Research Square

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# Improvement in Suicide Crisis Syndrome Symptoms Predicts Reduced Psychiatric Readmission

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# Abstract

### Background

Suicide Crisis Syndrome (SCS) is an acute clinical syndrome under consideration for inclusion in DSM as a suicide-specific disorder. SCS diagnosis at admission to an inpatient psychiatric has been shown to be protective against readmission, but the mechanism remains unclear. This study examines whether SCS symptom reduction from admission to discharge is protective against readmission risk, even after controlling for psychosis and suicidal thoughts and behavior at admission.

### Methods

A sample of 134 psychiatric inpatients from the Mount Sinai Health System was assessed for SCS at admission and discharge. Data on psychiatric readmissions and Comprehensive Psychiatric Emergency Program (CPEP) visits within 18 months post-discharge were extracted from electronic health records and coded as readmitted vs. non-readmitted. Logistic regressions examined whether baseline SCS diagnosis and symptom improvement were associated with reduced readmission risk. Mediation analysis tested whether symptom improvement accounted for the association between baseline SCS severity and readmission.

### Results

Overall, 14.7% of patients ($n$ = 33) were readmitted within 18 months. Both SCS diagnosis at admission ($OR$ = 0.277, $p$ = .022) and greater improvement in SCS symptoms ($OR$ = 0.878, $p$ = .007) were significantly associated with decreased readmission risk; the latter remained so after controlling for baseline severity, suicidal ideation, and current psychotic disorder. In mediation analysis, symptom improvement fully explained the association between baseline SCS severity and readmission (indirect effect $B$= −0.102, 95% CI [−0.201, −0.016]).

### Conclusion

This study demonstrates that SCS is treatable and that symptom improvement during inpatient treatment is a meaningful predictor of reduced risk for readmission, independent of suicidal ideation or behavior at admission.


# Introduction

Suicide is a major global public health concern, contributing to over 700,000 deaths annually worldwide. According to the World Health Organization, an estimated 727,000 people died by suicide in 2021, accounting for 1.1% of all global deaths [1]. The global age-standardized suicide rate was 8.9 per 100,000 population, with rates ranging from fewer than one to nearly forty deaths per 100,000 across countries. In the United States, suicide was the 11th leading cause of death in 2022, accounting for 49,476 deaths [2]. These statistics underscore suicide as a pressing public-health priority worldwide.

Despite decades of prevention efforts, accurately identifying individuals at imminent risk remains a central challenge. Traditional suicide risk assessments have primarily relied on patients' self-reported suicidal ideation (SI), yet this approach presents several limitations. Many patients do not openly disclose suicidal thoughts in clinical settings [3], and suicidal ideation itself fluctuates markedly over time [4]. Its predictive validity for suicide-related outcomes is limited, only marginally better than chance [5].

In response to the limitations of SI-based risk assessment, recent research has increasingly focused on identifying the acute affective state that precedes and predicts suicidal behavior. The concept of Suicide Crisis Syndrome (SCS) was introduced as an acute, hyperaroused, negative-affect and cognitively dysregulated state predictive of near-term suicidal risk [6]. SCS is characterized by a pervasive sense of entrapment, accompanied by disturbances across four domains: affective disturbance, loss of cognitive control, hyperarousal, and acute social withdrawal. Rather than relying on patients' disclosure of SI, SCS identifies individuals at imminent risk through a cluster of observable symptoms, providing a more observable and dynamic assessment of suicide risk.

Evidence supports both the predictive validity and clinical utility of the SCS. In a prospective inpatient study, patients who met diagnostic criteria for SCS were nearly seven times more likely to attempt suicide within two months after discharge, independent of suicidal ideation and depression [7]. Subsequent validation studies further demonstrated that higher SCS severity prospectively predicted suicidal ideation, preparatory behaviors, and suicide attempts at one-month follow-up [3] and a recent systematic review found that these associations are consistent across studies and stronger than those for suicidal ideation alone [8].

