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What Factors Determine Disclosure of Suicide Ideation in Adults 60 and Older to a Treatment Provider?

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Correlates of patient disclosure of suicide ideation to a primary care or mental health provider were identified. Secondary analyses of IMPACT trial data were conducted. Of the 107 patients 60 years of age or older who endorsed thoughts of ending their life at least “a little bit” during the past month, 53 indicated they had disclosed these thoughts to a mental health or primary care provider during this period. Multiple logistic regression was used to identify predictors of disclosure to a provider. Significant predictors included poorer quality of life and prior mental health specialty treatment. Among participants endorsing thoughts of suicide, the likelihood of disclosing these thoughts to a provider was 2.96 times higher if they had a prior history of mental health specialty treatment and 1.56 times higher for every one-unit decrease in quality of life. Variation in disclosure of thoughts of suicide to a mental health or primary care provider depends, in part, on patient characteristics. Although the provision of evidence-based suicide risk assessment and guidelines could minimize unwanted variation and enhance disclosure, efforts to routinize the process of suicide risk assessment should also consider effective ways to lessen potential unintended consequences.

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Approximately 75% of adults who die by suicide had seen a primary care physician and approximately 33% had seen a mental health provider in the year prior to death by suicide (Luoma, Martin, & Pearson, 2002). This suggests a need for primary care and mental health providers to be vigilant in recognizing suicide risk and to be aware of factors that may contribute to nondisclosure of suicide ideation among their patients (Heisel, Duberstein, Lyness, & Feldman, 2010). Paradoxically, older adults are less likely to report thoughts of suicide than younger adults, even though they are more likely to die by suicide (Duberstein et al., 1999; Heisel et al., 2006). Consequences of underreported thoughts of suicide are undetected suicide

risk, missed opportunities for intervention and treatment, and an increased number of deaths by suicide.

Research on this topic is challenging given the need to estimate how frequently an individual fails to disclose suicide ideation to a clinician when actually experiencing these thoughts. No study has directly examined this topic, but it has been addressed indirectly. Forsell, Jorm, and Winblad (1997) compared patient reports of suicidal thoughts during a physician interview to a nurse interview with an informant. This study found that suicidal thoughts were reported 20.9% more often when the interview was conducted by a physician. McAvay, Raue, Brown, and Bruce (2005) compared patient and informant (family member, close friend) reports of suicide ideation on a structured interview of depressive symptoms and found agreement in 90% of cases. In cases of disagreement, patients were more likely to report suicide ideation than the informant. More recently, Heisel, Conwell, Pisani, and Duberstein (2011) assessed patient-proxy agreement in reports of patient suicide ideation. Findings suggested that proxy reports of suicide ideation for patients reporting suicide ideation were associated with greater depressive symptom severity. Among patients who reported suicide ideation, but whose proxy did not report that they appeared to be suicidal, depressive symptom severity was lower. Vannoy and Robins (2011) looked at primary care patients scoring greater than 14 on the Patient Healthcare Questionnaire (PHQ-9) and found that only 7% of the patients who endorsed ideation on the PHQ-9 disclosed these thoughts to their physician without being asked, and all of these patients were female.

To the best of our knowledge, no study has identified variables that are associated with depressed older adults' verbal disclosure of suicide ideation to a primary care or mental health provider. In this study we examined this issue in older adults newly enrolled in a depression treatment trial.

METHOD

Participants

Participants in this study were part of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) trial comparing a collaborative care management program for late life depression to usual care. A complete description of the IMPACT trial methods has been reported elsewhere (Unützer et al., 2001, 2002).

Participants in IMPACT were identified through referrals of depressed older adults from primary care clinics or by screening using a 2-item depression screener (Kroenke, Spitzer, & Williams, 2003) in the context of a primary care visit. Participants completed an eligibility interview within 4 weeks of screening or referral. Inclusion criteria for the study included: aged 60 and older; met criteria for current major depression, dysthymia, or both on the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (SCID; Spitzer, Williams, Gibbon, & First, 1990); and planned to use one of the eight primary care clinics participating in the IMPACT study over the following year. Participants were excluded based on the following: current alcohol abuse, severe cognitive dysfunction, a history of bipolar disorder or psychosis, and acute risk of suicide. As suicide ideation is a variable of interest in this study, it is important to note that less than 1% of potential subjects were excluded due to acute risk for suicide.

