



Suicidal ideation disclosure: Patterns, correlates and outcome

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ABSTRACT

This study aimed to identify how frequently suicidal individuals disclosed their ideation, assess which sources were perceived to be most helpful and identify correlates of disclosure and source helpfulness. A cross-sectional survey was conducted with 1,616 Australian adults reporting suicidal ideation in the past 12-months. Participants were recruited from social media and reported on their disclosure of suicidal thoughts to formal and informal sources. 39% of participants did not disclose to anyone, while 47% disclosed to an informal source and 42% to a health professional. The responses of psychologists and counsellors were perceived to be the most helpful, while parents and hospital-based health professionals were perceived to be the least helpful. Severity of suicidal thoughts, younger age, and a suicide attempt in the past 12-months were associated with greater likelihood of disclosure, while participants who were younger, linguistically diverse, had greater suicidal ideation or personal stigma were less likely to perceive the response of a GP to be helpful. This study demonstrates that non-disclosure of suicidal thoughts is frequent and that the response received to a disclosure may not always be perceived to be helpful. Further research is needed to identify how best to support individuals who disclose suicide.

1. Introduction

Suicide is a significant public health problem and is associated with substantial social and economic burden. Each year, approximately 800,000 people die by suicide worldwide, which represents a suicide rate of 11.4 per 100,000 people annually (World Health Organization, 2014). Research suggests that help-seeking for suicide is low, with 55% of people who die by suicide having no contact with a primary care provider in the month before their death, and 68% having no contact with mental health services in the year before suicide (Luoma et al., 2002).

Help-seeking for suicide, as with help-seeking for mental disorders, is a complex process that involves recognising the need for psychological support and then actively seeking out and using formal or informal social relationships to obtain the help needed (Rickwood et al., 2005). Although the act of disclosing suicidal thoughts and/or behaviour to another person is often an essential first step in the provision of services and support for suicide, very little research has been conducted in this area (Fulginiti et al., 2016). Of the research that has been conducted, most studies have focused on rates and correlates of disclosure with a limited range of sources explored (e.g., family, friends and non-specific mental health providers). One exception to this is a study conducted by Frey et al. (2016), which assessed contact with a range of

formal and informal sources following a suicide attempt or suicidal ideation. They found that disclosure responses were commonly perceived to be stigmatising, particularly from individuals who were not mental health professionals, and that stigmatising responses had a negative impact on mental health outcomes.

Rates of disclosure of suicidal thoughts and behaviour have varied considerably across studies, with as few as 29% of suicide attempt survivors reporting a disclosure prior to their attempt (Barnes et al., 2001), up to as many as 80% of participants with a serious mental illness disclosing their suicidal thoughts or behaviours (Fulginiti et al., 2016). Within community samples, suicidal thoughts and/or behaviour disclosure rates have been reported to be around 50% (Cukrowicz et al., 2014; De Luca et al., 2014; Encrenaz et al., 2012; Husky et al., 2016). The number of confidants that individuals tend to disclose to is one or two (Chu et al., 2011; Encrenaz et al., 2012; Fulginiti et al., 2016), with family and friends the more likely target of disclosure than health professionals (Barnes et al., 2001; De Luca et al., 2014; Encrenaz et al., 2012; Eskin, 2003; Husky et al., 2016). In a study by Encrenaz et al. (2012), 40% to 43% of participants reported disclosing to a friend or family member, compared to 21% to 38% reporting a disclosure to a health professional. Disclosure to a health professional has been found to increase with reports of suicide plans and attempts (Encrenaz et al., 2012; Husky et al., 2016).