Beyond its predictive validity, SCS has shown important clinical utility. Diagnosis of SCS in the psychiatric emergency department (ED), using the Abbreviated SCS Checklist, was robustly associated with decisions to admit patients to the inpatient services, whereas SI alone was not a significant predictor [9]. Moreover, in a follow-up study, Cohen et al. found that patients diagnosed with SCS upon initial ED visit (over 90% of whom were subsequently admitted to inpatient care) were approximately 70% less likely to be readmitted to the ED within three months compared to those without an SCS diagnosis, even after controlling for SI, self-harm behavior, and psychosis [10]. While this study demonstrates a promising relationship between SCS diagnosis and readmission risk, the mechanism underlying this association remains unclear, as does how inpatient clinical information can be used to identify patients at risk for post-discharge deterioration.

Psychiatric readmission serves as an important indicator of treatment effectiveness and continuity of care, reflecting whether patients' acute crises are sufficiently resolved during hospitalization. The present study, therefore, aims to replicate and extend prior findings in an inpatient sample by examining whether SCS diagnosis and changes in SCS symptoms during hospitalization predict psychiatric readmission. We hypothesized that:

H1: SCS diagnosis at admission would be associated with a lower likelihood of readmission,

H2: Greater improvement in SCS symptoms during hospitalization would predict reduced risk of readmission, and

H3: The relationship between baseline SCS severity and readmission would be explained by symptom improvement. If supported, these findings would provide further validation of SCS as a treatable and clinically meaningful diagnostic entity.

# Method

### Participants

A total of 225 psychiatric inpatients were recruited between March 2023 and May 2025 from four Mount Sinai Health System hospitals in New York City: Mount Sinai Hospital, Mount Sinai West, Mount Sinai Morningside, and the Mount Sinai Behavioral Health Center. Eligible participants were identified within three days of admission through electronic health records (Epic) and confirmed by nursing staff for clinical stability and safety. Patients were then approached and introduced by nursing staff and those who consented were enrolled. Inclusion criteria required that participants be within three days of admission and able to provide informed consent. Exclusion criteria included inability to speak English, cognitive impairment precluding consent, current risk of violent or sexually aggressive behavior, or lack of a permanent mailing address for follow-up. Participants received compensation for their time and effort. Compensation amounts varied by protocol, ranging from $100 to $120, depending on study completion. All study procedures were approved by the Institutional Review Board at the Icahn School of Medicine at Mount Sinai (IRB#23-00911). All procedures performed in this study were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki Declaration and its later amendments.

Of the 225 enrolled participants, 134 had complete data on all variables required for the current analyses and therefore comprised the final sample. The remaining participants were excluded due to missing data. To evaluate potential selection bias, we compared the final sample ($n$ = 134) with the excluded participants on demographic variables and clinical characteristics. Independent-samples t tests and chi-square tests indicated no significant differences between included and excluded participants on age, gender, current psychotic disorder, SCS-C diagnosis, or suicidal ideation. All descriptive statistics, regression models, and mediation analyses reported in this paper were conducted using this final sample ($N$ = 134).

### Measures

The following three measures were administered by trained research assistants. The SCS-C was administered at admission and discharge whereas the other two measures were only administered at admission.

**The Suicide Crisis Syndrome Checklist (SCS-C).**

The SCS-C [11] is a 15-item semi-structured interview assessing diagnostic criteria for SCS. The checklist assesses two overarching diagnostic criteria: Entrapment (Criterion A) and Associated Disturbances (Criterion B). Criterion B comprises four subcriteria: Affective Disturbance (B1), Loss of Cognitive Control (B2), Hyperarousal (B3), and Acute Social Withdrawal (B4). To meet diagnostic criteria for SCS, patients must meet Criterion A as well as have at least one symptom from each of the four subcriteria B1 through B4. Sample items include “feeling trapped with no way out” (Entrapment) and “rapid spikes of negative emotions or extreme mood swings” (Affective Disturbance). Individual items are binary (0 = no, 1 = yes), with higher total scores indicating greater number of symptoms present and a maximum score of 15. The SCS-C has demonstrated strong psychometric properties in the recent validation study among adult psychiatric inpatients [11], showing high internal consistency, interrater reliability, and good evidence of validity, including a clear factor structure and significant associations with concurrent suicidal behaviors. The present study examined three SCS-C scores: (1) a binary diagnosis of SCS at admission, (2) the total number of symptoms rated positive at admission, and (3) the change in total score from admission to discharge. These three variables were evaluated as predictors of psychiatric readmission.