Materials and Procedure

Participants who were eligible for the study were scheduled for a baseline interview within 4 weeks of the eligibility interview. At the baseline interview, participants were asked to sign a written informed consent and engage in a 60-minute baseline interview. Following the baseline interview, 1,801 participants were randomly assigned to the IMPACT intervention or to usual

care. We used the baseline data for the present study. Included participants were those whose answer ranged from 1 (*a little bit*) to 4 (*extremely*) to a question assessing how much the participant was distressed by thoughts of ending his or her life over the past month ($n = 107$). Participants endorsing 0 (*not at all*) were not included in analyses ($n = 1,694$). Baseline interviews were conducted by trained interviewers and included demographic characteristics (age, gender, race, education, marital status), self-reports of previous therapy, chronic diseases, quality of life during the past month, the Sheehan Disability Scale, and items from the NEO-Personality Inventory-Revised (NEO-PI-R; Costa & McCrae, 1992).

Suicide Ideation. To assess suicide ideation, the IMPACT study utilized an item from the Hopkins Symptoms Checklist (HSCL-20; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974; "In the past month, how much were you distressed by thoughts of ending your life?"). Response options were, *Not at all* (0), *A little bit* (1), *Moderately* (2), *Quite a bit* (3), or *Extremely* (4). Consistent with standard practice in suicidology, suicide ideation was considered present if the participant endorsed any non-zero response to this item. They were then asked whether (yes/no) they had discussed those feelings and thoughts with a mental health or primary care provider.

Other Variables. Mental health specialty treatment was assessed by asking participants if they had ever participated in mental health therapy, including outpatient care offered by physicians, psychologists, and other counselors. Participants also indicated whether they had been treated for any of 11 chronic diseases (e.g., lung diseases, hypertension, diabetes, heart disease). The variable representing chronic health conditions was a sum of the number of conditions the participant endorsed. Trait neuroticism was measured using seven items from the NEO-PI-R Neuroticism scale (Costa & McCrae, 1992) rated on a 5-point Likert-type scale. Quality of life was

assessed by asking participants to indicate on a 0–10 scale (0 = *situation as bad as death*, 10 = *situation perfect*) their quality of life during the past month. Finally, participants rated the three items from the Sheehan Disability Scale (Sheehan, 1983), a scale representing impairment caused by symptoms in work/school, social life and home life, or family responsibilities.

Data Analysis

A forward selection procedure was used to derive the final model. Variables included were age, gender, race (White, Black, Asian, Indian, Hispanic, Other), education (less than high school, high school graduate, some college, college graduate), marital status (married, not married, widow), any specialty mental health treatment, NEO Neuroticism, Sheehan Disability Scale score, quality of life, and a sum of chronic diseases.

RESULTS

The mean age of participants included in the sample of 107 was 70.75 ($SD = 7.72$), and 64% were women. Approximately 26% were from ethnic minority groups. Thirty-eight percent of participants reported either some high school education or high school diploma, and the remaining 62% endorsed some college or college graduation. Forty-two percent of participants were married, 29% were not married, and 29% were widowed. Forty-eight percent had received mental health specialty treatment during their lifetime.

Predictors of Disclosure of Suicide Ideation to Provider

Six percent ($n = 107$) of the 1,801 IMPACT participants reported being distressed by thoughts of suicide at baseline. Descriptive statistics for potential predictors are presented in Table 1. Results of

TABLE 1
Descriptive Statistics

Variable	Mean	SD	Range
NEO neuroticism	25.78	5.13	12–35
Chronic diseases	4.10	2.07	0–9
Overall quality of life	4.36	1.97	0–8
Sheehan disability	5.92	2.57	0–10

the forward stepwise logistic regression are presented in Table 2. Among these participants, the logistic regression indicated that history of mental health specialty treatment (OR = 2.956, 95% CI = 1.263, 6.921, $p = .013$) and past-month quality of life (OR = 1.564, 95% CI = 1.220, 2.006, $p < .000$) were significant predictors of disclosure of suicide ideation to a provider. No other variables were significant ($p > .05$).