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A range of sociodemographic and psychological factors have been explored as potential correlates of suicide disclosure. The effects of age and gender have been mixed, with some studies finding no association between these factors and the disclosure of suicidal thoughts and behaviour (Cukrowicz et al., 2014; Eskin, 2003) and others finding younger age (Encrenaz et al., 2012), older age (Husky et al., 2016) and male gender (Encrenaz et al., 2012; Husky et al., 2016) to be associated with lower disclosure. Less social support and connectedness (Fulginiti et al., 2016; Husky et al., 2016) has also been associated with lower levels of disclosure, as well as ethnicity (Chu et al., 2011; Fulginiti et al., 2016), higher levels of stigma (Fulginiti et al., 2016), and greater quality of life (Cukrowicz et al., 2014). Lastly, increasing suicidal behaviour (e.g., plans and attempts; Chu et al., 2011; Encrenaz et al., 2012; Husky et al., 2016), the presence of mental disorders (Husky et al., 2016) and a history of mental health treatment (Cukrowicz et al., 2014) have been found to be associated with greater likelihood of disclosing suicidal thoughts or behaviours.

The aim of the current study is to extend upon previous research by (i) estimating rates of disclosing suicidal ideation across a wider range of formal (e.g., general practitioner [GP], psychologist, psychiatrist, counsellor, social worker) and informal sources (e.g., intimate partner, friend, parent, other relative), (ii) assessing the perceived helpfulness of disclosing to each source, and (iii) identifying correlates of disclosure to each source, source helpfulness and total number of disclosure sources. Based on previous research, it is hypothesised that participants will be more likely to disclose to informal than formal sources and that they will on average disclose to one or two people. It is further hypothesised that participants will be more likely to disclose their suicidal ideation to a range of sources if they speak only English at home, have lower levels of stigma, or experience high levels of suicidality (history of suicide attempt and greater suicidal ideation). Collectively this research will assist in better understanding who is more likely to disclose suicidal thoughts and behaviour, who they are likely to disclose to and how helpful the disclosure is likely to be for the individual. This information will assist in targeting gatekeeper training to those people who are most likely to receive a disclosure of suicidal thoughts or behaviours to better prepare them for this role, as well as raising the awareness of clinicians to those populations most at risk of non-disclosure.

2. Method

2.1. Participants and procedures

Participants were recruited to the current study through advertisements on the social media website Facebook between January and February 2016. The Facebook advertisements invited participation in a mental health survey, were targeted to all Australians aged 18 years and older and provided a link directly to the survey. The survey was delivered online using Qualtrics survey software and included measures of psychological distress, mental disorders, suicidality, fatigue, sleep disturbance, help-seeking, suicide disclosure, demographics and personality. The survey took approximately 40 min to complete and no incentives were provided for participation. Ethical approval was obtained from the Australian National University Human Research Ethics Committee (protocol #2015/717).

Prior to the collection of informed online consent, participants were provided with a detailed information sheet that outlined what was involved in the survey, potential risks of participation and contact details for psychological and crisis support services across Australia. A total of 7174 users clicked the advertisements with 5379 (75%) consenting to complete the survey. Of those consenting respondents, a total of 3577 (66%) completed the full survey. Given that the focus of this study was on suicide disclosure, a sub-sample of participants who reported suicidal ideation in the past year was drawn from the total sample of participants. This equated to 1616 (45%) participants who are thus the focus of the current study. There were no missing data as responses

were required for all questions, except age and gender, with participants encouraged to discontinue if they were uncomfortable with survey questions.

2.2. Measures

Presence of suicidal ideation in the past 12 months was assessed using single items regarding the presence and frequency of active suicidal thoughts from the Psychiatric Symptom Frequency scale (PSF; Lindelow et al., 1997) and the Suicidal Ideation Attributes Scale (SIDAS; van Spijker et al., 2014a). Participants who endorsed one or both of these items were classified as having suicidal ideation, while participants who did not endorse either of the items were treated as having not had suicidal ideation in the past year and were not presented with the suicide disclosure items and consequently excluded from the present analyses.