**The Columbia Suicide Severity Rating Scale (C-SSRS)**

The Columbia Suicide Severity Rating Scale [12] is a widely used measure that provides a standardized assessment of suicide risk. The scale consists of two main components: suicidal ideation and suicidal behaviors. The ideation section is rated across five levels of severity: (1) wish to be dead, (2) nonspecific active suicidal thoughts, (3) active suicidal ideation without specific intent, (4) active ideation with some intent, and (5) active ideation with specific plan and intent that had occurred in the past week. The behavior section includes actual suicide attempts, interrupted attempts, aborted attempts, and preparatory acts or behaviors that had occurred in the past week. C-SSRS ratings were used to create two binary variables: suicidal ideation and suicidal behavior (0 = absent, 1 = present). Suicidal ideation reflected the presence of any level of suicidal ideation and suicidal behavior, the presence of any suicide attempt, interrupted attempt, or aborted attempt.

**The Mini International Neuropsychiatric Interview (MINI)**

The Mini International Neuropsychiatric Interview [13] is a brief structured diagnostic interview designed to assess major psychiatric disorders according to DSM-5 and ICD-10 criteria. This study used Module K (Any Psychotic Disorder) from the MINI 7.0 for DSM-5, which assesses delusions (e.g., paranoid, thought insertion, ideas of reference), hallucinations, and other psychotic features. Participants were coded as having a current psychotic disorder if they endorsed any criterion consistent with DSM-5 psychotic disorders (e.g., schizophrenia, schizoaffective disorder, delusional disorder). In the present study, current psychotic disorder, as assessed with the MINI, was coded as a binary variable (0 = no, 1 = yes) and entered as a covariate in the multivariable logistic regression analyses to control for the potential influence of psychosis on readmission outcomes.

**Psychiatric readmission**

Data on psychiatric readmission were extracted from the Mount Sinai Health System's electronic medical record (Epic). Psychiatric readmissions and Comprehensive Psychiatric Emergency Program (CPEP) visits were recorded only if they occurred after participants completed study assessments and were discharged from the hospitalization in which they were enrolled in the study. Readmissions were tracked for up to 18 months post-discharge. The occurrence of either event was classified as a psychiatric readmission and represented as a binary variable (0 = no psychiatric readmission or CPEP visit; 1 = at least one psychiatric readmission or CPEP visit). Psychiatric readmission served as the primary outcome variable in all analyses.

**Covariates**

Several demographic and clinical covariates were included to account for potential confounding effects. Demographic covariates were age and gender. Clinical covariates included current psychotic disorder, past week suicidal ideation, and suicidal behavior as assessed at admission. Including these covariates enabled us to assess the predictive value of SCS independent of established demographic and clinical risk factors for readmission [14-17].

**Data Analysis**

All statistical analyses were conducted using IBM SPSS Statistics (Version 30.0). Univariate logistic regression analyses were first performed to examine associations between demographic variables (age, gender), clinical variables (SCS-C diagnosis, SCS-C score change, past-week suicidal ideation, past-week suicidal behavior, and current psychotic disorder), and psychiatric readmission. These analyses were conducted for descriptive purposes and to identify potential covariates for multivariable modeling. In the univariate analyses, both the binary and continuous forms of the SCS-C variable were examined. The binary SCS-C variable reflected its diagnostic use in clinical practice, whereas the continuous form represented higher symptom presence.

Variables that demonstrated statistical significance in univariate analyses ($p < .05$) would be incorporated as covariates for multivariable models. In addition, suicidal ideation and current psychotic disorder diagnosis were retained in multivariable models as theory-driven covariates, regardless of univariate significance, given prior evidence linking these factors to increased risk of psychiatric rehospitalization [14,16].

