricacies. In contrast, when clinicians meet with

extraverted patients, they may unwittingly or even unconsciously assume that such patients will be forthcoming about their SI, take the patients' answers at face value and conduct less thorough inquiries. This may be particularly true in the present study in which most clinicians were trainees, and thus had less experience than seasoned clinicians in the assessment of suicide risk. In contrast, RAs followed a set interview routine that was identical for all the patients, such that the thoroughness of their interview was not impacted by their clinical judgment or their relationship with the patient.

When comparing patients who disclosed suicidal intent to RAs only to those who disclosed suicidal intent to clinicians only, the only factors that predicted disclosure patterns were trait anxiety and extraversion. Namely, patients who disclosed to RAs versus clinicians had higher levels of extraversion and trait anxiety. As mentioned previously, patients with more anxiety may have been more concerned with being judged, feeling ashamed or embarrassed, and losing their autonomy (i.e., being forcefully hospitalized), and thus may have felt more comfortable sharing their suicidal intent with RAs who did not have any impact on clinical decision-making. Moreover, with regard to the patients' extraversion, the combination of extraversion and features of the assessment and interviewers discussed above may have predicted disclosure in tandem. Clinicians may not have encouraged or facilitated disclosure of suicidal intent, whereas RAs conducted comprehensive, structured interviews and were not directly involved in the patients' treatment, thereby facilitating disclosure of suicidal intent.

These findings have several important clinical implications in the context of suicide risk assessment. First and foremost, clinicians need to be aware that patients make conscious decisions to conceal their suicide intent, and that these decisions cannot be explained solely by the transient nature of suicidal intent. Secondly, clinicians need to be aware that certain personality traits are associated with increased chances of intent disclosure. Namely, patients with high trait anxiety and/or extraversion may be less likely to disclose intent. With patients who have elevated trait anxiety, and who may thus be more concerned about the implications of intent disclosure, clinicians should put forth great effort to foster a strong alliance, engage in inviting conversations about the patients' concerns, and explore safety planning strategies that do not impede the patients' autonomy.⁶¹ With extraverted patients, clinicians need to be aware of their possible inclination to underestimate the patients' ambivalence about intent disclosure, and make sure that they encourage honest conversations on the topic. To this end, clinicians may need to stay updated about the recent

literature on the application of alliance-enhancing techniques to suicide risk assessments and safety planning.⁶² Finally, our findings also carry implications for research, where individual's self-reported suicidal ideation and behaviors are most often assessed by RAs and not by treating clinicians, and may thus be more accurately reported, and thus more predictive of risk than ideation and behaviors reported to clinicians.

4.1 | Strengths, Limitations and Future Directions

This study's main strengths include its large sample size of adult outpatients with diverse demographic and clinical characteristics, which ensures better generalizability of its findings, as well as its innovative approach to investigate the phenomenon of disclosure. In contrast to the majority of studies on the topic, which assessed concealment using patients' retrospective report^{8,16} or the patients' responses to two sets of questions on one occasion,³² this study compared the patients' disclosure to clinicians and RAs within two distinct assessments. The resulting disclosure patterns (patients were significantly more likely to disclose to RAs than to clinicians) and their associated patient characteristics allowed us to conjecture that intent denial likely stemmed from concealment and not only transient intent. Lastly, but not least, this study is the first to assess the association of a comprehensive set of patient demographic, trait and state variables to intent disclosure and concealment.

However, the study does not come without limitations. First, a period of up to 2 weeks passed between the assessment of suicidal intent by clinicians and RAs. It is thus possible that discrepancies in disclosing intent to clinicians versus RAs may be attributable, at least in part, to the patients' changes across this period. While the documented transient nature of suicidal ideation¹⁴ would suggest such may have been the case, recent literature suggests that suicidal intent is less variable across time,⁶³ bolstering our confidence that the differential disclosure patterns observed are not due to the time elapsed between the assessments. Second, the specific measures used to assess disclosure of intent to RAs (item 4 on the C-SSRS) and clinicians (i.e., clinician report on the SCARS module of the MARIS that patients endorsed suicidal intent) differed, potentially contributing to the discrepancies between disclosure to RAs and clinicians. However, it is important to note that the clinicians' report on the SCARS immediately followed clinicians' assessment of their patient suicidal risk using the C-SSRS structure and questions.

Thirdly, the internal reliability of the secure and pre-occupied attachment subscales was low in our sample, possibly impacting our findings. Fourthly, the present study was developed ad-hoc with available archival data. Future studies should include additional state measures assessing a wider range of symptoms. Finally, most of the clinicians.

were trainees with limited experience in suicide risk assessment. Future research should examine whether similar patterns occur among clinicians and researchers with more substantial assessment experience.

Notwithstanding these limitations, the present study added to the existing literature by highlighting several patient characteristics that may be associated with preferential disclosure of suicidal intent to clinicians versus RAs. Given the potential implication of these findings in the identification of patients who may be inclined to conceal ideation from their clinicians, and thus, for suicide prevention, the future research efforts should aim at replication and extension of these findings in diverse samples with concurrent timeframes and standardized assessment.

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CONFLICT OF INTEREST

There are no conflicts of interest.

PEER REVIEW

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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