TABLE 2
Predictors of Disclosure of Suicide Ideation

	OR	95% confidence limits		<i>df</i>	Wald	<i>p</i>
Block 0						
Intercept	1.019			1	0.009	.923
Block 1						
Intercept	0.082			1	13.824	.000
Lifetime therapy	2.956	1.263	6.921	1	6.235	.013
Quality of life	1.564	1.220	2.006	1	12.424	.000
		Score	<i>df</i>	<i>p</i>		
Block 1 Not in Equation						
Age		0.060	1	.806		
Gender–male		0.172	1	.678		
Race		2.931	5	.711		
White		0.780	1	.377		
Black		0.664	1	.415		
Asian		0.400	1	.527		
Indian		0.133	1	.715		
Hispanic		1.346	1	.246		
Education		1.065	3	.785		
Less than high school		0.209	1	.785		
High school graduate		0.705	1	.401		
Some college		0.035	1	.851		
Marital status		1.169	2	.560		
Married		0.456	1	.499		
Not married		1.151	1	.283		
Sheehan disability		1.124	1	.289		
Sum of chronic diseases		0.017	1	.895		

The likelihood that a participant disclosed suicide ideation to a provider was 2.956 times higher for participants with a history of mental health specialty treatment during their lifetime compared to those who had not received mental health services. The likelihood that a participant disclosed suicide ideation was 1.564 times higher for every one-unit decrease in quality of life over the past month. Disclosure was not associated with demographics, neuroticism, disability, or chronic disease.

DISCUSSION

Approximately 6% of a sample of over 1,800 depressed older adults reported being distressed by suicide ideation in the

past month. Among those, approximately half indicated that they had discussed the thoughts with a primary care or mental health provider. While it is impossible to know how many of these older adults failed to disclose this information when directly queried by a clinician, it is clear that many older adults choose to refrain from disclosing thoughts of suicide. These findings are worrisome but not surprising, as prior research has documented that older adults, despite their elevated suicide risk, are less likely to seek care for mental health (Bogner, de Vries, Maulik, & Unützer, 2009; Garrido, Kane, Kaas, & Kane, 2011) and suicide ideation (Corna, Cairney, & Streiner, 2010).

Among those who did report having discussed the thoughts with a provider, a history of prior mental health specialty treatment was one of the two significant predictors. Prior participation in mental health treatment may mitigate the uncertainty older adults have about the likely outcomes of disclosing suicide ideation, perhaps because it influences an individual's perception of the medical or mental health community. Specifically, patients may have disclosed deeply personal or stigmatizing information to providers and experienced no negative outcomes as a result (e.g., unwanted hospitalization or treatment, intrusive questions). Previous specialty mental health treatment may also lead to perceptions that providers are invested in decreasing distress and determining referral plans that will benefit the patient as much as possible. Further, negative beliefs related to the stigma of psychological disorder and treatment may have been addressed in previous treatment. Individuals who have not participated in mental health specialty treatment may believe that any acknowledgment of thoughts of suicide will result in an undesirable outcome, such as overreaction by provider (e.g., hospitalization, other unwanted treatment), intrusive questions, and disclosure of their private information to others. Finally, older adults who have participated

in treatment during their lifetime may be more likely to view it as beneficial and believe that disclosing thoughts of suicide will lead to subsequent benefit. Another possibility is that older adults who are more open to receiving mental health specialty treatment may be more open to disclosing suicide ideation.

Poorer quality of life (i.e., rating their quality of life during the past month closer to "as bad as death" than "situation perfect") also increased the likelihood of disclosure. Perhaps depressed older adults disclose their thoughts of suicide to providers when the distress associated with suicidal thoughts is greater than the distress associated with uncertainty about the outcomes of disclosing these thoughts. Alternatively, providers may ask more direct questions about thoughts of suicide when providers perceive that patient quality of life has decreased.