The suicide disclosure items consisted of a list of sources that a person with suicidal thoughts may disclose to. Participants were asked to select which sources they had told about their suicidal thoughts, with the option 'Not told anyone' also available for those who had not shared their thoughts with anyone. The sources from which participants could select were: intimate partner (e.g., girlfriend, boyfriend, husband, wife, defacto [live-in partner]), other relative/family member, psychiatrist, hospital inpatient/outpatient, phone helpline (e.g., Lifeline), friend (not related to you), doctor/GP, counsellor, complementary therapist (e.g., acupuncturist, naturopath, herbalist), parent, psychologist, social worker, internet therapy program and 'other'. Following the selection of disclosure sources, participants were then prompted to rate how helpful or harmful the source's response to the disclosure had been on a 5-point scale ranging from 1 (Very helpful) to 5 (Very harmful).

A range of other variables were also measured as potential correlates of suicide disclosure. An item from the PSF (Lindelow et al., 1997) was used to assess suicide attempt in the past 12 months, while the total score from the SIDAS (van Spijker et al., 2014a) was utilised to measure severity of suicidal ideation. The stigma and glorification sub-scales of the Stigma of Suicide Scale (Batterham et al., 2013) were used to measure the influence of suicide stigma on disclosure, while an adapted version of these scales was used to assess the impact of self-stigma. Background characteristics were also collected including age group, gender, years of education, employment status (full-time, part-time/casual, unemployed, not working), location of residence (metropolitan, regional or rural/remote area) and language spoken at home (English only vs. other).

2.3. Analyses

Responses to each of the disclosure sources were tabulated to assess the proportion of participants who had disclosed to each source or to nobody. The proportion of participants who found each source to be helpful or harmful was also calculated, with the 'very helpful' and 'helpful' categories combined and the 'very harmful' and 'harmful' options pooled together. A series of logistic and linear regression analyses were conducted to identify potential correlates of: (i) source of disclosure, (ii) helpfulness of each type of disclosure and (iii) number of total disclosures. Within these analyses, age was reduced to three categories (younger age [18–35 years], middle age [36–55 years] and older age [≥ 56 years]) for ease of interpretation and comparison. All statistical analyses were performed in SPSS Version 24.0 for Windows (IBM Corp, Chicago IL USA).

3. Results

Table 1 presents participant characteristics for the current study. Overall, participants tended to be female (79%), reasonably well educated ($M = 15.1$ years of education), only spoke English at home (93%) and lived in a metropolitan area (52%). Table 1 also provides a

Table 1
Participant background characteristics.

	Ideation (n = 1616)	No ideation (n = 1961)	χ^2/t	p
Age			189.4	<0.001
18–25 years	421 (26%)	268 (14%)		
26–35 years	237 (15%)	199 (10%)		
36–45 years	263 (16%)	273 (14%)		
46–55 years	327 (20%)	410 (21%)		
56–65 years	276 (17%)	538 (27%)		
66 years or older	92 (6%)	273 (14%)		
Gender			6.4	0.011
Female	1275 (79%)	1613 (82%)		
Male	341 (21%)	348 (18%)		
Years of education, M (SD)	15.1 (2.3)	15.6 (2.3)	6.0	<0.001
Language			0.5	0.490
Other	117 (7%)	154 (8%)		
English only	1499 (93%)	1807 (92%)		
Employment status			58.4	<0.001
Full-time	438 (27%)	607 (31%)		
Part-time/casual	472 (29%)	576 (29%)		
Unemployed	264 (16%)	161 (8%)		
Not working	424 (26%)	590 (30%)		
Location			1.4	0.506
Metropolitan area	834 (52%)	1035 (53%)		
Regional area	598 (37%)	690 (35%)		
Rural or remote area	184 (11%)	236 (12%)		

comparison between the participants in the current study and those participants from the larger study who did not report suicidal ideation in the past year. As is evident from this table, participants reporting suicidal ideation differed to those participants without ideation in terms of age, gender, years of education and employment status, in that they tended to be younger, more likely to be male, less educated and more likely to be unemployed.

