

Disclosure of Suicidal Thoughts and Behaviors Among Adolescent Psychiatric Inpatients: Differences by Sexual and Gender Minority Status

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ABSTRACT

Rates of adolescent suicide have risen over the last 10 years, creating a public health crisis. Disclosure of suicidal thoughts and behaviors (STBs) is one help-seeking strategy available to adolescents. Estimates from prior studies on the frequency of youth STB disclosure vary considerably. It is crucial to understand patterns and rates of STB disclosure for youth at elevated risk for suicide, including those who have been psychiatrically hospitalized or who hold sexual and gender minority (SGM) status. To examine STB disclosure in this high-risk population, the current study examined self-report of STB disclosure behaviors, including to whom, how, and when disclosure occurred, as well as the outcome of the disclosure in a sample of psychiatrically hospitalized youth with prior STBs (N=163).

Data showed that the most common recipients of disclosures were caregivers, health professionals, and in-person friends. The most frequently endorsed method of disclosure was doing so in person, and there were no significant differences in when adolescents disclosed STBs (before, during, or after the experience). SGM adolescents were half as likely as non-SGM adolescents to disclose to parents or caregivers, and SGM adolescents disclosed more often during the STB than non-SGM youth. These findings can inform future interventions targeted at reducing STBs in youth or increasing help-seeking behaviors for psychiatrically hospitalized adolescents.

KEYWORDS: suicide; disclosure; adolescent; sexual and gender minority

INTRODUCTION

Suicide is a leading cause of death in adolescents, and close to 12% of adolescents report lifetime suicidal ideation (SI).¹ Assessment of suicidal thoughts and behaviors (STBs) is central to suicide prevention, and disclosure of STBs is a critical pathway for youth to seek and receive support. A 2024 scoping review of rates of STB disclosure found that among both adolescents who endorsed SI and general samples, rates of disclosure have ranged widely from 23% to 70%.² This review also found that adolescents disclosed

most frequently to parents, friends, and mental health professionals. Disclosure may be especially consequential for psychiatrically hospitalized adolescents at elevated risk for hospital readmission and suicide attempts after discharge.³ A 2018 study found that 53.1% of adolescents admitted to a psychiatric hospital were admitted due to STBs.⁴ Further, in a sample of psychiatrically hospitalized adolescents, lower rates of disclosure were associated with more intense reports of SI.⁵ This suggests that STB disclosure can serve as a protective factor for youth experiencing SI. A better understanding of rates of STB disclosure, recipients of disclosure, and outcomes of disclosure could inform interventions and treatment.

Understanding STB disclosures is especially important for youth at higher risk for suicide, including sexual and gender minority (SGM) adolescents. SGM youth report higher rates of suicidal thoughts and non-suicidal self-injury, as well as greater risk for attempting suicide during their lifetime compared to non-SGM youth.^{6,7} Reported STB disclosure rates among SGM adolescents who died by suicide range from 28–40%.⁸ Research has demonstrated differences in disclosure among SGM youth and non-SGM youth, with some studies finding more frequent disclosure among SGM youth, but others reporting greater reluctance to disclose to parents among SGM teens.⁹ Higher levels of minority stress are also associated with greater reluctance among SGM to disclose STBs.¹⁰

The current study examined psychiatrically hospitalized adolescents' history of disclosure, using descriptive analyses to explore factors such as the recipient of disclosure, the means of communication, the timing of the disclosure, and the adolescents' feelings after the disclosure. A secondary aim of this study was to explore the differences in STB disclosure among SGM adolescents versus non-SGM adolescents.

MATERIALS AND METHODS

The study was part of an IRB-approved retrospective chart review of adolescents (N=322, $M_{age}=14.98$ (1.66) years old, range=11–18) admitted to Bradley Hospital's adolescent inpatient psychiatric unit between September 2024 and May 2025 who endorsed either a lifetime history of SI or suicide attempt(s).

Measures

At intake to the psychiatric unit, adolescents completed self-report measures, including items capturing age, sex, race, sexual orientation, and gender identity. STBs were measured using the *Self-Injurious Thoughts and Behaviors Interview-SITBI*.¹¹ The SITBI is a semi-structured interview that gathers information about SI, suicide plans, suicide attempts, and non-suicidal self-injury. The SITBI measure demonstrated strong inter-rater and test-retest reliability and concurrent validity in adolescents and young adults. Because there are no validated measures surrounding STB disclosure in adolescents, disclosure was assessed through five self-report questions created by the research team: 1) has the youth disclosed a STB to someone, 2) the relationship of the disclosure recipient, 3) the method of disclosure, 4) the timing of disclosure (participants could select any combination of “before the STB”, “during the STB”, or “after the STB”), and 5) the emotional response following disclosure (feeling better, the same, or worse). Items were not specific to one STB event but rather to any incident of STB prior to admission. Therefore, adolescents could select multiple recipients, methods, and timings of disclosure.