Hierarchical logistic regression analyses were conducted to examine whether SCS-C score change predicted psychiatric readmission after controlling for baseline SCS symptom severity and relevant covariates. Covariates identified in the univariate analyses, along with the theory-based variables, were entered in separate blocks. This analytic structure enabled us to evaluate the incremental predictive value of SCS-C score change while minimizing the risk of model overfitting, given the limited number of readmission events ($n = 33$) [18,19]. Logistic regression results are reported as odds ratios (*OR*) with 95% confidence intervals (CIs). All tests were two-tailed, with statistical significance set at $p < .05$.

Next, mediation analyses were conducted using Hayes's PROCESS macro (Model 4) to examine whether SCS-C score change explained the association between baseline SCS-C severity and psychiatric readmission. In this model, both baseline SCS-C severity and SCS-C change were treated as continuous variables using the SCS-C total score, rather than the binary diagnostic indicator used in the logistic regression analyses. This approach preserved variability in symptom severity and allowed us to evaluate whether the magnitude of symptom change was associated with readmission risk [20].

# Result

### Patient Characteristics

A total of 134 participants with complete data were included in the analytic sample. Demographic and clinical characteristics for this sample are presented in Table 1.

The mean SCS-C total score at admission was 8.72 (*SD* = 5.67), and the mean score at discharge was 5.12 (*SD* = 4.45). The mean change in SCS-C total scores (admission − discharge) was 3.60 (*SD* = 5.44, range = −9 to 17), indicating overall improvement in SCS symptoms during hospitalization.

### Univariate Logistic Regression Analyses

Univariate logistic regression analyses were conducted to examine individual associations between each potential predictor and psychiatric readmission (Table 2). SCS-C diagnosis at admission was entered as a *binary variable* (0 = no SCS, 1 = SCS present) to capture diagnostic status, whereas SCS-C score change was treated as a *continuous variable* representing symptom improvement from admission to discharge. Both SCS-C indicators were significantly associated with readmission. Patients meeting diagnostic criteria for SCS at admission (*OR* = 0.227, 95% CI [0.063, 0.810], *p* = .022) and those with greater improvement in SCS-C scores (*OR* = 0.878, 95% CI [0.799, 0.964], *p* = .007) had a lower risk of psychiatric readmission. No other predictors,including age, gender, psychosis, suicidal ideation, or suicidal behaviors, were significantly associated with readmission (all *p* > .05).

### Multivariable Logistic Regression Analyses

Multivariable hierarchical logistic regression analyses were then conducted to determine whether SCS-C score change predicted psychiatric readmission after accounting for baseline symptom severity and theoretically relevant clinical covariates (see Table 3). Although neither variable was significant in the univariate analyses, suicidal ideation and psychotic symptoms were retained in the multivariable models due to their established roles as clinically salient indicators of acute risk and treatment need.

In Model 1, baseline SCS-C total score and SCS-C score change were entered to evaluate whether improvement in SCS symptoms predicted readmission risk after controlling for initial severity. Only SCS-C score change significantly predicted lower odds of readmission. In Model 2, current psychotic disorder was added. SCS-C score change remained a significant predictor, while psychotic disorder was not

significant. In Model 3, suicidal ideation was included. SCS-C score change continued to predict lower risk of readmission, whereas suicidal ideation did not emerge as a significant predictor.

### Mediation Analyses

Mediation analyses were conducted using Hayes's PROCESS macro (Model 4) to test whether improvement in SCS symptoms during hospitalization explained the relationship between baseline SCS severity and psychiatric readmission ($N$ = 130). Baseline SCS-C total score significantly predicted greater improvement in SCS symptoms (a path: $B$ = .652, $SE$ = .061, $p$ < .001, 95% CI [.531, .773]). In turn, improvement in SCS symptoms significantly predicted reduced risk of readmission (b path: $B$ = −.156, $SE$ = .061, $p$ = .010, 95% CI [−.275, −.038]). The indirect effect through SCS-C change was significant ($B$ = −.102, $SE$ = .046, 95% CI [−.201, −.016]), rendering the direct effect of Baseline SCS-C score on readmission non-significant ($p$ = .48), indicating that symptom improvement during hospitalization fully mediated the association between baseline SCS severity and readmission risk (Figure 1).