Table 2 displays the proportion of participants who reported disclosing their thoughts of suicide to each source and the proportion of disclosing participants that perceived the disclosure to be helpful or harmful. A high level of non-disclosure was reported, with 39.5% of participants reporting that they did not disclose their suicidal thoughts to anyone. The highest rate of disclosure was to a friend (27.2%), followed by intimate partner (26.0%), psychologist (25.1%) and GP (24.2%). A greater proportion of participants reported disclosing their suicidal ideation to an informal (47.2%) than formal health/allied professional (42.2%) source. On average, participants tended to

Table 2
Source disclosure rates and ratings of source helpfulness/harmfulness following disclosure.

Source	Disclosure rate	Helpful	Harmful
Any informal source:	778	47.2%	
Intimate partner	429	26.0%	62.7%
Friend (not related to you)	449	27.2%	65.5%
Parent	165	10.0%	44.8%
Other relative/family member	140	8.5%	50.7%
Any health/allied professional:	696	42.2%	
Doctor/General Practitioner	399	24.2%	64.7%
Health professional in inpatient/outpatient setting	97	5.9%	54.6%
Psychologist	414	25.1%	72.0%
Psychiatrist	217	13.2%	64.5%
Counsellor	192	11.6%	69.8%
Social worker	43	2.6%	67.4%
Other:	170	10.3%	
Phone helpline (e.g. Lifeline)	111	6.7%	55.9%
Internet therapy program	22	1.3%	40.9%
Complementary therapist	15	0.9%	73.3%
Other	39	2.4%	51.3%
Nobody	651	39.5%	

disclose to 1.63 (*SD* = 2.00) sources, with a range of 0 to 13 sources reported.

The perceived helpfulness of the responses received by participants following a disclosure of suicidal ideation to a source varied considerably. The source whose response to the disclosure was perceived to be most helpful was complementary therapist (73.3%; which covered acupuncturist, naturopath and herbalist), followed by psychologist (72.0%), counsellor (69.8%), social worker (67.4%) and friend (65.5%). The source whose response to the disclosure was perceived as most harmful was parent (18.8%), followed by health professional in an inpatient or outpatient setting (17.5%) and internet therapy program (13.6%). Very few participants reported disclosing to a complementary therapist (*n* = 15) or in the context of an internet-based therapy program (*n* = 22), so ratings for these sources should be treated cautiously.

Table 3 presents a summary of the significant correlates of disclosure to each of the sources and to nobody. Participants who were younger, reported more severe suicidal ideation or at least one suicide attempt in the past 12 months were more likely to have disclosed their suicidal ideation to a range of sources. Participants who spoke languages other than English were also more likely to have disclosed their suicidal thoughts to a complementary therapist. Participants were less likely to have disclosed to nobody if they had had a suicide attempt in the past 12 months or reported greater suicidal ideation severity. Younger age and greater personal stigma were associated with a lower likelihood of having disclosed to a complementary therapist and psychiatrist respectively.

A summary of the correlates of perceived response helpfulness following the disclosure of suicidal ideation to each source is presented in Table 4. Greater suicidal ideation severity was associated with perceiving the response of a GP, psychologist, psychiatrist and counsellor as being less helpful, and the response of a phone helpline as more helpful. A number of participant characteristics, such as younger age, linguistic diversity, greater ideation severity and higher personal stigma, were associated with perceiving the response of a GP to be less helpful following a disclosure of suicidal thoughts. Disclosure to phone helplines was more likely to be perceived as helpful when participants reported greater suicidal ideation severity, but less likely to be perceived as helpful when participants reported a suicide attempt in the past 12 months.

Lastly, a linear regression conducted to identify correlates of the number of disclosure sources found younger ($\beta = 0.53, p < .001$) and middle ($\beta = 0.29, p = .02$) age, more severe suicidal ideation ($\beta = 0.02, p < .001$), reporting a suicide attempt in the past 12 months ($\beta = 1.21, p < .001$) and lower suicide stigma ($\beta = -0.52, p = .04$) to be associated with disclosing to more sources.