Data Analysis

Participants who did not endorse prior STBs were excluded from the dataset. SGM teens were defined as those who responded “no” to either cisgender gender identity or heterosexual sexual identity. Logistic regression models were used to examine the association between SGM (vs. non-SGM) identity and disclosure behaviors, controlling for prior suicide attempts.

RESULTS

Of the 322 adolescents psychiatrically hospitalized during the study period, 282 (87.6%) reported STBs. Seven adolescents selected either “prefer not to answer” or “other” for both gender and sexual orientation questions and were excluded from the analyses, yielding an analytical cohort of 275 adolescents who reported any STB. Of those who reported STBs, 52% (N=143) were SGM adolescents, and 48% (N=132) were non-SGM adolescents. **Table 1** provides details on participant demographics, including gender identity, sexual orientation, and race.

Of the 275 adolescents who reported STBs, 169 (61.4%) reported disclosing an STB before admission. Of the youth who reported disclosing their STBs, the majority disclosed to a parent or caregiver (45%), to a doctor or mental health worker (42%), or to an in-person (rather than online) friend (42.6%) [**Table 2**]; 80.5% of adolescents disclosed by telling the recipient verbally. The timing of disclosure was evenly split: 47% of all participants reported at least one instance of disclosure before suicidal behaviors; 46% of all participants

reported at least one instance of disclosure during STBs; and 44% of all participants reported at least one instance of disclosure after STBs. Most participants felt better (39.6%) or the same (40%) after their STB disclosure, but 20.4% of participants endorsed feeling worse after STB disclosure.

Contrary to the secondary hypothesis, STB disclosure did not differ significantly by SGM status: 67.8% of SGM youth disclosed STBs (97 of 143), compared to 55.3% of non-SGM youth (73 of 132). Of those who made a disclosure, SGM adolescents disclosed 1.89 times more often during the behavior than non-SGM adolescents, but 0.48 times as often to parents or primary caregivers than their non-SGM adolescent peers [**Table 3**]. There were no significant differences in the method of disclosure or emotional responses after disclosure between SGM and non-SGM youth. The differences in disclosure during the STB and to primary caregivers remained statistically significant when controlling for lifetime instances of suicide attempts.

Table 1. Participant Demographics (N=169)

	N (%)
Sexual Orientation (select all that apply)	
Heterosexual	71 (42%)
Asexual	12 (7.1%)
Bisexual or Pansexual	56 (33.1%)
Gay or Lesbian	13 (7.7%)
Questioning or Unsure	17 (10.1%)
Sex Assigned at Birth	
Male	51 (30.2%)
Female	118 (69.8%)
Gender Orientation (select all that apply)	
Cisgender Male	51 (30.2%)
Cisgender Female	103 (60.1%)
Transgender Female	1 (0.01%)
Transgender Male	3 (1.7%)
Nonbinary	3 (1.7%)
Gender Fluid	11 (6.5%)
Unsure	7 (4.1%)
Racial Identity (select all that apply)	
American Indian or Alaskan	10 (5.9%)
Asian	8 (4.7%)
Black or African American	33 (19.5%)
Hispanic, Latino, or Spanish Origin	54 (31.9%)
Native Hawaiian or other Pacific Islander	3 (1.8%)
White	105 (62.1%)
Middle Eastern	2 (1.2%)
Other	8 (4.7%)

Table 2. Descriptives of psychiatrically hospitalized adolescents endorsing disclosure behaviors (N=169)

	N (%)
Who the adolescent disclosed to	
Primary caregiver	76 (45%)
Adult family member	27 (16%)
Sibling	22 (13%)
Doctor or Mental Health Worker	71 (42%)
Teacher or adult at school	38 (22.5%)
In-person friend	72 (42.6%)
Online friend	31 (18%)
Somebody else	21 (12%)
How the adolescent disclosed	
By telling them directly	136 (80.5%)
Through social media	23 (13.6%)
Through text or email	58 (34%)
Through a note	14 (8%)
Another way	18 (10.7%)
When the adolescent disclosed	
Before STB	80 (47%)
During STB	78 (46%)
After STB	75 (44%)
How the adolescent felt after disclosure	
Better	67 (39.6%)
The same as before	68 (40%)
Worse	34 (20.4%)

Note: For questions asking about the recipient of disclosure, the method of disclosure, and the timing of disclosure, participants were able to select multiple options.