## Discussion

The present study aimed to replicate and extend prior findings on the association between SCS diagnosis and lowered risk of psychiatric readmission in an inpatient sample and to examine whether changes in SCS symptoms during hospitalization explained this relationship. Consistent with previous evidence, SCS diagnosis at admission was associated with a lower likelihood of readmission, and greater improvement in SCS symptoms predicted reduced readmission risk. Importantly, symptom change remained a significant predictor even after accounting for suicidal ideation, suggesting that changes in SCS symptoms during hospitalization may provide a clinically meaningful indicator of post-discharge risk. Together, these findings provide further validation of SCS as a treatable and clinically meaningful diagnostic entity.

Consistent with the findings of Cohen et al., the present study found that SCS diagnosis at admission was significantly associated with a lower likelihood of psychiatric readmission [10]. Cohen et al. examined emergency department patients using the Abbreviated Suicide Crisis Syndrome Checklist, which assessed five SCS criteria, and reported that patients diagnosed with SCS were approximately 70% less likely to be readmitted within three months, even after controlling for suicidal ideation, self-harm behavior, and psychosis [10]. The current study extended this association to an inpatient population assessed with the full 15-item SCS-C and looking at readmission within 18 months, considering both psychiatric rehospitalizations and Comprehensive Psychiatric Emergency Program (CPEP) visits as indicators of readmission. Despite differences in setting, assessment approach, and follow-up period, both studies demonstrate that SCS functions as a robust clinical marker associated with more favorable post-discharge outcomes.

The present study further identified a potential mechanism underlying this association, as mediation analysis showed that improvement in SCS symptoms during hospitalization fully accounted for the

observed association between baseline SCS severity and readmission, showing that resolution of SCS in high-risk psychiatric inpatients has measurable clinical benefit. This finding provides empirical support for the theoretical model proposed by Galynker, which conceptualizes SCS as a dynamic and reversible syndrome [6]. These results underscore the value of targeting and monitoring SCS symptoms throughout hospitalization, as changes in SCS symptoms may serve as a clinically meaningful indicator of post-discharge risk, and their reduction appears to signal clinical recovery.

The current findings extend prior work validating the SCS as a marker of near-term suicidal risk [6,7,8] by demonstrating that reductions in SCS symptom severity during inpatient treatment are also protective against psychiatric readmission over an 18-month period. Importantly, this effect remained significant in multivariable analyses after accounting for potential clinical confounds, including suicidal ideation, suggesting that SCS change represents a meaningful indicator of readmission risk independent of suicidal ideation. Taken together, this growing body of evidence supports SCS as a clinically meaningful and highly treatable entity that can guide both acute risk assessment and ongoing inpatient care.

The present findings suggest that SCS reflects a dynamic and treatable clinical state rather than a fixed trait. Likewise, the results demonstrate that SCS shows clinical utility both when scored categorically,as a diagnostic indicator of acute crisis, and when measured dimensionally, as a continuous index of symptom severity. This dual utility supports SCS as a flexible and clinically meaningful indicator for assessing crisis resolution and post-discharge risk, with potential to guide inpatient assessment and treatment.

# Limitations

This study has several limitations. The sample size was relatively small and limited to a single hospital system in New York City, although it included multiple inpatient sites across Manhattan. Additionally, some patients classified as not readmitted may have been hospitalized elsewhere, which was not captured in this dataset. The SCS-C is a newly developed clinician-rated measure, and to date only one validation study has been published [11].

Nonetheless, within the context of these limitations, the present study provides important new information on SCS. To our knowledge, it is the first to demonstrate that reductions in SCS symptoms during inpatient treatment predict lower risk of psychiatric readmission over an 18-month follow-up period. Strengths of this study include its use of a real-world inpatient sample, multiple clinical sites, and its prospective design. Together, these findings strengthen the empirical foundation for the SCS as a clinically significant and treatable syndrome.