4. Discussion

Close to 40% of participants in the current study reported that they had not disclosed their thoughts of suicide with anyone. This finding is in line with previous research, which has found community suicide disclosure rates of approximately 50% (Cukrowicz et al., 2014; De Luca et al., 2014; Encrenaz et al., 2012; Husky et al., 2016), and suggests that a significant number of people are still not seeking any help or support for suicidal thoughts. The tendency for community-based participants to disclose more frequently to informal versus formal sources (Barnes et al., 2001; De Luca et al., 2014; Encrenaz et al., 2012; Eskin, 2003; Husky et al., 2016) was also evident in the current study, as was the propensity to disclose to between one and two sources (Chu et al., 2011; Encrenaz et al., 2012; Fulginiti et al., 2016).

Participants reported disclosing most frequently to a friend, intimate partner, psychologist or GP. The high level of trust and closeness that people often have with friends and intimate partners may explain the greater disclosure of suicidal thoughts to these sources, while the expertise of psychologists and access of GPs might be the drivers of disclosure to the latter sources. Given these results, it may be beneficial

Table 3
Significant correlates of likelihood of disclosing suicidal ideation to each source.

Characteristic	More likely to disclose ideation to	Less likely to disclose to
Younger age (18–35 vs. ≥ 56 years)	Intimate partner (OR = 1.71, $p < .01$), friend (OR = 1.77, $p < .001$), parent (OR = 36.67, $p < .001$), psychologist (OR = 1.89, $p < .001$), social worker (OR = 3.11, $p = .046$)	
Middle age (36–55 vs. ≥ 56 years)	Intimate partner (OR = 1.39, $p = .048$), parent (OR = 13.08, $p < .001$), psychologist (OR = 1.52, $p = .01$)	Complementary therapist (OR = 0.17, $p = .03$)
Male gender		
Linguistic diversity	Complementary therapist (OR = 5.39, $p < .01$)	
More education		
Suicide attempt in the past 12 months	Intimate partner (OR = 2.54, $p < .001$), friend (OR = 1.89, $p < .01$), parent (OR = 1.70, $p = .047$), relative (OR = 1.86, $p = .04$), GP (OR = 2.07, $p < .001$), other (OR = 3.86, $p < .01$), hospital (OR = 4.75, $p < .001$), psychiatrist (OR = 1.89, $p < .01$), counsellor (OR = 1.99, $p < .01$), social worker (OR = 3.09, $p < .01$)	Nobody (OR = 0.37, $p < .001$)
Greater ideation severity	Friend (OR = 1.01, $p = .01$), phone helpline (OR = 1.06, $p < .001$), GP (OR = 1.02, $p < .001$), hospital (OR = 1.03, $p < .01$), psychologist (OR = 1.01, $p < .01$), psychiatrist (OR = 1.03, $p < .001$), internet therapy (OR = 1.04, $p = .04$)	Nobody (OR = 0.97, $p < .001$)
Greater personal stigma		Psychiatrist (OR = 0.97, $p = .04$)
Greater personal glorification		
Greater self-stigma		
Greater self-glorification		

to implement broad community-based programs that provide information to the public about how best to support an individual who discloses suicidal thoughts. Gatekeeper training should also be targeted at psychologists and GPs, so as to better prepare them for disclosures of suicide and to provide subsequent support.

Overall, the rate of disclosure to individual professional types in the present study was low, with only one in four participants reporting a disclosure to a GP and/or psychologist, and 58% of participants did not disclose to any health or allied professional. These findings are concerning, as people with suicidal thinking are likely to benefit from professional help. As such, raising the community's awareness to the importance of seeking help early and the support that can be offered by health professionals is important, as well as debunking myths around what will happen if suicidal thoughts are disclosed to a professional.