DISCUSSION

This study contributes to the literature examining STB disclosure in a sample of psychiatrically hospitalized adolescents by exploring the recipients, method, timing, and emotional response to disclosure. Adolescents disclosed most often to their parents or caregivers, a mental health professional, or an in-person friend. This aligns with previous research that found hospitalized adolescents often disclose STBs to parents or friends.⁹ Previous research supports parent-child connection and parental support as a protective factor against suicide in adolescents.¹⁴ Understanding common recipients of disclosure may inform future interventions for adolescents in a psychiatric hospital, improve relationships, and enhance skills in responding to STBs among individuals to whom youth frequently disclose STBs. This could include facilitating conversations about STBs in family therapy and providing guidance to parents and peers to support youth safety in the context of STBs. Given the balanced distribution in the timing of disclosure, which included before, during, and after the behavior,

clinicians may want to consider ways to proactively facilitate disclosure in patients at risk for STBs.

The study also provided insight into the timing of disclosure and found unexpected differences in disclosure behaviors between SGM and non-SGM adolescents. Whereas there was no difference in disclosure frequency before or after the STB, SGM adolescents were approximately twice as likely to disclose during the STB as non-SGM adolescents. Previous literature has not examined the timing of disclosure among SGM adolescents, nor has it examined it in comparison to non-SGM adolescents. Future work should examine the underlying motivation for SGM adolescents in disclosing during an STB.

Most participants reported that they felt the same or better than before the disclosure, suggesting that disclosure may have a buffering effect for youth exhibiting STBs. This finding is consistent with prior research which found that adolescents who disclosed non-suicidal self-injury or STBs reported higher self-esteem and future optimism than those who did not disclose.¹² While prior research has not thoroughly explored how previous disclosure experiences impact future disclosure experiences, one study showed that adolescents who disclosed a suicide attempt were more likely to seek professional help after disclosing, and that disclosures were regarded as helpful.¹³ This suggests that disclosures may promote safety and encourage help- and treatment-seeking behaviors. While most adolescents reported feeling the same or better after disclosure, a minority of participants reported feeling worse. Due to the limitations of the chart review format of the present study, the exact reasons for the worsening of mood cannot be determined. Potential factors include an invalidating response to the disclosure, or that the disclosure led to the present hospitalization that the adolescent may find distressing at this stage of their treatment and recovery. This finding reinforces the need for close monitoring and follow-up after disclosures.

There were no significant differences between SGM and non-SGM adolescents in the frequency of disclosure of STBs. Although this study did not find differences in the likelihood of disclosure between SGM and non-SGM youth, it found that SGM teens were about half as likely as their non-SGM peers to disclose to primary caregivers. SGM youth reported disclosing to a caregiver about 37% of the time, less than previously reported for psychiatrically hospitalized SGM youth who endorsed STBs (>50%).⁹ It remains unclear which factors, including the strength of the relationship between SGM adolescents and their primary caregivers, influence the likelihood of disclosure, highlighting the need for future research on this topic.

When analyzing differences between SGM and non-SGM adolescents, it was hypothesized that if rates of disclosure were analyzed without considering severity of STBs, there may be more STB disclosures due to more frequencies of STB, and therefore more opportunities to disclose, rather

Table 3. Descriptives and logistic regressions estimating odds of SGM adolescents endorsing disclosure behaviors (relative to non-SGM), including controlling for frequency of prior suicide attempts