## Abbreviations

SCS: Suicide Crisis Syndrome

SCS-C: Suicide Crisis Syndrome Checklist

SI: Suicidal Ideation

SB: Suicidal Behavior

CPEP: Comprehensive Psychiatric Emergency Program

C-SSRS: Columbia-Suicide Severity Rating Scale

MINI: Mini International Neuropsychiatric Interview

ED: Emergency Department

# Declarations

### Ethics approval and consent to participate

This study was reviewed and approved by the Icahn School of Medicine at Mount Sinai Institutional Review Board (IRB#23-00911). All participants provided written informed consent prior to participation.

### Consent for publication

Not applicable.

### Availability of data and materials

The data that support the findings of this study are not publicly available due to privacy and ethical restrictions.

### Competing interests

The authors declare no known conflicts of interest.


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### Authors' contributions

Conceptualization: S.C., L.J.C., B.D.P.

Data curation: S.C.

Formal analysis: S.C.

Funding acquisition: I.G.

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Project administration: S.C., L.J.C.

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Supervision: L.J.C., I.G.

Validation: L.J.C.

Visualization: S.C.

Writing – original draft: S.C.

Writing – review & editing: S.C., L.J.C., B.D.P., E.W., I.G.

Author contributions are reported using the CRediT (Contributor Roles Taxonomy) system. All authors have read and agreed to the published version of the manuscript.

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# Tables

**Table 1** *Demographic and clinical Characteristics of the Participants*

| Sample Characteristics | *n* | % |
|---|---|---|
| Age (*M*, *SD*) | 31.20 | 12.31 |
| Gender | | |
| Male | 53 | 39.6 |
| Female | 68 | 50.7 |
| Other | 13 | 9.7 |
| Race | | |
| White | 52 | 38.8 |
| Black | 30 | 22.4 |
| Native American | 5 | 3.7 |
| Asian | 15 | 11.2 |
| Pacific islander or Native Hawaiian | 1 | 0.7 |
| Two or more races | 12 | 9.0 |
| Other | 15 | 11.2 |
| Psychotic disorder | | |
| Yes | 28 | 20.9 |
| No | 106 | 79.1 |
| Suicidal ideation | 2.66 | 1.9 |
| Suicidal behavior | | |
| Any attempt | 57 | 42.5 |
| No attempt | 77 | 57.5 |
| SCS diagnosis (binary) | | |
| SCS positive | 49 | 36.6 |
| SCS negative | 85 | 63.4 |
| SCS score change | 3.60 | 5.44 |

Note. Percentages are based on valid data. Range for age was 18-75.

**Table 2** *Univariate Logistic Regressions Analyses of Psychiatric Readmission, with sample characteristics (n, %)*

| Variable | Readmitted | | Not Readmitted | | 95% C.I. for EXP(B) | | | |
|---|---|---|---|---|---|---|---|---|
| | *n* | % | *n* | % | *OR* | Lower | Upper | *p* |
| Age(*M, SD*) | 28.18(10.51) | | 31.79(12.59) | | .971 | .928 | 1.017 | .214 |
| Gender Identity | | | | | | | | |
| Male(ref.) | 10 | 18.9 | 43 | 81.1 | | | | |
| Female | 11 | 16.2 | 57 | 83.8 | .830 | .323 | 2.132 | .698 |
| Other | 1 | 7.7 | 12 | 92.3 | .358 | .042 | 3.085 | .350 |
| SCS-C Diagnosis | | | | | | | | |
| SCS Negative(ref.) | 19 | 22.4 | 66 | 77.6 | | | | |
| SCS Positive | 3 | 6.1 | 46 | 93.9 | .227 | .063 | .810 | **.022** |
| SCS Total Score | 9.01(5.77) | | 7.27(5.03) | | 0.946 | 0.871 | 1.028 | .191 |
| SCS Score Change | 0.64(5.14) | | 4.19(5.32) | | .878 | .799 | .964 | **.007** |
| Psychotic Disorder | | | | | | | | |
| No(ref.) | 18 | 17.0 | 88 | 83.0 | | | | |
| Yes | 4 | 14.3 | 24 | 85.7 | 0.815 | 0.252 | 2.635 | .732 |
| Suicidal Ideation | 2.45(1.85) | | 2.70(1.96) | | .935 | .737 | 1.186 | .581 |
| Suicidal Behavior | | | | | | | | |
| Any Attempt(ref.) | 10 | 17.5 | 47 | 82.5 | | | | |
| No Attempt | 12 | 15.6 | 65 | 84.4 | 1.152 | .460 | 2.890 | .762 |