The results of the current study indicate that there was significant variability in the perceived helpfulness of the response received from sources following a disclosure of suicidal thoughts. The most helpful responses came from health professionals, such as psychologists and counsellors, who would have the training and expertise to assist someone reporting suicidal ideation and who may already be known to the individual. This finding may be related to the less stigmatising responses of mental health professionals observed by Frey et al. (2016). The exception to this was that health professionals in inpatient/outpatient settings (e.g., emergency department, psychiatric hospital ward) attracted the second highest harmfulness rating. This finding may reflect reduced familiarity of health professionals in these settings, or a poorly resourced and staffed public mental health system that is unable to adequately meet the needs of people accessing the service, resulting in perceived unhelpful responses to disclosures of suicidal ideation. It may also reflect a negative perception of the hospital environment,

which may be a traumatic environment for individuals with suicidal thoughts and behaviour, even if the treatment they receive is beneficial. (McKay and Shand, 2018; Shand et al., 2018). Further research is needed to better understand the types of responses that are being received from inpatient and outpatient settings to help identify ways to improve responses to disclosures of suicide ideation, although the findings are consistent with other studies examining the care received after a suicide attempt (Shand et al., 2018).

The responses of parents and other relatives to disclosures of suicide were also found to be less helpful and more harmful in the current study than other informal sources. Possible explanations for these findings are unclear, and warrant further investigation, although unhelpful responses of parents could reflect a refusal to take the disclosure seriously or minimising its legitimacy due to feelings of stigma, shame, responsibility or denial, or a lack of physical or emotional resources to process and manage the disclosure. It may also be the case that some parents use disclosure as an opportunity to encourage formal help seeking, which the suicidal individual may find confronting or objectionable due to previous negative experiences with formal care. Further educating the community on how to respond and support a person disclosing suicidal thoughts, and the origins and causes of suicide, may help to improve the response of close family members, such as parents, to disclosures of suicide. Nevertheless, nuance around appropriate responses may be needed, taking into account the individual's context, including their chronicity of suicidal thinking, their experience with specific healthcare services and underlying mental health issues, which may influence their perceptions of the helpfulness of the response.

The few participants who reported disclosing their suicidal ideation within the context of an Internet programs tended to find this setting unhelpful. While there are emerging programs that may be effective in

Table 4
Significant correlates of likelihood of perceiving source response helpful to disclosure of suicidal ideation.

Characteristic	More likely to find helpful	Less likely to find helpful
Younger age		GP (OR = 0.40, $p < .01$)
Male gender		
Linguistic diversity		GP (OR = 0.38, $p = .03$)
More education	Friend (OR = 1.17, $p < .01$)	
Suicide attempt past 12 months		Phone helpline (OR = 0.23, $p = .04$)
Greater ideation severity	Phone helpline (OR = 1.06, $p < .01$)	GP (OR = 0.98, $p = .03$), Psychologist (OR = 0.97, $p = .01$), Psychiatrist (OR = 0.96, $p = .01$), Counsellor (OR = 0.95, $p < .01$)
Greater personal stigma		
Greater personal glorification		
Greater self-stigma	Counsellor (OR = 1.07, $p = .02$)	
Greater self-glorification		

treating suicidal thinking (van Spijker et al., 2014b), other Internet programs may be ineffective and typically do not provide personalised feedback. Providing more targeted and relevant support options outside of the Internet program, such as region specific support lines and face-to-face service options, may help to improve the experiences of people using Internet therapy programs.

Generally, the total number of disclosures and the disclosure of suicidal thoughts to a range of sources was associated with younger age, more severe suicidal ideation, having had a suicide attempt in the past 12 months and lower levels of suicide stigma. To date, the association between age and disclosure of suicidal thoughts has been mixed, with no clear consensus on the relationship between these two factors. In the current study, the accessibility of particular sources may be one possible explanation for the findings, with younger people often having more ready access to friends and parents, or possibly less shame around disclosing personal issues. Further research exploring the availability of sources may help to further understand interpret some of the associations observed in the current study, as an individual cannot disclose to a person that is not present in their social network.