	SGM N=143; N=97 for disclosure details N(%)	Non-SGM N=132; N=73 for disclosure details N(%)	Odds-ratio (OR) of disclosure behavior (95% CI)	OR controlling for lifetime instances of suicide attempts (95% CI)
Disclosed STB	97 (68%)	73 (55%)	1.62 (0.99–2.67)	1.54 (.93–2.56)
Who the adolescent disclosed to				
Primary caregiver	36 (37%)	41 (56%)	0.48 (0.26–0.89)*	0.43 (0.23–0.82)*
Adult family member	14 (14%)	13 (18%)	0.80 (0.35–1.82)	0.81 (0.35–1.87)
Sibling	12 (12%)	10 (14%)	0.91 (0.37–2.24)	0.86 (0.34–2.15)
Doctor or Mental Health Worker	46 (47%)	26 (36%)	1.56 (0.83–2.91)	1.61 (0.86–3.06)
Teacher or adult at school	24 (25%)	15 (21%)	1.31 (0.63–2.72)	1.33 (0.63–2.80)
In-person friend	48 (49%)	26 (36%)	1.70 (0.91–3.17)	1.86 (0.98–3.53)
Online friend	20 (21%)	11 (15%)	1.41 (0.62–3.18)	1.50 (0.65–3.45)
Somebody else	12 (12%)	9 (12%)	1.03 (0.41–2.59)	1.03 (0.40–2.62)
How the adolescent disclosed				
By telling them directly	78 (80%)	60 (82%)	0.87 (0.40–1.90)	0.95 (0.43–2.12)
Through social media	17 (18%)	6 (8%)	2.43 (0.91–6.53)	2.54 (0.93–6.95)
Through text or email	38 (39%)	20 (27%)	1.69 (0.87–3.27)	1.70 (0.87–3.33)
Through a note	10 (10%)	4 (5%)	2.03 (0.61–6.75)	2.08 (0.61–7.02)
Another way	13 (13%)	6 (8%)	1.77 (0.64–4.91)	1.68 (0.60–4.71)
When the adolescent disclosed				
Before STB	45 (46%)	36 (49%)	0.89 (0.48–1.63)	0.90 (0.48–1.67)
During STB	51 (53%)	27 (37%)	1.89 (1.02–3.53)*	2.07 (1.09–3.92)*
After STB	44 (45%)	32 (44%)	1.11 (0.60–2.04)	1.05 (0.56–1.96)
How the adolescent felt after disclosure				
Better compared to the same	33 (34%) compared to 41 (42%)	34 (47%) compared to 28 (39%)	1.51 (0.77–2.97)	0.73 (0.48–1.09)
Better compared to worse	33 (34%) compared to 23 (23%)	34 (47%) compared to 11 (15%)	2.15 (0.91–5.11)	0.71 (0.43–1.19)
The same compared to worse	41 (42%) compared to 23 (23%)	28 (39%) compared to 11 (15%)	1.43 (0.60–3.39)	0.98 (0.59–1.64)

Note: * $p < 0.05$. SGM= Sexual and/or Gender Minority identity. OR=odds ratios from logistic regressions predicting disclosure behavior from SGM identity (vs non-SGM), without covariates and covarying, lifetime, suicide-attempt frequency, as assessed with the SITBI.11 After removing those who did not disclose STBs, a sample size of 170 adolescents remained for further analysis. The last question, which assessed how adolescents felt after disclosure, was analyzed using a multinomial logistic regression, instead of a logistic regression.

than differences in SGM status. Therefore, in analyses, lifetime instances of suicide attempts were controlled in order to control for the severity of STBs. However, as seen in **Table 3**, the odds ratios were similar between analyses without controlling for lifetime instances of suicidal thoughts, and analyses controlling for those with lifetime instances of suicidal thoughts.

Limitations

Findings should be considered in the context of the study's limitations. First, the sample consisted of adolescents hospitalized at a psychiatric hospital in the Northeast United States. The adolescents in the study may present with more severe psychopathology and STBs than a community-based sample, thus impacting the generalizability of the findings. Additionally, the sample was predominantly White, so the

results may not be generalizable to other cultures and races. Culture can influence help-seeking and STB disclosure, with some cultural groups showing fewer help-seeking behaviors for STBs than others, so future research should address how different cultures engage in help-seeking behaviors, such as disclosure of STBs.¹⁵ The cross-sectional nature of this study is also a limitation. Due to the nature of data collection, no longitudinal data were collected. Therefore, it was not possible to track participants' disclosure behavior over time, to assess how emotional response to disclosure trends over time, or to assess how others' response to disclosure impacts future disclosure behavior or treatment-seeking behavior. Finally, due to limited power, gender and sexual minority status could not be analyzed separately; future studies with larger samples should examine them independently.

CONCLUSIONS

Future work should examine the effect of responses to STB disclosure on the likelihood of disclosing in the future, and how the severity of STBs impacts disclosure behavior. Clinicians may also explore how to increase adolescents' access to and comfort with help-seeking behaviors, including disclosure. This is particularly important for youth at higher risk for suicide, such as those psychiatrically hospitalized or marginalized based on sexual or gender identity. This may include creating future opportunities for disclosure of STBs to family members or treatment providers following discharge from the psychiatric hospital.

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