Patients' decisions to disclose thoughts of suicide (or any historically marginalized topic) to a clinician are inherently characterized by outcome uncertainty (Epstein & Gramling, 2013) due in part to stigma. One can never be sure exactly how a health care system or health care provider will respond. Interventions both at the macrolevel and point of care (microlevel) could enhance efficiency by increasing the likelihood of appropriate disclosure of thoughts of suicide and an appropriate provider response to disclosures. At the macrolevel, the lack of reliability among health services systems in provider responses or behavior to reports of suicide ideation may inhibit disclosure. Between systems, there are significant disparities in provider behavior in large part because not all systems are equipped or trained in how to handle positive responses. Developments in information systems could be used to create a standardized, empirically based approach to screening and referral (e.g., Joiner, Walker, Rudd, & Jobes, 1999) as well. In addition, question prompt lists could be used to encourage patients to disclose thoughts of suicide and suggestions

for how to ask questions and seek assistance from their provider (Shepherd et al., 2011). At the point of care, providers should work to dispel any concerns the patient may have about referral to inpatient services or other negative outcomes associated with acknowledging suicide ideation prior to asking these questions. Educating patients about mental health and the likely outcomes of assessment responses that indicate suicide risk will decrease uncertainty. As part of routine assessment of suicide risk, providers should discuss the actions they are likely to take in response to acknowledgment of suicide risk, including the most frequent outcome of continued monitoring and the creation of safety plans.

An advantage to standardizing the assessment and referral process is that it could increase provider confidence in handling suicide while also increasing patient exposure to these questions. Patients may become more comfortable answering questions about thoughts of suicide if these questions are asked routinely. Statements that normalize thoughts of suicide in the context of difficult life circumstances may also decrease stigma and increase honest responding. Potential disadvantages to the use of screens include false positives. For some patients, the doctor's "rush to referral" may lead to greater reluctance to disclose thoughts of suicide in the future. Given the severe time constraints in the primary care setting, the standardized assessment of suicide risk may crowd out an assessment of concerns patients believe are more important or relevant. The routine assessment of suicide and other marginalized topics (e.g., domestic violence) could be tailored to patients' priorities and goals for treatment (Fried, McGraw, Agostini, & Tinetti, 2008). The use of question prompt lists could also be considered (Shepherd et al., 2011).

The results of this study indicate that providers should be attuned to the possibility of suicide ideation in depressed older adults. Providers should be attuned to signs

of low quality of life, regardless of factors that may contribute to that low quality of life (e.g., depressive symptoms).

Several limitations should be considered in interpreting these findings. It is unknown whether participants disclosed their thoughts of suicide to a primary care or mental health provider. Data are unavailable on whether participants intentionally concealed their thoughts of suicide in response to direct provider inquiries or whether they spontaneously disclosed these thoughts absent an inquiry. As a cross-sectional study, causal inferences cannot be drawn. Participants with prior histories of specialty treatment may have differed systematically from those without such histories in ways that may be related to the tendency to disclose thoughts of suicide to a provider. Finally, it is possible that confounding variables such as severity of depressive symptoms or intensity of suicide ideation may have influenced both disclosure and history of specialty mental health treatment. Prospective research is needed to enable causal inferences and mixed methods research could also yield insights into the nature of disclosures and provider response (Feldman et al., 2007; Vannoy & Robins, 2011).

This study contributes to the existing literature on suicide prevention by identifying variables associated with the likelihood that older adults with MDD being seen in a primary care setting will have discussed recent suicide ideation with a professional health care provider. The low rate of disclosure in this high-risk population is concerning, and it is imperative that we develop efficient and effective methods for identifying high-risk individuals. Older depressed patients who have no history of mental health specialty care and appear to have a "good" life may be particularly vulnerable to not discussing their thoughts of suicide. More rigorous research is needed, and interventions at the point of care and at macrolevels may be warranted.

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