In line with previous research (Chu et al., 2011; Encrenaz et al., 2012; Husky et al., 2016), the current study also found an association between higher levels of suicidality and the disclosure of suicidal thoughts. This finding may reflect the salience of more severe suicidality (attempts may be more difficult to mask than ideation) or existing connections to services that would facilitate the disclosure of suicidal thoughts to formal sources. Specifically, individuals with comorbid mental health problems or history of suicide attempt may be more likely to have pre-existing connections to health services. Regardless of the drivers, this is a promising finding in that it suggests that those at greatest risk of suicide are disclosing their suicidal ideation, which could facilitate the provisions of treatment and support to those most in need of it. The finding is somewhat inconsistent with the help negation theory (Wilson and Deane, 2010), which suggests individuals with suicidal thoughts shun professional help as their severity of ideation increases. In contrast, perhaps certain thresholds of suicidal severity precipitate disclosure to others, although such disclosure may not always result in receiving treatment. Consistent with previous research, low suicide stigma was also found to be associated with the disclosure of suicidal thoughts (Fulginiti et al., 2016). This association likely stems from people with low suicide stigma not feeling ashamed or embarrassed to admit that they are having thoughts of suicide.

Interestingly, a number of groups, such as those who were younger, linguistically diverse, those with more severe suicidal ideation or greater personal stigma were less likely to perceive the response of a GP to be helpful following disclosure. This is somewhat problematic, as GPs are often viewed as the gateway to mental health care. The finding suggests that further mental health training may be needed to better equip GPs to manage and support patients at risk of suicide, particularly those who are younger or from ethnically diverse backgrounds, or to provide patients with referrals to additional support. This finding may also reflect a mismatch between the individual with suicidal thought's perceptions of the helpfulness of the care they receive and the positive intentions of GPs in providing that care. Lastly, the response of telephone help-lines to the disclosure of suicidal thoughts was perceived to be more helpful among participants with suicidal ideation but less helpful among those with a suicide attempt in the past 12 months. This finding suggests that helplines may not be as equipped to support people with active suicidal behaviour, who may need more targeted and personalised face-to-face support. As helplines are typically used in crisis situations, future research should investigate how helplines respond to individuals in acute crisis, and whether alternative response models can be developed that are perceived to be more helpful by the individuals who use these services.

There are some limitations to the current study that should be considered. For instance, participants were recruited through an online social network and therefore selectively chose to participate in the

study. This potential selection bias is observed in the female dominant sample and higher prevalence rate of suicidal ideation compared to other community based studies (Slade et al., 2009). Nevertheless, the high prevalence of suicidal ideation provided the study with sufficient power to investigate correlates of disclosure, and the nature of the study did not necessitate an entirely representative sample (Rothman et al., 2013). Recent research also suggests that community-based samples drawn from Facebook are as representative as other survey methods (Batterham, 2014), and surveying from a clinical setting for the current study would have precluded people not accessing mental health services. As noted throughout, perceptions of helpfulness do not necessarily equate to actual benefit from a specific type of service. Finally, as the study was cross-sectional, causation cannot be inferred. In particular, use of services may be related to individual characteristics that may also influence the likelihood that an individual will perceive a disclosure source to be helpful.

Overall the results of the current study indicate that the disclosure of suicidal thoughts is low, particularly to formal sources, and that not all disclosures of suicidal ideation are necessarily positive or helpful. As such, social movements encouraging people to “come out” and publicly disclose their thoughts of suicide need to be carefully considered, with adequate supports put in place to ensure no harm is caused by the experience. Further research is needed to identify how best to support individuals who disclose thoughts of suicide across a range of settings, and how to adequately prepare and educate formal and informal sources to support individuals who disclose suicidal thoughts or behaviours. Additional research is also needed to better understand the help-seeking behaviour that follows a disclosure and what effect the disclosure has on the individual experiencing thoughts of suicide.

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Conflict of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

Supplementary materials

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