**Table 3** *Hierarchical Multivariable Logistic Regression Predicting Psychiatric Readmission*

| Variable | | 95% C.I. for EXP(*B*) | | |
|---|---|---|---|---|
| | *AOR* | Lower | Upper | *p* |
| Model 1 | | | | |
| SCS-C Score | 1.031 | .925 | 1.149 | .581 |
| SCS-C Score Change | .861 | .765 | .969 | **.013** |
| Model 2 | | | | |
| SCS-C Score | 1.032 | .925 | 1.152 | .574 |
| SCS-C Score Change | .861 | .765 | .969 | **.013** |
| Psychotic Disorder | .929 | .270 | 3.194 | .907 |
| Model 3 | | | | |
| SCS-C Score | 1.038 | .928 | 1.161 | .510 |
| SCS-C Score Change | .859 | .763 | .967 | **.012** |
| Psychotic Disorder | .888 | .256 | 3.083 | .851 |
| Suicidal Ideation | .936 | .727 | 1.204 | .605 |

# Figures

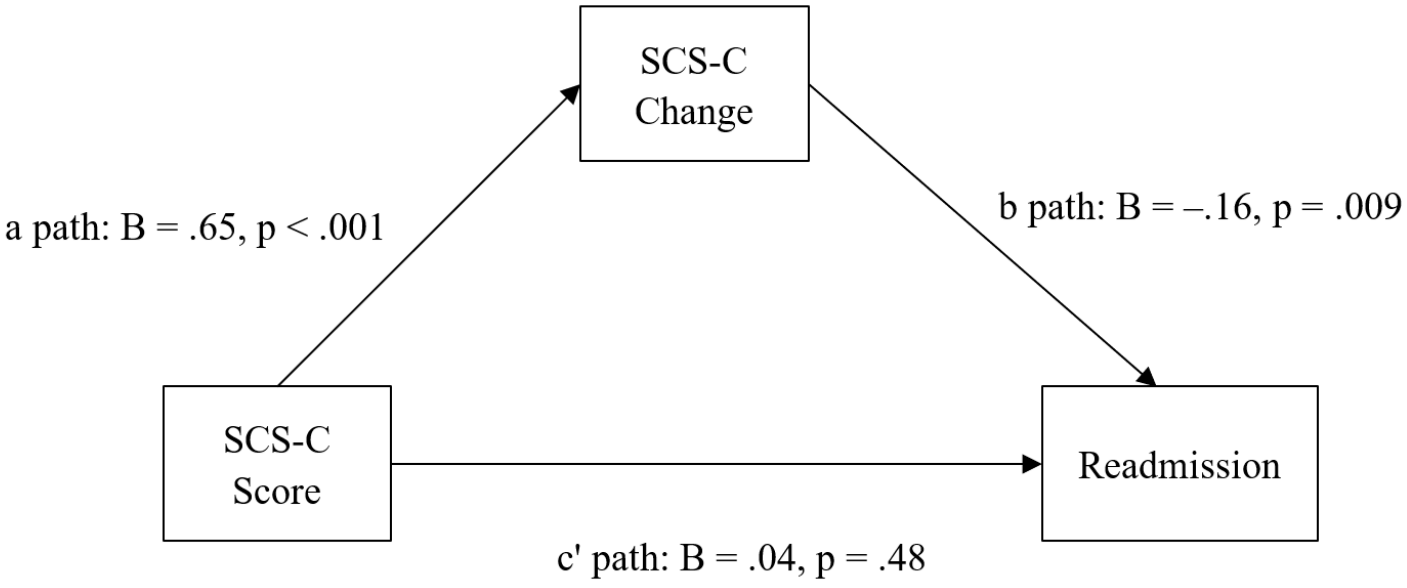



**Figure 1**

*A simple mediation model in path diagram form*